Minnesota Department of Human Services
Mental Health Division

Three - Year Plan for Services for Persons With Mental Illness

Revised
September 1989

DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH DIVISION
THREE-YEAR PLAN FOR SERVICES
FOR PERSONS WITH MENTAL ILLNESS

Prepared by Staff of the Mental Health Division
September 1989

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DEPARTMENT OF HUMAN SERVICES

MENTAL HEALTH DIVISION

THREE-YEAR PLAN FOR SERVICES FOR PERSONS WITH MENTAL ILLNESS

TABLE OF CONTENTS

GLOSSARY

Active Psychiatric Treatment. The federal Health Care Financing Administration (HCFA) defines as having five phases: (1) pre-admission assessment; (2) assessment and diagnosis; (3) treatment goal setting; (4) treatment interventions and re-evaluation; (5) discharge and aftercare planning. Each phase, under the direction of a psychiatrist, is multidisciplinary.

Alcohol, Drug Abuse, Mental Health Block Grant (ADM). A block grant of federal funds to states. 25% of Minnesota's grant is dedicated to mental health programs for American Indians; 15% for planning and evaluation; 5% for administration; and the remaining 55% for special projects for children, elderly persons, homeless persons, and others.

Case Management Services: The Comprehensive Mental Health Act (Minnesota Statutes, section 245.462, subdivision 3), as amended in 1988, defines case management services for persons with mental illness as "activities that are coordinated with the community support services program...and are designed to help people with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management services include developing an individual community support plan, referring the person to needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Child and Adolescent Service System Program (CASSP). A technical assistance program for states, sponsored by NIMH, to develop systems of coordination for services for children with emotional disturbance.

Child With Severe Emotional Disturbance (SED). For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or
(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or
(3) the child has one of the following as determined by a mental health professional:
    (i) psychosis or a clinical depression; or
    (ii) risk of harming self or others as a result of an emotional disturbance; or
    (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or
(4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Community Mental Health Center (CMHC). A community based outpatient clinic specializing in outpatient, medical, community support, and other services for persons with mental illness.

Community Social Services Act (CSSA). Legislation (M.S. 256E) passed in 1979 which shifted the responsibility for planning and implementing human service programs from the state level to the local level. CSSA is a block grant replacing a variety of categorical funds dedicated to specific health and social purposes. CSSA funds incorporate federal Title XX funds ($45 million annually) state dollars ($50 million annually) and county tax dollars ($200 million annually). An average of twenty percent of CSSA funds, approximately $60 million in F.Y. 1988, goes toward mental health services.

Community Support Services Program (CSP). Programs offering community support to persons with mental illness originally encouraged by the National Institute of Mental Health. (In Minnesota Comprehensive Mental Health Act, Minnesota Statutes, section 245.462, subdivision 6.) A "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the clinical supervision of a mental health professional designed to help people with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,
(2) medication management
(3) assistance in independent living skills,
(4) development of employability and supportive work opportunities,
(5) crisis assistance,
(6) psychosocial rehabilitation,
(7) help in applying for government benefits, and
(8) the development, identification, and monitoring of living arrangements.

The county is responsible for coordinating the activities of community support services and case managers.

Continuum of Care. The availability to clients in a geographic area of a comprehensive array of preventive, emergency, diagnostic, treatment, and rehabilitative mental health services which offer varied amounts of support and care depending on the individual client's needs.

DHS. Minnesota Department of Human Services

DJT. Minnesota Department of Jobs and Training.

DRS. Division of Rehabilitation Services of the Minnesota Department of Jobs and Training.

Diagnostic Assessment. For adults, "diagnostic assessment" means a written summary of the history, diagnosis, strengths, vulnerabilities, and general service needs of an adult with a mental illness using diagnostic, interview, and other relevant mental health techniques provided by a mental health professional used in developing an individual treatment plan or individual community support plan.

DSM-MD - Diagnostic and Statistical Manual of Mental Disorders. Along with the ICD-9-CM, a manual used to assist clinicians in the diagnosis of mental illness and emotional disturbance. Periodically revised by the American Psychiatric Association.

EPSDT - Early and Periodic Screening, Diagnosis, and Treatment. A program for Medical Assistance eligible children. A mental health screen will be developed to assist in the early intervention of emotional disturbances.

ED - Emotionally Disturbed. An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the ICD-9-CM or the DSM-MD, and seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

GA - General Assistance. A state and county income program to low income persons who do not quality for any federal programs. Individual General Assistance recipients receive payments of $209 monthly.

GAMC - General Assistance Medical Care. Health coverage for low income persons not eligible for other health care programs; supported from state and county funds.

Health and Human Services. U.S. Department of Health and Human Services.

HMO - Health Maintenance Organization. An organization providing comprehensive health care to enrollees on a fixed and prepaid basis, without regard to the frequency or extent of services.

HRD - Human Resource Development. A broad complex set of activities directed towards increasing the numbers and effectiveness of the work force engaged in the provision of mental health services. HRD involves planning and evaluation, education and training, work force management, and sanctions and regulations.

HUD - Housing and Urban Development. Federal agency.

Individual Community Support Plan.

(a) The case manager must develop an individual community support plan for each adult that incorporates the client's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual community support plan. The individual community support plan must be developed within 30 days of client intake and reviewed every 90 days after it is developed. The case manager is responsible for developing the individual community support plan based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual community support plan. To the extent possible, the adult with serious and persistent mental illness, the person's family, advocates, service providers and significant others must be involved in all phases of development and implementation of the individual or family community support plan.

(b) The client's individual community support plan must state:

(1) the goals of each services;
(2) the activities for accomplishing each goal;
(3) a schedule for each activity; and
(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual community support plan.

Individual Family Community Support Plan. For children, "individual family community support plan" means a written plan developed by a case manager in conjunction with the family and the child with severe emotional disturbance on the basis of a

diagnostic assessment and a functional assessment. The plan identifies specific services needed by a child and the child's family to:

(1) treat the symptoms and dysfunctions determined in the diagnostic assessment;
(2) relieve conditions leading to emotional disturbance and improve the personal well-being of the child;
(3) improve family functioning;
(4) enhance daily living skills;
(5) improve functioning in education and recreation settings;
(6) improve interpersonal and family relationships;
(7) enhance vocational development; and
(8) assist in obtaining transportation, housing, health services and employment.

Individual Treatment Plan. A written plan of intervention, treatment, and services for a person with mental illness, or a child with emotional disturbance, that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsibility for providing treatment to the person with mental illness, or child with emotional disturbance.

IMDs - Institutions for Mental Diseases. Federally defined facilities which provide diagnosis, treatment or care to more than 16 persons who have mental illness. Persons between the ages of 22 and 64 who reside in IMDs do not quality for Medicaid coverage for services. IMDs can include hospitals, nursing homes and Rule 36 facilities.

ICD-9-CM - International Classification of Diseases. See DSM-MD.

Medical Assistance. (Also known as Medicaid, MA or Title XIX). A matched federal, state, county program of medical insurance for persons receiving AFDC, SSI or meeting income eligibility guidelines.

Medicare. Federal health insurance for elderly and certain disabled persons (Title XVIII of the Social Security Act).

Mental Health Practitioner. By Minnesota Statute, a mental health practitioner is a person providing services to persons with mental illness who is qualified to provide services to persons with mental illness in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and has at least 2,000 hours of supervised experience in the delivery of services to persons with mental illness;
(2) has at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness;
(3) is a graduate student in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness;
(4) holds a master's or other graduate degree in one of the behavioral fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness.

Mental Health Practitioner For Children. For children, a "mental health practitioner" means a person providing services to children with emotional disturbance. A mental health practitioner must have training and experience in working with children. A mental health practitioner must be qualified in at least one of the following ways:

(1) hold a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and has at least 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances;
(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances;
(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or
(4) hold a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of emotional disturbance.

Mental Health Professional. By Minnesota Statute, a mental health professional is a person qualified to provide clinical services in the treatment of mental illness in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under M.S. 148.171 to M.S. 148.285 and who is certified as a clinical specialist by the American Nurses Association;
(2) in clinical social work: a person licensed as an independent clinical social worker under Minnesota law (section 148B.21, subdivision 6) or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of past master's supervised experience in the delivery of clinical services in the treatment of mental illness;
(3) in psychology: a psychologist licensed under Minnesota law (sections 148.88 to 148.98) who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;
(4) in psychiatry: a physician licensed under Minnesota law (Chapter 147) and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry; or
(5) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post master's supervised experience in the delivery of clinical services in the treatment of mental illness.

For children, a "mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under M.S. 148.171 to 148.285 and who is certified as a clinical specialist in psychiatric or mental health nursing by the American Nurses Association;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under M.S. 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;
(3) in psychology, the mental health professional must be a psychologist licensed under M.S. 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;
(4) in psychiatry, the mental health professional must be a physician licensed under Chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry; or
(5) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

MHD - Mental Health Division. Mental Health Division, Minnesota Department of Human Services.

Mental Illness. (A) An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work and recreation.

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

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

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;
(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;
(3) the adult:
    (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;
    (ii) indicates a significant impairment in functioning; and
    (iii) has a written opinion from a mental health professional stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless an ongoing community support services program is provided; or
(4) the adult has been committed by a court as a mentally ill person under Chapter 253B, or the adult's commitment has been stayed or continued.

MN. State of Minnesota.

Mental Retardation. Significantly subaverage general intellectual functioning (an IQ of 70 or below) with onset before the age of 18. Mental retardation may result in deficits or impairments in adaptive behavior.

MHFA. Minnesota Housing Finance Agency.

M.S. Minnesota Statutes.

MSA - Minnesota Supplemental Aid. Payments to supplement SSI funds for low income elderly and disabled persons, supported from state and county funds. Ordinarily these payments go to facilities to support residents rather than to the residents themselves.

NIMH - National Institute of Mental Health.

Nursing Home. Facilities licensed to serve persons who require continuing nursing care as well as personal care and supervision. Nursing homes are licensed by the Minnesota Department of Health.

PAS/ACG - Pre-Admission Screening/Alternative Care Grants Program and CADI - Community Alternatives for Disabled Individuals. Statewide programs designed to prevent premature or unnecessary institutionalization by screening nursing home applicants to determine if nursing home placement is necessary or desirable. ACG is the program which provides funds for alternative community care for persons aged 65 and older. CADI is the funding program for disabled persons under age 65.

PASARR - Pre-Admission Screening, Annual Resident Review. A federally mandated program designed to prevent inappropriate nursing home admission for persons who have a mental illness.
The program went into effect in January, 1989. By April 1, 1990, states are to have reviewed all persons residing in nursing homes who have a mental illness. States must also conduct an annual resident review of all such persons.

RTCs - Regional Treatment Centers. Formerly known as state hospitals, six of Minnesota's RTCs, at Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter and Willmar, serve persons with mental illness. The Minnesota Security Hospital at St. Peter has a capacity of 236 beds for patients judged mentally ill and dangerous. Regional treatment center inpatient services means the medical, nursing, or psychosocial services provided in an RTC operated by the state.

Residential Treatment. Residential treatment means a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center, that must be licensed as a residential treatment facility for persons with mental illness. See Rule 36 and also Rule 5.

RFP - Request for Proposal. A document that is distributed by a funding agency to request proposals to receive such funds.

RIAD - Refugee Immigration Assistance Division. Refugee Immigration Assistance Division, Minnesota Department of Human Services.

Rule 5. Minnesota state licensing rule establishing the requirements of residential programs for children and youth who are emotionally disturbed and/or behaviorally disordered. Forty-one residential treatment facilities were licensed under Rule 5 in April 1987.

Rule 12. Minnesota funding mechanism which supports Rule 36 residential treatment facilities.

Rule 14. Minnesota funding mechanism for community support programs for persons with mentally illness.

Rule 29. Minnesota's voluntary certification of mental health clinics and centers for third party reimbursement. These programs must have a multi-disciplinary staff, a staff of at least four persons, and regular service of a psychiatrist and psychologist.

Rule 36. First promulgated in 1974, Minnesota's Rule 36 sets licensing standards for residential programs for mentally ill adults. It ensures that, in addition to providing residents with room and board, facilities will offer appropriate programmatic services aimed at maximizing a resident's ability to function independently.

Section 8 Lower-Income Rental Program. A housing assistance program, administered by the U.S. Department of Housing and Urban Development, under which eligible families, handicapped and elderly persons pay no more than 30% of their income toward rent. The Section 8 Existing Housing Program, administered by the local housing authority, gives eligible tenants "Section 8 Certificates" for rental subsidy. When the tenant finds a suitable dwelling, the local housing authority contracts with the landlord to pay the rental subsidy.

Serious and Persistent Mental Illness. (See "Mental Illness".)

SSDI - Social Security Disability Income. A federal social security program for persons with disabilities who have worked a certain time in the past. Monthly payments vary according to the length of time worked and the person's income level during employment. Persons qualify if they have:

> Mental illness resulting in marked constriction of activities and interests, deterioration in personal habits or work-related situations, and seriously impaired ability to get along with other people.

SSDI recipients ordinarily qualify for either Medicare or Medicaid.

SMHAC - State Mental Health Advisory Council. Minnesota's 30-member state level advisory body, as required by the Comprehensive Mental Health Act and P.L. 99-660.

SMHRCY - State Mental Health Representatives for Children and Youth.

SSI - Supplemental Security Income. A federal program for persons with demonstrated disabilities which prevent productive work. SSI recipients usually qualify for Medical Assistance. Individual recipients currently receive payments of $369 monthly. SSI, in contrast to SSDI, is for individuals who have not worked extensively before the onset of their disability.

TEFRA 134 - (Tax Equity and Fiscal Responsibility Act of 1982). A provision of TEFRA allows states to consider only the child's assets (rather than the child and family's) in determining the child's eligibility for Medical Assistance (MA). The child must meet federal disability criteria and must be at risk of institutionalization to quality under the TEFRA option.

Title XIX. Medicaid.

Title XX. Federal Social Service funds passed through to county by state for use for low income persons and persons with handicaps.

*With thanks to the League of Women Voters of Minnesota for the development of parts of this section. From Mental Health System Monitoring Workbook, copyright League of Women Voters of Minnesota.

Chapter I Executive Summary

This document is an update and revision of Minnesota's January 1989 Three-Year Plan for Services for Persons with Mental Illness. Because of substantial new developments at the federal, state, and local levels, this document does not focus on information provided in the January 1989 Plan. Rather, the contents of this document continue to have a future orientation in: 1) describing the major issues facing the development of a community-based system of services for persons with mental illness or emotional disturbance; and 2) developing goals, objectives, and measurable tasks to address those issues.

The first part of this Executive Summary mirrors the format of the Plan itself, for readability purposes. Part II of the Executive Summary contains material required by the National Institute of Mental Health in its June 26, 1989 transmittal to state mental health program directors.

PART I

Chapter II - Introduction

The recent history of Minnesota's mental health system is highlighted with the release of three critical reports: 1) Mandate for Action, by a Commission appointed by Governor Perpich; 2) Deinstitutionalization of Mentally Ill Persons, by the Minnesota Legislative Audit Commission; and 3) nationwide rankings of state mental health systems by the Public Health Interest Research Group (the so-called Torrey Reports).

This Chapter also provides an overview of the planning process in Minnesota, and highlights the roles of the State Advisory Council on Mental Health (Minnesota's P.L. 99-660 planning body), the Mental Health Division of the Department of Human Services (DHS), other DHS Divisions, the Legislature, the Governor, and interested parties.

Chapter III - Mission, Goals, and Objectives

Along with mission statements established in Minnesota Statutes for adults with mental illness and children with emotional disturbance, the Chapter outlines nine major goals and related objectives for the Mental Health Division. These goals and objectives range from the provision of statewide leadership, to the successful implementation of quality services, to the empowerment of consumers and families and the battling of stigma. The objectives are then repeated throughout the remainder of the Plan where appropriate, along with specific tasks.

Chapter IV - Mental Health Services for Children

Along with an overview of the recent history of efforts related to the establishment of children's mental health services, this Chapter reviews the planning process leading up to the development of legislation for the 1989 session, and the results of that legislative initiative. The Chapter also summarizes eight children's pilot projects currently being funded by the ADM Block Grant and state funds. Finally, objectives and tasks highlight the importance Minnesota attaches to coordination among systems in the development and implementation of services to meet the needs of children with emotional disturbance.

Chapter V - Mental Health Services for Adults

This chapter addresses nine priority issues in the implementation of the Comprehensive Adult Mental Health Act:

1. Case management
2. Community support services

3. Employability services
4. Institutions for Mental Diseases (IMDs)
5. Housing
6. Federal Nursing Home Reform Act (or OBRA)
7. Rule 36 & reconfiguration of licensed residential programs
8. State health facility system (Regional Treatment Centers)
9. Information systems development

Each issue discussion includes background, current issues, and tasks designed to move toward resolution of the identified issues.

Chapter VI - Special Initiatives

The overall goal for the Mental Health Division's special projects is to utilize special projects as appropriate to promote the development of a unified service delivery system for children and adults which incorporates the culturally, chronologically, and geographically diverse mental health needs of Minnesotans through integration into the mental health system and development of appropriate special programs.

Discussions of the following projects are subsequently included:

1. Mental health services for American Indians
2. Mental health services for refugees
3. Services for homeless persons with mental illness
4. Rural mental health services
5. Mental health services for older adults
6. Mental health services for compulsive gamblers

After objectives and tasks for these projects are listed, there are brief discussions of the Division's anti-stigma and consumer/family empowerment efforts. These discussions have their own objectives and tasks.

Chapter VII - Human Resource Development Issues

This chapter discusses the need on the part of the mental health system to enhance its capacity to train and hire mental health professionals for service in all areas of the state and to all persons in need.

Tasks include establishing linkages with educational institutions and mental health services agencies; developing a distinct Human Resource Development (HRD) plan; and establishing a data base to assist in HRD planning efforts. Successful application to NIMH for a HRD capacity building grant is central to the MHD's success with these efforts.

Chapter VIII - Mental Health Funding

This chapter highlights new funding appropriated by the 1989 Legislature ($15.8 million total for the 1990-91 biennium). It also reviews upcoming funding studies that were required by the Legislature. Many of these studies pertain to the improved coordination of existing funding sources. A more complete overview of this Chapter appears later in this Executive Summary.

Chapter IX - Services to Protect Client Rights

This chapter provides a brief update on the responsibilities of Minnesota's statutory protector of client rights, the Ombudsman for Mental Health and Mental Retardation.

Chapter X - Inter/Intradepartmental Coordination

This chapter reviews the MHD's efforts to coordinate with other state agencies, and other Divisions of DHS, to implement the Comprehensive Mental Health Act.

PART II

A summary of the MHD's efforts to meet the P.L. 99-660 compliance criteria are listed below:

1. The State Plan shall provide for the establishment and implementation of an organized and comprehensive community-based system of care for severely mentally ill individuals. (Minnesota uses the term "persons with serious and persistent mental illness".)

   This is clearly central to Minnesota's efforts. The mission statements at the beginning of Chapter III of the Plan are statutory and are the basis for the goals and objectives that follow. They require the Commissioner of the Department of Human Services to implement unified, accountable, and comprehensive mental health service systems for adults and children.

   Issues pertaining to the establishment of community-based services are discussed in Chapters IV (for children), V (for adults), and VI (special initiatives).

2. The State Plan shall contain quantitative targets to be achieved in the implementation of such a system, including numbers of severely mentally ill individuals residing in the areas to be served under such a system.

   Appendix A provides tables of projected costs and utilization of specific services in each of Minnesota's 87 counties. The narrative describes how these data are used in implementing services. Essentially, Minnesota uses a combination of incidence and historical data, by county and service, as a screen to identify counties or providers that may be in need of technical assistance in implementing services. These data are submitted to the MHD with biennial county plans.

3. The State Plan shall address how severely mentally ill persons will gain access to treatment, prevention, and rehabilitation services at the community level.

   The Comprehensive Mental Health Act identifies the needs of adults with serious and persistent mental illness and children with severe emotional disturbance as the highest priorities in the receipt of services. Case management and community support services are central to the individual's ability to gain access to services. Current issues in the implementation of these services for adults are discussed in Chapter V.

4. The State Plan shall address how rehabilitation services, employment services, housing services, medical and dental care, and other support services will be provided to severely mentally ill persons to enable them to function outside of inpatient institutions to the maximum extent of their capabilities.

   Vocational services are provided by the Division of Rehabilitation Services of the Minnesota Department of Jobs and Training. Recent state legislation created additional funding for housing programs under the Minnesota Housing Finance Agency. The MHD provides clinical and program expertise in coordinating with these entities on a regular basis to provide such services. Additional discussion is found in Chapter V.

   Health and dental care is arranged for by each individual's case manager, as necessary and appropriate. Additionally, Minnesota's residential program rule (Rule 36) requires medical examinations prior to admission to a residential program.

5. The State Plan shall provide for activities to reduce the rate of hospitalization of severely mentally ill individuals.

   In addition to Minnesota's efforts to implement community-based services as alternatives to hospitalization (including case management and community support services), the Department of Human Services is nearing completion on a clinical survey of the existing regional treatment center patient population. The results of this survey will be used in the planning of additional community-based services for this clientele. The effort is discussed under the heading State Regional Treatment Centers in Chapter V.

6. Case management services shall be designed for each severely mentally ill individual in the State who receives substantial amounts of public funds or services, and these services will be phased in over the period of fiscal year 1989 through fiscal year 1992.

   Implementation of Minnesota's case management system began on January 1, 1989. Issues that have arisen in the brief period of time since implementation, including case management reimbursement rates, the role of the case manager, and county administrative issues, are discussed in Chapter V.

7. The State Plan shall provide for the establishment and implementation of a program of outreach to, and services for, severely mentally ill individuals who are homeless.

   Minnesota's services for homeless persons are described in Chapter VI. Eight demonstration projects, including three in metropolitan areas, are discussed. Future plans include analysis of the needs of homeless veterans and youths.

8. In developing the State Plan, the State shall consult with representatives of employees of State institutions and public and private nursing homes who care for severely mentally ill individuals.

   The majority of Minnesota's efforts in this regard were directed at a comprehensive negotiations process, led by the Commissioner of Human Services, to determine the future role of the regional treatment center (RTC) system. These negotiations occurred over a span of nine months, involved over 40 participants (including representatives of all of the major employee unions), and resulted in a major proposal that was submitted to the 1989 session of the Legislature. Employee unions negotiated and signed a Memorandum of Understanding which addressed their long-term employment and job security concerns. Plans for the RTC system which developed from the negotiations and the legislation are discussed in Chapter V.

   Employee representatives were also provided with opportunities to comment on drafts of the State Plan.

Human Resource Development (HRD)

Historically, Minnesota has not had the capacity to make the development of mental health work force issues a priority. However, with the passage of the adult and child Comprehensive Mental Health Acts in the 1987 and 1989 legislative sessions, major new legislation calling for new planning and resources for the state's RTC system, and ongoing access issues for certain geographic areas and population groups, Minnesota is at a critical point in developing its human resource development (HRD) capacity.

Along with an application for funding to the NIMH for resources to strengthen Minnesota's HRD capacity, the following objectives are part of the MHD's workplan:

1. develop appropriate planning linkages with academic institutions, mental health service agencies, and other related agencies in order to encourage research into mental illness and effective treatment modalities, and promote appropriate training of the state mental health work force;

2. begin to develop a separate and distinct State HRD Plan to include as part of the MHD's State Mental Health Services Plan; and

3. implement a minimum HRD data set which interfaces systematically with the organizational and client data sets.

Mental Health Funding

In addition to new appropriations of $15.8 million over the next two years for community-based mental health services, the 1989 Legislature also made a policy commitment and provided initial funding to plan for the development of small, state-operated community programs for persons with mental illness as an alternative to long-term residence in regional treatment centers.

Minnesota's primary funding strategy for the immediate future, as reflected in a number of studies required by the 1989 Legislature, is to investigate and plan for measures to standardize and consolidate existing funding mechanisms and reporting. Concerns have been expressed that mental health funding and reporting is currently too fragmented and uncoordinated.

Related to this strategy is the continued development of mechanisms to enable new and existing mental health services to become eligible for Medical Assistance (MA) reimbursement. Finally, the State Advisory Council on Mental Health (Minnesota's P.L. 99-660 planning body) is playing a lead role in the investigation of issues and problems of access and reimbursement for services by private, third-party payers.

Membership and Affiliation of State Advisory Council on Mental Health

The State Advisory Council on Mental Health is Minnesota's P.L. 99-660 planning body. As such, it serves as the principle resource for public input into the state's mental health system.

Historically, the Council - created in Minnesota statute in 1987 along with a Children's Subcommittee created in 1988 - has not met for the purpose of assembling Minnesota's State Plan. Rather, it has chosen to comprehensively address the issues facing the state in the implementation of community-based services, making recommendations that are then considered in the development of the State Plan. Of the issues discussed in the this draft, only one - information systems development as discussed in Chapter V - has not received the recent attention of the Council or Children's Subcommittee.

In addition, the Council has heard presentations from four of the MHD's special projects: for refugees, rural residents, homeless persons, and American Indians. Council members served on the negotiations team for the future role of the regional treatment centers (RTCs), and have been appointed to committees addressing RTC planning, revisions to Rule 36, human resource development, and case management implementation.

Finally, the Council and Children's Subcommittee reviewed an initial draft of the State Plan, both individually and in a special three-hour meeting. Their comments were incorporated in the drafting of the final copy of the State Plan.

Members of the Advisory Council, with affiliations, are:

Norma Schleppegrell, Chair
Provider

Monte Aaker
Minnesota Housing Finance Agency - state agency representative of housing

*Howard Agee
Alliance for the Mentally Ill of Minnesota

Barbara Amram
Social worker representative - provider

Lee Beecher, M.D.
Psychiatrist representative - provider

*Linda Berglin
State Senator

*Craig Brooks
County social services administrator (rural)

Jere Chapman
Provider

*William Conley
Mental Health Association of Minnesota

Miller Friesen
Provider

Peter Glick
Provider

Ron Hook
DHS Title XIX program representative

Jim House
Division of Rehabilitation Services, Minnesota Department of Jobs and Training - state agency representative of vocational rehabilitation

Barbara Kaufman
DHS Assistant Commissioner of Mental Health - state agency representative of mental health and social services

*Patricia Lamppa
Consumer

*Susan Lentz
Minnesota Association of Mental Health Residential Facilities
Minnesota Psychologists in Private Practice

*Paul McCarron
County Commissioner (urban)

*Ruth Myers
American Indian representative

*David Nass
Parent

Jo Rohady
Psychiatric Nurse representative - provider

*Robert Roufs
County Commissioner (rural)

*Gloria Segal
State Representative

*Patricia Siebert
Minnesota Mental Health Law Project

*Sharon Silkwood
Parent

Zigfrids Stelmachers
Psychologist representative - provider

*Michael Weber
County social services administrator (urban)

Currently in the gubernatorial appointments process:

+ two consumers (one vacancy, one new position)
+ one state agency representative of education
+ one state agency representative of corrections

* = non-state employees or providers (16 of 30 members)

Chapter II Introduction

The recent history of Minnesota's mental health system has been marked by critical evaluation from a number of independent bodies, and by major corrective action by the Minnesota Legislature. This history dates back to June of 1985, when Governor Rudy Perpich announced the formation of a Mental Health Commission to examine the state of Minnesota's system of services.

The Governor's Commission released its report, Mandate for Action, in early 1986, concluding that "the system of mental health services is, to a significant extent, divided, inconsistent, uncoordinated, undirected, unaccountable, and without a unified direction."

Mandate for Action was quickly followed by critical reports from the Minnesota Legislative Auditor's Office and the Washington, D.C. based Public Health Interest Research Group. The latter report ranked Minnesota's system 37th among the states, while the chief finding of the former was that significant numbers of persons were released from regional treatment centers without adequate discharge plans or follow-up care.

Finally, in the summer of 1986, ten statewide hearings were held with Governor Perpich and the Commissioner of Human Services to give the public an opportunity to express to the Governor and Commissioner their concerns about Minnesota's mental health system. All of the critical evaluation led the 1987 Legislature to pass the Comprehensive Mental Health Act, which called upon the Commissioner of Human Services to create a system of services in all counties of the state for persons with mental illness.

During the 1987 Legislative session, it was agreed that the needs of children with emotional disturbance would be the focus of attention in the following (1988-89) biennium. As a result, the 1988 Legislature passed a mission statement which called for the Minnesota Department of Human Services (DHS) to submit a proposal for a statewide, comprehensive, coordinated system of mental health services for children. This system of care was then planned for under the coordinated efforts of DHS, the Children's Subcommittee of the State Advisory Council on Mental Health (successor to the Governor's Commission mentioned above), and other state departments and agencies.

A major part of this effort were public hearings conducted by the Children's Subcommittee of the State Advisory Council. These hearings and a survey of county social services directors was followed by passage of the Comprehensive Children's Mental Health Act in the spring of 1989.

When the 1987 Legislature made permanent the Governor's Mental Health Commission by creating the State Advisory Council, it revised its membership requirements to adhere to federal Public Law 99-660. Since the appointment of members to the Council, it has worked with DHS and others to address such issues as the future role of regional treatment centers; the human resource development needs of Minnesota's mental health system; and plans for long-term and permanent housing for persons with mental illness, in addition to the needs of children and adolescents with emotional disturbance.

This report updates Minnesota's January 1989 Plan for Services for Persons with Mental Illness by including actions of the 1989 Legislature. This plan also identifies the major issues of the next one to three years and outlines the DHS' strategies for addressing them.

Overview - How the Planning Process Operates in Minnesota

To a certain degree, laws and budgets passed by the Minnesota Legislature and approved by the Governor serve as the DHS's true planning documents. While the Mental Health Division (MHD) of DHS continues to play the lead role in planning for and drafting mental health legislation, it is the Legislature and the Governor which determine the level of program funds, and the administrative and planning staff at the state level.

Prior to the legislative session, the input of the State Advisory Council, the Children's Subcommittee, advisory councils to special projects, county advisory councils, and other public bodies is used heavily. The timetable for planning for the 1989 legislative session, and implementation of its outcomes, is as follows:

January 1988	first county plans for 1988-89 for adult mental health services reviewed by MHD (mandated by 1987 Comprehensive Mental Health Act)
spring/summer 1988	drafting of MHD/DHS budget for 1990-91 biennium begins (to be acted on by 1989 Legislature)
	drafting of first P.L. 99-660 Plan begins
	drafting of legislation for 1989 session begins
January 1989	submission of first P.L. 99-660 Plan to NIMH
spring 1989	Legislature reviews and approves budget and legislation for 1990-91 biennium (including Comprehensive Children's Mental Health Act); adjourns May 22
August 1989	second round of county plans for 1990-91 for adult mental health services due for MHD review and approval
	P.L. 99-660 Plan revisions continue (spring and summer 1989)
November 1989	initial county plans for children's mental health services due (mandated by 1989 Comprehensive Children's Mental Health Act)

As indicated in the timetable with the submission of county plans, Minnesota has a state-administered, county-operated system of service delivery. This often means that the budgetary, administrative, and political needs of two levels of government must be addressed in the development and operation of programs. The membership of the State Advisory Council and Children's Subcommittee reflect this arrangement with their inclusion of county commissioners and social services directors.

Typically, the need to address a given issue is identified by a variety of sources. A few of these are: 1) MHD regional and special project staff, who have the responsibility of

working with counties to ensure that services required by the Comprehensive Mental Health Act are available, accessible, and are of high quality; 2) county social services personnel, who develop biennial plans for mental health services and who must implement the programs required by the state; 3) mental health services providers; 4) members of the State Advisory Council, the Children's Subcommittee, and county advisory councils and children's coordinating councils; 5) advocacy organizations; and 6) federal programs and government.

These sources and the issues they identify are very much interrelated. For example, the budget and program needs of counties, as well as new issues identified in county plans, are used to develop responses that have applicability across the entire state. These responsibilities may be administrative, budgetary, or legislative in nature. Much of the material in this State Plan is based upon needs and issues identified in county plans.

Similarly, the MHD and bodies such as the State Advisory Council identify new congressional, legislative, judicial, county, and local decisions requiring a response. Thus, while information presented in county plans, State Advisory Council studies, and other reports influence future directions, so also do counties and the state continue to implement past state and federal directives.

Because staff shortages are more often the rule than the exception at all levels of Minnesota's mental health system, identified needs generally are addressed by proposing new legislative and budgetary initiatives. Thus, as indicated earlier, much of what the MHD and DHS plan for can be implemented only with the approval of the Legislature and the Governor, within the constraints of state and federal laws and regulations, and tailored to the needs identified by counties, providers, and consumers and families.

New legislation goes through countless drafts in an effort to respond to the concerns of all affected parties. Similarly, the MHD's budget request (appropriated on a biennial basis) is reviewed by DHS, the Department of Finance, the State Planning Agency, the State Advisory Council, and the Governor's Office before it is submitted to the Legislature with the rest of the Governor's legislative and budgetary initiatives.

Ultimately, the needs of persons with mental illness are balanced with the needs of many others seeking the assistance of the state. In the 1989 session, legislative leaders and the Governor determined public education and property tax relief to be major priorities overall. In the human services arena, new laws reflecting the Legislature's priorities were passed to create a system of services for children with emotional disturbance; and to plan for the future role and mission of Minnesota's regional treatment centers. Each of these initiatives represent progress in the implementation of a comprehensive system of care for adults with mental illness and children with emotional disturbance. Needless to say, the MHD's responsibility to provide leadership to the state's mental health system means that these successes provide the foundation for additional progress.

This plan reports on those legislative outcomes and discusses old and new issues confronting the development of a comprehensive, community-based system of mental health services. Coordinated efforts of the Mental Health Division, the Department of Human Services and other state departments, the Governor, the Legislature, counties, and the State and local Mental Health Advisory Councils are crucial for success. Ultimately, a degree of trust must continue to be developed in ensuring that all parties aim for the same goal. This plan can serve as one vehicle to continuing to build that trust.

Chapter III Mission, Goals, and Objectives

As stated in Minnesota's January, 1989, mental health services plan, the 1987 and 1988 Legislatures established the mission of the Department of Human Services in implementing a comprehensive system of mental health services. For adults,

> The Commissioner shall create and ensure a unified, accountable, comprehensive adult mental health service system that:
>
> (1) recognizes the right of adults with mental illness to control their own lives as fully as possible;
> (2) promotes the independence and safety of adults with mental illness;
> (3) reduces chronicity of mental illness;
> (4) eliminates abuse of people with mental illness;
> (5) provides services designed to:
> (i) increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning;
> (ii) stabilize adults with mental illness;
> (iii) prevent the development and deepening of mental illness;
> (iv) support and assist adults in resolving mental health problems that impede their functioning;
> (v) promote higher and more satisfying levels of emotional functioning; and
> (vi) promote sound mental health; and
> (6) provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.

For children,

> The Commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that is consistent with the provision of public social services for children as specified in Section 256F.01 and that:
>
> (1) identifies children who are eligible for mental health services;
> (2) makes preventive services available to all children;
> (3) assures access to a continuum of services that:
> (i) educate the community about the mental health needs of children;
> (ii) address the unique physical, emotional, social, and educational needs of children;
> (iii) are coordinated with the range of social and human services provided to children and their families by the departments of education, human services, health, and corrections;
> (iv) are appropriate to the developmental needs of children; and
> (v) are sensitive to cultural differences and special needs;
> (4) includes early screening and prompt intervention to:
> (i) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and
> (ii) prevent further deterioration;
> (5) provides mental health services to children and their families in the context in which the children live and go to school;
> (6) addresses the unique problems of paying for mental health services for children, including:
> (i) access to private insurance coverage; and
> (ii) public funding;

(7) includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs; and

(8) when necessary, assures a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age.

The MHD utilized these mission statements in establishing its own goals and objectives, and in preparing drafts of this Plan. These goals and objectives are listed below.

Goal #1:

To provide leadership to the state's mental health system for children and adults.

Objectives:

1-A. To provide linkages and respond to requests for information, task force membership, etc., which expand knowledge, awareness and expertise in mental health issues.

1-B. To achieve positive and innovative change in the planning and delivery of local mental health services.

1-C. To enhance leadership of state and local advisory councils.

Goal #2:

To ensure statewide availability, accessibility, and provision of services for children and adults as required by the Comprehensive Mental Health Act.

Objectives:

2-A. To supervise counties in planning for and providing mental health services.

2-B. To provide effective management for Rule 12 and Rule 14 grants.

2-C. To assist counties in identifying persons in need of services, including those identified in the nursing home screening process.

2-D. To supervise local mental health authorities in arranging for the safe and orderly discharge of persons with mental illness who are found to be inappropriately residing in nursing facilities.

2-E. To assure client access to the least restrictive, most appropriate services through reasonable and equitable fee policies and other mechanisms which account for an individual's inability to pay for services.

Goal #3:

To effectively plan for, manage and evaluate the state's mental health service system for children and adults, including human resource development.

Objectives:

3-A. To maximize the use of all available or develop new funding resources, including human resources, in the provision of mental health services.

3-B. To implement the new community mental health reporting system (CMHRS).

3-C. To maintain and manage the computer resources of the Division to maximize staff efficiency and effectiveness.

3-D. To implement effective methods to utilize available mental health data from MA/GAMC, RTCs, and other information systems.

3-E. To develop appropriate planning linkages with academic institutions, mental health service agencies, and other related agencies in order to encourage research into mental illness and effective treatment modalities, and promote appropriate training of the state mental health work force.

3-F. To develop staff capacity to do work assignments effectively.

3-G. To maximize opportunities to plan service development systematically, based on client needs.

3-H. To implement statutory requirements for reporting children's residential treatment data.

3-I. To implement statutory requirements for annual report from the local children's coordinating councils.

3-J. To begin to develop a separate and distinct State Human Resource Development Plan to include into the agency's State Mental Health Services Plan.

3-K. To implement a minimum HRD data set which interfaces systematically with the organizational and client data sets.

3-L. To assess progress toward meeting the MHD's goals, objectives and tasks.

Goals #4:

To assure that mental health services for children and adults meet standards of quality and when feasible, are based on relevant research findings and consistent with professional standards in the field of mental health.

Objectives:

4-A. To promote high standards of care to providers and counties.

4-B. To reassess rule development and revision plans and develop/revise rules accordingly.

4-C. To collaborate with Residential Program Management Division and DHS Transition Team (responsible for monitoring progress of RTC legislation passed in 1989) to enhance service quality in the regional treatment center system and to promote continuity with community based services.

4-D. To enhance Division's capacity to evaluate service provision.

4-E. To determine the best methods for assuring that out-of-home placements of adults and children are appropriate and necessary.

4-F. To develop new high quality services for children with emotional disturbance.

Goal #5:

To ensure the provision of services in the least restrictive environment which increases the level of functioning and safety of children and adults needing services.

Objectives:

5-A. To define an appropriate array of services for adults and children.

5-B. To promote community based services in the least restrictive environment that is clinically appropriate to the client's needs. To use information from assessments of RTC patients to actively plan for their community services needs.

5-C. To assess current rules to determine the degree to which these promote increasing individuals levels of functioning and safety.

Goal #6:

To assure the coordinated development of the mental health system for children and adults.

Objectives:

6-A. To develop state level inter- and intra-agency coordination for the development, implementation, and funding of mental health services.

6-B. To assure that mental health service development and implementation is coordinated at the local level.

6-C. To assure individual case level coordination among service providers and clients.

Goal #7:

To promote the development of a unified service delivery system for children and adults which incorporates the culturally, chronologically, and geographically diverse mental health needs of Minnesotans through integration into the mental health system and development of appropriate special programs.

Objectives:

7-A. To develop systems to identify underserved persons and populations or groups of persons in need of services.

7-B. To assure that services for persons and populations or groups of persons with diverse mental health needs are appropriately addressed by the system.

7-C. To maximize all existing and/or develop new funding resources, including resources devoted to the RTCs, to assure that the diverse mental health needs of Minnesotans are incorporated.

7-D. To target use of all available funding sources in providing services to diverse population groups.

Goal #8:

To empower adult and child consumers of mental health services and their families to participate in the development of the mental health service system and in development of their individual treatment plans.

Objectives:

8-A. To provide active outreach in order to elicit consumer input.

8-B. To assure involvement of families and consumers in the treatment process.

8-C. To promote the employment of consumers.

Goal #9:

To work actively on lessening the stigma of mental illness and emotional disturbance.

Objectives:

9-A. To develop an anti-stigma campaign RFP, contract, and program.

9-B. To integrate anti-stigma efforts throughout all activities of the Division.

9-C. To involve state and local mental health advisory councils, other advisory groups, and special grant projects in promoting anti-stigma efforts.

Chapter IV Mental Health Services for Children

BACKGROUND:

As indicated in Minnesota's January, 1989 State Plan, significant new legislation to meet the needs of children with emotional disturbance was introduced in the 1989 Legislature. That legislation was passed and has significantly increased the MHD's responsibilities. Because children's mental health represents a major new initiative, this chapter presents a more thorough analysis compared to others in the State Plan.

Since January, 1988, three major efforts have taken place to build a children's mental health system. The 1988 Legislature established a mission for children's mental health services which set the stage for 1989 legislative action. In 1989, the Comprehensive Children's Mental Health Act was passed, mandating a comprehensive and coordinated delivery system by 1992. In addition, the DHS funded eight demonstration projects which are modeled after the CASSP framework of interagency coordination and service delivery. These form the foundation for future department work on children's mental health.

The 1989 Comprehensive Children's Mental Health Act represents a commitment to the children of Minnesota to provide a comprehensive and coordinated system of care for their mental health needs. The Legislature appropriated $2.3 million over the 1990-91 biennium to begin the implementation of this initiative after a period of planning. Additional state funding will be required in the following biennium to complete the implementation of mandated services.

The passage of this legislation represents the effort of many persons. In conjunction with DHS, the State Mental Health Advisory Council's Children's Subcommittee collected information from parents, children, providers, advocates, county personnel, and others in a series of statewide hearings. DHS also collected survey information from counties about their current systems of care for children. The resulting legislation thus was able to address the concerns identified during this planning process.

The legislation was designed to accomplish three primary goals:

1. Mandate a comprehensive set of services throughout the state so that all children, and their families, receive services based upon their individual level of need;
2. establish mechanisms at the state, local and individual case levels for coordination between agencies serving children with mental health needs and their families; and
3. establish advisory councils at the state and county levels, assuring input from parents, providers, advocates, and others.

In the next section, gaps and issues identified during the planning process are presented. Features of the Comprehensive Children's Mental Health Act follow, and new legislative funding is discussed. Finally, goals and objectives for the children's mental health system over the next three years are described in Part III.

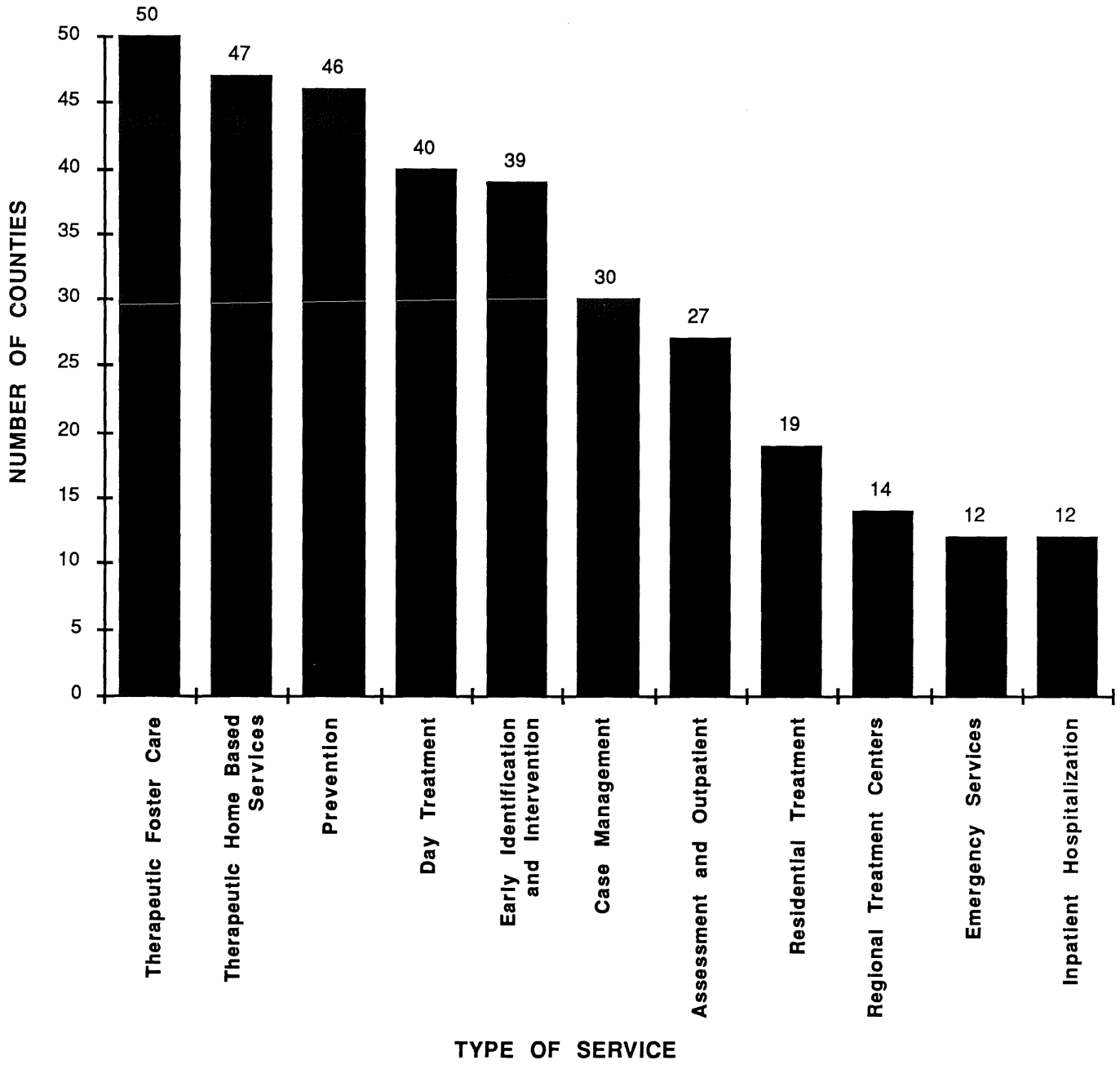
PART I -- GAPS AND PROBLEMS IDENTIFIED THROUGH THE PLANNING PROCESS

By the Children's Subcommittee on Mental Health

Membership of the Children's Subcommittee of the State Mental Health Advisory Council, formed in September of 1988, is legislatively mandated to include a diverse group of persons who work with children's issues statewide. The group includes

State Children's Mental Health Plan Type of Service by Number of Counties Expressing Need (N=78)

The survey of county social service directors also provided information on their perceived need for mental health services in their county. The following chart identifies needed services ranked on a statewide basis:



NOTE: "Need" means a county director rating of "Available, More Needed" or "Not Available, but Needed".

parents, providers, a former consumer of adolescent mental health services, county representatives, mental health professionals working in hospital and outpatient settings, a school social worker, representatives of advocacy organizations and representatives of culturally diverse programs. In addition, representatives from the Departments of Human Services, Corrections, Health, State Planning, and Education participate on the Subcommittee.

At its inception, the group established task forces which advised the DHS on all aspects of the proposed children's mental health legislation and funding. The Subcommittee estimated that $20 million in additional state funding would be necessary to provide needed services for children over the two-year state biennial period.

Subcommittee members continued to advise DHS and the bill's authors, Senator Linda Berglin and Representative Gloria Segal, (both are members of the State Mental Health Advisory Council), as well as other legislators to gain their support until the bill was passed.

The Children's Subcommittee also conducted seven public hearings on the needs of children and adolescents with emotional disturbance from December 1988 through February 1989. More than 325 persons attended the hearings with 75 providing testimony. Several common themes emerged from the hearings:

- In delivering services for children with emotional disturbance, the needs of the entire family should be addressed, unless clinically inappropriate.

- Mental health services for children must be coordinated with other services they may receive: education, vocational development, juvenile corrections, and child protection services.

- Available funding in both the private and public sectors is often the determining factor in the type of services children receive.

- Many counties outside the metropolitan area have limited local resources in terms of services, funding, and trained professionals.

- Paperwork, financial disincentives, and other barriers often postpone the access of a child to services until a crisis situation exists.

- Early intervention by professionals is needed.

In general, many people testified that the system needs were two-fold: first, to coordinate existing and new services; and second, to develop and provide additional mental health services specifically for children and adolescents.

(Minnesota State Advisory Council on Mental Health, "Report: Public Hearings on Children's Mental Health Issues", March 1989.)

By the DHS Study on the County Mental Health System of Care

As a part of its planning for the legislative proposal, the MHD surveyed counties on the mental health system of care for children and youth. Questionnaires were sent to the directors of all 87 county social service agencies; 78 questionnaires were returned for an 88% response rate. The survey questions addressed the following:

- the existing continuum of mental health services;
- service location;

- problems within these mental health services;
- types of services needed on an overall basis; and
- differences between services in the metropolitan region and other regions of the state.

Regarding the availability of services, the questionnaire asked the directors' opinions of the availability and need for various mental health services. Directors rated services according to whether they were:

- available and needed;
- available, more needed;
- not available but needed; and
- not available and not needed.

The following chart summarizes the responses only for "available more needed" and "not available, but needed" categories.

Other key findings from the study include the following:

1. County directors indicated that both mental health and other support services for children and youth with severe emotional disturbances are in some cases totally unavailable or unavailable in sufficient quantities to meet the needs.
2. Many county directors indicated that they use residential mental health treatment facilities in locations which may be more than an hour's drive from the child's home community.
3. Barriers to mental health services exist in some counties in terms of:
   a) eligibility and admissions;
   b) affordability;
   c) lack of acceptance by parent/child;
   d) culture/language; and
   e) coordination problems.
4. Metro area counties (seven in all) tended to have more services available, but the need for services equalled or exceeded that in non-metro counties. Non-metro counties (80) often had fewer available services to begin with.

PART II -- STATE CHILDREN'S MENTAL HEALTH INITIATIVES

A. Minnesota Comprehensive Children's Mental Health Act

The Minnesota Comprehensive Children's Mental Health Act was adapted for Minnesota's government structure from the CASSP model of the National Institute of Mental Health's Children's Program. The following is an overview of the Act.

OVERVIEW: Children's Comprehensive Mental Health Act

I. State Responsibilities:

a. Mission

The mission of the Department's efforts on behalf of children with emotional disturbance and their families is to ensure the creation of a unified, accountable, comprehensive children's mental health service system. Implementation of the service system must take place by January 1, 1992.

The Department will provide each county with information about the predictors and symptoms of children's emotional disturbances and information about groups identified as at risk of developing emotional disturbance to assist in planning for services. (M.S. 245.4872, subd. 2 and subd. 3.)

b. Services

Required services in each county and implementation dates include:

- Education and prevention.....Current
- Emergency services.....Current
- Outpatient services.....Current
- Residential treatment services.....Current
- Acute care hospital inpatient services.....Current
- Screening for inpatient and residential treatment.....Current
- Early identification and intervention.....1/1/91
- Professional home-based family treatment.....1/1/91
- Case management services.....7/1/91
- Family community support services.....7/1/91
- Day treatment services.....7/1/91
- Benefits assistance.....7/1/91
- Therapeutic foster care.....1/1/92

c. State Level Coordination:

The Department must convene quarterly meetings with the Commissioners, or designees of Commissioners, of the Departments of Human Services, Health, Education, Commerce, State Planning and Corrections and a representative of the Minnesota District Judges Association Juvenile Committee, in order to coordinate planning, funding and implementation of services.

No service shall be provided unless consent to the services is obtained. No information about the child/family shall be disclosed without informed written consent, unless required to do so by statute. Procedures must be established to ensure that the names and addresses of children receiving mental health services and their families are released only under very specific conditions (such as to service providers). A child or a child's family who requests services must be advised of services available and the right to appeal. (M.S. 245.4886.)

d. Continuation of Services:

Counties must continue to provide case management, community support services, and day treatment to children with serious and persistent mental illness as required by the Comprehensive Mental Health Act of 1987. By August 1, 1989, counties must notify providers of services to children eligible for case management, day treatment, and community support services under the Comprehensive Mental Health Act of their obligation to refer children for services. (M.S. 245.487, subd. 5.)

e. Local Agency Coordination:

By January 1, 1990, the county must establish a local coordinating council at the county level, including representatives of mental health, social services, education, health, corrections, and vocational services (and an Indian reservation authority where a reservation exists within the county.) When possible, the council must also include a representative of juvenile court or the court responsible for juvenile

issues and law enforcement. The members of the council must meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. The council must provide written interagency agreements and report annually to the Commissioner about unmet children's needs, service priorities, and the local system of care. (M.S. 245.4872, subd. 3 and M.S. 245.4875, subd. 6.)

f. Individual Case Coordination:

Coordination by the case manager is required with any other person responsible for planning, development, and delivery of social services, education, corrections, health or vocational services for the individual child. (M.S. 245.4872, subd. 4.)

The case manager must arrange for a diagnostic assessment, determine the child's eligibility for family community support services, develop an individual family community support plan, perform a functional assessment, and provide for service coordination for the child. (M.S. 245.4881.)

II. Services Eligibility:

Emotional disturbance is defined as an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that:

1. is listed in specific code ranges of the International Classification of Diseases (ICD-9), current edition, or in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition; and

2. seriously limits a child's capacity to function in primary aspects of daily living, such as personal relations, living arrangements, work, school, and recreation (M.S. 245.4871, subd. 15.)

Eligibility for case management and family community support services requires that the child meet the definition of emotional disturbance and one of the following:

1. Admission within the last three years (this is included in an effort to provide follow-through coordination to children who have been removed from home) or is at risk of being admitted to inpatient or a residential treatment program for an emotional disturbance, or

2. Receipt of treatment for an emotional disturbance by a Minnesota resident through the interstate compact, or

3. A determination by a mental health professional that the child has:

   (i) psychosis or clinical depression; or
   (ii) risk of harming self or others as a result of an emotional disturbance; or
   (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year, or

4. As a result of an emotional disturbance, significantly impaired home, school or community functioning of a child that has lasted at least one year, or, in the written opinion of a mental health professional presents substantial risk of lasting one year. (M.S. 245.4871, subd. 6.)

B. NEW MENTAL HEALTH FUNDING

Up to now, children with mental health needs have received services at the county level largely through the Community Social Services Act (CSSA). This block grant fund, consisting of federal, state, and county dollars, has supported a variety of services, although there is little data about the kinds and amounts of mental health services children receive under CSSA. In particular, residential treatment programs have been paid for by CSSA. Other mental health services have been provided to children through the MA system. But, because an array of services was not available in all areas of the state, DHS requested new state dollars to begin the balanced development of several services in areas of the state where they were needed.

The 1989 Legislature's appropriations for the 1990-91 biennium included $2.3 million in new funds for children's mental health services. The DHS will work with counties and the Children's Services and Health Care Management Division within DHS to begin to develop these services.

In addition, the Legislature appropriated funding for two staff positions for children's mental health within DHS. This includes funding for an existing position which had been financed by temporary federal funds. This compares to four new positions recommended by the Governor.

Finally, the Department is developing mechanisms to serve children with severe emotional disturbance who are not currently eligible through its MA Program. The outcome of this project and a mandated study of current mental health funding to be completed over the next biennium will frame future funding requests. Additional funding will be necessary before the Comprehensive Children's Mental Health Act is totally implemented. Current DHS estimates are that the Legislature will need to appropriate $27 million in the next biennium to fund newly mandated children's mental health services.

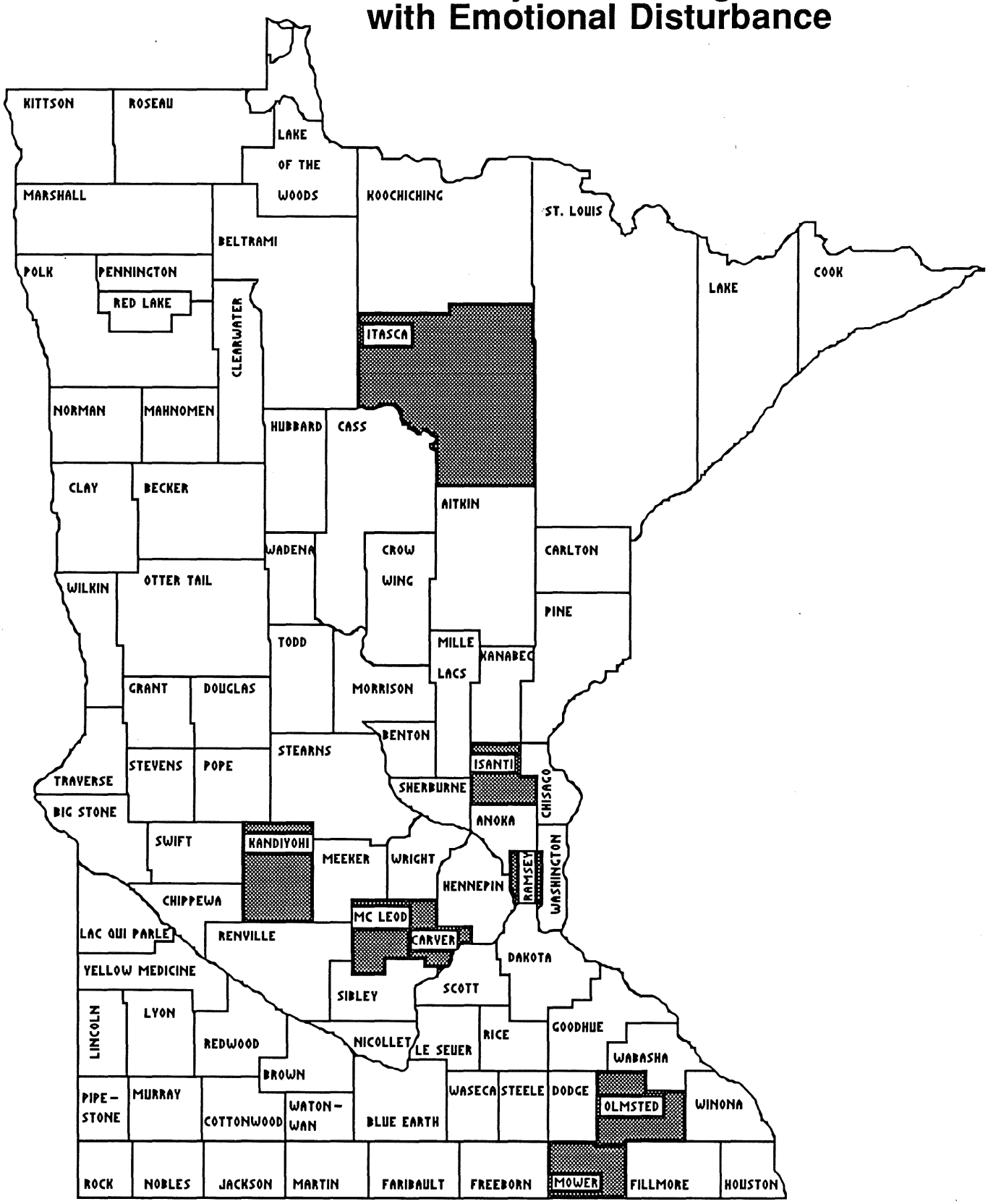
C. MENTAL HEALTH PROJECTS SERVING CHILDREN AND ADOLESCENTS

During the past year, the DHS has undertaken a major new effort using block grant funds to establish pilot projects to serve severely emotionally disturbed children. Projects were required to use the CASSP service delivery model developed by NIMH. This model has been most helpful in guiding the development of a children's mental health system. Below is a summary of the eight projects which are currently funded with the federal block grant dollars. Unfortunately, Minnesota's federal mental health block grant for the current year has been reduced to the point where these projects will need to be cut by approximately 15%. In addition, no new projects will be able to be added. The MHD is working with each program to develop alternative funding wherever possible.

1. Carver County

The Youth Resource Program for Carver County promotes the availability and coordination of a full continuum of services by the many agencies serving children and their families. The intent of the program is to increase local community based access to a full range of services by children who are presently

Pilot Projects Serving Children with Emotional Disturbance



underserved due to a variety of factors. This effort requires participation and cooperation by all agencies presently serving children and adolescents. It will result in a more unified and systematic delivery of multi-agency services through development and adherence to an Individual Community Support Plan.

Evaluation of the entire system of care will determine which services must be expanded or developed, with emphasis on reducing reliance on intensive out-of-county resources, such as residential treatment programs. Key components will be the process of early identification and increased access to less restrictive treatment options. During the first year, two local therapeutic foster homes will be recruited and begin accepting children. The largest budget item is for a project coordinator. Small amounts will also be used to hire a therapeutic foster care consultant to get that program set up, and limited amounts for day treatment and in-home counseling.

2. Isanti County

The primary objective of this project will be to develop and implement comprehensive therapeutic/educational treatment plans for children with emotional disturbance served by the therapeutic day treatment program, a community based program to be established through interagency cooperation. Family involvement, through support group and therapeutic activities, is emphasized throughout as an integral part of each child's treatment plan. Treatment plans will be developed jointly by the Interagency Team, a multiagency group of educational, social service and mental health personnel.

The objectives of the project will be accomplished by the initiation and expansion of mental health services in the areas of education and prevention, outpatient services, day treatment, and professional family-based services. The program's budget shows a creative use of a number of local funding resources including special education funds, local school district funds, and county dollars.

3. Itasca County

The project will strengthen early intervention and service coordination activities for severely emotionally disturbed children and adolescents. Staff serving geographic areas of the county will provide information and resources to parents, become actively involved in suicide prevention activities, foster care training and crisis supervision of children in foster homes, and work on early identification of "at risk" children. The funds are used primarily to support regional service coordinators who will serve these functions.

4. Kandiyohi County

The project will bring together local community agencies to coordinate services for children. About half of the funds will be used to expand prevention and education and outpatient services including assessment. Lutheran Social Services will receive a contract to provide professional family based services.

5. McLeod County

The project will develop and expand services to children with emotional disturbance by hiring a care coordinator. The coordination will assist in the

identification of children in need, and provide necessary linkages between providers and the child's family to assure that needed services are provided and to provide parent education.

6. Mower County

The goal of the project is to implement a service coordination team under the leadership of a newly hired project manager. Funding will be used for the project manager position and subcontracts will be developed to provide consultation and training for foster care families, prevention and education activities, and foster home recruitment.

7. Olmsted County

For several years, Olmsted County has attempted to create community based care for children in need of out of home services. The county will become the lead agency in fostering the interagency collaboration needed to develop the comprehensive community based service system for children with severe emotional disturbance. A coordinator will be hired and funds will be used for an extended family home and emergency home.

8. Ramsey County

Funding will be focused on development of one specific professional family based enhancement to a school program. The project will serve level 5 (special education) students by providing intensive in-home mental health services to families and by offering intensive social skills for children and behavior management groups for parents in the school.

D. Children's Services Grant Application

The MHD has submitted a system development grant application to the Children's Services Division of NIMH. If funded, the MHD plans to institute an interagency planning process around the needs of homeless youth with mental illness, expand the involvement of parents and minorities in the implementation of the children's mental health system, and provide information and resources to inform the state and local legislative implementation process.

III. OBJECTIVES AND TASKS:

A. To provide linkages and respond to requests for information, task force membership, etc., which expand knowledge, awareness and expertise in mental health issues.

TASKS:

1. Participate in National Association of State Mental Health Program Directors, Child and Adolescent Services System Program, State Mental Health Representatives for Children and Youth, and other national organizations as DHS representative -- ongoing.
2. Prepare for and attend advisory council meetings -- ongoing.
3. Develop relationships with advisory groups and professional organizations -- ongoing.
4. Review literature and present relevant research findings to staff and outside groups -- ongoing.
5. Maintain resource information on mental health programs and services from other states and throughout Minnesota -- ongoing.

B. To achieve positive and innovative change in the planning and delivery of local mental health services.

TASKS:

1. Provide staff support to SMHAC and Children's Subcommittee in developing recommendations -- ongoing.
2. Utilize SMHAC, consumers, and advocacy groups input in developing budget and statutory amendment proposals -- October, 1989; May and June, 1990.
3. Meet with mental health providers to ascertain provider needs and effective approaches to programmatic issues -- October, 1989; May, 1990.
4. Recommend "clean up" language changes for CMHA and Children's Comprehensive Mental Health Act consistent with research findings -- November, 1989.
5. Provide legislative analyses and fiscal notes as appropriate -- October, 1989 to April, 1990.
6. Participate in developing draft plan for funding mechanism for children's services - June 1, 1990.

C. To develop new high quality services for children with emotional disturbance.

TASKS:

1. With EPSDT, Minnesota Department of Health, and Minnesota Department of Education staff determine appropriate mechanism for including mental health need identification in EPSDT and ECS (Early Childhood Screening) as part of Early Identification and Intervention Service -- January 1, 1990.
2. With EPSDT and Minnesota Department of Health staff, determine need for and appropriate method of providing training to EPSDT providers on use of mechanism -- January 1, 1990.
3. With Health Care Management and Children's Division staff, determine appropriate standards for Home-Based Services so that rulemaking can occur -- June, 1990.
4. With Children's Health Plan (CHP) staff, participate in study of mental health services inclusion in Children's Health Plan -- January, 1990.
5. With CHP staff, determine appropriate standards for and develop provider and informational bulletins on use of CHP for outpatient mental health services for eligible children -- June, 1990.
6. Collaborate with Children's Services Division in development of a white paper on rules governing children's services -- August 31, 1989.
7. With Children's Services Division, develop RFP for pilot program in therapeutic foster care, review grant applications, and award grants.
8. With Children's Services and Licensing Divisions, determine what licensure requirements and training are necessary to assure quality of therapeutic foster care so that rules can be promulgated -- June, 1990.
9. With Department of Education and Children's Division, develop RFP for pilot program in family community support services -- June, 1990.
10. With Medical Assistance and Department of Education, determine what standards and training are necessary to assure quality of family community support services so that rules can be promulgated-- June, 1990.

11. Provide staff support to the Children's Subcommittee of SMHAC to enable participation and involvement in Tasks 1-13 -- ongoing.
12. Issue bulletin on continuation of county children's demonstration grants from ADM funding -- July 15, 1989.
13. Review applications for county children's demonstration grant funding -- August 1-15, 1989.
14. Award grants for county children's demonstration projects -- August 15, 1989.
15. Determine whether to renew county demonstration evaluation contract at the University of Minnesota and if appropriate design ongoing evaluation/data collection mechanism for county demonstration projects -- March 1, 1990.
16. Issue continuation bulletin on county children's demonstration projects -- May 1, 1990.
17. Collect and analyze evaluation data on county children's demonstration projects -- May, 1990.
18. With Health Care Management Division, determine appropriate standards for case management for children so that rules can be promulgated -- June, 1990.
19. With Health Care Management and Long Term Care Divisions, maximize the availability of MA through TEFRA 134 option for children at risk of institutionalization as a result of severe emotional disturbance -- June 1989.

D. To assure that mental health services development and implementation is coordinated at the local level.

TASKS:

1. Identify training needs of local coordination councils -- February, 1990.
2. Provide workshop for local mental health advisory councils, including children's subcommittee -- February, 1990.
3. Provide staff support in coordinating efforts of local advisory councils -- ongoing.
4. Update current CSSA Manual section on mental health and submit completed manual section for draft review -- August 15, 1989.
5. Modify draft review and submit final approved section to Social Services Division -- December 1, 1980.
6. Complete development of model contract with appropriate divisions -- August 15, 1989.

E. To assure individual case level coordination among service providers and clients.

TASKS:

1. Plan and schedule training for children's case managers -- June 1990.
2. Participate with Special Education and Developmental Disabilities Division in State Transition Interagency Committee process (responsible for issues pertaining to transitioning persons with disabilities from services to community living) -- ongoing.

F. To supervise counties in planning for and providing mental health services.

TASKS:

1. Develop Children's Mental Health Plan review process -- July, 1989.
2. Issue instructions for Children's Plan -- July, 1989.
3. Review county Children's Mental Health Plans -- November 15, 1989 to March 9, 1990.
4. Monitor county plan special conditions -- ongoing.
5. Provide counties with children's information from CASSP and from other states on programs, treatment, modalities and research regarding service provision in the least restrictive environment appropriate to the clinical needs of the child -- ongoing.

G. To implement statutory requirements for reporting children's residential treatment data.

TASKS:

1. Compile data from facilities and hospitals on children's mental health placements -- October, 1989.
2. Incorporate data into state children's mental health planning -- November, 1989.
3. Recommend improvement in Juvenile Code reporting requirements based on data and planning -- November, 1989.

H. To implement statutory requirements for annual report from the local children's coordinating councils.

TASKS:

1. Develop a format for report and advise counties and councils -- December 1, 1989.
2. Assist local councils in obtaining the required data -- ongoing -- January, 1990.
3. Collect data and prepare report -- June, 1990.

I. To assist counties in identifying children in need of services.

TASKS:

1. Provide counties with report on symptoms and predictors of emotional disturbance in children -- January 1, 1990.

J. To determine the best methods for assuring that out-of-home placements of children are appropriate and necessary.

TASKS:

1. Establish contract for preparation of analysis for joint adult and children's task forces on screening for inpatient and residential treatment services -- August 15, 1989.
2. Establish task forces -- August, 1989.
3. Develop task force recommendations and submit report to Legislature as required by statute -- August 1989 to February 15, 1990.
4. Advise/update SMHAC on progress of efforts; provide staff support for SMHAC participation if appropriate -- ongoing until February 15, 1990.
5. With Medical Director and Residential Program Management Division, determine appropriate services for children who are currently in the regional treatment center system -- June, 1990.

Chapter V Mental Health Services for Adults

Provisions of the 1987 Comprehensive Mental Health Act were described in Minnesota's January 1989 State Plan. As implementation has proceeded, a number of key issues have been either newly identified or have been confirmed as ongoing aspects of Minnesota's system requiring attention.

This Chapter provides an overview of these issues and gives plans on the part of DHS to address them. It is not intended to be a presentation of all of the activities of the MHD to implement the Comprehensive Mental Health Act, but rather to give focused attention to key systemic issues. A primary goal of the MHD continues to be to ensure that statewide availability, accessibility, and provision of services for children and adults, including multicultural services, as required by the 1987 and 1989 Comprehensive Mental Health Acts.

1. Case Management Services for Persons with Mental Illness:

BACKGROUND:

Case management services are defined in the Comprehensive Mental Health Act as services designed to help adults with serious and persistent mental illness gain access to needed medical, social, educational, vocational, and other necessary services as they relate to the person's mental health needs. According to statute, case management services are to be coordinated with community support programs, which are also mandated to be available in each of the 87 counties in Minnesota.

The primary goal and responsibility of the case manager is to develop an individual community support plan which is based both on a diagnostic and a functional assessment. The case manager then refers the person to needed mental health and other services identified in this plan, and provides the coordination and ongoing monitoring and evaluation of these services. DHS views case management as a cornerstone to the overall delivery of a comprehensive mental health system for persons with mental illness in Minnesota.

The underlying philosophy of case management in Minnesota is based on the idea that adults with serious and persistent mental illness:

(1) are often involved with more than one service provider;
(2) have difficulty managing multiple systems, e.g., mental health, financial, social services, education; and
(3) are unable to access necessary mental health services.

Case management is one of the services required by the Comprehensive Mental Health Act to ensure the provision of services in the least restrictive environment which increases the level of functioning and safety of children and adults needing services.

The delivery of case management has been defined in Rule 74 (the DHS body of regulations governing its provision) to ensure that each adult with serious and persistent mental illness will be offered the services of a case manager with primary responsibility for assisting that person in accessing the kinds of services necessary to enhance that person's life. The responsibility for providing the service rests with the county or local agency. The rule requires the first source of payment to be Medical Assistance (MA) for eligible persons, and targets this assistance toward persons with

the most serious illnesses to help ensure that they are a priority for receiving such services. However, counties are required to make case management available to all persons with mental illness, and may use CSSA (Community Social Services Act) dollars and Rule 14 funding for non-MA eligible persons.

Another component of Minnesota's philosophy is that the case manager should work with persons in an ongoing manner over the long term so that the case manager will continue to follow up and be a constant presence in that persons life, whether or not that client:

- is involved in one or many services;
- is successful or unsuccessful in a variety of programs; or
- is hospitalized.

A third component is that case management needs to be provided in the client's own environment. This means that the responsibility to access case management should be the case manager's.

An amendment to the 1987 Comprehensive Mental Health Act added a provision to permit refugees to receive case management services from other refugees who may not yet meet the minimum professional requirements of a case manager. The amendment includes a sunset provision to allow existing refugee case managers additional time to meet the minimum requirements.

CURRENT ISSUES:

1. Implementation: The implementation of case management services began January 1, 1989, and thus is in its initial stages. It is anticipated that, over time, the MHD will continue to identify specific problems that will need to be addressed.

   Initially, counties resisted providing case management. This resistance was partly due to the development of case management as an independent mental health service and not as a traditional social service function of the county. Counties have needed to restructure and reorganize internal administrative processes to accommodate the provision of case management as defined in Rule 74. In many cases, these adjustments have led the county to become a vendor of services in much the same way as other mental health providers in the overall system.

2. Reimbursement rate: There continues to be concern that the MA reimbursement rate for case management is not adequate to cover the true cost of providing the service. This appears to be more of an issue in the metropolitan area than in greater Minnesota. Metro counties have tended to use county social workers and service providers as case managers. Often the experienced social worker earns significantly more than the reimbursement rate allows. Many metro area social workers have master's degrees with several years experience, while Rule 74 requires case managers only to have a bachelor's degree and one year of experience.

3. Functions of the case manager: Finally, there are concerns that Rule 74 limits the function of the case manager. Rule 74 clearly defines the role and responsibilities of case managers and further requires that they not provide mental health and other services to clients they are case

managing. This is to comply with federal MA regulations, and, from a programmatic perspective, ensures that the case manager continues to work with the client beyond a time-limited treatment period.

TASKS:

A. Continued education regarding Rule 74, with clarification that it is not only an MA reimbursement rule, but is also based on sound mental health principles to best meet the needs of persons with serious and persistent mental illness.

While technical assistance was provided to all counties as part of the implementation of Rule 74, additional assistance will be given to case management providers in developing the internal structure and organization necessary to accommodate the implementation of Rule 74.

B. Joint monitoring by the Mental Health and Medical Assistance Reimbursement Divisions of DHS to ensure that counties are maximizing the availability of MA as a funding source, yet not using the MA reimbursement rate as the sole funding source.

C. Development of a case management implementation committee. The function of the implementation committee is to identify issues and concerns, suggest solutions, and otherwise advise the MHD on the implementation of case management services in Minnesota. It includes representatives from the Minnesota Association of County Social Services Directors, the State Mental Health Advisory Council and the Children's Subcommittee, the Minnesota Association of Community Mental Health Center Directors, the Mental Health Association of Minnesota, the Alliance for the Mentally Ill, and consumer and case manager representatives.

2. Community Support Services for Persons with Mental Illness:

The MHD's regional consultants continue to provide technical assistance to counties to develop or continue community support programs (CSPs) as needed. This technical assistance is provided on an ongoing basis and is also tailored to needs identified by counties in their mental health plans.

A highlight of this past year's technical assistance effort was a statewide, three-day conference attended by 300 CSP workers, county social service administrators, local advisory council members, and others. Norma Schleppegrell, Chair of the State Mental Health Advisory Council, and Howie the Harp, consumer organizer from Oakland, California, provided keynote presentations. The Department of Human Services' Medical Director, Thomas Malueg, also gave a presentation on linkages between regional treatment centers (RTCs) and community support programs (CSPs). Limited scholarship funding allowed two persons from each Minnesota county to attend without charge.

The conference's success was indicated by plans to replicate it annually, with the second conference scheduled for May, 1990.

In addition to the provision of technical assistance by the MHD, the Governor submitted to the 1989 Legislature a request to expand funding for CSPs so that each county would receive a minimum of $50,000 or $1.80 per capita in state funding, compared to last year's minimum of $25,000 per county or $1.00 per capita. The Legislature approved enough funding for $40,000 or $1.65 per capita, so implementation of CSPs in all counties will proceed, but at a slightly

lower level than needed. This issue will need to be revisited in upcoming legislative sessions.

In fact, a special session of the Minnesota Legislature in September, 1989, may take up the issue of state take-over of some county funded social services costs. The MHD is investigating the possibility of securing additional funding for CSPs as part of that process.

3. Employability Services for Persons with Mental Illness:

BACKGROUND:

Employability services are increasingly being viewed as top priorities in the development of a community based system for persons with mental illness. Indeed, along with housing, employability was considered most important in a recent survey of consumer members of local mental health advisory councils.

Through an interagency agreement created in 1987, the MHD has been coordinating efforts with the Division of Rehabilitation Services (DRS), part of the Minnesota Department of Jobs and Training to establish employability and work-related opportunities in all areas of the state. These services are designed to be a part of CSP services in all 87 counties and include:

a. functional and situational employability assessments to determine the person's employability needs, strengths, and goals;

b. habilitative services designed to prepare the person for employment in the community; and

c. ongoing supportive services (not time limited) to enable the person to manage his or her mental health in the work setting and to stabilize and maintain employment.

CURRENT ISSUES:

Employability services have for some time been inadequate to meet the need in Minnesota. The historical mission of DRS has been to serve persons with physical and developmental disabilities; only recently was there a recognition of the job-related needs of persons with mental illness. In addition, while DRS provides services such as job training and placement, work evaluations, and so forth, the CSP program role is to assist persons with mental illness to improve their employability through activities such as medications management or assistance in developing social interaction skills through employment or volunteer work.

Although funding for employability services historically has been inadequate, many counties have created their own programs by using Rule 14 (the source of funds for CSP services) and other funds. With the passage of the Comprehensive Mental Health Act, all counties were required to provide employability services as part of a full array of CSP services. Counties which had been using their entire Rule 14 allocation to finance employability services were now faced with the need to provide all CSP services rather than just one component. At the same time, other counties which had not previously used Rule 14 funds for employability services now were required to do so. The availability and quality of such services has been uneven as a result.

In response, DRS has as a top priority the development of services for persons with mental illness. The 1987 DRS/MHD Interagency Agreement clarified responsibilities and work plans.

TASKS:

1. Meet with DRS on employability issues six times a year -- ongoing.
2. Develop workplan with DRS -- December 31, 1989.
3. Renew DHS/DRS interagency agreement -- December 1989.
4. Participate in monthly internal DHS supported employment meetings and State Supported Employment Advisory Council meetings -- ongoing.
5. Participate in review process for DRS-MI grants -- ongoing.

4. Institutions for Mental Diseases (IMDs):

BACKGROUND:

As a result of federal legislation and the Health Care Financing Administration regulation which reclassified services provided to persons with mental illness in residential programs, a number of such programs were declared IMDs on January 1, 1989. The effect of this declaration was to make the residents of these facilities ineligible for all MA funded services.

The 1989 Legislature precluded the possibility of mass discharges from residential programs by expanding eligibility guidelines for GAMC to include persons who would have been eligible for MA if they hadn't been living in these facilities. The Legislature also:

1. expanded the types of services under GAMC to more nearly equate to those under MA, including reimbursement for case management services;

2. let expire a temporary provision which had reimbursed mental health providers less under GAMC than under MA. The effect of this provision could have been to discourage mental health providers from serving persons receiving GAMC; and

3. raised the room and board reimbursement rate for certain residential program providers to the level allowed under the state's MA program.

CURRENT ISSUES:

In the next year, the MHD will be working with providers to downsize programs, where feasible, to 16 or fewer beds to fall under the bed capacity set by federal law. Five programs have downsized to 16 or fewer beds to date.

A number of reports and studies on the housing and residential treatment needs of persons with mental illness were required by the 1989 Legislature. As the MHD prepares or participates in the development of these studies, additional plans will be developed, including the long term implications of the IMD regulations on the funding and structure of Minnesota's mental health system, and on the availability of housing and residential services for persons with mental illness.

For more information, see the following sections on housing issues, the Nursing Home Reform Act, and revisions to DHS Rule 36.

TASKS:

1. With Long Term Care Division staff, undertake the IMD study required under M.S. 245.463, subd. 3, including data collection, projected fiscal impact of maximizing availability of MA for persons with mental illness residing in IMDs -- January, 1990.
2. Develop a plan to identify the long term fiscal impact of downsizing programs to avoid IMD determination and to study mental health funding as required by M.S. 245.463 -- April, 1990.
3. Assist facilities identified as IMDs or potential IMDs in downsizing, obtaining JCAHO accreditation, etc., to permit residents to regain/retain MA eligibility -- June, 1990.
4. Advise/update and provide staff support to State Mental Health Advisory Council on progress of these efforts -- ongoing.

5. Housing Services for Persons with Mental Illness:

BACKGROUND:

Housing for persons with mental illness continues to be identified as a primary need of persons in need of a community based system of services. It was identified as the greatest need among non-mental health services in a recent survey of consumer members of local mental health advisory councils. As such, the MHD has been actively involved in coordinating efforts with other agencies that are responsible for housing in Minnesota, including the Minnesota Housing Finance Agency (MHFA) and Housing and Urban Development (HUD).

In addition to continuation of efforts to serve homeless persons with mental illness (See Chapter V) and revisions to DHS Rule 36, the MHD plans to continue for a second year several housing support pilot projects. This second year funding was made possible with the appropriation of $500,000 per year from the 1989 Legislature. These pilot projects will result in the collection of information and experiential data for a base of information on what services work well in Minnesota to help persons maintain their living situation. Tasks related to this effort are listed below.

The 1989 Legislature also established in law a mission statement on housing upon which the MHD's implementation plans will be based.

> "The Commissioner shall ensure that the housing services provided as part of a comprehensive mental health service system:
>
> (1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;
>
> (2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and
>
> (3) provide necessary support regardless of where persons with mental illness choose to live."

Finally, a representative of the Minnesota Housing Finance Agency has joined the State Advisory Council at the same time as coordination of efforts continue between the MHD and relevant staff persons at MHFA. These developments are in addition

to an appropriation by the 1989 Legislature to the MHFA to provide additional housing subsidies and loans for persons with mental illness.

Other efforts include MHD participation in the development and review of HUD 202 applications with the Minnesota Office of Housing and Urban Development. HUD 202 applications include the rehabilitation of old, and development of new, buildings for persons with mental illness.

TASKS:

1. Assess value of housing support projects and their continuation -- December, 1989.
2. Issue continuation bulletin for F.Y. 91 Housing Support Services if appropriate -- January 1, 1990.
3. Review applications for Housing Support Services, if appropriate -- May-June 1990.
4. Award grants/contracts for Housing Support Services, if appropriate -- June 30, 1990.
5. Collect and analyze evaluation data on Housing Support Services for use in F.Y. 91 grant reviews and for preparation of 92-93 budget, if appropriate -- May 1, 1990.
6. Meet with Interagency Task Force on Homelessness -- ongoing.
7. Coordinate with HUD and MHFA regarding housing issues of persons with mental illness -- ongoing.
8. With Department of Health and DHS Divisions, participate in the development of Supportive Living Residences emergency rule and report to the Legislature as required by 1989 Session Laws, Chapter 282, Section 213 -- January, 1990.

6. OBRA -- The Federal Nursing Home Reform Act:

BACKGROUND:

The MHD is implementing the Federal Nursing Home Reform Act (P.L. 100-203) by adapting the previously existing nursing home preadmission screening program of DHS and by utilizing the Quality Assurance and Review program of the Minnesota Department of Health.

In 1979, the Minnesota Legislature decided to develop a program which would help prevent the premature or unnecessary institutionalization of elderly people, by screening all applicants to nursing homes to determine if nursing home placement is necessary or desirable. In 1980, the Minnesota Legislature established a pre-admission screening program for nursing home applicants in two counties as a pilot project. The pilot project proved to be successful and, in the 1981 Legislative Session, the program was funded for statewide implementation. In addition, the program was expanded to include funds for alternative care grants for case management, adult day care, homemaker services, home health aide services, foster care services, personal care services and respite services.

The Pre-Admission Screening Program is perceived as a valuable, systematic approach to assess the need for and the provision of long-term care services. Therefore, the MHD determined that the most effective method by which to implement P.L. 100-203 would be to build upon the existing Pre-Admission Screening Program.

Prior to the enactment of P.L. 100-203, the MHD was awarded an NIMH grant for a demonstration of community based services for older adults with serious and

persistent mental illness. (See Chapter V, section on Mental Health Services for Older Adults.) Objectives of the project included enhancing the mental health portion of the pre-admission screening process and improving community based services for older adults regardless of their place of residence. The Pre-Admission/Alternative Care Grant rule now requires that a Pre-Admission Screening team that has reason to believe a person being screened has been diagnosed or may be diagnosed as mentally ill to refer the person for services. These services include screening, development of an individual service plan and case management services under the Comprehensive Mental Health Act. Also, the Pre-Admission Screening instrument has been revised to include an enhanced mental health screen.

Each county will be required to develop and submit a document which must describe how they will implement OBRA. This supplement will require the following information:

1) identification of person(s) responsible for implementation of P.L. 100-203;
2) development of policies and procedures for handling referrals from the pre-admission screening team and from the ARR process, making arrangements for diagnostic assessments, determining whether nursing facility services are appropriate, and arranging for safe and orderly discharges as required; and
3) development of systems to monitor implementation and track persons identified in the Pre-Admission Screening/Annual Residence Review (PASARR) process.

Residents will be encouraged to participate in determining appropriate alternative placements and mental health services. In addition, Minnesota Statutes, Section 245.467, Subdivision 1, mandates that the required services be provided under conditions which protect the rights and dignity of the individuals being served; be provided in the most appropriate, least restrictive setting available to the local mental health authority; and be based on individual clinical needs, cultural and ethnic needs, and other special needs of individuals beings served.

Although Minnesota does not anticipate that a large number of persons with mental illness will need discharge from nursing facilities in order to comply with P.L. 100-203, one must be mindful of the fact that the mental health system is in transition and that by April 1, 1990, local mental health authorities will have had less than two years to develop services mandated by the Comprehensive Mental Health Act.

In fact, case management, probably the most crucial component in ensuring a safe and orderly discharge for persons with mental illness, will have been operational for only a little over a year. Moving all 300 persons who are currently in nursing homes by April 1, 1990, has budget implications of up to $5,000,000 per year and sufficient state funding cannot be obtained to relocate and provide or arrange for the provision of appropriate mental health services for all 300 persons by that time. Therefore, in order not to overburden a developing mental health system, the MHD requested an extension to June 30, 1992, which HCFA approved.

The 1989 Legislature approved an additional $3,000,000 in funding to support alternative services (primarily Community Support Services and Residential Treatment Services, including relocation to appropriate Institutions for Mental Diseases) to relocate a portion of the 300 persons each year between April 1, 1989, and June 30, 1992.

Based on Quality Assurance and Review (QAR) data from the Department of Health from September, 1988, 586 persons were in nursing facilities who were not of advanced age and who were identified as having a diagnosis of mental illness, excluding Alzheimer's disease or related disorder, and who were additionally identified as not having a terminal condition or severe illness. It is expected that after assessing each individual, about 300 persons currently residing in nursing facilities may need to be discharged in a safe and orderly manner.

In January, 1989, county nursing home Pre-Admission Screening teams began implementing the Pre-Admission Screening process required by P.L. 100-203 and, in April, 1989, the Health Department Quality Assurance and Review teams began implementing the Annual Resident Review process required by P.L. 100-203, as described in the state's Alternative Disposition Plan.

All 87 Minnesota counties have begun to develop a system of locally available and affordable mental health services. Although all of the services should be available for an individual who must be discharged from a nursing facility, current funding is limited, as counties had developed their initial plans based on the needs of persons who were then residing in non-institutional settings. Many local authorities were unable to anticipate the need for additional services for this population.

OBJECTIVES AND TASKS:

Schedule:

January 1, 1990 to March 30, 1990:

Relocate and provide or arrange for the provision of appropriate community-based or residential services for 50 persons.

April 1, 1990 to march 30, 1991:

Relocate and provide or arrange for the provision of appropriate community-based or residential services for 100 additional persons. (Total -- 150 persons.)

April 1, 1991 to June 30, 1992:

Relocate and provide or arrange for the provision of appropriate community-based or residential services for 150 additional persons. (Total -- 300 persons.)

A. To supervise local mental health authorities in arranging for the safe and orderly discharge of persons with mental illness who are found to be inappropriately residing in nursing facilities.

TASKS:

1. Identify county contacts -- July 1, 1989.
2. Develop and implement data collection system to monitor implementation of OBRA/PASARR process.
3. Issue bulletin/RFP regarding state alternative placement funds -- August 15, 1989.
4. Provide technical assistance on OBRA to counties and providers -- September 1989.
5. Report to HCFA -- August 1989, February 1990.
6. Receive applications for alternative placement funds -- October 1, 1989.
7. Prepare LAC report for state OBRA funds transfers, if appropriate -- November 1, 1989.

8. Establish alternative placement monitoring system -- June 1989.
9. Assist counties in their use of PASARR process for determining appropriateness of mental health placements -- ongoing.
10. Provide monitoring and technical assistance for alternative placements -- ongoing.
11. Issue bulletin for F.Y. 91 funds -- January, 1990.
12. Review applications for F.Y. 91 -- May 1, 1990.
13. Award F.Y. 91 grants -- June 30, 1990.
14. Make ARR referrals to counties -- ongoing.

7. Rule 36 -- Revision of Rule 36 and Reconfiguration of Licensed Residential Programs for Adults with Mental Illness:

BACKGROUND:

Rule 36 is the body of DHS regulations that govern the provision of rehabilitation services in residential settings for adults with mental illness. Most programs governed by Rule 36 are based in the community, although Minnesota's regional treatment centers (RTCs) also hold Rule 36 licenses. The rule is being revised for the first time since 1982. The rule revision process is expected to take 18 to 24 months.

Prior to the development of a first draft of the rule, three focus group meetings were held, two involving consumers of mental health services, and one with providers of residential programs.

The purpose of the consumer focus group was to gather input on each individual's first hand experience in residential programs under the existing rule. Topics discussed included issues such as client rights, family involvement, health and safety, and quality of care.

The provider focus group was convened to gain input on a variety of technical concerns regarding the delivery of services. These include program evaluation, treatment planing, core services in a residential rehabilitation program, and service models.

The input from these focus groups was used in combination with reviews of recent research findings and program models in other states to complete an initial draft of the rule.

Next, an advisory committee was formed in May 1989. Membership includes consumers, family members, advocacy groups, providers, county social service agencies, members of the State Advisory Council, and regional treatment centers. Throughout the process, the advisory committee will review and provide input relating to drafts of the rule as they are developed.

Tasks have been assigned to subcommittees of the advisory committee on issues relating to rehabilitation services in a residential setting, including health and safety standards, crisis services, adult foster care program and licensing, and the provision of rehabilitation services within and in coordination with RTCs. The subcommittees will meet throughout the rule writing process, as needed, to provide information in the development of future drafts of the rule.

CURRENT ISSUES:

Rule 36 will need to address a number of issues, many of which were identified in the information gathering process described earlier. These issues include:

(1) Client Empowerment:

Assuring through the rule that those who are receiving the services are allowed to make choices on their own behalf, and that their individual freedom and independence is promoted within programs;

(2) Regulatory Consistency:

The rule will be updated to correspond with the requirements and standards existing in the Comprehensive Mental Health Act and current statutes, rules, and regulations.

(3) Quality Assurance:

The rule will require all mental health services to be based upon current research and accepted contemporary professional practices. It also will require services to be available to persons of all ages and ethnicities.

(4) Expansion of the Array of Services:

The treatment needs of individuals who have a mental illness are often better met through services other than those that are provided by a traditional residential program. For this reason, the scope of regulation will be expanded to include additional types of residential programs and services. This scope will be predicated on the development of an array of services as described in Goal 5-A in Chapter III.

(5) Facility Size:

The rule will address the reduction and/or limitation of the size of current residential programs. Currently, many facilities in Minnesota have more than 16 beds. This not only increases the likelihood of such facilities becoming "mini-institutions", but residents of such facilities are ineligible for Medical Assistance under the recent MA/IMD interpretation. In an effort to create environments which are more conducive to effective treatment and community integration, DHS will phase out some of its larger programs and limit the development of larger new Rule 36 programs.

TASKS:

1. Complete Rules 12/26 revision including appropriate sections on crisis/respite residential services -- April, 1990.
2. Advise/update SMHAC and Children's Subcommittee on progress in rule development -- ongoing.
3. Work with the Legislative Audit Commission in providing information for Rule 36 audit -- ongoing until October, 1989.
4. Review Legislative Audit Commission's Draft Rule 36 Audit Report -- October, 1989.

8. State Regional Treatment Centers:

BACKGROUND:

The primary mission of the regional treatment centers (RTCs) is to provide quality services and appropriate individualized treatment to people suffering from symptoms of acute mental illness. This treatment is to be in accordance with professional standards.

There are six RTCs located throughout the state providing inpatient services for persons with mental illness. The RTCs provide active psychiatric treatment designed to:

- stabilize the symptoms which required the individual to be admitted to the RTC;
- restore individual functioning to a level permitting return to the community;
- strengthen family and community support; and
- facilitate discharge, after-care and follow-up as persons return to the community.

Psychiatric services currently offered by the RTCs are as follows:

A. Inpatient hospital psychiatric services:

1. Crisis stabilization and emergency services;
2. acute inpatient care of a duration shorter than 30 days, actively focused, designed to address the sudden onset of mental illness or a reoccurrence of an acute episode of mental illness;
3. intense psychiatric treatment, generally longer than 30 day duration, actively focused, for persons with major mental illness whose acute symptoms are not promptly resolved. These persons require active treatment in a highly structured, supervised environment for which a community place is not clinically appropriate.

B. Other psychiatric services:

1. Continued care for persons until their symptoms have been stabilized, at which time a planned transition to an appropriate community placement will occur in conjunction with the county of residence;
2. short-term services to discharged persons to facilitate successful community transition;
3. services for persons committed by the court;
4. Professional and consultative services for community groups and agencies as arranged through shared service agreements.

CURRENT ISSUES:

Eighteen months ago the Commissioner of the Department of Human Services assembled representatives of 34 separate interest groups to begin negotiating a plan for the future direction of the state RTCs. Membership included representatives of mental health consumers, families, provider organizations, communities, and representatives of employees working in the RTCs. A consensus proposal was reached in March, 1989, and brought to the 1989 Legislature for action.

The proposal restated the role of the RTCs and a modified restructuring plan was approved. Inpatient active psychiatric treatment will continue to be one of the components in Minnesota's array of mental health services. RTCs will continue to provide treatment to residents in their service areas. Inpatient active psychiatric treatment for adults will continue to be located at Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter and Willmar. Inpatient active psychiatric treatment for children/adolescents will continue at Brainerd and Willmar until adequate state-operated programs are developed off campus. Any expansion of these facilities may be considered only after a thorough analysis of need and in conjunction with a comprehensive mental health plan.

Specific measures approved by the Legislature include:

- By January 1, 1990, a plan to establish 35 auxiliary beds at the Minnesota Security Hospital will be developed.

- By January 31, 1990, a proposal to recapitalize three RTCs will be developed.

- Beginning July 1, 1991, a system of state operated community based services for persons with mental illness will be established.

- Funding was include in the legislation to plan for a modern psychiatric facility to serve the heavily populated metropolitan areas of Minneapolis/St. Paul.

Responsibility for implementation will be shared by the DHS Residential Program Management Division, the Mental Health Division, and a transition team. A DHS policy board will provide guidance and direction throughout the planning and implementation stages. The policy board is composed of the Deputy Commissioner of DHS, the State Medical Director, 5 Assistant Commissioners, (including the Assistant Commissioner for Mental Health), the DHS Deputy Assistant Commissioner and other members that are experienced in health care delivery systems.

The 1989 legislation requires that need for psychiatric services will be based on individual assessments of persons receiving treatment in the RTCs. Under the project leadership of the State Medical Director, a clinical survey of patients was initiated in June, 1989. The results of this clinical survey, to be available in the fall of 1989, will provide information essential to planning and redesigning of treatment services within the RTCs and of community based services for those needing treatment in a less restrictive environment.

Target dates for this statewide clinical patient survey are:

- June, 1989.....Survey data collection

- October, 1989.....Data analysis and development of patient and RTC profiles.

- December, 1989.....Final report of survey and recommendations for RTC and community based treatment service planning.

Objective and Tasks:

To collaborate with the Residential Program Management Division and Transition Team to enhance service quality in the RTC system and to promote continuity with community-based services.

TASKS:

1. Work with RTC transition team to provide input for decisions about RTC-MI program development, including planning for MI-state operated community services (SOCS) and Brainerd secure facility use and development -- ongoing.
2. With Medical Director and Residential Management Program Division, determine what services for children are appropriate in the RTC system -- June, 1989.
3. Participate in analysis of RTC assessment data -- October-December, 1989.

4. Participate in final report on RTC client needs -- January, 1990.
5. Participate with Medical Director and Residential Program Management Division in consideration of criteria development for admission and continued stay in RTCs -- June 1, 1990.
6. Incorporate retraining programs for RTC staff into overall statewide Human Resource Development (HRD) program -- June, 1990.
7. Provide staff support to SMHAC's legislative mandate to be involved in RTC issue resolution, including assessment -- January, 1990.
8. Begin process for determining appropriate regulatory mechanism for RTC programs -- June, 1990.
9. Participate with Residential Program Management Division regarding nursing home bed placements planning for RTCs (M.S. 251.012), Subd. 1 and 2) -- June, 1990.
10. Develop a plan for assessing mental health needs in south east Minnesota -- January 1, 1990.
11. With Medical Director and Residential Program Management Division, plan for establishment of 35 security beds at Brainerd RTC -- January 1, 1990.

9. Information Systems

BACKGROUND:

Agencies of the state of Minnesota did not have an integrated mental health information system prior to 1989. Mental health data were collected through a combination of methods: annual aggregate reports from state-funded community support (Rule 14) or adult community residential treatment (Rule 12) programs; fiscal year summaries of counties' use of RTCs; fiscal year summaries of the use of MA-reimbursed mental health services; and calendar year aggregate reports of mental health service use from county social service information systems.
There were several problems with this makeshift "system", including:

1. data were not compatible across data sources;
2. the aggregate nature of much of the data limited the number of useful analyses;
3. data from the county social services system was out of date and questionable in its reliability and validity, due mainly to definitional problems;
4. very little information on non-grant reimbursed mental health services provided by mental health centers could be linked to a specific provider; and
5. without client-specific information across the different systems, an accurate, unduplicated count of clients and service use was impossible.

Partly out of response to the problems caused by the lack of an integrated mental health information system, the 1987 Legislature mandated the establishment of a "Mental Illness Information Management System" by January 1, 1990. To meet that requirement, the MHD is implementing a management information system (MIS) throughout 1989, which will provide a more complete picture of all publicly funded mental health services.

The MIS is composed of two major subsystems. The first is a recently implemented system of data transfer from the data systems of local service providers to the state agency. A core set of data on publicly funded services and clients are transferred through various electronic and paper media. This subsystem is called the Community Mental Health Reporting System (CMHRS).

The second subsystem is a set of reports and special studies designed to meet information requirements that the CMHRS is unable to meet. It typically addresses issues that are too specific and nonroutine for the CMHRS. This second system is particularly important in producing information about client and service outcomes in state grant programs.

Further development of the MIS is planned in three areas:

1. increasing the performance of the system;
2. expanding the capabilities of the database subsystem; and
3. developing decision-support procedures that will enable the use of data-based information in decision-making.

CURRENT ISSUES:

Performance

The adequacy, credibility, and efficiency of the MIS will be formally assessed each year. The purpose of each assessment will be to quantify the extent to which previously identified performance criteria are being met and to identify new criteria. The assessments will also specify changes to be made in the system.

1. Adequacy will be measured in terms of the number of information requirements the system is able to meet. Some of these requirements have been identified in the legal and regulatory mandates of DHS, and in the Division's workplan; others will arise more spontaneously from management, policy makers, service providers, and the public in the course of conducting business. Currently, the system is not capable, in its content, of meeting all known requirements. Adequacy will increase as the capabilities of the system are expanded (see below).

2. In past years, users of state level information have increasingly questioned its quality. Information credibility, based on the validity, reliability, and accuracy of measurement (data), and on the integrity of data processing techniques is now a primary concern of the MHD. Assessment of performance will look at all of these aspects of the system, with special attention to computation of data error rates for the purpose of identifying where better data definition and more training is needed.

3. Implementation of the new database subsystem had as one of its main objectives the replacement of labor intensive statistical reports from service providers with more efficient methods. Database to database transfers coupled with more focused studies using statistical samples would be less intrusive, more productive, and less costly in the long run. Assessments of the MIS will determine the extent to which this replacement has occurred.

Capabilities

The database subsystem now includes only nine data elements: program, provider, client ID, sex, race, date of birth, severity of mental illness, service received, and amount of service. These elements are capable of meeting core requirements relating to the concerns of external (e.g., funding) sources, such as accountability, availability, and descriptions of service utilization. However, they are not able to meet many of the questions of management -- planning, control, program development, or program evaluation.

Expansion of the system's capabilities must begin with its content. Grant funding being sought from the federal government will be used to examine which data elements from a set of national data standards will be most useful and cost-effective to implement in Minnesota. The products of this grant will include specification of the changes needed in local systems to capture, store, transmit, and use additional data.

Decision Support

To fulfill its potential, the MIS must include decision-support procedures for integrating the information it produces into decision making processes. These procedures will be developed during the second and third years of the plan period, preceded by an analysis of the decision structure within the MHD during the first year. They will consist of computer programs, spreadsheets, and other software suitable for use by management personnel. Their flexibility will allow decision makers to test alternative decisions against outcomes predicted from the database. Once in place, the ways in which these procedures are used, and by whom, will be continually monitored.

Some initial planned uses for the service data include:

1. Comparison of actual service utilization with county mental health plan projections.
2. Monitoring availability and accessibility of services in each county.
3. Comparison of per capita utilization rates across counties to identify extreme variants.

OBJECTIVES AND TASKS:

A. To implement the new community mental health reporting system (CMHRS).

TASKS:

1. Collect, store, and process data reported through the CMHRS -- ongoing.
2. Identify incomplete and inaccurate data records, obtain corrected records from counties, and update the database -- ongoing.
3. Provide technical support -- ongoing.
4. Manage performance of Division's work items in the CSIS contract -- ongoing.
5. Meet with Division staff and staff of reporting agencies to identify changes to be made in the CMHRS system to improve its quality and efficiency -- July, 1989.
6. Revise CMHRS system specifications and documentation, and distribute these to reporting agencies -- October, 1989.
7. Provide input and assistance to technical staff regarding the development of children's data reporting -- ongoing.

B. To maintain and manage the computer resources of the Division to maximize staff efficiency and effectiveness.

TASKS:

1. Maintain operational effectiveness of hardware and software -- monthly.
2. Review and revise policies and standard procedures for use of computer resources -- June, 1990.
3. Install the hardware and software to implement the network -- July, 1989.

4. Obtain training for network administration and operation -- August, 1989.
5. Train appropriate division staff to perform E-Mail, file transfer, and peripherals utilization -- September, 1989.

C. To implement effective methods to utilize available mental health data from MA/GAMC, RTCs, and other information systems.

TASKS:

1. Test programming and storage requirements for MA/GAMC Extract System -- June, 1989.
2. Implement system for storing extracted data -- July, 1989.
3. Incorporate MA/GAMC data into state and local reports -- November, 1989.
4. Participate in the development of the RTC information system and arrange for appropriate linkages -- ongoing.

D. To implement statutory requirements for reporting children's residential treatment data.

TASKS:

1. Compile data from facilities and hospitals on children's mental health placements -- October, 1989.
2. Incorporate data into state children's mental health planning -- November, 1989.
3. Recommend improvements in Juvenile Code reporting requirements based on data and planning -- November, 1989.

E. To enhance Division's capacity to evaluate service provision.

TASKS:

1. Negotiate new federal grant for mental health information system improvement -- October, 1989.
2. Implement federal grant if appropriate by hiring needed staff -- October, 1989.
3. Recruit MHCs and CSPs to participate in the project and organize advisory committees -- November, 1989.
4. Study MIS and DSS requirements of participating agencies -- March, 1990.
5. Identify the information requirements of the Division and ways in which this information can be used to improve the Division's performance of its role(s) -- May, 1990.

Chapter VI Special Initiatives

MULTICULTURAL MENTAL HEALTH PROGRAMS

The Mental Health Division recognizes the need to develop programs and human resources to meet multicultural mental health needs in the state. Although the growth of minority populations in Minnesota may not be as substantial as previously thought, the experiences with the Asian refugee community (through the NIMH grant) and with Indian communities (through ADM block grant funds) have shown that planning, organizing and delivering services to multicultural communities requires the combined efforts of the Multicultural Program Advisor and the MHD's regional consultants.

The overall goal for the MHD is to utilize special projects as appropriate to promote the development of a unified service delivery system for children and adults which incorporates the culturally, chronologically, and geographically diverse mental health needs of Minnesotans through integration into the mental health system and development of appropriate special programs.

The following sections are updates on the MHD's efforts to meet the needs of diverse populations. Plans for the next year are listed at the end of the Chapter.

Mental Health Services for American Indians

BACKGROUND:

Agencies that provide culturally relevant services for the American Indian population are limited in number. However, under the Comprehensive Mental Health Act all counties must provide for an array of mental health services to all persons living in a county. The new state legislation included increased funding for Indian mental health services, setting aside 25% of Minnesota's federal mental health block grant allocation for Indian mental health services. The Minnesota Comprehensive Mental Health Act also created an opportunity for the Indian population to access additional mental health services previously inaccessible due to lack of coordination and gaps in services.

An ideal system would be one which recognizes and accepts cultural differences in mental health services delivery, allows the client to make choices, and provides flexibility the clients and their families. Therefore, in counties where there is a significant multicultural population, the MHD will continue to work with local mental health authorities to develop appropriate services to reach multicultural persons at risk of mental illness.

At the state level, the Minnesota Indian Mental Health Advisory Council, comprised of representatives from the eleven reservations and urban Indian communities of Minneapolis, St. Paul, and Duluth, meets quarterly and provides information to the staff of the MHD on issues, concerns, and needs in their communities. Updates are provided on their mental health programs as well. These meetings also create opportunities to provide mutual support among programs as some are in isolated areas of the state.

The service system problems for the American Indian population in Minnesota are due to cultural differences, inadequate funding, and fragmentation between substance abuse and mental health programs. Results in inefficient and ineffective programs, and a lack of coordination between Indian mental health programs and the local mental health system.

The increased share of federal block grant funds made it possible to create new and expanded Indian mental health programs in 1988. Two urban programs were funded in addition to the eight programs which had previously been funded. However, a recent reduction in Minnesota's total federal mental health block grant allocation will require a cut of approximately 15% next year in these programs.

Indian Health Board, located at 1315 East 24th Street, South Minneapolis, provides comprehensive mental health services for children, adolescents, adults and families. Mental Health services include: outreach and intervention, independent living skills training, a drop-in center program and case management services.

Upper Midwest American Indian Center, located in north Minneapolis, is a multi-service agency and provides the following services: child welfare, employment, housing and education assistance. Through the federal block grant funds, the program has employed a mental health worker to assist American Indians living in north Minneapolis to access mental health services in their area.

The following eight Minnesota reservations continue to receive federal block grant funds to help provide mental health services and have contracts or arrange for provision of services:

1. Fond Du Lac, Cloquet, which includes the Duluth area, provides individual, couple, family, and group counseling and psychiatric and psychological evaluations through a contract with the Human Development Center in Duluth.

2. Bois Forte, located in the most northern part of the state in St. Louis and Koochiching Counties and also serves the Vermilion and Deer Creek communities, provides education and prevention, crisis assistance, outpatient treatment services, outreach and supportive services. The Range Mental Health Center, located in Virginia, Minnesota, provides the five required services.

3. Grand Portage, located in Cook County, provides information and education case management, independent living skills training, client outreach, and consultation. Clinical supervision is provided by Cook County Mental Health Services in Grand Marais, Minnesota, which is 35 miles south of Grand Portage.

4. Leech Lake, located 14 miles east of Bemidji, provides case management, client outreach, crisis assistance, medication management, education and prevention, and advocacy. (The reservation extends into five counties: Cass, Itasca, Beltrami, Hubbard and Crow Wing.) The Upper Mississippi Mental Health Center (Bemidji) provides coordination.

5. Mille Lacs, located in the four north central counties of Aitkin, Mille Lacs, Pine and Kanabec provides outpatient counseling, consultation, education, and coordinating services with the three counties of Aitkin, Mille Lacs and Pine. The two local mental health centers are Northland Mental Health Center, Grand Rapids, and Five County Mental Health Center, Braham. Regional treatment centers located in Brainerd and Moose Lake are also available.

6. Lower Sioux Community, at Morton in Redwood and Renville Counties, provides outreach services and information and referral to West Central Community Services Center (Willmar) and to the Rural Rainbow Project at Marshall, Minnesota.

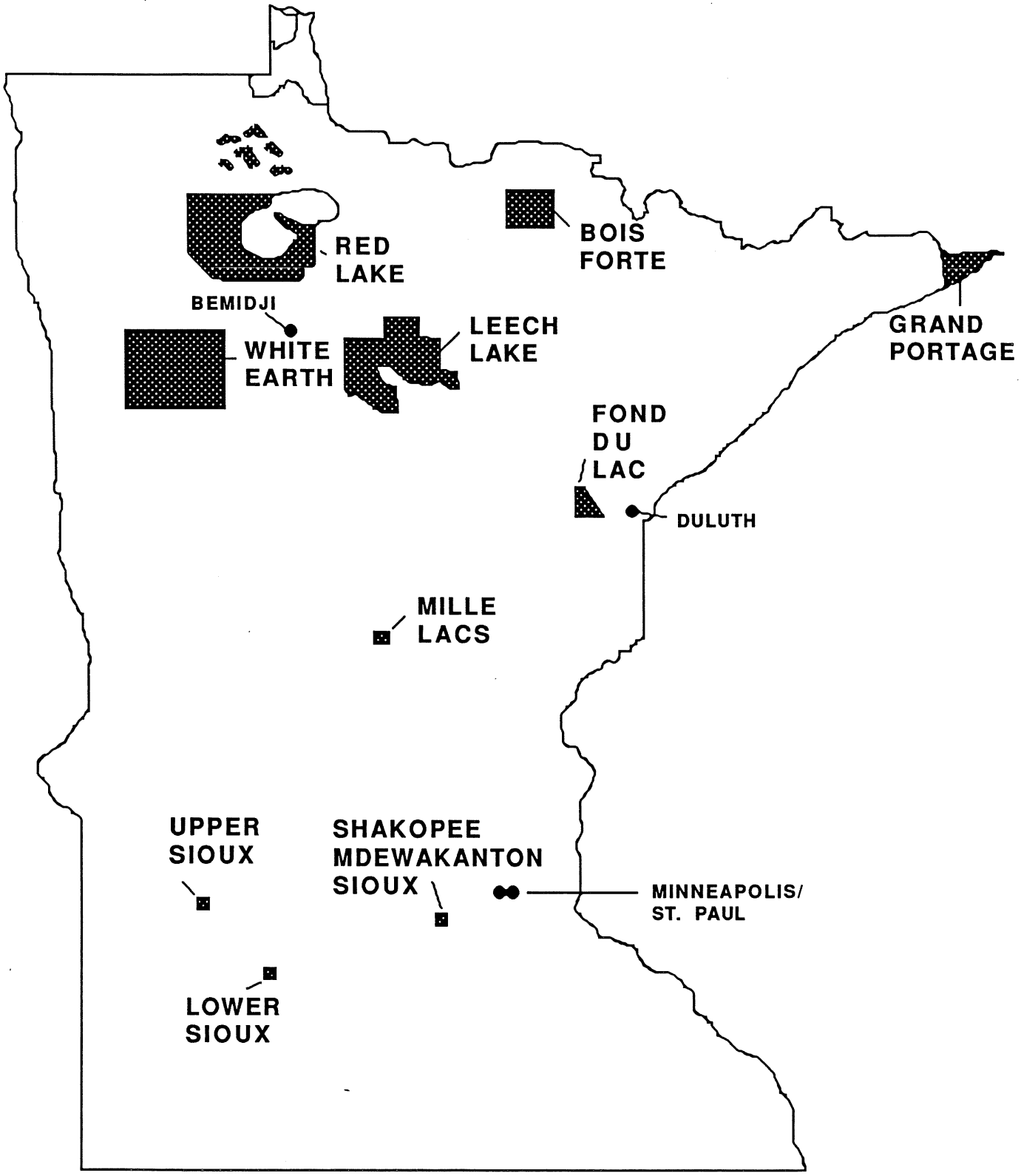
7. Upper Sioux Community, located in Yellow Medicine County, provides outreach, advocacy services and coordination of services with the Harley Clinic and Western Human Development Center in Marshall, Minnesota.

8. Shakopee Mdewakanton Sioux Community, located in Scott County, 25 miles from Minneapolis, provides case management, counseling, information, education and prevention and advocacy.

The following two Minnesota Reservations provide mental health services, but do not receive federal block grant funds:

1. White Earth, located in the northwestern part of the state in Mahnomen, Clearwater, and Becker Counties, includes the Indian communities of White Earth, Pine Point/Ponsford, Naytahwaush, Rice Lake, Calloway, Elbow Lake and Ebro. The mental health services are provided through Indian Health Services and include family therapy, marriage counseling and child/adolescent behavioral evaluation. Fergus Falls Regional Treatment Center is used for extended mental health treatment.

Reservations with Federal Block-Grant Funded Mental Health Programs



2. Prairie Island Community is located in Prairie Island in Goodhue County. Mental health services are funded through Indian Health Services.

One Minnesota reservation, Red Lake, is a "closed" reservation and is not subject to state law. Therefore, the reservation does not have a contract with the state for providing mental health services using federal block grant funds. The reservation, located in northwestern Minnesota, includes four reservation communities: Red Lake, Redby, Ponemak and Little Rock. The reservation provides a comprehensive health care program for their enrolled members.

Mental Health Services for Refugees

BACKGROUND:

Minnesota ranks fourth among the states for refugees resettled within their borders, with an estimated refugee population of 37,862. The state continues to accept new refugees, with 1,174 new arrivals during the first half of F.Y. 1989, and has historically been an area of net gain due to secondary migration of refugees as well. Because of these factors, refugees are a prominent special needs group within the mental health services system.

In an effort to address those needs, Minnesota became one of twelve states to participate in the Refugee Assistance Program-Mental Health (RAP-MH) program funded by the federal Office of Refugee Resettlement and administered by the National Institute of Mental Health. The Minnesota RAP-MH program has been housed within the MHD as the "Refugee Mental Health Program" (RMHP). After a no-cost extension of the RAP-MH grant monies, the RHMP will end on August 31, 1989.

During its existence the RMHP has:

1. identified the mental health needs of refugees;
2. ascertained gaps in service provision;
3. identified system changes needed to improve refugee access to mental health services;
4. identified and design model programs;
5. identified resources in the state;
6. coordinated and provide training to mainstream and bicultural staff;
7. provided a mechanism for networking and resource development; and
8. made recommendations about service provision to refugees.

Several changes over the past year, both legislative and administrative, should improve the quality and availability of mental health services for refugees.

Legislative changes include:

a. appropriation of funds for refugee and immigrant social adjustment/mental health programs;
b. appropriation of funds to reimburse the cost of language interpreters in MA-reimbursable health care situations; and
c. a sunset waiver (effective until 6/30/91) allowing bilingual refugee mental health case managers to operate under supervision while working toward credentials required for case managers.

Administrative changes include:

a. a grant with the Mental Health Association of Minnesota (D/ART - Depression/Awareness, Recognition and Treatment) and the Zumbro Valley Mental Health Center to translate educational materials into refugee languages and provide training for bilingual personnel in their effective use;
b. a requirement that counties with refugee populations exceeding 100 identify and plan to overcome obstacles to refugee access to their local services; and
c. the creation of an ex-officio seat for the Chair of the Refugee Mental Health Advisory Council on the State Mental Health Advisory Council to provide a voice for refugee concerns in the Council's work.

CURRENT ISSUES:

Current issues facing the MHD regarding provision of services to refugees fall within two main categories. First, work remains for improving the accessibility and effectiveness of mental health services for refugees. Second, the termination of the RMHP presents challenges to the MHD to ensure continued input on its work from those knowledgeable and interested in refugee mental health issues.

These issues for improving services for refugees include:

1. Interpreters and western professionals with training in cultural sensitivity remain unavailable at many mainstream mental health services locations such as RTCs, residential facilities, and community mental health centers. This is particularly true outside of the Minneapolis/St. Paul metro area.

2. Current arrangements with counties allow them to enter into agreements with neighboring areas for the provision of services. Since the technical ability to work with refugees remains localized in Hennepin, Ramsey, and Olmsted Counties, these arrangements result in refugees going great distances for treatment, if indeed the assessment that treatment is needed ever occurs. Combined with the issues raised above, this results in an over-reliance on acute and emergency care, as well as refugees who must seek help outside of their own communities.

3. Federal funding for refugee assistance has been declining steadily on a per capita basis over the past ten years. While Minnesota has endeavored to make up some of the difference, there is simply less money with which to work.

Issues of continued input on refugee mental health concerns include:

a. With the termination of the RMHP, the MHD will lose its focal point for refugee mental health concerns. Consequently, it will need to develop a method for preserving the expertise and knowledge gained through the course of the project as well as maintain a channel for gaining input on refugee needs and on strategies for meeting those needs.

b. Because of the highly decentralized, county-based service system in Minnesota, there is a need for refugee input at the county level as well as at the state level.

Services for Homeless Persons with a Mental Illness

BACKGROUND:

The state of Minnesota has probably had homeless people since the days of its discovery; however, the number of homeless people has varied through the years. In the early 1900s there was an increase in the number of homeless individuals when a large number of immigrants came to the state and housing was in short supply. Once the number of housing units grew and jobs were found, the number of homeless individuals declined. Again, the number of homeless individuals increased drastically during the Depression. Many people were not able to afford housing because of a loss of jobs and savings. The government and community responded to provide a larger continuum of a welfare system and social services and eventually met the needs of many of these people.

In 1981, the number of homeless individuals again rose with federal cuts in social services, a rise in unemployment and the continued erosion of affordable housing. The cut in social services compounded the problem of addressing a lack of effective community mental health services. A shortage of affordable housing and difficulties in referring skeptical clients to mental health professionals when street workers finally gain their trust continue to be major issues. The most notable current problem is the number of migrant workers who arrive in Minnesota during the spring and summer to work on farms in the Red River Valley.

Since 1985, the Minnesota Department of Jobs and Training (DJT) maintained a quarterly one-night count of the number of homeless people sheltered in the state. Transitional housing units, battered woman's shelters, community action vouchered beds, public and private shelter beds and runaway children's beds are counted. On the night of the first shelter count there were 1,165 sheltered people and a capacity to shelter 1,165 people. On August 24, 1988, when the last quarterly recording was completed, shelter capacity was exceeded. There were 2,922 people sheltered in a system with a capacity to shelter only 2,320 people.

Minnesota's Mental Health Grant:

When funding became available to offer professional mental health outreach to persons who were homeless, Minnesota used the DJT statistics to target the areas of need. Based on the identified needs, seven counties have received funding from the MHD to hire personnel and develop programs for persons who are homeless or at risk of being homeless and who have or are at risk of having a serious and persistent mental illness. The project staff are required to have experience in mental health and the program must be available to homeless people during their times of need rather than the times that may be most convenient for the county to offer them.

The 1987 Legislature appropriated $350,000 for the biennium to deliver mental health services to homeless individuals, especially homeless persons in Minnesota's largest metropolitan counties (Hennepin, Ramsey, and St. Louis). The money was held while Congress debated the McKinney Act and the match that would be required. On November 30, 1987, the state of Minnesota applied for Public Law 100-77, Title V of the Public Health Service Act, Part C Community Mental Health Services for Homeless Individuals.

Minnesota was notified of its award on January 5, 1988. The award period was from October 1, 1987 through September 30, 1989 and required a contribution equal to not less than $1 for each $3 of federal funds provided in the grant.

On January 8, 1988, the MHD informed six counties that federal and state funds were available to provide community mental health services to homeless persons with mental illness. These six areas were chosen from the DJT surveys over the previous two years. The counties and their community areas were:

Blue Earth County	-	Mankato
Clay/Wilkin Counties	-	Moorhead/Breckenridge
Hennepin County	-	Minneapolis
Polk County	-	Crookston
Ramsey County	-	St. Paul
St. Louis County	-	Duluth

Each of the counties accepted local responsibility for providing mental health services to homeless persons and submitted a proposal for funding. Wilkin County decided to support Clay County's involvement, rather than develop a separate proposal.

In February, 1988, Minnesota received a special notice that Congress had approved additional funds for the fiscal year ($176,083). The total amount of federal funds for Minnesota then totalled $572,273.

Proposals were received in March and April of 1988. A state review team comprised of a representative of the Alliance for the Mentally Ill, the Mental Health Association of Minnesota, the Minnesota Coalition for the Homeless, the Mental Health Law Project and several staff from the DHS met on April 28, 1988, to review the proposals. The team approved all proposals based on certain provisions being fulfilled.

The amount of funds granted amounted to the total federal and state funds, less $79,450 for training and administration. Shortly after all grants were approved, it was determined that a portion of the state funds ($350,000) needed to be spent before June 30, 1988, or would be lost. The state funds had been divided between the years of the biennium; $150,000 for 1987 and $200,000 for 1988 (If the $150,000 could not be spent before June 30, 1988, it could not be spent in the next fiscal year).

It was impossible for most counties to begin as soon as was needed to expend the 1987 allotments. With additional funding by the federal government, it became possible to have all the projects receive the full amount originally proposed. After allotting the additional dollars to the six counties, $59,276 remained.

A second request for proposals was sent in August, 1988 to two counties/areas:

Anoka	-	suburban Anoka County
St. Louis	-	Northern St. Louis County

These two areas were selected because the DJT surveys had lumped suburbs and rural areas together and found that they contained a large number of homeless individuals. Because the small amount of funds made it impossible to accomplish anything significant in rural or suburban Minnesota as a whole, the MHD choose to fund a small area in rural and suburban Minnesota to illustrate the potential of programs in these areas.

Proposals were reviewed and both counties were granted funds to provide services to homeless persons who were mentally ill. These projects were to begin September 1, 1988.

Activities of the projects over the past year have included:

1. a first meeting of the six county projects in Duluth on May 13,1988. The purpose of the meeting was to begin to network together and meet with the Minnesota Homeless Coalition, which was having its annual meeting in Duluth at the same time;

2. a second meeting/training in Alexandria, Minnesota on August 18-19, 1988. The purpose of this meeting was to inform mental health professional staff about homelessness in Minnesota;

3. a third meeting in Crookston on October 13, 1988. The purpose was to share updates, first quarter reports and learn about the host project.

Quarterly meetings have been scheduled throughout 1989 and take administrators and, in some cases, staff to different project areas each meeting. These have included:

1. a Second Quarter meeting and training on January 26-27, 1989 in Minneapolis, Quarterly reports were presented, training on multi-cultural and crisis issues was given, and case histories were given;

2. a Third Quarter meeting was held in Mankato on April 14, 1989. Project funding was examined for F.Y. 1990 and issues were raised for the Fourth Quarter meeting.

The following is a brief synopsis of each program and how it aims to meet requirements of the federal grant:

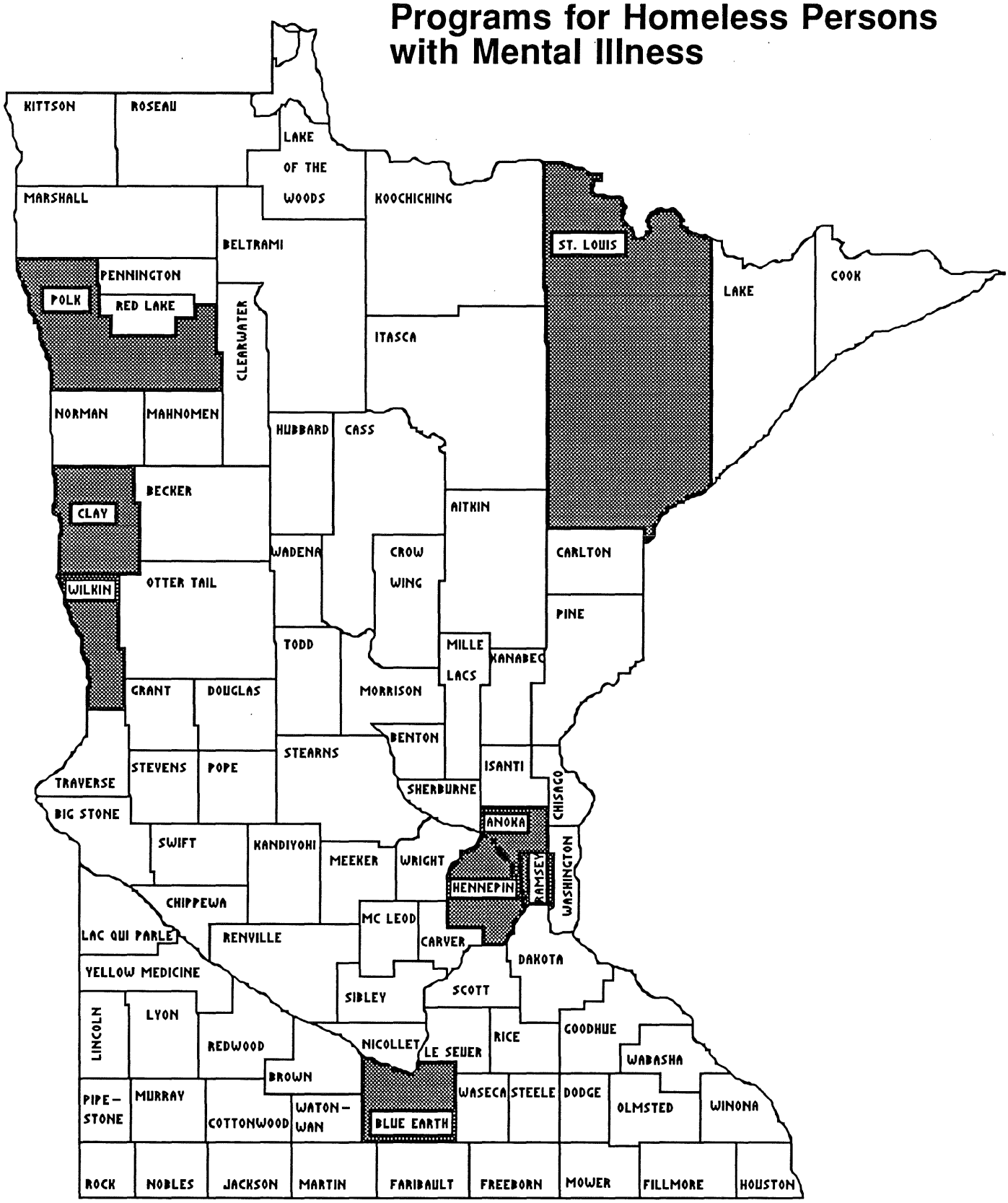
A. Anoka County. The county contracts with Rise, Incorporated to provide outreach and supportive housing services to homeless individuals. Rise has hired one and a half FTE outreach/service workers. Anoka County was selected because it represents a suburban area of the state, which accounted for 5.2% of all sheltered homeless individuals in Minnesota in 1987.

B. Blue Earth. In May 1987, Blue Earth sheltered 2.6% of the homeless individuals in Minnesota. The county operates the project itself through its Community Support staff. One outreach worker has been hired to walk the streets and visit shelters and drop-in centers.

C. Clay County. This county has contracted with Lakeland Mental Health Center's Community Support Program. Lakeland has hired two case managers to work with providers of services and shelter to homeless persons in Moorhead. The county was chosen based on the May 1987 shelter statistics that indicate Moorhead had 2.4% of sheltered homeless persons in Minnesota.

D. Hennepin County. 46.4% of the 1987 Minnesota homeless population are sheltered in Hennepin County. The county has hired seven staff in its Community Services Unit as assessment and psychological workers. Four of the staff work with the Homeless Primary Health staff to assess homeless people in shelters, drop-in centers and other locations in the county. The other three staff are a psychiatrist, a psychiatric nurse and a social worker. They work with persons who have mental health problems, train staff at the shelters and drop-in centers, and have shelter and drop-in "office hours" to see those people who wish to talk to someone about their mental health problems.

Programs for Homeless Persons with Mental Illness



E. Polk County. The Northwest Mental Health Center has taken the lead to coordinate a project with Polk County Social Services and Care and Share, Inc., a nonprofit program for homeless individuals. Two specialist have been hired to work with Care and Share staff to provide mental health care to those who come to the center and to others in the community. Crookston accounted for 6.4% of the homeless sheltered in 1987, this was the fourth largest number of homeless people sheltered.

F. Ramsey County. In 1987, St. Paul sheltered 23.3% of homeless individuals, which was half the number sheltered in Minneapolis. Ramsey County Human Services has contracted with a private mental health provider, South Metro Regional Treatment Center (SMRTC). SMRTC has hired four case managers to work with the providers of services to homeless persons. They use a pager system that allows the providers to access them at anytime.

G. St. Louis County. St. Louis County has contracted with the Human Development Center. Duluth has a network of providers of services to homeless persons with whom mental health personnel work. When an additional $176,000 became available, St. Louis County was also chosen to demonstrate a rural model of providing services to persons who are homeless and have mental illness. The northern St. Louis County Community Support Program hired a half-time person to travel the back roads of the county in search of homeless persons staying in county and state parks, abandoned buildings and wayside rest. (Minnesota's rural areas had sheltered 6.7% of persons who were homeless in the state.)

CURRENT ISSUES:

The DHS is one of five departments that make up the Interagency Task Force on Homelessness, which has prepared the State's 1989 Comprehensive Homeless Assistance Plan. The representative of DHS is the program advisor for mental health services to persons who are mentally ill.

For 1989 five issues are being addressed:

- homeless veterans;
- homeless youth;
- data privacy;
- social detoxification; and
- discharge planning.

These issues were also identified by the 16 staff in the demonstration projects.

In addition, research is needed to determine how many persons who are homeless have a serious and persistent mental illness. Persons who are homeless undoubtedly suffer mental stress; but it is unclear whether they have serious and persistent mental illness.

Rural Mental Health Services

BACKGROUND:

Minnesota has been one of four states participating in an 18-month NIMH Rural Mental Health Demonstration Project. The Demonstration is limited to 15 counties in the southwest area of the state and is funded through the MHD. The project was designed specifically to be time-limited; it will terminate in 1989. Additionally, the project is geographically limited; it only serves the southwest portion of the state.

Over the course of this decade adverse agricultural economic conditions combined with severe drought have served to increase stress reactions among farm families. Drought conditions throughout the state continue to have a variety effect on the farm economy. In general, economic conditions are better than in 1988, but a large central portion of the state remains without adequate rainfall. In virtually all portions of the state, moisture levels are low to barely adequate, with groundwater levels depleted everywhere. A recent survey of farm wives in the Southwest areas indicated that family stress levels are as high as they have ever been in the extreme west central portion of the state, but have eased elsewhere. Those with crops to sell have found a strong market, owing to drought-induced reduction of overall supply. FmHA foreclosures have eased for the time being throughout most of the southwest portion of the state.

The Demonstration Project has accomplished tasks in a number of program areas. Though the project is terminating, efforts will be made to build upon the linkages the project has established. Predictably, there has been much less progress in the larger, more intractable problems facing rural communities.

Examples of innovative service delivery are listed below:

1. Attempts to facilitate clergy involvement in rural community support has yielded good participation in a grant-sponsored "caring week". Local clergy were given materials and sermon ideas on stewardship and community support.

2. Grant staff have initiated adolescent peer counseling programs in a number of high schools, thanks to combined efforts by the Department of Human Services and contributions from a state foundation.

3. School folders and folios with community mental health information will be distributed at local high schools. Students have participated in the artwork and content of the folios.

4. Peer helping networks are being supported through training and organizational help by demonstration staff.

5. A teleconference which disseminated innovations through the project in August, 1989.

6. Regular newspaper columns emphasizing rural mental health have been well received, according to a recent survey by the grant administrator at the MHD.

Examples of interagency relations include:

1. The Interagency Committee for the grant has helped cement working relationships among its members, DHS, the Minnesota Department of Agriculture, and the Minnesota Extension Service. The three state agencies have begun exchanging information and resources, including expertise on projects.

2. The 26-member state advisory committee (composed of representatives from agencies ranging from the Minnesota Bankers Association to Lutheran Social Services) for the grant is completing formulation of recommendations for distribution to appropriate bodies. These recommendations are listed below.

3. Local linkages are numerous and varied, occurring pragmatically as programs are devised by the local interagency task forces.

CURRENT ISSUES:

Issues affecting rural areas and the demonstration project have not changed since the January 1989 plan. The issues and solutions mentioned below have been generated and continue to be addressed by the Rural State Advisory Committee.

1. Shortage of Professional Personnel

   There is a severe shortage of mental health service providers in rural areas. According to national data, less than 7% of child psychiatrists work in communities of 50,000 or less. According to another recent national study of 952 counties with less than 100 persons per square mile, 75% had no licensed psychologist. The reasons for this dearth of professionals are obvious: professionals prefer urban settings and are often forced by financial choices to seek communities with larger populations. Additionally, there is a failure of professional training programs to direct their students toward rural populations.

2. Lack of Coordination

   Programs for rural residents at risk for environmentally induced stress lack a coordinated approach. They are scattered unevenly throughout the state and are often uncoordinated with the goals of the mental health provider housing them. Many other programs are run by lay people without adequate credentials or supervision, simply because no alternative exists.

   Outreach programs set up for farm families and individuals must be connected with a wide range of resources and referral sources. What is needed is more information on programs and innovative alternatives.

Mental Health Services for Older Adults

BACKGROUND:

According to 1985 population estimates, 489,646 Minnesotans are aged 65 and older. About 49,000 are in nursing or board and care homes, leaving about 440,646 living in the community; 6,000 of whom are receiving community and in-home long term care services. National studies indicate:

1. 50-65% of elderly persons in nursing home have serious mental health problems, or 24,500 to 31,850 people in Minnesota;
2. 15-25% of elderly persons in the community have moderate to severe mental health problems, or 66,096 to 110,162 people in Minnesota;
3. about 85% of elderly persons living in the community have received no diagnostic assessment or treatment;
4. about 3% of elderly persons with moderate to severe mental health problems who are living in the community are using community based mental health services, or 1,947 to 3,278 Minnesotans;
5. at least 50% of the major mental disorders of old age can be attributed to physical causes such as Alzheimer's Disease (33,048 to 55,081 Minnesotans);
6. 65% of elderly persons may have depression, or 318,270 Minnesotans, according to estimates by Roybal (1984); 16% of all suicides in 1978 occurred among persons over age 65.

Because of these and other factors, the MHD has initiated a project targeting CSP services at older adults. The project includes a rural demonstration in St. Louis County, a sparsely populated, large county in northeastern Minnesota. (Forty-one percent of Minnesota's older adults live in rural areas: 35% in small towns, 5% on small farms and 1% in heavily forested and widely scattered areas.) The population of 210,000 (19% are 60 years of age or older) live in 6,000 square miles, with 45% of the population residing in the 5,000 square mile area of northern St. Louis County. Most of the population of northern St. Louis County (25,000) lives in the Virginia-Hibbing area, the site of the demonstration project. The primary economic activity of the county has revolved around iron ore mining.

Depletion of natural resources (iron and lumber) and industry-related declines have produced extremely high rates of unemployment.

Recognizing that the mental health problems of older adults are not the sole responsibility of the mental health system nor of the aging network, the project goals are to:

1. Enhance collaboration and linkages between the MHD and the Aging, Long Term Care, Health and Social Services networks in the state.

2. Clarify roles among these networks to assist in identifying service gaps and avoid competition for valuable, scarce resources.

3. Strengthen the use of community-based services and facilities and decrease the use of more restrictive alternatives.

4. Stimulate creative approaches to providing an accessible, high quality and cost effective array of mental health services.

5. Enhance provider knowledge and skills with increased emphasis on geriatric training for mental health providers and on sensitivity to mental health needs for geriatric care providers.

6. Collect data for further planning and evaluation in order to build on the model to adapt it to other settings.

7. Promote public education about mental health and aging.

The State Project Director in the MHD is responsible for overall monitoring and evaluation as well as for developing linkages with Mental Health, Aging, Long Term Care, Social Services and Gerontology Divisions within DHS and also with the State Departments of Health and Veterans Affairs and the federal Veterans Administration. The State Project Director is also involved in implementing the Comprehensive Mental Health Act; analyzing statewide data on mental health needs and services to older adults; assuring that the mental health needs of older adults are addressed in local mental health proposals and therefore in the redesign of the mental health system in Minnesota; and providing technical assistance to local mental health authorities and providers.

The county role is that of local planning and coordination, pre-admission screening and alternative care grants, case management and other generalist services. St. Louis County has a relatively long history of well organized social services including mental health and aging, but the linkage between the mental health system and the aging and other health and human services networks was not formalized. The Range Mental Health Center in Virginia (in St. Louis County) provides the contractual, specialized treatment services such as adult day care and treatment, home care, supervised apartment services, respite services, family support, inpatient and outpatient geriatric psychiatry service, medication management, emergency service, and consultation and outreach to nursing homes, board and lodging facilities, senior centers and senior high rises. Both St. Louis County Social Services and Range Mental Health Center are involved in voluntary networks of service providers and consumers. The grant capitalizes on these networks and serves to stimulate them to be sensitive to the mental health needs of older adults and to promote their involvement in the planning and delivery of services.

In addition to the NIMH funded project, the MHD funded eight additional projects in 1988 with the federal ADM Block Grant. Each project demonstrates a different model or approach to providing mental health services for older adults. A description of the project models follows:

PROJECT MODELS: Community Based Mental Health Services
for Older Adults (Funded by Federal ADM Block Grant)

1. Lead Agency: Dakota County Community Mental Health Center

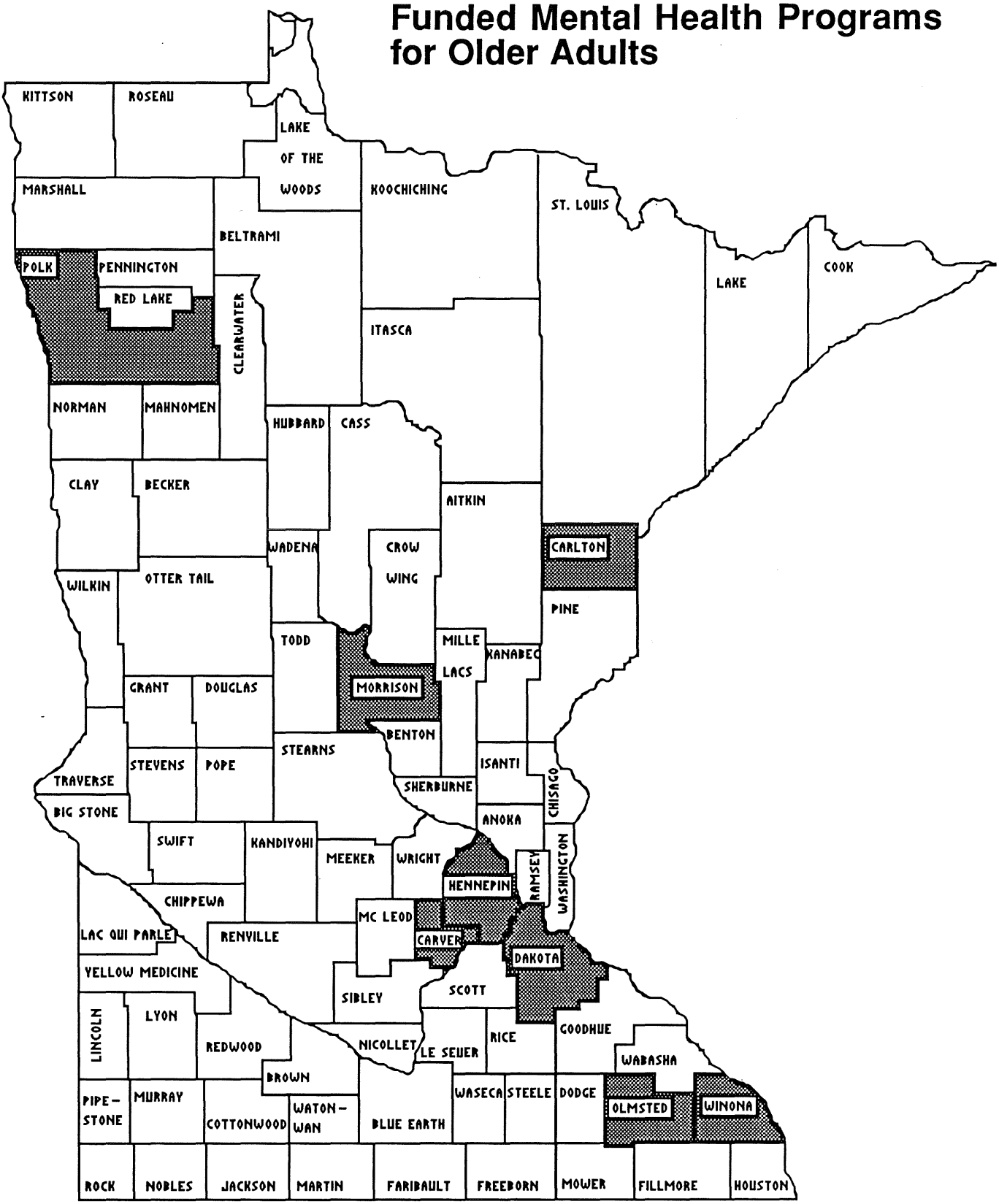
   Other Agency(ies): Community Health Services of Dakota County

   Focus: To tie together existing providers, provide for special needs and not be costly (addresses system barriers).

2.* Lead Agency: Community Health Nursing (Olmsted County)

   Other Agency(ies): Community Mental Health Center
   County Mental Health Center
   County Chemical Dependency Unit
   County Senior Services
   Area Agency on Aging

Federal Block Grant - Funded Mental Health Programs for Older Adults



Focus: To address training and coordination issues in a "resource (manpower) rich" area (addresses provider barriers).

3.* Lead Agency: Hiawatha Valley Mental Health Center and Winona County Community Health Nursing

Other Agency(ies): Area Agency on Aging
County Mental Health Service
Baccalaureate Nursing Program
County Senior Services

Focus: To develop a comprehensive, coordinated interagency system to provide a continuum of services: outreach, assessment, treatment, education (addresses system behavior).

4.* Lead Agency: Polk County Social Services Board

Other Agency(ies): Northwestern Community Mental Health Center
Community Health Nursing
Area Agency on Aging/County Senior Services

Focus: To provide coordination (developing a combined Mental Health and Aging Advisory Council), service (outreach, assessment and treatment case management) and consultation (addresses system barriers).

5.* Lead Agency: Carver County Human Services Department
(Includes Social Services, Mental Health, Community Health and Aging)

Other Agency(ies): Community Mental Health Center

Focus: To address client, provider and system barriers through education and outreach in order to assist older adults to utilize services available.

(This project did not reapply for funding for the 1990 state fiscal year. The county Human Service Department is incorporating the activities into the overall programs.)

6.* Lead Agency: Morrison County Social Services and County Mental Health Services (CSP)

Other Agency(ies): County Extension Service
Community Health Services

Focus: To provide coordination, case management and education.

7.* Lead Agency: Carlton County Social Services, County Senior Services and Community Mental Health Center (CSP)

Other Agency(ies): Community Health Services

Focus: To address client barriers through education to older adults and their families.

8.* Lead Agency: Pyramid Community Mental Health Center

Other Agency(ies): Senior Services Division of
Hennepin County Social Services Nursing

Focus: To address client and provider barriers through education and training: peer counselors, older adults and their families, health care providers, older adults as spokepersons.

*Denotes rural project.

Compulsive Gambling

BACKGROUND:

The 1989 Legislature directed DHS to establish a program for the treatment of compulsive gamblers. The program may include the establishment of a statewide toll-free number, resource library, public education programs, regional in-service training programs and conferences for health care professionals, educators, treatment providers, employee assistance programs, and criminal justice representatives; and the establishment of certification standards for programs and service providers. The program may also include inpatient and outpatient treatment and rehabilitation services and research studies. The research studies must include baseline and prevalence studies for adolescents and adults to identify those at the highest risk. $300,000 in fiscal year 1990 and $300,000 in fiscal year 1991 was appropriated to implement the compulsive gambling treatment program.

The program is being developed in the Special Projects Unit of the MHD. The plan for state F.Y. 1990 is as follows:

1. Staffing: Prepare job description and negotiate job classification by August 1, 1989. Have the position filled by early October 1989.

2. Advisory Task Force: Organize a regional based task force during October/December 1989.

3. Research (incidence, and prevalence for adults and adolescents): Prepare an RFP during October 1989; publish RFP by November and plan to begin conducting the research project by January 1990.

4. In-Service Training for Community Treatment Personnel: Prepare RFP during December 1989/January 1990, with plan to begin conducting the training sessions during February and March of 1990. Efforts made to enter into a contract with the Minnesota Council on Compulsive Gambling for this service.

5. Public Education and Information: Prepare an RFP during February/March 1990 and plan for the contract to be effective by April 1990.

6. Toll-Free Telephone Line: In place by April 1990.

7. Community Treatment Grants: If time and funds allow, make one or two grants for period beginning April 1, 1990.

The overall goal for the MHD is to utilize special projects as appropriate to promote the development of a unified service delivery system for children and adults which incorporates the culturally, chronologically, and geographically diverse mental health needs of Minnesotans through integration into the mental health system and development of appropriate special programs.

OBJECTIVES AND TASKS FOR MHD SPECIAL PROJECTS:

A. To develop systems to identify underserved persons and populations or groups of persons in need of services.

TASKS:

1. Provide technical assistance to counties and providers on meeting diverse needs -- ongoing.
2. Develop/continue grant programs for older adults, persons who are homeless, Indian communities and other groups identified as having special needs -- ongoing.
3. Conduct quarterly meetings of persons working with Homelessness/MI projects -- July, 1989, October, 1989, January, 1990 and May, 1990.
4. Establish Compulsive Gambling Task Force -- October-December 1989.
5. Develop and publish RFP for Compulsive Gambling Incidence and Prevalence Study -- November, 1989.
6. Receive and review proposals for Compulsive Gambling Incidence and Prevalence Study -- November, 1989.
7. Award grant for Compulsive Gambling Incidence and Prevalence Study -- November, 1989.
8. Develop contract for public education campaign on compulsive gambling -- April, 1990.
9. Provide staff support and attendance at SMHAC and Children's Subcommittee regional hearings -- ongoing.
10. Review county plans to assure they address cultural, age, and geographically diverse mental health needs of each county -- August, 1989; November, 1989.
11. Collect appropriate data on service utilization and unmet needs -- ongoing.
12. Review and plan for special projects need for ongoing funding, including public education, housing support services, and homeless services - June 1, 1990.

B. To assure that services for persons and populations or groups of persons with diverse mental health needs are appropriately addressed by the system.

TASKS:

1. Conduct site visits at special projects:
   a. Homelessness
      Moorhead - July, 1989
      Duluth - August 1989
      Ramsey County - August 1989
      Crookston - August 1989
      Hennepin County- October 1989
      Hibbing - October 1989
      Anoka County - January 1990
      Mankato - February 1990
   b. Rural Crisis -- July, 1989 (with external evaluators).
   c. Indian Communities:
      Mille Lacs, Leech Lake, Net Lake, Grand Portage -- July-October 1989.
      Upper Midwest Indian Center, Minneapolis Indian Health Board -- October, 1989 - January, 1990.
      Shakopee, Upper Sioux Community, Lower Sioux Community -- January - April 1990.
   d. Older Adults:
      NIMH: August, December, 1989
      ADM: July, 1989, January, 1990
2. Review reports from special projects -- quarterly and annually.
3. Prepare and distribute final report on Refugee Mental Health Project -- August, 1989.

4. Prepare and distribute final report on Rural Crisis Project -- August, 1989.
5. Prepare and distribute final report on Older Adult Project -- December, 1989.
6. Amend regional consultant quarterly meetings, coordinate site visits with regional consultants, attend and assist in Mental Health Division conferences -- ongoing.
7. Present special population/special project issues to SMHAC -- ongoing.
8. Prepare for, attend and follow up special population/special project advisory groups:
   a. Indian communities -- July, October, 1989 and January, April 1990.
   b. Compulsive Gambling -- October/November, 1989.
   c. HRD -- January, 1990.
9. Hire new staff for special projects:
   a. Compulsive Gambling -- September, 1989.
   b. Human Resource Development -- November, 1989.
   c. Older Adults -- July, 1989.
10. Plan and conduct statewide conferences to address diverse needs:
   a. Older Adults -- October, 1989.
   b. Indian Community -- May-June 1990.
11. Prepare and distribute Homelessness Newsletter -- September, 1989; December, 1989; March, 1990.
12. Develop/update homelessness slide presentation -- September, 1989.
13. Conduct rural project teleconference in Marshall -- August, 1989.
14. Present materials at national rural mental health and rural social work meetings -- July, 1989; August, 1989.
15. Complete contract and begin provider training regarding compulsive gambling -- February, 1990.
16. Establish compulsive gambling hotline -- April 1990.
17. Hold meetings with at least 3 special populations advocates on state plan -- ongoing.

C. To maximize all existing and/or develop new funding resources to assure that the diverse mental health needs of Minnesotans are incorporated.

TASKS:

1. Obtain input to RFPs, grant and plan reviews from specialized needs consumers through Division mailings -- ongoing.
2. Assess carry over funds (from S.F.Y. 89) for Homelessness and Mental Illness projects and distribute to projects -- September, 1989.
3. Prepare and distribute F.Y. 91 RFPs:
   a. Homelessness -- September, 1989.
   b. Older Adults -- January, 1990.
   c. Indian Communities -- January, 1990.
4. Review proposals from F.Y. 91 RFPs:
   a. Homelessness -- April, 1990.
   b. Older Adults -- April, 1990.
   c. Indian Communities -- July-August, 1989.
5. Prepare and distribute grant awards:
   a. Homelessness -- June, 1990.
   b. Older Adults -- June, 1990.
   c. Indian Communities -- September, 1989.
6. Develop position description for Compulsive Gambling Program Director -- August 1, 1989.
7. Hire Compulsive Gambling Program Director -- September, 1989.
8. Assess possibility of extending NIMH Older Adult Grant and request extension, if appropriate -- September 1989.

D. To target the use of all available funding sources in providing services to diverse population groups.

TASKS:

1. Include needs of diverse populations as part of all RFPs, grant applications, and plans -- ongoing.
2. Seek funding as appropriate from special grants to fund services -- ongoing.
3. With Departments of Commerce and Health, identify issues for future study regarding availability of insurance coverage for mental health services -- June, 1990.

E. To develop state level inter- and intra-agency coordination for the development, implementation, and funding of mental health services for diverse population groups.

TASKS:

1. Develop policy statement for Housing Task Force -- October, 1989.
2. Assist in preparing CHAP (Comprehensive Homelessness Assistance Plan) for 1990 -- January 1, 1990.
3. Develop discharge planning paper with Interagency Homelessness Task Force -- September 15, 1989.
4. Continue coordination with Minnesota Extension Services and Minnesota Department of Agriculture regarding rural mental health issues -- ongoing.
5. Participate in Governor's HIV Issue Team -- August, 1989, November, 1989, February, 1990, May, 1990.
6. Continue coordination of multicultural mental health issues with Chemical Dependency and Children's Divisions -- ongoing.
7. Explore including MHD representative on Interagency Board on Quality Assurance (Long Term Care) -- November, 1989.
8. Establish state level intra-agency library on homelessness, including mental health issues -- July 15, 1989.
9. Prepare agreement with DHS Refugee and Immigrant Assistance Division (RIAD) for supervising administration of mental health/social adjustment funds -- July 1989.

ANTI-STIGMA EDUCATIONAL EFFORTS

The MHD continues to promote an overall goal of lessening the stigma of emotional disturbance and mental illness. In the past year, the Minnesota Department of Health developed and implemented, through a contract with DHS, a self-esteem and wellness program targeted at young children. The program was developed in conjunction with the MHD and the State Mental Health Advisory Council

The MHD recently initiated a new undertaking: developing and implementing an anti-stigma public education campaign using special projects funds appropriated by the Legislature. The campaign will focus on either of two subjects: 1) battling negative images of persons with mental illness; or 2) addressing the stigma of obtaining mental health services.

The MHD's objectives and tasks toward actively lessening stigma are:

OBJECTIVES:

A. To develop an anti-stigma campaign RFP, contract, and program.

TASKS:

1. Develop an anti-stigma RFP by July 1, 1989.
2. Finalize contract for anti-stigma campaign -- August 31, 1989.
3. Negotiate continuation of depression education contract -- July, 1989.
4. Consult with appropriate SMHAC subcommittee on priorities, target populations, etc. -- March, 1990.
5. Consult with consumer and family organizations and representative of special populations on methods of addressing stigma -- March, 1990.

B. To integrate anti-stigma efforts throughout all activities of the Division.

TASKS:

1. With assistance of DHS Public Information Officer, develop Division policy regarding stigmatizing jargon and appropriate terminology -- November, 1989.

C. To involve state and local mental health advisory councils, other advisory groups, consumers and special initiatives grant projects in promoting anti-stigma efforts.

TASKS:

1. Require mailings of contractors to state special initiative, and local advisory councils -- August, 1989.

The MHD also has as a goal the empowerment of adult and child consumers of mental health services and their families to participate in the development of the mental health service system, and in the development of their individual treatment plans.

This goal has brought about renewed dedication on the part of the MHD to work on behalf of consumers and families. Objectives and tasks toward this end include:

OBJECTIVES:

A. To provide active outreach in order to elicit consumer input.

TASKS:

1. Develop a consumers-only mailing list -- September, 1989.
2. Regularly survey consumer members of local advisory councils and other consumer organizations on division policies, programs, etc. -- ongoing.
3. Identify classes of consumers not currently involved in creation of the mental health system and provision of services -- December, 1989.
4. Plan methods of including classes of consumers not currently involved in mental health system planning and development -- January, 1990.
5. Include consumers and family members in rulemaking process -- ongoing.
6. Encourage consumer skill development through participation in workshops, conferences, and training -- ongoing.
7. Assess the possibility for reimbursement of transportation costs to enable consumers to participate in DHS processes -- January, 1990.
8. Hold meetings with at least 4 consumer/family organizations on the state plan -- July, 1989.
9. Meet individually with consumer members of SMHAC and subcommittees, regarding state plan -- ongoing.
10. Distribute anonymous needs assessment survey to consumer members of local mental health advisory council members -- March, 1990.

B. To assure involvement of families and consumers in the treatment process.

TASKS:

1. Arrange for Monitoring Division to assess, monitor sample ITPs of individual clients for statewide system impact for family and consumer involvement -- August, 1989.
2. Review county plans and grant applications for methods of assuring such involvement -- August/November 1989.

C. To promote the employment of consumers.

TASKS:

1. Include consumers in solicitations for hiring -- ongoing.
2. Encourage consumer hiring as criterion in RFP/grant process, as appropriate -- ongoing.
3. Include employment themes into anti-stigma campaigns -- July, 1989.
4. Explore coordination with academic institutions and technical institutes to train additional vocational rehabilitation specialists -- March, 1990.
5. With Department of Employee Relations, Personnel Division, and Department Medical Director, develop DHS policy to encourage employment of persons with mental illness and coordinate with HRD effort -- April 1990.

Chapter VII Human Resource Development Issues

HUMAN RESOURCE DEVELOPMENT

BACKGROUND:

Although DHS has recognized the significance of mental health human resource development (HRD), it has not been a high priority until recently as the role of the RTCs and of related personnel changes, and as the third year of implementation of the 1987 Comprehensive Mental Health Act begins. DHS has not had a systematic mental health HRD plan, nor have there been formal liaisons with academic institutions. Furthermore, the data which has been collected on the mental health work force, other than on the Department's employees in the RTCs, has been incidental and therefore of minimal benefit for planning purposes.

Minnesota is at a critical point in developing and shaping the mental health system to meet the needs of persons with mental illness appropriately, especially those with serious and persistent mental illness. To assure that the system will address future as well as currently identified needs and to recognize that mental health HRD efforts involve several program divisions with DHS, the Assistant Commissioner responsible for Personnel and Staff Development established a HRD work group representing the Mental Health, Developmental Disabilities, Chemical Dependency, Residential Programs, Licensing, Personnel and Staff Development Divisions to address human resources issues as they relate to RTC personnel. This work group has been replaced by the RTC Transition Team, which includes the DHS Medical Director, and whose purpose is to guide changes made in the role and function of the RTCs.

In addition, the MHD has utilized the expertise developed by its special initiatives (such as those for refugees, American Indians, and the elderly) and information gathered in hearings held by the State Advisory Council on Mental Health to identify the HRD needs of specific target populations and geographic areas of the state. With this information, the MHD has renewed its commitment to meet the specialized service needs of children, refugees, American Indians, elderly persons, those in rural areas, homeless persons and others. The MHD also will target the unique expertise and insights of consumers where appropriate in planning for a comprehensive HRD system.

CURRENT ISSUES:

Minnesota's RTCs are located throughout the state, with only one in the Minneapolis/St. Paul metropolitan area. The distance from the metropolitan area to the other RTCs ranges from 73 to 190 miles. In addition, Minnesota is largely a rural state. Although other population centers include Rochester, St. Cloud, and Duluth, approximately 50% of the population is scattered throughout 95% of the geographic area, either in small agricultural communities and the surrounding farms or in heavily forested areas with small communities and scattered, often isolated home sites. These present challenges for the creation of a systematic, coordinated and comprehensive mental health HRD program.

The 1987 Comprehensive Mental Health Act also created a framework for a unified, statewide system of comprehensive community based mental health services. After two years of effort to implement the law, the state's renewed commitment to mental health services is evident. There still is much work to be done and DHS recognizes the relationship of a strong human resource development capacity to the system's service delivery goals.

The HRD capacity needed to continue to make progress in improving the delivery of community based mental health services is not yet available. For example, Minnesota has not been able to fully participate in the activities of the Midwest Consortium for Leadership Development because of a lack of a focal point for mental health HRD. Also, NIMH commented in the review of Minnesota's first P.L. 99-660 State Plan that the state needs to articulate the role of state supported higher education in human resource development for mental health programming, and provide more details on such issues as the required number and distribution of professionals. Furthermore, DHS needs to include more details on how goals and objectives will be implemented, including financial and human resource needs. To improve planning and to participate fully in activities such as the Midwest Consortium for Leadership Development, DHS must build its mental health HRD capacity. In view of both the continuing implementation of the Comprehensive Mental Health Act and changes in the RTCs, the time is ripe for developing this capacity.

In May 1989, the MHD submitted its HRD capacity building proposal to NIMH for a three year grant. The objectives stated in the proposal were:

A. To develop appropriate planning linkages with academic institutions, mental health service agencies, and other related agencies in order to encourage research into mental illness and effective treatment modalities, and promote appropriate training of the state mental health work force.

TASKS:

1. Assess relationships of the Department with colleges and universities in the state for the purpose of establishing productive linkages -- December, 1989.
2. Plan mechanisms for improving coordination which will enhance mental health human resource development throughout the system -- January, 1990.
3. Review policies regarding the roles, responsibilities and coordination in relationship to the Department's overall strategic and operational plans to support staff development, recruitment, retention and distribution/redistribution so as to continue to improve the delivery of mental health services in the state in the most cost-effective manner -- May, 1990.
4. Plan cooperative linkages between the Department and academic institutions -- February, 1990.
5. Assess the nature of internship opportunities for students in public sector mental health for the purpose of supporting and enhancing those internships -- May, 1990.
6. Analyze existing situation to identify and describe current mental health resource development strengths and limitations, barriers, and constraints -- January, 1990.
7. Identify and encourage methods to expand collaboration between public sector mental health systems and the Department -- June, 1990.
8. Develop linkages with organizations responsible for licensure, certification and reimbursement policies and processes affecting the deployment and utilization of the mental health system's work force -- June, 1990.
9. Participate in National HRD Assembly -- October, 1990.
10. Participate in DHS Institutional Review Board -- monthly.
11. Participate in the development of Public/Academic Liaison Initiative (PALI) report (M.S. 245.4861) -- June 15, 1990.

12. Develop a Draft Mental Health Human Resource Development Plan to be included in the Three-Year Plan -- June 1990.
13. Advise appropriate SMHAC subcommittees on progress -- ongoing.

B. Begin to develop a separate and distinct State Human Resource Development Plan to include into the agency's State Mental Health Services Plan.

TASKS:

1. Assimilate minority concerns, children's issues, rural service issues and consumer input into the draft State Human Resource Development Plan -- June, 1990.
2. Identify human resource development issues and priorities -- January, 1990.
3. Develop a draft Human Resource Development mission statement including goals and objectives consistent with statutory requirements -- June, 1990.
4. Assess current problems facing the Department and incorporate into the plan -- June, 1990.
   a. Client-based service outcomes.
   b. Changing role of hospital personnel.
   c. Client needs link to staff skills.
   d. Training support for staff who want to change roles.
   e. Quality assurance and training linkages.
5. Enhance opportunities for involvement of the academic community in planning -- June, 1990.
6. Develop and improve training for mental health administrators at state and county levels through full participation in the Midwest Consortium for Leadership Development -- April, 1990.
7. Explore the feasibility of joint appointments and joint recruitment with academic and service institutions -- June, 1990.

C. Implement a minimum HRD data set which interfaces systematically with the organizational and client data sets.

TASKS:

1. Analyze existing documents to determine what elements of the minimum HRD data set are not implemented, in order to assure a data and information system that describes the current work force -- February, 1990.
2. Assess how the HRD data set can be interfaced systematically with organizational and client data sets to help determine the short and long term needs and begin appropriate planning -- February, 1990.
3. Prepare a report of specific kinds of work force data to be collected -- May, 1990.
4. Prepare a plan for developing a data system to meet human resource development needs -- June, 1990.

Chapter VIII Mental Health Funding

1989 Legislative Action

The Minnesota Legislature concluded its 1989 Session on May 22, 1989, with a number of significant decisions regarding funding of mental health services. These decisions were partly due to issues identified in Minnesota's Three-Year Plan for Services to Persons with Mental Illness and partly due to public comments regarding the Three-Year Plan.

A major theme evident throughout the 1989 Legislature's funding decisions was a priority for adults with serious and persistent mental illness and for children with severe emotional disturbance. 1989 amendments to the 1987 Comprehensive Mental Health Act for adults, and the 1989 Children's Mental Health Act, spell out this priority for the entire statewide mental health system. The 1989 Legislature concentrated almost all new state mental health funds on the group of persons which NIMH has referred to as "the long-term mentally ill."

These decisions include:

- New state funding of $2.3 million for the initial phases of a comprehensive children's mental health system. Full funding for the new mandates which are scheduled to be effective in 1991 and 1992 is expected to be $27 million in the next biennium. See Chapter IV for a more complete discussion of the state's plans for implementing the children's legislation.

- New state funding of $3.1 million over the next two years for continued expansion of community support programs for adults with serious and persistent mental illness. See Chapter V for a more complete discussion of the state's plans for addressing this issue.

- New state funding of $6.8 million to provide case management, residential and medical services for persons with mental illness who have lost their Medical Assistance (MA) eligibility due to their residence in facilities which have been determined to be Institutions for Mental Diseases (IMDs). See Chapter V for a more complete discussion of the state's plans for addressing the IMD issue.

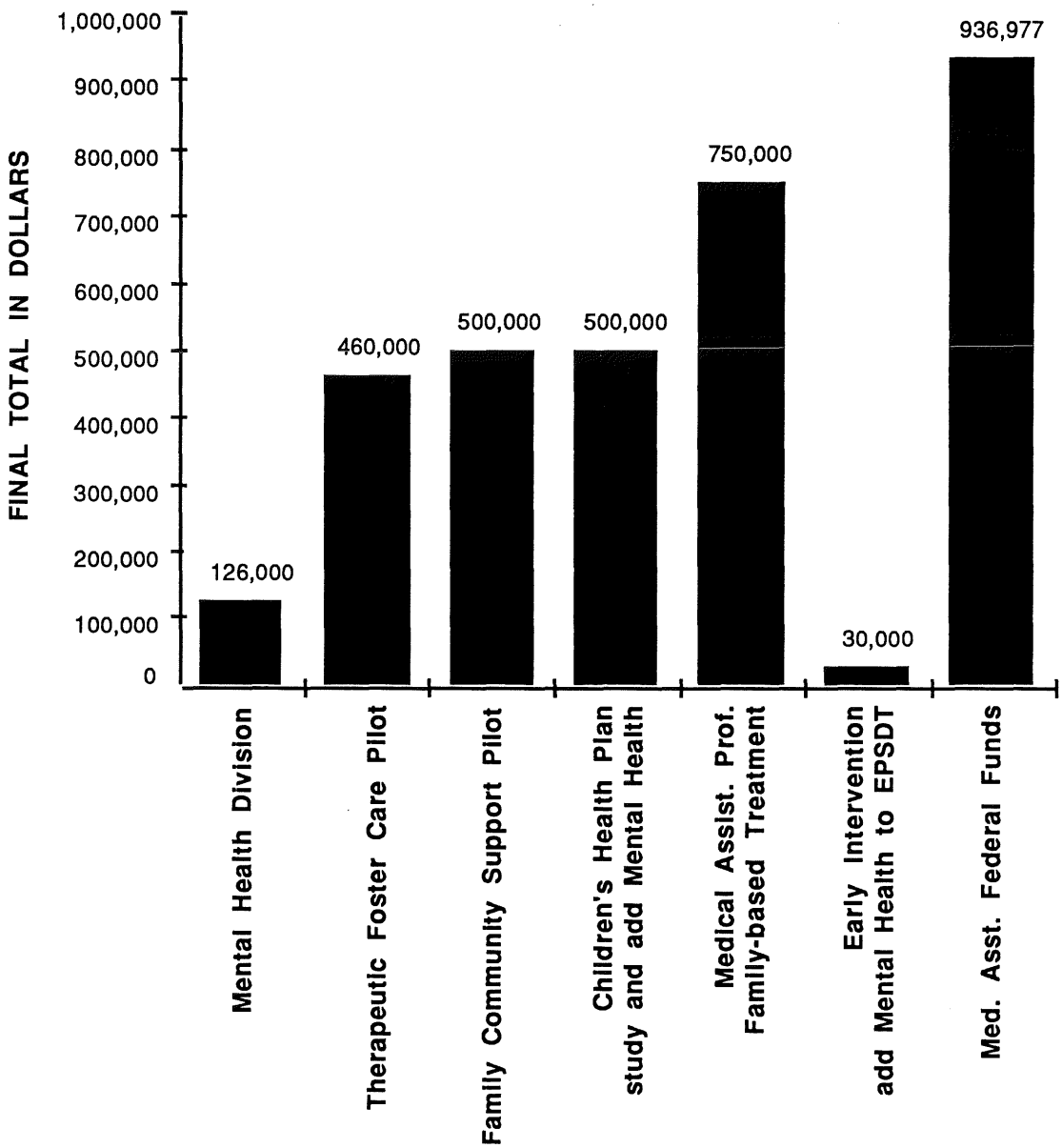
- New state funding of approximately $3.0 million for community alternatives for persons with mental illness who will be required to move out of nursing homes due to federal requirements (OBRA-87). See Chapter IV for a more complete discussion of the state's plans for addressing this issue.

- New legislation and state funding of $600,000 to establish a program for treatment of compulsive gambling.

- A policy commitment and initial funding to plan for the development of small state-operated community facilities for persons with mental illness as an alternative to continued long-term residence in RTCs.

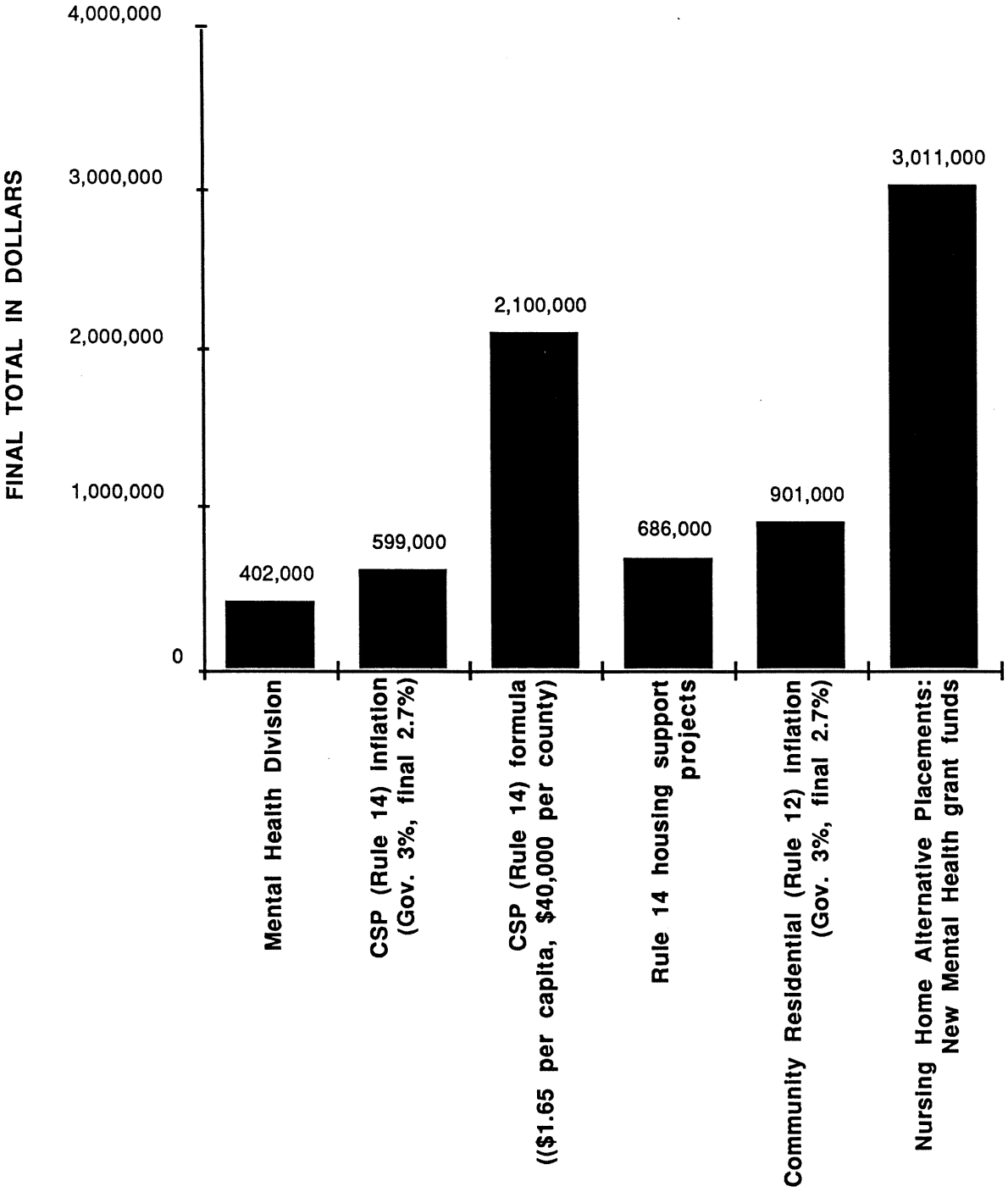
In addition to the appropriations decisions, the 1989 Legislature requested DHS to conduct a number of studies related to the funding system for all mental health services and to recommend improvements to the 1990 and 1991 Legislatures.

1990-91 Biennium
New Funds
Children's Mental Health



Total State and Federal - Children's Mental Health = $3,302,977

1990-91 Biennium
New Funds
"Mental Health Initiative" - Adults



Total "Mental Health Initiative" - Adults = $7,699,000

- DHS must recommend measures by February 15, 1990 to improve the efficiency of the state's mental health funding mechanisms, and to standardize and consolidate fiscal and program reporting. Concerns have been expressed that mental health funding and fiscal reporting is too fragmented, and that the different funding mechanisms need to be more streamlined and standardized.

- DHS must, by January 31, 1991, complete a review of all mental health funds and recommend alternative means of funding mental health services. This request arose from the planing process for the future role of the RTCs, and related particularly to concerns about the current separation of RTC and community mental health funds.

- DHS and the Department of Health must develop a joint report for the 1991 Legislature for increasing the number of small community-based residential programs and support services for persons with mental illness. In addition, DHS is required to adjust funding mechanisms to reflect the requirements of different levels of residential treatment and support services.

- DHS must report to the 1990 Legislature regarding improved screening mechanisms for residential and inpatient services, including an evaluation of the impact of different financial reimbursement rules for different types of placements.

- DHS and the Department of Health must develop a joint report for the 1990 Legislature regarding the existing use of board and lodging facilities throughout the state and recommendations regarding regulation and funding. It is estimated that over 1,000 persons with mental illness reside in board and lodging facilities which are neither licensed nor adequately staffed to serve persons with mental illness.

Funding for State Administration

According to the most recent national data available, Minnesota has the lowest spending in the country for state level mental health administration. In 1987, Minnesota spent twelve cents per capita for mental health administration. The national average was almost ten times Minnesota's level.

The 1987 Legislature approved a doubling of state spending for mental health administration for 1988. Even with this increase, it is expected that Minnesota will remain in the bottom 10 nationally on per capita spending for mental health administration.

State level expenses for planning, evaluation and administration of mental health services are expected to remain at the 1988 level for the next two years. While the 1989 Legislature provided a small increase in state funding for planning and administration, federal funding (especially through the mental health portion of the ADM block grant) has declined. Minnesota's federal mental health block grant for federal F.Y. 1988 was $122,000 less than 1987; the federal 1989 grant, in turn is $201,000 less than 1988. (Minnesota has used 5% of its block grant for administration and 15% for planning and evaluation.) This cutback in federal funds has required new state funding to be used to maintain existing staff who used to be on federal funds.

During the past two years, Minnesota has also relied heavily on the special $82,000 federal planning grant. Staff funded by this grant have been a critical part of the major changes now underway in Minnesota's mental health system. However, despite the Congressional requirement that this three-year plan be updated again next year, it appears that the planning grant will not be renewed next year.

Additional Graphics Describing Current Funding

This update includes the following graphics, which were developed for the 1989 Legislature to illustrate computer spreadsheets which were included in the January 1989 Three-Year Plan:

1. 1989 Estimated DHS Funding for Mental Health Services:

   This pie chart describes the proportion of DHS funding which goes for each of the major types of mental health services. "Regional treatment centers" means state-operated inpatient services. "Residential treatment" means privately operated community residential treatment which is licensed to serve persons with mental illness.

2. Federal, State and County Shares of Funding for Selected Mental Health Services:

   This chart shows that the largest share of state funding goes for RTC state-operated inpatient services.

3. Federal, State and County Funding Sources: Mental Health Services for Children and Adults.

   This chart shows that counties are the primary funding source for mental health services for children.

4. Expenditures Department of Human Services Mental Health:

   This chart describes the increasing community mental health state funding administered by the Mental Health Division of the Department of Human Services. For 1990-1991, the Governor requested an increase of $9,858,000. The Legislature approved $9,145,000 (not including the IMD package).

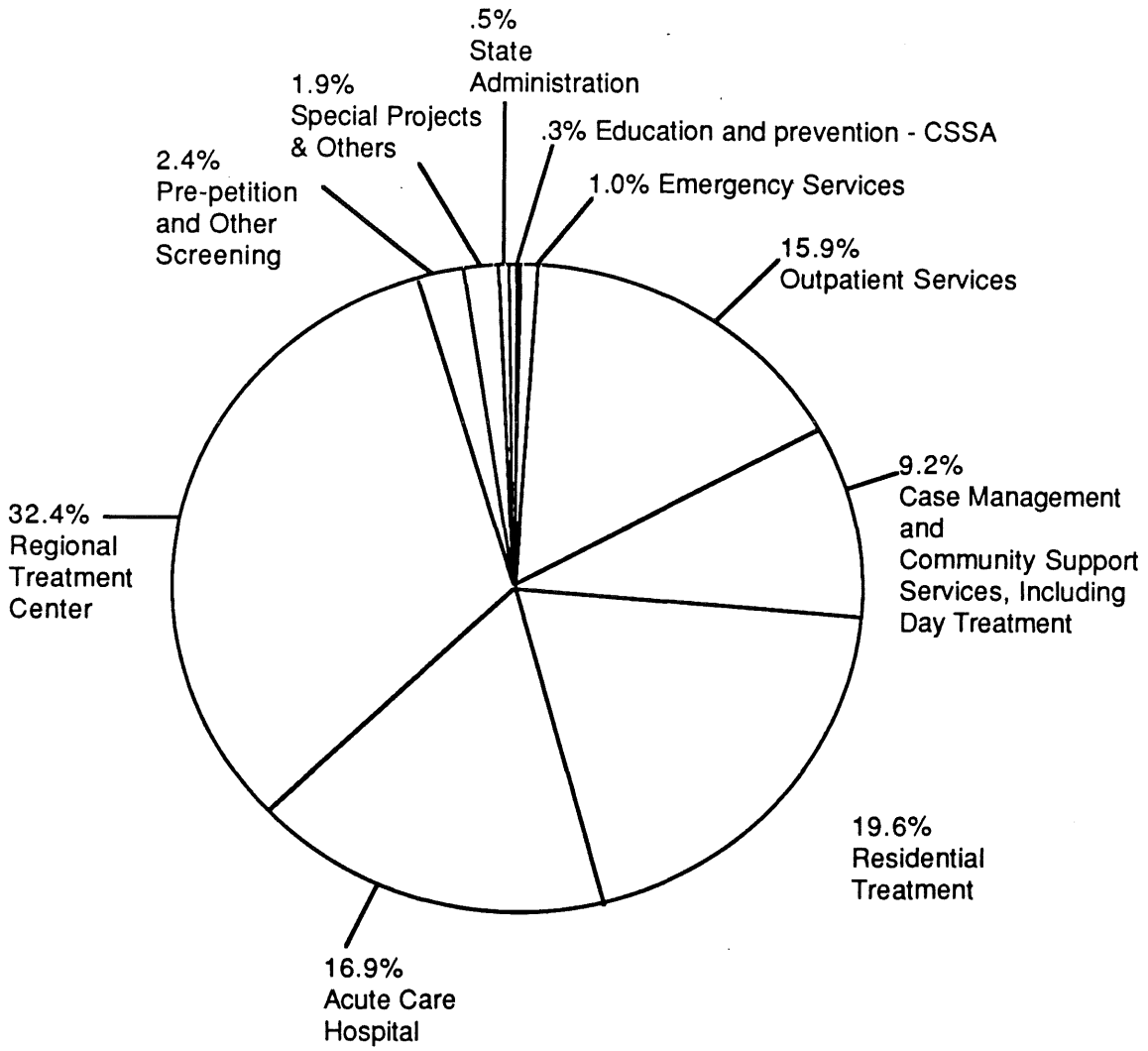
These graphics proved to be helpful in obtaining legislative approval for new community mental health service mandates and the associated funding.

In addition, two graphics are attached highlighting the Governor's 1989 initiatives for children's mental health and adult community based mental health. The dollars quoted in these graphics are the final amounts approved by the Legislature, which were slightly less than the Governor recommended.

Fiscal Projections for 1990-1991

County agencies are preparing county mental health plans and budgets for 1990 and 1991 to reflect the 1989 Legislature's new service mandates and new state funding. Counties have significant flexibility in deciding how much local and other funding to add to the state funds. Similar county budgets (prepared in 1988 for 1989) were the key source for the 1989 comprehensive fiscal projections in the January 1989 Three-Year Plan.

1989
Estimated DHS Funding for Mental Health Services



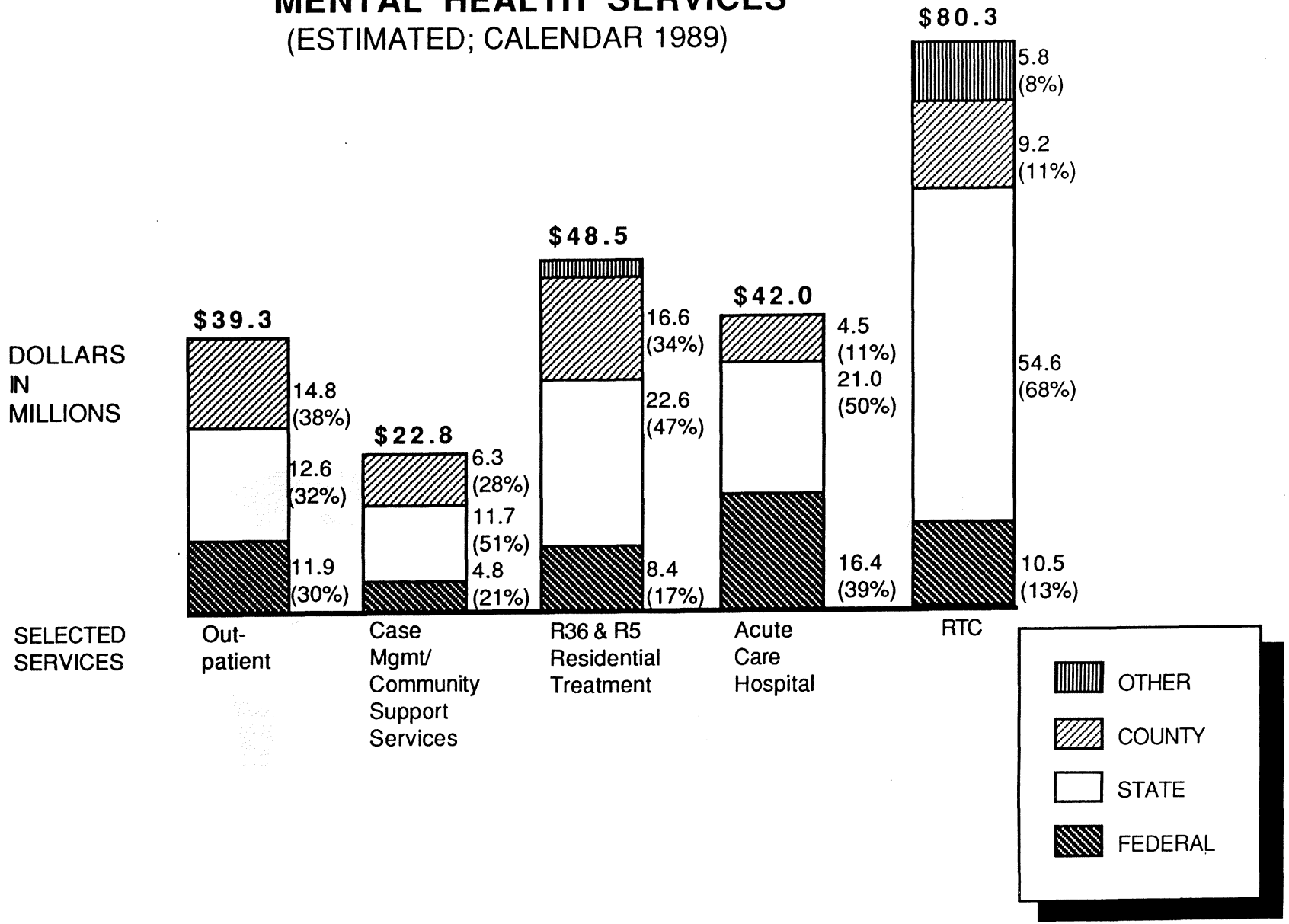
TOTAL: $248,032,755

In addition to the above, MH services are also funded by the Departments of Education, Corrections, Jobs and Training, plus direct federal funding to providers through Medicare and Veterans Administration, plus private insurance and private pay.

This table does not include Income Maintenance payments for living expenses of persons with mental illness who are not residents of Rule 36 facilities, nor does it include nursing home services.

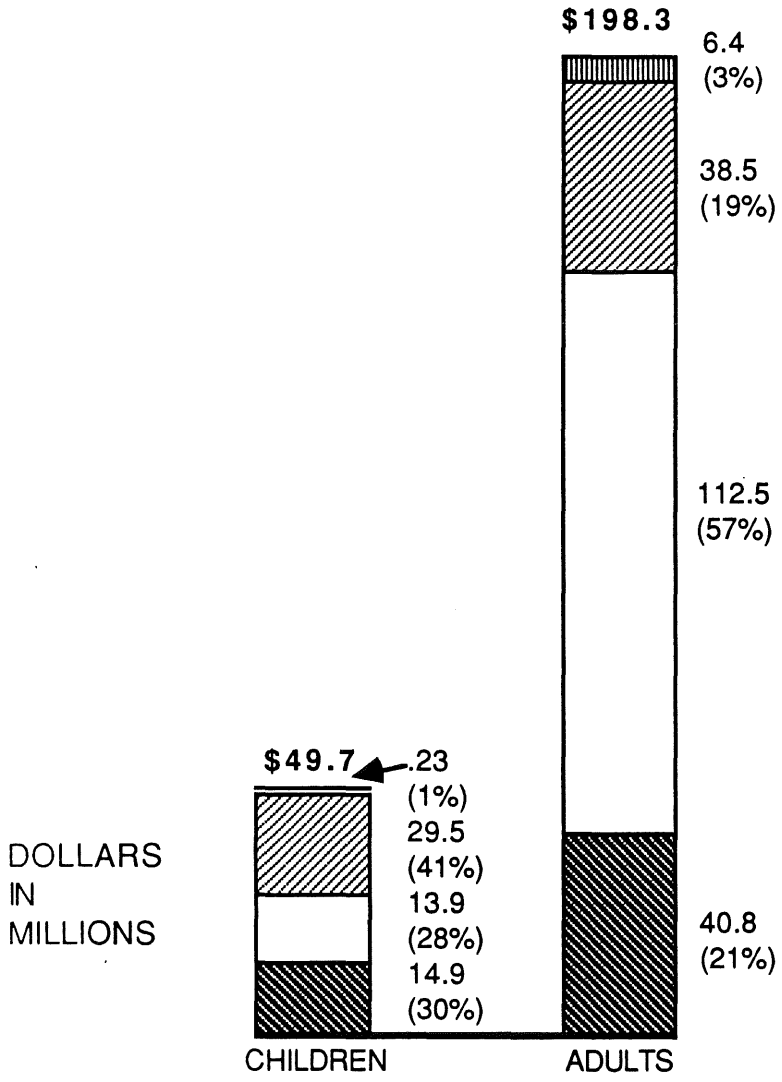
FEDERAL, STATE AND COUNTY SHARES OF FUNDING FOR SELECTED MENTAL HEALTH SERVICES

(ESTIMATED; CALENDAR 1989)

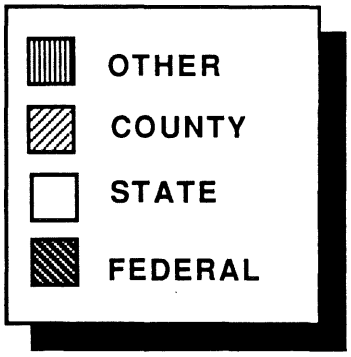


FEDERAL, STATE AND COUNTY FUNDING SOURCES: MENTAL HEALTH SERVICES FOR CHILDREN AND ADULTS

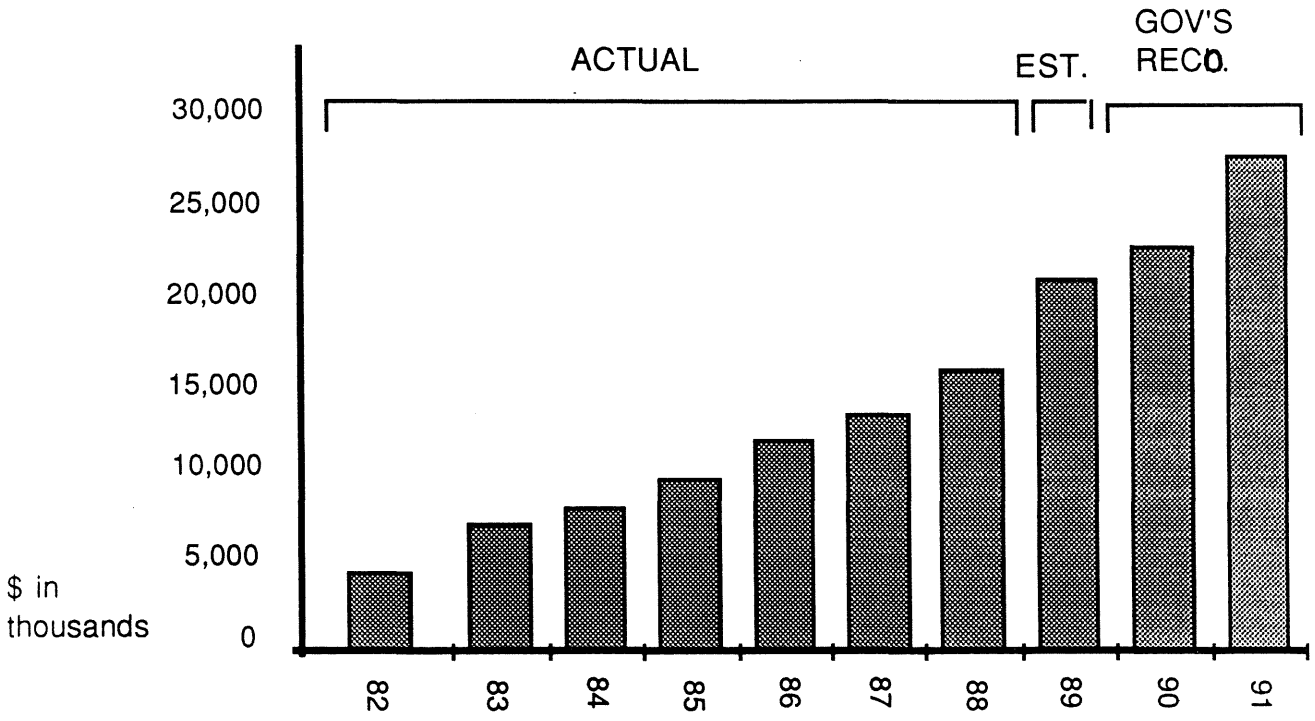
(ESTIMATED; CALENDAR 1989)



State DHS funding represents 28% of all funding for mental health services for children, 57% of all funding for mental health services for adults



EXPENDITURES
DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH
(STATE DOLLARS ONLY)



Note: This table includes only those funds directly administered by the Mental Health Division. It does not include funds which are included under Medical Assistance, RTCs, CSSA, etc.

This year, the 1990-91 county mental health plans for adults were due to the state by August, 1989. The 1990-91 plans for children are due by November, 1989. Additional time is provided this year only for the children's plan to reflect the major new children's legislation enacted in May, 1989. Both the children's and the adult plan are expected to be reviewed by the state, revised as necessary, and finalized by December 31, 1989.

Preliminary 1990 data are attached (Appendix A) showing total projected expenditures and numbers of clients, by service, by county for adult mental health. These data do not include the state share of regional treatment center costs, nor does it include state Medicaid payments for outpatient, day treatment, and inpatient services. It is expected that more comprehensive data, including that for children's mental health, will be available for the next three-year plan update.

OBJECTIVES:

A. To maximize the use of all available or develop new funding resources, including human resources in the provision of mental health services.

TASKS:

1. Assure that rules are developed or revised so that MA funding is not precluded in the future -- ongoing.
2. With Health Care Management and Long Term Care Divisions, maximize the availability of MA through TEFRA 134 (see Glossary) option for children at risk of institutionalization as a result of severe emotional disturbance -- June, 1989.
3. Update children's bill fiscal note -- May 1, 1990.
4. Maintain division files and record keeping procedures to ensure accountability for program and fiscal audits -- ongoing.
5. Participate in the development of a unified format for fiscal and program reporting by counties as required by M.S. 245.482, subd. 2 -- January, 1990.
6. Prepare annual legislative report on fiscal data obtained from counties -- February 15, 1990.
7. With Departments of Commerce and Health, identify issues for future study regarding availability of insurance coverage for mental health services -- June, 1990.
8. Provide legislative analyses and fiscal notes as appropriate -- October, 1989 to April, 1990.
9. Participate in developing draft plan for funding mechanism for children's services -- June 1, 1990.
10. Review and plan for special projects' need for ongoing funding, including public education, housing support services, and homeless services -- June 1, 1990.

B. To assure client access to services through reasonable and equitable fee policies.

TASKS:

1. Develop unified procedures to review and approve county mental health fee policies in coordination with CSSA procedures -- September 1, 1989.
2. Implement fee policy review as part of county plan review -- November 15, 1989.

C. To provide effective management for Rule 12 and Rule 14 grants.

TASKS:

1. Compile and analyze annual evaluation data -- determine use of evaluation data for monitoring and grant reviews -- November 15, 1989 and April 15, 1990.
2. Issue bulletins for F.Y. 91 -- January 2, 1990.
3. Develop consistent criteria for grant special conditions -- January 1990.
4. Provide technical assistance and contract management -- ongoing.
5. Review applications -- April 15, 1990 to June 15, 1990.
6. Award grants -- June 30, 1990.

D. To supervise local mental health authorities in arranging for the safe and orderly discharge of persons with mental illness who are found to be inappropriately residing in nursing facilities.

TASKS:

1. Issue bulletin/RFP regarding state alternative placement funds -- August 15, 1989.
2. Prepare Legislative Audit Commission report for state OBRA funds transfer, if appropriate -- November 1, 1990.
3. Issue bulletin for F.Y. 91 -- May 1, 1990.
4. Review applications for F.Y. 91 -- May 1, 1990 and award F.Y. 91 grants -- June 30, 1990.

E. To define an appropriate array of services for adults and children.

TASKS:

1. Identify funding needed so that funding and authority can be obtained as appropriate for provision of new services -- April, 1990.

F. To promote community based services in the least restrictive environment when clinically appropriate to the client's needs.

TASKS:

1. Issue continuation bulletin for F.Y. 91 Housing Support Services if appropriate -- January 1, 1990.
2. Review applications for Housing Support Services, if appropriate -- May-June 1990
3. Award grants/contracts for Housing Support Services, if appropriate -- June 30, 1990.
4. Collect and analyze evaluation data on Housing Support Services for use in F.Y. 91 grant reviews and for preparation of 92-93 budget, if appropriate -- May 1, 1990.

Chapter IX Services to Protect Client Rights

SERVICES TO PROTECT CLIENT RIGHTS:

Several changes were made to the authorities of the Office of the Ombudsman for Mental Health and Mental Retardation during the 1989 Legislative Session.

As stated in Minnesota's Three-Year Plan submitted in January, 1989, the Minnesota Legislature determined during the 1987 session that the formal state responsibility for protecting the rights and dignity of persons receiving care for mental illness should be independent and distinct from those state agencies, including the MHD, that provide and/or fund such care. As a result, the Ombudsman's Office was created.

Copies of the Office's 1988 Report to the Governor are available from the Ombudsman's Office, Suite 202, Metro Square Building, St. Paul, Minnesota 55101. The report outlines the mission, duties, and recent activities of the Ombudsman. In addition, changes made to its authorities during the 1989 session are as follows:

1. "serious injury" was defined for purposes of mandating the reporting of such injuries to the Ombudsman. The definition covers:

    a. fractures;
    b. dislocations;
    c. evidence of internal injuries;
    d. head injuries with loss of consciousness;
    e. lacerations involving injuries to tendons or organs, and those for which complications are present;
    f. extensive second degree or third degree burns, and other burns for which complications are present;
    g. irreversible mobility or avulsion of teeth;
    h. injuries to the eyeball;
    i. ingestion of foreign substances and objects that are harmful;
    j. near drowning;
    k. heat exhaustion or sunstroke; and
    l. all other injuries considered serious by a physician.

2. subpoena power was granted to the Ombudsman;

3. facilities are now required to notify the Ombudsman within 24-hour of a client death or serious injury; and

4. two weeks notice must be given to the Ombudsman when screening team meetings are scheduled for persons under public guardianship.

Chapter X Inter/Intradepartmental Coordination

INTER/INTRADEPARTMENTAL COORDINATION

Over the course of the past year, both the Mental Health Division (MHD) and Department of Human Services (DHS) have experienced leadership changes. In late 1988, Mental Health Assistant Commissioner Allyson Ashley resigned her position; Barbara Kaufman was named the new Assistant Commissioner in February. Then, in late May 1989, DHS Commissioner Sandra Gardebring was named by Governor Perpich to the Minnesota Court of Appeals. Two weeks later Minnesota House of Representatives Majority Leader Ann Wynia was named to replace Gardebring.

While these changes did cause some manner of disruption, coordination of the development of services for persons with mental illness and emotional disturbance continued with other departments of state and other divisions of DHS. The Comprehensive Mental Health Act delegates to the MHD the role of leader and facilitator, gathering together the resources, many outside its jurisdiction, needed for successful implementation. The following is a brief review of some of these efforts.

INTERDEPARTMENTAL COORDINATION:

Interagency Board on Quality Assurance

The Interagency Board on Quality Assurance (IBQA) is coordinating the implementation of P.L. 100-203 in Minnesota. The IBQA includes staff from the Departments of Health and of Human Services, the State Planning Agency, the Minnesota Housing Finance Agency, and the Minnesota Board on Aging. IBQA meetings are open to the public and are generally attended by residents, responsible relatives, advocates, concerned citizens, and representatives of providers.

County-level mental health authorities, the Health Care Management and Long Term Care Management Divisions of DHS, and the Quality Assurance/Review and Survey/Compliance Sections of the Department of Health also are involved in the implementation of P.L. 100-203.

Department of Education:

Objective C of Chapter IV illustrates the degree of coordination taking place as the Comprehensive Children's Mental Health Act is being implemented. A representative of the Commissioner of Education is part of a group including representatives from Human Services, Corrections, Health, and Commerce that meets quarterly to coordinate efforts. In addition, a representative of the Special Education Unit of the Department of Education sits on the Children's Subcommittee of the State Advisory Council.

Department of Corrections

Two representatives from the Juvenile Release Program of the Department of Corrections, as well as representatives of community corrections agencies and the Minnesota District Judges Association's Juvenile Committee, sit on the Children's Subcommittee. A Corrections Department representative will soon be named to the full Advisory Council.

Department of Jobs and Training

The MHD and the Division of Rehabilitative Services (DRS) of the Department of Jobs and Training coordinate all activities as they relate to employability for persons with mental illness. Additional details on these efforts can be found under Issue 3 in Chapter V. Examples include the adoption of a new interagency agreement which includes ongoing administrative coordinating mechanisms, joint review of programs, grants, and proposals, and other cooperative efforts. Current efforts include joint site visits, evaluations, and technical assistance by a team of DRS and MHD staff of employability programs funded by both agencies.

Department of Health

The MHD continues to work with the Department of Health on issues directly related to community residential facilities. Currently, the MHD is working with the Health Department to establish the scope of regulations for supportive living residences. The Health Department also is participating in the rewriting of DHS Rule 36 (see Issue 7 in Chapter V).

In addition, the Health Department is a participant of the Children's Subcommittee of the State Advisory Council. The Department's expertise is being used to develop a mental health component to the EPSDT program, and advises on the development of the Children's Health Plan (a state initiative to provide health coverage for uninsured youth).

The MHD has also been contracting with the Education Division of the Health Department to implement anti-stigma public education programs. Members of the State Advisory Council serve on this project's advisory committee. A more complete discussion can be found in Chapter VI.

Finally, the State Advisory Council will be working with the HMO Unit of the Health Department, and the state Department of Commerce unit responsible for insurance, to investigate issues related to access to and quality of private, third-party funded mental health services.

Minnesota Housing Finance Agency

During the past year, the MHD has continued to coordinate regularly with the Minnesota Housing Finance Agency (MHFA) and the Housing and Urban Development (HUD) office regarding housing for persons with mental illness. These groups also participate in the Governor's Issue Team on Homelessness, and a MHFA representative sits on the State Advisory Council. Finally, the MHD participates in the review of applications to HUD for long-term, stable, affordable housing.

INTRADEPARTMENTAL COORDINATION:

Coordination among divisions within the Minnesota Department of Human Services occur on a daily basis. Highlights include:

Health Care Programs Division

Efforts continue during 1989 between the MHD and the Health Care Programs Division to jointly work on improving MA funding for persons needing mental health services, including rule revisions and new rule development (such as Rule 47 for MA services, and Rule 74 for case management services). Legislation affecting MA and GAMC rates and coverage

for mental health services has been jointly addressed. Intensive work has begun to implement the TEFRA 134 home care option for children with severe emotional disturbance. Also, intensive home-based professional treatment will be developed as a statewide MA-reimbursable service for all MA-eligible children by January 1, 1990.

For adults, work has been initiated (and is planned throughout 1989 and 1990) to expand MA community support program services for persons with long-term mental illness under the MA rehabilitation option.

Long Term Care Management Division

The State Project Director of the NIMH grant on older adults has been the MHD's link and coordinator with the DHS Divisions of Long Term Care Management, Gerontology, and Aging.

The MHD has worked with the Long Term Care Management and Developmental Disabilities Divisions to plan for the implementation of P.L. 100-203, the Nursing Home Reform Act (see Chapter V). This included development of a pre-admission screening and annual resident review process for persons with mental illness and/or mental retardation, as well as the development of alternative disposition plans and coordination of training and technical assistance to counties and providers.

Residential Program Management Division

Coordination of planning for community-based programs with those in Minnesota's regional treatment centers (RTCs) occurs frequently. As the Residential Program Management Division (RPMD) and a new RTC Transition Team begin to implement recently-passed legislation regarding the future role of the RTCs (see Issue 8 in Chapter V), the MHD will be participating in the analysis of data collected from the current patient population to plan for additional community-based services.

Coordination between the RPMD and the MHD frequently occurs on a variety of programmatic issues as well.

Aging Division and Minnesota Board on Aging

The Board on Aging and the Aging Division has worked with the MHD to coordinate the provision of mental health services for older adults. The Board on Aging has also facilitated the involvement of Area Agencies on Aging in services provision and education and training. Coordination has also occurred with the MHD in developing RFPs, reviewing proposals, and planning a fall 1989 statewide conference on mental health and aging. The conference will focus upon the eight federal block grant-funded projects highlighted in Chapter VI.

Refugee and Immigrant Assistance Division

The MHD has developed a cooperative agreement with the Refugee Immigrant and Assistance Division (RIAD) to 1) ensure cooperative planning, program implementation, and supervision to address the mental health needs of refugees; and 2) to ensure that funds appropriate for refugee mental health/social adjustment are used for programs that are clinically sound and in compliance with the Minnesota Comprehensive Mental Health Act.

Children's Services Division

Coordination with this Division in implementing the 1989 Children's Comprehensive Mental Health Act has been the highest priority. The Children's Services Division of DHS is responsible for adolescent social services, adoption and guardianship services, child protection services, foster care programs, American Indian children's programs, and permanency planning coordination. Successful delivery of child mental health services must include coordination with all these efforts, making coordination in this area a high priority.

Appendices

September 25, 1989

SUMMARY OF COUNTY MENTAL HEALTH PLAN EXPENDITURES FOR 1990 IN MINNESOTA

COUNTY	EDUCATION/ PREVENTION	EMERGENCY SERVICES	OUTPATIENT TREATMENT	COMMUNITY SUPPORT	DAY TREATMENT	CASE MANAGEMENT	RULE 36 CSSA/RULE 12	RULE 36 GA/MSA	ACUTE CARE HOSPITAL	REG. TX. CENTER (SH)	PRE-PETITION SCREENING	ALL OTHER SERVICES
AITKIN	$1,500	$11,000	$62,290	$39,132	$16,000	$20,254	$5,000	$13,435	$7,000	$23,760	$1,800	$0
ANOKA	$56,400	$88,900	$403,500	$632,800	$6,500	$489,400	$351,000	$42,500	$100,800	$356,400	$70,000	$0
BECKER	$1,500	$2,000	$130,000	$39,600	$11,500	$11,000	$54,680	$0	$8,000	$40,100	$2,400	$0
BELTRAMI	$2,000	$103,051	$89,275	$137,033	$44,464	$17,779	$145,113	$0	$1,548	$63,216	$15,833	$15,310
BENTON	$1,000	$2,566	$61,046	$42,872	$23,625	$67,222	$61,236	$23,176	$0	$60,000	$8,537	$0
BIG STONE	$600	$400	$7,000	$35,000	$0	$13,000	$800	$15,000	$8,000	$30,060	$3,000	$0
BLUE EARTH	$5,400	$11,050	$257,550	$62,800	$63,440	$45,253	$123,097	$56,297	$60,950	$136,500	$11,798	$0
BROWN	$4,000	$4,000	$130,000	$43,237	$51,500	$72,000	$127,000	$107,000	$10,000	$52,686	$29,000	$0
CARLTON	$37,750	$6,800	$115,000	$63,408	$0	$45,000	$100,200	$69,300	$0	$41,200	$10,000	$0
CARVER	$11,562	$16,794	$175,960	$98,597	$0	$68,456	$20,400	$46,346	$20,100	$20,000	$10,628	$22,900
CASS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHIPPEWA	$2,500	$9,000	$106,667	$22,000	$24,500	$61,388	$10,000	$55,000	$1,000	$24,840	$2,000	$1,800
CHISAGO	$1,000	$2,000	$80,000	$49,150	$20,793	$11,500	$5,000	$13,802	$7,500	$3,500	$1,000	$0
CLAY	$17,016	$6,035	$179,037	$87,807	$16,505	$24,323	$147,042	$75,605	$32,500	$76,000	$14,686	$204,683
CLEARWATER	$300	$7,630	$26,250	$31,156	$6,000	$13,119	$11,700	$11,700	$13,914	$3,125	$3,130	$0
COOK	$4,800	$5,700	$39,940	$20,591	$0	$31,325	$0	$14,400	$0	$9,810	$5,000	$28,980
COTTONWOOD	$2,748	$7,433	$76,220	$24,617	$12,843	$25,026	$23,391	$27,637	$15,000	$30,824	$8,030	$11,375
CROW WING	$4,000	$10,000	$145,000	$109,738	$27,500	$175,000	$170,255	$105,000	$3,000	$201,560	$25,000	$0
DAKOTA	$15,430	$309,237	$742,125	$318,419	$156,750	$395,258	$532,950	$300,308	$202,193	$113,562	$94,514	$0
DODGE	$920	$1,000	$23,000	$33,323	$4,550	$34,609	$5,275	$0	$7,400	$5,400	$1,000	$3,250
DOUGLAS	$1,500	$10,000	$41,000	$42,000	$0	$30,000	$114,198	$140,000	$1,000	$48,600	$2,000	$0
FILLMORE	$1,500	$6,800	$45,000	$39,178	$0	$8,500	$12,500	$0	$2,300	$14,500	$2,818	$0
FMW	$2,156	$1,260	$158,520	$208,810	$97,772	$46,658	$46,784	$45,939	$15,883	$88,812	$9,929	$0
FREEBORN	$4,200	$6,000	$330,000	$54,800	$126,000	$60,000	$138,900	$40,000	$25,000	$51,200	$12,700	$0
GOODHUE	$33,720	$41,433	$126,175	$153,835	$14,175	$52,329	$22,200	$30,900	$0	$40,500	$616	$1,839
GRANT	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HENNEPIN	$0	$378,875	$6,002,691	$3,896,640	$350,115	$2,656,833	$4,924,473	$0	$0	$2,018,434	$1,431,732	$176,734
HOUSTON	$1,600	$3,439	$28,980	$26,706	$51,494	$42,920	$19,580	$0	$0	$24,264	$0	$0
HUBBARD	$500	$1,550	$42,000	$66,500	$0	$37,600	$27,690	$0	$31,500	$26,910	$2,500	$0
ISANTI	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ITASCA	$63,987	$49,559	$144,854	$0	$11,922	$85,506	$2,099	$48,479	$0	$51,000	$39,815	$0
JACKSON	$1,605	$1,873	$15,816	$33,249	$0	$60,840	$1,519	$7,546	$11,339	$9,000	$10,300	$9,650
KANABEC	$0	$0	$18,412	$55,747	$0	$26,444	$84,063	$0	$0	$42,840	$0	$22,266

September 25, 1989

SUMMARY OF COUNTY MENTAL HEALTH PLAN EXPENDITURES FOR 1990 IN MINNESOTA

COUNTY	EDUCATION/ PREVENTION	EMERGENCY SERVICES	OUTPATIENT TREATMENT	COMMUNITY SUPPORT	DAY TREATMENT	CASE MANAGEMENT	RULE 36 CSSA/RULE 12	RULE 36 GA/MSA	ACUTE CARE HOSPITAL	REG. TX. CENTER (SH)	PRE-PETITION SCREENING	ALL OTHER SERVICES
KANDIYOHI	$34,900	$13,850	$233,728	$149,225	$126,590	$78,300	$506,010	$0	$0	$192,450	$8,700	$0
KITTSON	$475	$325	$1,200	$35,592	$0	$10,575	$3,050	$0	$21,650	$2,600	$2,750	$9,215
KOOCHICHING	$3,000	$8,000	$77,854	$39,686	$26,900	$9,985	$0	$26,000	$1,800	$25,100	$2,240	$8,000
LAC QUI PARLE	$13,877	$6,791	$34,830	$37,120	$0	$17,593	$2,900	$4,500	$900	$28,089	$250	$250
LAKE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
LAKE OF WOODS	$1,182	$963	$3,782	$212	$963	$2,123	$424	$0	$9,456	$3,151	$637	$1,061
LE SUEUR	$5,050	$6,600	$131,095	$20,000	$3,000	$16,000	$0	$40,000	$6,500	$66,960	$4,000	$2,000
MCLEOD	$2,560	$8,200	$72,400	$45,000	$25,000	$35,000	$19,000	$96,221	$12,500	$30,263	$4,000	$3,000
MAHNOMEN	$500	$2,500	$30,000	$25,163	$4,500	$8,000	$2,651	$15,908	$1,800	$11,160	$1,650	$0
MARSHALL	$7,600	$1,000	$2,200	$4,300	$0	$31,800	$9,200	$0	$15,400	$10,700	$1,500	$0
MEEKER	$14,600	$8,100	$58,000	$33,716	$46,000	$32,000	$161,801	$32,000	$1,800	$92,034	$10,000	$4,500
MILLE LACS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
MORRISON	$28,496	$4,402	$66,690	$101,903	$0	$16,080	$153,500	$32,634	$253	$107,100	$5,345	$3,000
MOWER	$1,000	$17,500	$250,500	$138,500	$47,000	$42,300	$143,627	$112,855	$50,000	$62,000	$30,000	$0
NICOLLET	$17,000	$20,000	$135,000	$30,000	$35,000	$33,000	$8,000	$16,000	$12,000	$71,670	$7,000	$7,000
NOBLES	$2,432	$6,485	$122,902	$26,635	$13,896	$4,632	$36,641	$7,750	$32,000	$30,000	$3,175	$72,000
NORMAN	$500	$12,000	$37,000	$18,711	$6,500	$13,000	$11,607	$15,908	$4,000	$20,970	$2,750	$0
OLMSTED	$4,000	$164,599	$614,067	$172,482	$102,299	$21,565	$605,854	$185,040	$5,000	$156,887	$6,447	$10,005
OTTER TAIL	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
PENNINGTON	$5,000	$7,500	$22,000	$40,022	$0	$30,000	$126,929	$74,723	$37,720	$26,623	$5,060	$500
PINE	$800	$1,000	$90,500	$30,095	$9,000	$91,397	$142,129	$28,021	$4,000	$31,287	$6,000	$0
PIPESTONE	$1,364	$3,636	$74,748	$12,798	$6,677	$15,000	$19,320	$0	$7,500	$11,000	$1,939	$0
POLK	$0	$0	$0	$100,153	$30,000	$0	$0	$48,600	$0	$94,248	$0	$93,200
POPE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
RAMSEY	$36,734	$564,886	$2,617,266	$2,377,750	$835,159	$3,034,175	$2,810,717	$1,607,645	$853,342	$909,558	$444,506	$0
RED LAKE	$300	$1,200	$10,200	$20,503	$4,680	$4,900	$0	$21,211	$900	$3,240	$2,200	$0
REDWOOD	$6,000	$7,000	$72,072	$40,000	$25,000	$20,000	$20,500	$20,500	$2,500	$43,920	$6,000	$0
REGION VIII	$11,537	$13,028	$170,572	$151,067	$0	$145,000	$160,431	$85,000	$1,000	$168,570	$20,000	$0
RENVILLE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
RICE	$2,500	$10,000	$80,500	$83,500	$10,000	$25,000	$24,000	$102,360	$8,000	$97,200	$6,000	$4,500
ROCK	$1,326	$3,537	$57,397	$14,527	$7,580	$14,250	$17,662	$0	$9,000	$9,167	$5,310	$0
ROSEAU	$100	$400	$12,800	$33,340	$1,000	$18,055	$6,000	$1,000	$20,000	$4,000	$2,000	$2,270
SAINT LOUIS	$58,000	$66,200	$604,000	$543,619	$0	$867,005	$573,012	$890,000	$0	$361,000	$105,000	$199,164
SCOTT	$4,000	$6,543	$110,716	$58,000	$9,352	$75,000	$50,000	$85,000	$10,000	$40,000	$2,600	$844
SHERBURNE	$2,000	$10,400	$89,440	$33,800	$6,656	$90,000	$14,560	$0	$12,000	$63,856	$3,640	$11,160

September 25, 1989

SUMMARY OF COUNTY MENTAL HEALTH PLAN EXPENDITURES FOR 1990 IN MINNESOTA

COUNTY	EDUCATION/ PREVENTION	EMERGENCY SERVICES	OUTPATIENT TREATMENT	COMMUNITY SUPPORT	DAY TREATMENT	CASE MANAGEMENT	RULE 36 CSSA/RULE 12	RULE 36 GA/MSA	ACUTE CARE HOSPITAL	REG. TX. CENTER (SH)	PRE-PETITION SCREENING	ALL OTHER SERVICES
SIBLEY	$16,250	$4,000	$36,000	$55,000	$4,000	$17,000	$9,000	$26,000	$13,000	$20,340	$1,500	$3,000
STEARNS	$2,014	$12,209	$275,070	$144,830	$141,410	$148,325	$115,523	$57,278	$17,315	$350,928	$7,398	$1,354,002
STEELE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
STEVENS	$1,000	$1,200	$3,000	$28,000	$0	$25,000	$144,000	$127,020	$5,000	$10,350	$8,000	$0
SWIFT	$7,500	$11,000	$75,500	$10,000	$58,000	$35,000	$13,280	$23,287	$1,500	$28,080	$3,750	$0
TODD	$4,500	$1,020	$87,083	$42,000	$17,000	$29,160	$7,000	$27,000	$18,000	$25,002	$2,500	$4,500
TRAVERSE	$4,000	$1,000	$20,500	$38,949	$0	$9,000	$30,000	$15,585	$2,250	$10,000	$3,750	$17,000
WABASHA	$2,200	$3,850	$39,612	$22,489	$38,592	$36,144	$8,674	$4,500	$0	$15,000	$1,500	$0
WADENA	$4,000	$2,000	$15,000	$34,000	$13,000	$8,000	$200,780	$22,000	$0	$10,000	$1,000	$500
WASECA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
WASHINGTON	$6,869	$69,197	$668,728	$501,194	$222,704	$174,736	$216,550	$287,197	$45,000	$100,530	$33,890	$0
WILKIN	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
WINONA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
WRIGHT	$0	$67,392	$226,320	$89,853	$27,247	$59,892	$29,991	$25,000	$0	$94,464	$0	$0
YELLOW MEDICINE	$3,585	$3,108	$47,550	$39,049	$20,000	$18,000	$39,150	$41,418	$6,000	$27,000	$5,000	$0
STATE TOTAL	$599,945	$2,258,006	$17,181,130	$11,891,528	$3,062,653	$10,090,534	$13,731,618	$5,494,531	$1,835,013	$7,175,100	$2,598,753	$2,309,458

NOTE: 1) The data for this table are from the Mental Health Plans submitted by counties by 9/20/89. Several counties will still be submitting information. In addition counties will probably be changing some of their data based on state feedback. 2) The Outpatient and Acute Care Hospital Expenditures do not include Medical Assistance payments. In addition Regional Treatment Center Data does not include the 90% state share or the Medical Assistance payments..

September 25, 1989

SUMMARY OF PRELIMINARY COUNTY MENTAL HEALTH PLAN CLIENT COUNTS FOR 1990 IN MINNESOTA

COUNTY	EDUCATION/ PREVENTION*	EMERGENCY SERVICES	OUTPATIENT TREATMENT	COMMUNITY SUPPORT	DAY TREATMENT	CASE MANAGEMENT	RULE 36 CSSA/wRULE 1	RULE 36 GA/wMSA	ACUTE CARE HOSPITAL	REG. TX. CENTER (SH)	PRE-PETITION SCREENING	ALL OTHER SERVICES*
AITKIN	N/A	187	220	19	5	26	2	3	8	15	8	N/A
ANOKA	N/A	0	0	0	0	0	0	0	0	0	0	N/A
BECKER	N/A	100	440	40	12	25	18	0	5	45	10	N/A
BELTRAMI	N/A	555	584	143	45	90	29	29	5	44	22	N/A
BENTON	N/A	78	211	150	4	120	12	12	0	25	14	N/A
BIG STONE	N/A	5	12	11	0	12	1	3	5	4	6	N/A
BLUE EARTH	N/A	420	550	230	65	120	28	28	44	45	23	N/A
BROWN	N/A	100	260	25	15	95	11	10	8	28	12	N/A
CARLTON	N/A	55	500	40	8	60	20	0	23	42	15	N/A
CARVER	N/A	341	412	50	0	58	17	15	11	9	8	N/A
CASS	N/A	0	0	0	0	0	0	0	0	0	0	N/A
CHIPPEWA	N/A	20	499	22	26	41	9	0	1	9	4	N/A
CHISAGO	N/A	30	450	10	5	30	9	0	10	16	12	N/A
CLAY	N/A	90	561	30	24	51	37	34	36	89	49	N/A
CLEARWATER	N/A	7	42	14	6	51	2	2	7	6	8	N/A
COOK	N/A	8	40	32	0	55	0	2	0	3	5	N/A
COTTONWOOD	N/A	90	234	36	26	61	6	6	10	22	10	N/A
CROW WING	N/A	400	650	70	68	72	32	0	5	160	50	N/A
DAKOTA	N/A	4,182	2,346	859	65	575	160	128	66	55	167	N/A
DODGE	N/A	7	175	8	7	21	4	0	14	4	3	N/A
DOUGLAS	N/A	21	75	20	0	16	29	0	1	30	10	N/A
FILLMORE	N/A	18	108	35	0	45	3	0	2	6	10	N/A
FMW	N/A	33	306	0	27	70	14	13	0	63	49	N/A
FREEBORN	N/A	96	550	85	19	60	17	0	13	40	10	N/A
GOODHUE	N/A	40	820	70	30	110	20	15	0	17	4	N/A
GRANT	N/A	0	0	0	0	0	0	0	0	0	0	N/A
HENNEPIN	N/A	35,545	11,742	1,433	95	2,129	1,000	0	0	798	671	N/A
HOUSTON	N/A	30	230	50	30	50	6	0	0	10	0	N/A
HUBBARD	N/A	12	110	20	0	60	5	0	15	16	16	N/A
ISANTI	N/A	0	0	0	0	0	0	0	0	0	0	N/A
ITASCA	N/A	161	625	0	21	1,344	2	11	0	24	81	N/A
JACKSON	N/A	18	55	18	0	18	5	3	6	5	7	N/A
KANABEC	N/A	0	60	15	0	25	5	0	0	17	0	N/A

September 25, 1989

SUMMARY OF PRELIMINARY COUNTY MENTAL HEALTH PLAN CLIENT COUNTS FOR 1990 IN MINNESOTA

COUNTY	EDUCATION/ PREVENTION*	EMERGENCY SERVICES	OUTPATIENT TREATMENT	COMMUNITY SUPPORT	DAY TREATMENT	CASE MANAGEMENT	RULE 36 CSSA/wRULE 1	RULE 36 GA/wMSA	ACUTE CARE HOSPITAL	REG. TX. CENTER (SH)	PRE-PETITION SCREENING	ALL OTHER SERVICES*
KANDIYOHI	N/A	370	1,380	180	280	110	150	0	0	80	38	N/A
KITTSON	N/A	20	2	0	0	0	2	0	17	4	0	N/A
KOOCHICHING	N/A	187	383	47	25	43	0	9	3	17	4	N/A
LAC QUI PARLE	N/A	140	106	5	0	22	9	3	1	14	3	N/A
LAKE	N/A	0	0	0	0	0	0	0	0	0	0	N/A
LAKE OF WOODS	N/A	1	10	1	1	10	2	0	6	5	3	N/A
LE SUEUR	N/A	104	425	22	3	55	0	13	18	22	12	N/A
MCLEOD	N/A	225	220	25	20	70	8	0	12	15	13	N/A
MAHNOMEN	N/A	5	55	10	6	25	1	2	2	4	3	N/A
MARSHALL	N/A	76	16	18	0	28	2	0	17	4	6	N/A
MEEKER	N/A	100	358	30	60	20	30	25	4	44	24	N/A
MILLE LACS	N/A	0	0	0	0	0	0	0	0	0	0	N/A
MORRISON	N/A	100	1,425	125	0	55	39	9	4	60	20	N/A
MOWER	N/A	180	500	125	27	70	7	14	20	35	18	N/A
NICOLLET	N/A	14	420	25	9	65	2	4	9	30	12	N/A
NOBLES	N/A	122	391	17	21	31	23	11	12	20	6	N/A
NORMAN	N/A	5	70	10	7	75	4	3	3	11	5	N/A
OLMSTED	N/A	177	568	306	30	278	90	0	2	100	54	N/A
OTTER TAIL	N/A	0	0	0	0	0	0	0	0	0	0	N/A
PENNINGTON	N/A	200	0	20	0	30	8	8	23	0	23	N/A
PINE	N/A	15	150	15	15	55	3	0	2	35	12	N/A
PIPESTONE	N/A	65	240	6	6	15	2	0	2	5	7	N/A
POLK	N/A	0	0	75	10	0	0	0	0	45	0	N/A
POPE	N/A	0	0	0	0	0	0	0	0	0	0	N/A
RAMSEY	N/A	16,680	5,746	4,777	300	1,742	612	0	0	314	370	N/A
RED LAKE	N/A	8	25	10	6	28	0	3	1	2	4	N/A
REDWOOD	N/A	60	250	10	5	25	6	6	2	22	4	N/A
REGION VIII	N/A	220	790	60	0	200	10	0	3	87	100	N/A
RENVILLE	N/A	0	0	0	0	0	0	0	0	0	0	N/A
RICE	N/A	25	135	40	8	45	15	16	8	42	20	N/A
ROCK	N/A	59	181	13	13	19	7	0	9	5	5	N/A
ROSEAU	N/A	15	30	10	5	30	2	1	15	8	15	N/A
SAINT LOUIS	N/A	0	2,400	626	195	350	100	100	0	208	225	N/A
SCOTT	N/A	100	462	30	16	95	29	18	3	19	33	N/A

September 25, 1989

SUMMARY OF PRELIMINARY COUNTY MENTAL HEALTH PLAN CLIENT COUNTS FOR 1990 IN MINNESOTA

COUNTY	EDUCATION/ PREVENTION*	EMERGENCY SERVICES	OUTPATIENT TREATMENT	COMMUNITY SUPPORT	DAY TREATMENT	CASE MANAGEMENT	RULE 36 CSSA/wRULE 1	RULE 36 GA/wMSA	ACUTE CARE HOSPITAL	REG. TX. CENTER (SH)	PRE-PETITION SCREENING	ALL OTHER SERVICES*
SHERBURNE	N/A	50	850	45	10	100	5	0	4	14	12	N/A
SIBLEY	N/A	30	93	21	2	30	10	231	12	12	6	N/A
STEARNS	N/A	67	3,098	220	75	288	53	53	12	173	86	N/A
STEELE	N/A	0	0	0	0	0	0	0	0	0	0	N/A
STEVENS	N/A	6	40	5	0	25	12	12	6	15	4	N/A
SWIFT	N/A	75	119	35	35	35	10	4	1	8	5	N/A
TODD	N/A	20	275	15	13	27	10	10	9	23	5	N/A
TRAVERSE	N/A	10	25	7	0	10	4	4	1	7	5	N/A
WABASHA	N/A	25	257	30	25	30	4	4	0	16	8	N/A
WADENA	N/A	0	0	0	0	0	0	0	0	0	0	N/A
WASECA	N/A	0	0	0	0	0	0	0	0	0	0	N/A
WASHINGTON	N/A	1,000	1,400	170	100	425	46	46	20	24	70	N/A
WILKIN	N/A	0	0	0	0	0	0	0	0	0	0	N/A
WINONA	N/A	0	0	0	0	0	0	0	0	0	0	N/A
WRIGHT	N/A	52	851	77	12	45	10	8	0	64	0	N/A
YELLOW MEDICINE	N/A	27	170	8	5	30	4	5	2	16	10	N/A
STATE TOTAL	N/A	63,284	46,783	10,806	1,948	10,126	2,834	936	560	3,276	2,534	N/A

NOTE: 1) The data for this table are from the Mental Health Plans submitted by counties by 9/20/89. Several counties will still be submitting information. In addition counties will probably be changing some of their data based on state feedback. 2) Theere were no Education and Prevention client numbers because of the nature of the service. In addition the numbers for all other services were not used because they were added across services which might inflate the figures when clients receive more than one of these other services.

APPENDIX B

Included in this appendix are discussions related specifically to NIMH's February 17, 1989, review of Minnesota's State Plan. A copy of the NIMH memo is attached (Appendix B-1). Some of the content in this appendix mirrors related discussions in the body of the plan, but this appendix also provides additional detail, specific to NIMH's February 1989 comments, that was not felt to be relevant for inclusion in the plan itself. Only those NIMH recommendations not specifically addressed in the Plan are included here.

Recommendation #1: Clarify the priority on serving the long term mentally ill.

The Comprehensive Mental Health Act clearly establishes a priority system of serving persons with serious and persistent mental illness before serving persons with other mental illnesses or persons receiving education and prevention services.

This provision states that locally available services to adults with serious and persistent mental illness and adults with acute mental illness must be developed within available resources prior to the provision of locally available services for adults with other mental illness and the provision of education and preventive mental health services targeted to high risk groups.

Additionally, under the Children's Comprehensive Mental Health Act, section 40, [245.4873] subd. 6 of the law states that the provision of locally available mental health services be given to all children with severe emotional disturbances as a priority over the provision of early identification and intervention services to children who are at risk of needing or who need mental health services, and as a priority over the provision of specialized mental health services regionally available to meet the special needs of all children with severe emotional disturbances and all children with emotional disturbances. The provision of locally available services to children with emotional disturbances and the provision of education and preventive mental health services are also a lower priority under the Act.

Recommendation #2: Provide a clearer, more detailed description of the planning for implementation of components of the envisioned system of care, including:

- Emergency services for long term mentally ill:

  Emergency services are mandated in the Adult and Children's Mental Health Acts and are to be provided to meet the needs of adults and children in the county who are experiencing emotional crises or mental illness. Emergency services must include assessment, intervention, and appropriate case disposition.

  All service providers of emergency services must provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional. Whenever emergency service during non business hours is provided by anyone other than a mental health professional, a mental health professional must be available for at least telephone consultation within 30 minutes.

The intent of the Adult Mental Health Act's emergency services are to (1) promote the safety and emotional stability of adults with mental illness or emotional crisis; (2) minimize the deterioration of adults with mental illness or emotional crises; (3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; and (4) prevent placement settings that are more intensive, costly or restrictive and necessary and appropriate to meet client need.

The Children's Mental Health Act has analogous mandates to meet the needs of children who are experiencing an emotional crisis or emotional disturbance. The purpose of these services are to promote the safety and emotional stability of children with emotional disturbances or emotional crises; minimize further deterioration of the child with emotional crisis; help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and prevent placement in settings that are more intensive, costly or restrictive and necessary and appropriate to meet the child's needs.

Each county's mental health plan must explain the emergency services being provided, who the care providers are, and how they are meeting emergency service needs. This information is reviewed by the MHD staff. Technical assistance is provided where it is believed that counties are not meeting the standards.

- Crisis Stabilization Services (and consider including services more comprehensive than the toll free number and 30 minute consultation):

- This is addressed above in the emergency services section. Emergency services must include assessment, intervention, and case disposition. Many times this includes crisis stabilization services. The toll free number with its access to a mental health professional is only the access into the system. It does not make up the entire emergency service system. Additional crisis stabilization services include crisis assistance under the Community Support Services program.

Crisis assistance services are those which:

A. Are in addition to, coordinated with, and do not duplicate emergency services as defined in Minnesota Statutes, sections 245.462, subdivision 11, and 245.469;

B. Help the adult identify and deal with individual crisis situations and symptoms that affect the adult's mental health.

C. Include, for each adult, the development of a written plan designed to alleviate or reduce the onset of crisis symptoms for that adult;

D. Provide referral and follow up to an adult to community resources and mental health professionals to deal with a crisis, when appropriate; and

E. Help an adult arrange for admission to acute care hospital inpatient treatment program, regional treatment center inpatient treatment, or residential treatment, if admission is determined to be necessary by a mental health professional. The admission shall be coordinated with the adult's case manager if the adult has one.

- Health and dental care:

Each person with serious and persistent mental illness and each child eligible for case management services who wishes to receive these services has a functional assessment completed by the case manager. The functional assessment includes eleven components. One of the components states that the person's medical and dental health must be assessed. The case manager is required to assure that clients in need of dental and medical care are referred to and receive those services. If this does not occur, the case manager must document the reasons for this.

Additionally, persons with mental illness who receive social services or other mental health services are referred for dental or medical care as needed. Minnesota's residential treatment facilities rule (Rule 36) requires medical examinations prior to entry into a residential facility. Dental appointments are also mandated yearly for persons receiving residential treatment services. Persons may refuse dental care, but they must be offered assistance in transportation and making appointments, and payment for these services are to be arranged by staff.

Medical Assistance (MA) reimburses health and dental care for persons who are eligible. Minnesota also provides for health, mental health and dental care of low income persons through a state funded medical care program, General Assistance Medical Care, GAMC. Many persons with mental illness who are not eligible for MA are on GAMC.

Public Health services are also set up throughout the state for low income persons. They provide services at shelters and soup kitchens for persons who are homeless or transient. This includes nursing care, physician care and referral for dental services.

- Peer supports and family supports:

Minnesota's Community Support Programs statewide are designed to offer family support services and peer support for persons with serious and persistent mental illness. This occurs in different ways throughout the state. In some counties, newsletters and peer support groups fulfill this need; in other counties, community support workers provide education sessions and support groups to families.

Additionally, the Alliance for the Mentally Ill and the Mental Health Association have family support groups throughout the state. Finally, many of the mental health centers offer family support services.

- Services to help gain access (client identification, outreach, case management, referral):

  The mental health system in Minnesota requires case management services to be offered to all persons with serious and persistent mental illness. Clients may refuse this service, but must be offered it by the county. Additionally, the Comprehensive Mental Health Act requires providers of mental health services to inform clients who have a serious and persistent mental illness about and/or to refer that client directly to the county for case management services. Providers required to make such referrals include those of emergency services, day treatment services, outpatient treatment, community support services, residential treatment, acute care hospital inpatient treatment, and regional treatment center inpatient treatment. The children's system also includes referral from providers of family community support services, screening, and professional home-based family treatment services.

  In effect, this means that any care provider in the county system is required by law to make referral for services.

  Additionally, the Community Support Program requires client outreach. Client outreach services must:

  A. be conducted throughout the calendar year;
  B. be an integral part of the community support program;
  C. occur where persons who have or may have serious and persistent mental illness live, congregate, or receive services; and
  D. include face-to-face contact with adults who have or may have serious and persistent mental illness.

Recommendation #3: Include an explanation as to why screening prior to hospitalization cannot be implemented until 1991 and delineate the incentives for diverting people from unnecessary inpatient care.

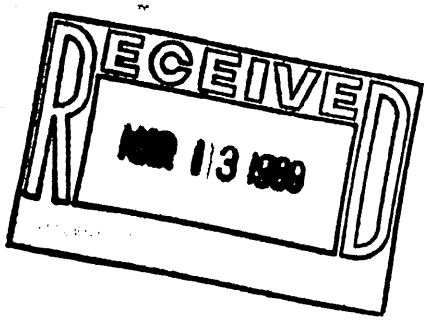
Screening by providers and referral sources to inpatient regional treatment center (RTC) care and residential programs currently exists. This is accomplished through assessments and admission criteria.

Currently, a study is taking place to see if additional screening instruments are needed to improve the system, and if so, what types of instruments.

The due date for implementation was delayed until 1991 to provide time to thoughtfully appraise the situation and develop solid recommendations.

Summary: Review of P.L. 99-660 State Plan - Minnesota

Contact: Sandra S. Gardebring, Commissioner, Minnesota Department of Human Services



Title: Department of Human Services, Mental Health Division, Three-Year Plan for Services for Persons with Mental Illness

NIMH Review Date: February 17, 1989

Summary of Major Issues: The Minnesota Plan reflects activities, since 1985, at the grass roots, State and local human service agency, and State legislative levels to "create and ensure a unified, accountable, comprehensive system of mental health services." This effort reflects, in various ways, the goals and objectives of P.L. 99-660. Studies undertaken by the Governor's Mental Health Commission, the Legislative Auditor's Office and a national consumer research group identified many problems and gaps in the system which were incorporated into legislation and subsequent statewide hearings. As a result, the State's Commissioner of Human Services was charged with development of a comprehensive service system which required all 87 counties to make an array of services available (most by July 1988); State and local mental health advisory councils were to be created to advise and monitor, each with representation of consumers, families, advocates, etc. A mission statement for children was introduced in the 1988 Legislative Session and will be submitted for the 1989 Legislature.

The P.L. 99-660 Plan is designed to build upon these past accomplishments and reportedly was circulated widely to a variety of individuals and organizations for comment. The document contains a statutory definition of mental illness upon which planning for services is based, current and planned management information systems, and the current and envisioned system of care. Goals and objectives/outcomes are set for different target populations/service systems, with specification of funding mechanism for some services. Several special populations are covered -- the homeless mentally ill, Native Americans, refugees, rural residents, seniors and children and adolescents. Services to protect client

rights, strategies, for inter/intradepartment coordination, funding for services and human resource development are discussed in some detail.

Minnesota (Page 2)

Strengths and Weaknesses: The Plan is considered basically sound and is strengthened by the listing of expected outcomes. The plan for children's services, while not complete in all details, is excellent in that it reflects a strategy for obtaining needed resources to implement the system and has a strong family orientation with involvement of the child and family in the services. The Plan seems strong in inter/intradepartmental coordination. The discussion of service principles reflects a humane, caring tone and the mission statement (pages 10-11) is excellent in the sense that it focuses on desired outcomes. The housing plan is also comprehensive and should provide additional funds for residential treatment and supportive housing. Definitions of the populations seem adequate (in general).

The descriptions of current and ideal system components, however, contains too few details and the priority for serving the long-term mentally ill is not clear. The definition of severely emotionally disturbed children and adolescents for case management purposes (page 53, [c]) seems inappropriate for this population (the definition of SED, pages 53-54, I-IV, seems more appropriate). Also unclear are: how County plans relate to the State Plan; why implementation of screening prior to hospitalization cannot be implemented until 1991; the rationale for the definition of the adult target populations; how a comprehensive plan is to be developed for providing appropriate services to the homeless mentally ill; and other areas included in the recommendations below.

Legislative Provisions: Comments on compliance to P.L. 99-660 in the Minnesota Plan are presented below.

1. The State Plan shall provide for the establishment and implementation of an organized and comprehensive community-based system of care for severely mentally ill individuals.
   Comments: The Plan contains basically sound descriptions of the current and an ideal community-based system of care, although the children's plan needs strengthening and there are too few details on serving the long-term mentally ill. Ways in which County plans relate to the State Plan and Planning Council, as well as involvement of other relevant State agencies, are particularly lacking. A system for tracking populations and services needs to be described.

2. The State Plan shall contain quantitative targets to be achieved in the implementation of such a system, including numbers of severely mentally ill individuals residing in the areas to be served under such

Minnesota (Page 3)

a system.

Comments: Goals and objectives/outcomes are set for different target populations and service systems. Specific details on implementation are lacking and goals/objectives are not related to service gaps.

3. The State Plan shall address how severely mentally ill persons will gain access to treatment, prevention, and rehabilitation services at the community level.

   Comments: The Plan provided too few details on services to help people gain access to services (e.g., client identification, outreach, referral).

4. The State Plan shall address how rehabilitation services, employment services, housing services, medical and dental care, and other support services will be provided to severely mentally ill persons to enable them to function outside of inpatient institutions to the maximum extent of their capabilities.

   Comments: The Plan did not provide a clear description of the involvement of other key agencies in the planning of rehabilitation, housing and Medicaid.

5. The State Plan shall provide for activities to reduce the rate of hospitalization of severely mentally ill individuals.

   Comments: The data provided indicate a significant reduction in hospitalization rates for clients using community services. A tracking system is in place. If current service development continues, it appears the State will continue to reduce hospital utilization rates.

6. Case management services shall be designed for each severely mentally ill individual in the State who receives substantial amounts of public funds or services, and these services will be phased in over the period of fiscal year 1989 through fiscal year 1992.

   Comments: There was little information on the philosophy, approaches and services provided through case management, the functions/roles of case managers, or ways of identifying clients.

7. The State Plan shall provide for the establishment and implementation of a program of outreach to, and services for, severely mentally ill individuals who are homeless.

   Comments: Using McKinney, HUD, and State funds, it appears that the

Minnesota (Page 4)

State is providing appropriate services for the homeless mentally ill population. However, there is no detail on how many are being served and where the gaps are. They do indicate that they will be working with other State agencies to develop a comprehensive plan for serving this population.

8. In developing the State Plan, the State shall consult with representatives of employees of State institutions and public and private nursing homes who care for severely mentally ill individuals. Comments: This was not clearly addressed in the Plan.

Recommendations: A number of recommendations were made for strengthening the Minnesota Plan:

- Clarify how the local County plans relate to the State Plan and to the State Planning Council.
- Provide a clear description on the involvement of other key agencies in the planning process (e.g., housing, vocational rehabilitation, Medicaid).
- Provide a clear description of the process for consulting with representatives of employees of State hospitals and nursing homes.
- Clarify the priority on serving the long-term mentally ill.
- Provide a clearer, more detailed description of the planning for and implementation of components of the envisioned system of care, including:
  - Emergency services for the long-term mentally ill
  - Crisis stabilization services (and consider including services more comprehensive than a toll-free number and 30 minute consultation)
  - Health and dental care
  - Peer supports and family supports
  - Services to help people gain access (client identification,

Minnesota (Page 5)

outreach, case management, referral)

- Residential (especially planning for defined levels of residential care)

- Case management (including more details on the philosophy/approaches to case management, location and organization, authority and responsibility, approaches for different populations).

- Service accountability mechanisms

- Provide a more detailed description of planning/services for several special populations: mi/h

  - Racially/culturally relevant services for minorities (other than refugees and Native Americans)

  - Seniors (address, especially, planning in regard to State agencies with overlapping responsibilities for the elderly)

  - Homeless mentally ill (include more information on the numbers, locations and needs of this population)

  - Children/adolescents (consider a less adult-oriented definition for case management)

- Consider strategies for using the existing data management systems to collect and analyze client data in terms of successful community living outcomes.

- Include an explanation as to why screening prior to hospitalization cannot be implemented until 1991 and delineate the incentives for diverting people from unnecessary inpatient care.

- Attention to/consideration of resource issues in moving toward a community-based system (i.e., the fact that the largest dollar increases go to State hospitals).

- A more detailed focus on developing formalized linkages between inpatient programs and community programs.

Minnesota (Page 6)

- Articulate the role of the State-supported higher education in human resource development for mental health programming and provide more details on such issues as required number and distribution of professionals.

- Include more details on how goals and objectives will be implemented, including financial and human resource needs, legislative/policy/regulatory issues, timeliness, responsibilities, etc., and how the goals/objectives relate to gaps in services.