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

SEPTEMBER 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH DIVISION

UPDATE OF THREE-YEAR PLAN FOR SERVICES FOR PERSONS WITH MENTAL ILLNESS

Prepared by Staff of the Mental Health Division
September 1990

Mental Health Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3828
(612) 296-4497

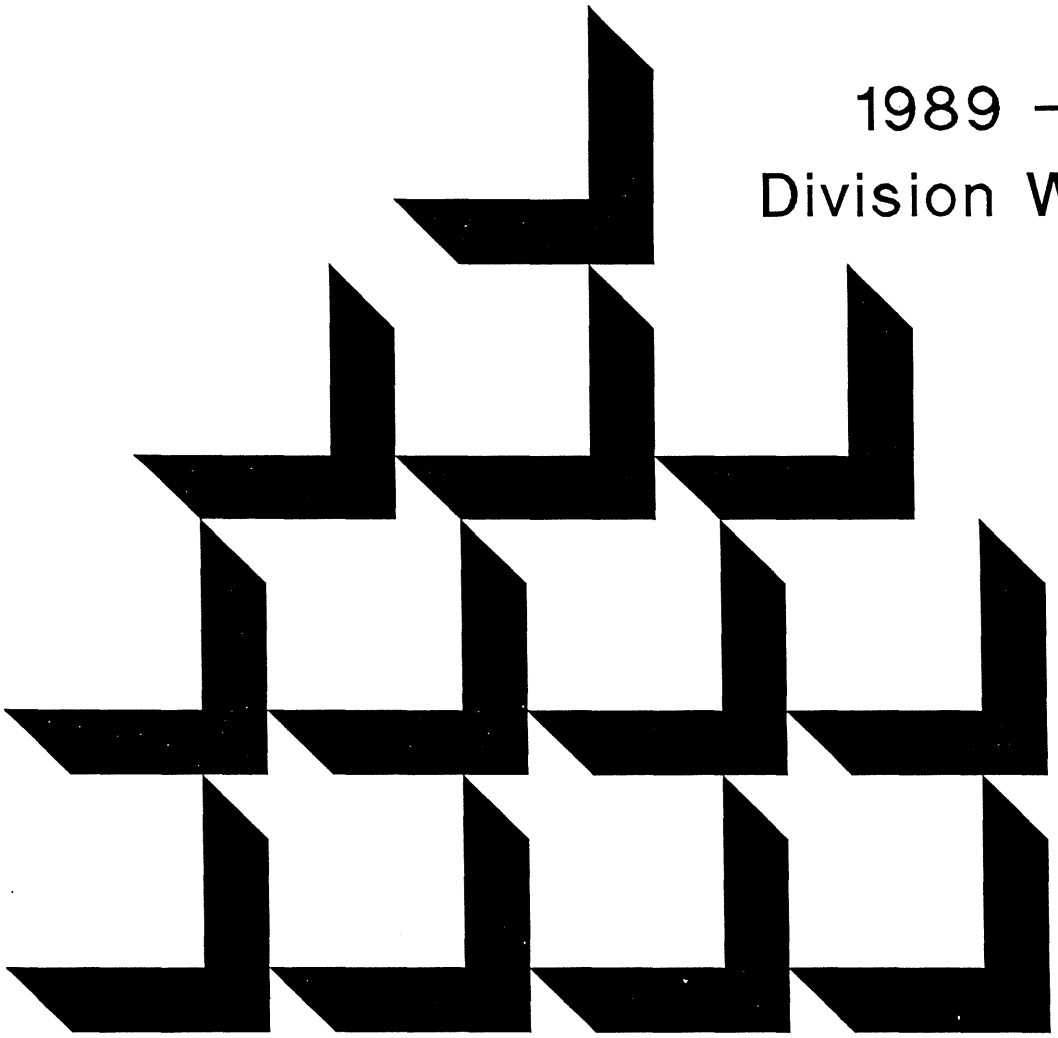
The Mental Health Division wishes to acknowledge with appreciation the assistance of Deborah Anderson in preparing this document.

MINNESOTA DEPARTMENT OF HUMAN SERVICES

MENTAL HEALTH DIVISION

UPDATE ON THREE-YEAR PLAN FOR SERVICES FOR PERSONS WITH MENTAL ILLNESS

TABLE OF CONTENTS



1989 – 1990
Division Work Plan

MENTAL HEALTH DIVISION WORKPLAN
(Goals and Objectives)

July 1, 1989 - June 30, 1990

GOAL 1:

To provide leadership to the state's mental helath 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 capacity 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, 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 services through reasonable and equitable fee policies.

GOAL 3:

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

GOAL 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 Transition Team 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. (See 3-E)

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 when clinically appropriate to the client's needs.

5-C. To assess current rules to determine the degree to which these promote increasing individual 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 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:

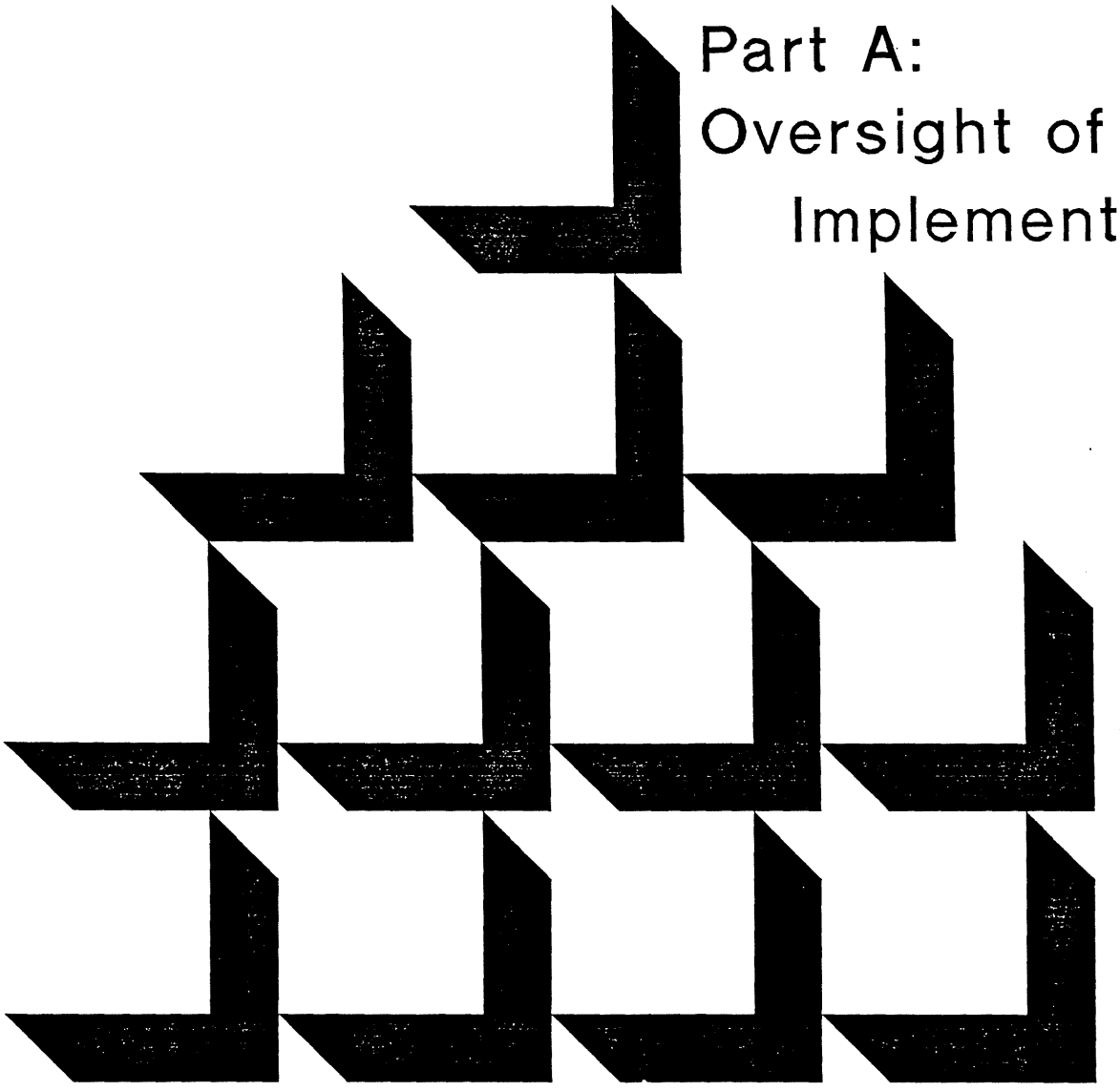
To work actively on lessening the stigma of mental illness and emotional disturbance.

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 ("persons with mental illness", etc., rather than "MI persons").

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



Part A: Oversight of Plan Implementation

PART A: OVERSIGHT OF PLAN IMPLEMENTATION

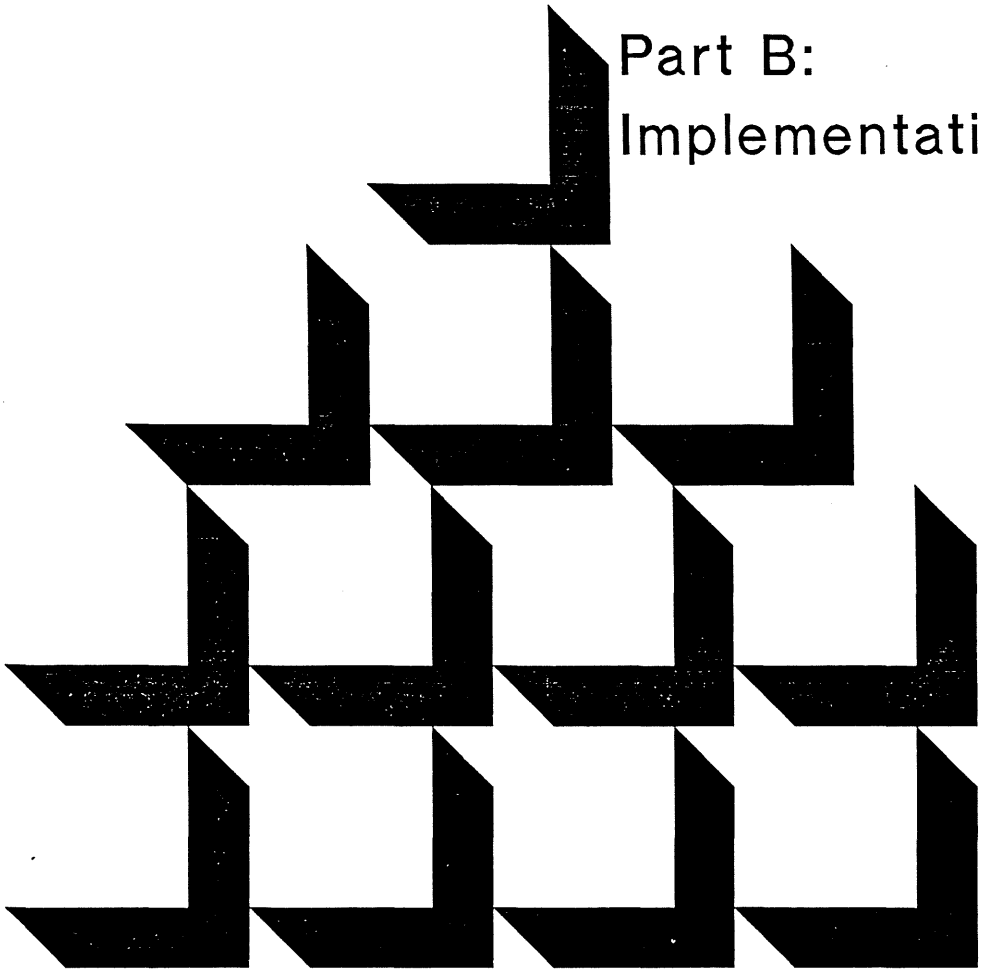
1. Titles and agencies of individuals responsible for overseeing implementation of the Plan are shown in Appendix A. Responsibility for the operation of Regional Treatment Centers (RTCs) and Medical Assistance Program (Medicaid) is lodged with Assistant Commissioner Maria Gomez. Assistant Commissioner Barbara Kaufman is responsible for community-based mental health services. The State Mental Health Advisory Council and its subcommittee relate directly to her. The Mental Health Division (MHD) is under the direction of Jerri Sudderth. Mental Health Division staff and their responsibilities are shown in Appendix B.

2. Support for each of these functions is provided through state legislative appropriations. Funding for some MHD staff is providing through the federal Alcohol, Drug Abuse and Mental Health Act block grant.

3. Members of the State Mental Health Advisory Council and its Children's Subcommittee and their affiliations are listed in Appendix C. The Council and the Subcommittee each meet monthly, with additional meetings scheduled for task forces and work groups on specific issues.

4. The Division Director of the Residential Program Management Division is a participant in the State Mental Health Advisory Council meetings. Larry Olson, M.D., Medical Director of the Willmar Regional Treatment Center is a regular member of that group. Members of the State Council and Children Subcommittees have provided input into the state Plan development process, as have representatives of the unions and the Minnesota Association of Mental Health Residential Facilities (community residential treatment providers). Representatives of affected unions (American Federation of State, County and Municipal Employees, Minnesota Association of Professional Employees, and Minnesota Nurses Association) are members of the task forces developing the two State-Operated Community Services for persons with mental illness (MI SOCS), as are staff from both the Willmar RTC and the Anoka Metro RTC. Input for the OBRA-87 Alternative Disposition Planning Process has been solicited from providers of nursing facility services. Staff from Anoka Metro RTC have cooperated in the planning for and implementation of the Anoka Alternatives project. Rule revision processes used by the Division include participation from both community-based service providers and RTCs.

Part B:
Implementation Progress



PART B: IMPLEMENTATION PROGRESS

Federal Requirements and State Objectives

REQUIREMENT I. The establishment and implementation of an organized, comprehensive community-based system of care for severely mentally ill individuals

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.

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

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

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

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

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.

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.

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

8-C. To promote the employment of consumers.

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

REQUIREMENT II. Specification of quantitative targets to be achieved

2-A. To supervise counties in planning for and providing 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-H. To implement statutory requirements for reporting children's residential treatment data.

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.

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

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

REQUIREMENT III. The description of services to be provided to enable these individuals to have access to mental health services, including treatment, prevention, and rehabilitation

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

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.

REQUIREMENT IV. The description of services to be provided to enable these individuals to function outside of inpatient institutions

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

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.

REQUIREMENT V. The reduction of the rate of hospitalization of these individuals

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.

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.

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

REQUIREMENT VI. The provision of case management to each individual with severe, disabling mental illness who receives substantial amounts of public funds

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

REQUIREMENT VII. The provision of a program of outreach to persons who are mentally ill and homeless

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.

REQUIREMENT VIII. The provision of consultation with representatives of employees of various long-term care facilities

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.

REQUIREMENT IX. The use of state mental health planning councils for advice on the development of the mental health services plan

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

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

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

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

PART B: IMPLEMENTATION PROGRESS - Implementation Narrative

REQUIREMENT I. The establishment and implementation of an organized, comprehensive community-based system of care for severely mentally ill individuals

Overview: The Mental Health Division (MHD) is responsible for statewide implementation of the Comprehensive Adult and Children's Mental Health Acts (included as Appendix D), assuring high quality, cost-effective, and efficient services to persons with mental illness in Minnesota, with particular concern for the approximately 30,000 adults with serious and persistent mental illness and 58,000 children with severe emotional disturbance. This includes five primary statewide functions: standard setting, resource allocation/development, monitoring for compliance/evaluation, technical assistance/consultation, and statewide planning.

1. Brief description of Initial Implementation Objective Identified in 9/89 Plan, under this Requirement.

a. The original milestone: 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.

b. description of whether the objective has been accomplished during the past year:

Reports to the Legislature: Legislation passed in 1989 required the Mental Health Division (MHD) to prepare 19 different reports for the Minnesota Legislature regarding various statewide mental health issues as part of the "February 1990 Mental Health report to the Legislature". These included: The annual reports on the progress of implementation of the Comprehensive Adult and Children's Mental Health Acts; a study and recommendations of screening for residential and inpatient treatment; consolidated reporting recommendations; mental health information system status report; and a number of reports on special initiatives. The MHD also assisted in preparation of the Legislative Auditor's major study of adult residential treatment, the Department of Health and Department of Human Services' (DHS) joint study of board and lodging facilities, and the DHS report regarding Institutions for Mental Diseases.

Task forces: Task forces were used 1) to provide general information (stage-setting); 2) for problem identification; and 3) to address specific alternatives for problem resolution.

In addition, the Division networked with other states to expand

the knowledge base and share information about programs, policies, etc. Information was shared with consumers, families, professionals, providers, and others through numerous public speaking forums, through consultation with other states, and through participation in national surveys and other information gathering efforts around mental health issues.

Data: Descriptive data was gathered on inpatient psychiatric patients and other populations indicating location, diagnosis, costs, services and other information. Data on compliance with major legislation (e.g., OBRA '87) was collected for multiple purposes: to assess compliance, as a basis for planning, and to provide a national picture of the progress and changes in the mandated area. The MHD also participated in a study of current patients at Regional Treatment Centers (RTCs, or state hospitals) which assessed mental and physical functioning. In addition, a parallel study is being completed on residents of community residential treatment facilities and participants in community support programs. The data obtained are being utilized in planning for community based service expansion.

Collaborative Reports: The MHD coordinated its efforts with the Legislative Audit Commission for its December 1989 report "Community Residences for Adults with Mental Illness," and completed a mandated report with the Department of Health on methods of licensing and monitoring board and lodge facilities. These reports resulted in new legislation in 1990 and laid the groundwork for future community-based mental health service development.

Technical Assistance: In 1989-90 the MHD's regional consultants provided technical assistance to counties to develop or continue community support programs (CSPs and other community-based services) as needed. This technical assistance was ongoing, and, to the extent possible, tailored to the needs identified by counties in their mental health plans. Quarterly meetings were held in each of the five regions of the state for service providers. The content of these meetings was tailored to address needs identified in regions. In addition, technical assistance was provided to local mental health advisory councils.

A highlight of this past year's technical assistance effort was a statewide, three-day conference (an annual CSP conference) attended by 447 participants, or 500 including staff and speakers. The Division subsidized the attendance of one consumer, one local advisory council member, one county mental health contact person and one community support person from each of Minnesota's 87 counties. The purpose of this conference was to help provide essential orientation and training resources. The conference program was designed to benefit staff, consumers and family members of those using CSP services, county social services agency personnel with mental health program

responsibilities, members of the local mental health advisory councils, and personnel from other community agencies.

Regular availability of training resources continues to be important to the development of an effective, comprehensive statewide system of CSP services. Training provided by means of a statewide conference increases the learning opportunities by bringing together both new and established CSP programs and new and experienced program personnel. The conference setting also provides a valuable opportunity to include program consumers, advisory council members and other community agency personnel also involved with CSP clients.

The Division provided extensive technical assistance to counties as part of the review process following submission of their state-required Mental Health Plans. Technical assistance was one means of assisting counties in developing comprehensive plans for adult and children's services. The Division conducted a total of 59 technical assistance workshops and 600 site visits to individual counties and providers in F.Y. 1990. In August, 1990, the Division reorganized to focus more on topic-based regional workshops and less on site visits to counties and individual providers. This may actually increase the total number of contacts and should improve the effectiveness and consistency of the Division's technical assistance.

State Level Coordination of Children's Mental Health Services: Minnesota Statutes, section 245.4873, subdivision 1, directs coordination of the development and delivery of children's mental health services on the state and local levels. Subdivision 2 requires the Departments of Human Services (DHS), Health, Education, State Planning, Corrections, and Commerce, along with a representative of the Minnesota District Judges Association Juvenile Committee, to meet at least quarterly through 1992 to: educate each agency about the policies, procedures, funding, and services in all agencies represented for children with emotional disturbances; develop mechanisms for interagency coordination on behalf of children with emotional disturbances; identify programmatic, policy or procedural barriers that interfere with delivery of mental health services for children with all agencies represented; recommend policy and procedural changes needed to facilitate the development and effective delivery of mental health services for children in the agencies represented; and identify mechanisms for better use of federal and state funding in the delivery of mental health services for children.

Special Projects: Special projects frequently make extensive use of networking. For example, a project funded by NIMH, "CSP services for older adults with serious and persistent mental illness", coordinates health and social services on the local and state levels. On the local level, project staff have been involved with coordinating a network of service providers to

respond to the needs of this target population and have held extensive educational programs for consumers and a wide range of providers in the county. At the state level, the State Project Director has established linkages with the Long Term Care, Aging, and Social Service Divisions within the Department as well as the gero-psychiatric sections of national associations and organizations.

c. description of problems encountered:

The original organization of the Division was based on providing training and technical assistance to counties and service providers. This proved a less than totally effective method due to a lack of staff and the demands of reviewing Mental Health Plans, which favored using technical assistance as a means of resolving issues with programs having difficulties instead of as a proactive strategy. In addition, there was a lack of specialty expertise among available consultants.

d. Outcomes from the accomplishment, and whether these were what the State expected:

MHD Reports to the Legislature: These reports resulted in new legislation in 1990 and laid the groundwork for future mental health service development. The new legislation included changes in the Mental Health Act regarding clarification of the case manager's responsibilities and timeline requirements for individual treatment plan development.

Technical Assistance and Review of Mental County Health Plans: County Mental Health Plans were significantly improved through a process of review and technical assistance.

Coordination/networking of providers of services to older p2eople in rural areas: Local mental health proposals have shown improvement in addressing the mental health needs of older adults in rural areas, but additional technical assistance is needed. Eight proposals for pilot projects in aging and mental illness were funded.

ACTIVITY STATISTICS:	F.Y. 90	F.Y. 91	F.Y. 92	F.Y.93
Number of technical assistance workshops	59	85	85	85
No. site visits to individual counties and providers	600	400	400	400
Responses to letters from legislators and public	130	130	130	130

e. Cross-reference to 1 of 22 topics listed in Attachment B: 8

2. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 1-B

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

b. description of whether the objective was accomplished during the past year:

Children's Services Legislation: Significant new legislation to meet the needs of children with emotional disturbance was introduced in the 1989 Legislature. The passage of that legislation has significantly increased the MHD's responsibilities. This 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 among agencies serving children with mental health needs and their families; and 3) establish advisory councils at the state and county levels, assuring input from former consumers, parents, providers, advocates, and others.

Children's Special Projects: The DHS funded eight children's mental health demonstration projects, modeled after the CASSP (Child and Adolescent Service System Program of NIMH) framework of interagency coordination and service delivery.

Adult Services Legislation: Legislation to substantially revise the nature and extent of adult services to persons with mental illness was introduced in the 1987 Legislature. The Adult Mental Health Act mandated a set of services based on best practice indicators so that service delivery to this population is considerably more comprehensive, flexible and community and consumer based than in the past. (See attachment for mandated services and implementation dates). Statewide implementation of one new service, case management services began Jan. 1, 1989

Community Support Services: The MHD's regional consultants provided technical assistance to counties to develop or continue CSPs as needed. This technical assistance and the opportunity for networking in a variety of settings has encouraged innovative planning. Local and state advisory councils met in the annual statewide CSP conference to discuss CSP services. By networking and sharing ideas with other counties and consumer representatives, counties have additional resources for problem-solving. Both new and experienced CSP staff were

involved, and the state funded a representative from the CSP, the county, the advisory council and consumers from each county (see program). Few states do this statewide without Federal dollars, underscoring Minnesota's commitment to the CSP program.

Mental Health Plans: Broad representation is included in the review of county mental health plans, including the State Advisory Council, the Alliance for the Mentally Ill, the Mental Health Law project, the League of Women Voters, and the Mental Health Association, which increases the opportunity to use multiple perspectives statewide. State staff work with counties to improve and strengthen plans following completion of initial reviews. In 1990, state funds were delayed to eleven counties until substantial planning and service delivery issues were resolved with the assistance of state staff.

Adult Special Projects: 1) Older adults. An NIMH funded project received by the State MHD and contracted to St. Louis County (Duluth, MN) which examined CSP services for older adults in rural areas developed, as part of this project, a service model aimed at statewide implementation. On the local level, the project has developed services geared to meet the needs of older adults, including older adult day treatment, respite care, adult day care, assisted living, and client advocacy with other health care providers. Eight pilot projects were funded by state monies to extend various aspects of the model into their (rural) communities.

2) Compulsive gambling. The MHD has developed a program, following introduction of the lottery in Minnesota, for compulsive gambling which uses lottery monies to fund a toll-free hotline and training of providers of services to compulsive gamblers. The program draws upon existing resources, including those of other states with this relatively new type of program.

3) Underserved populations. Minnesota has many special projects for Native Americans with mental illness. In this, the refugee populations, and other underserved populations, the MHD has developed extensive linkages with other State agencies providing services to these persons.

4) Anoka Alternatives Project. This project provides grants to counties using Anoka Metro RTC for the relocation of about 35 persons with mental illness to community settings. Uses of these funds include: Housing subsidies and support services to enable these individuals to live in their own homes; expanded staffing at existing programs to enable service to more difficult clients; and other services needed by these individuals to remain and function in their home communities.

5) Homelessness. In SFY 90, eight grants serving 2,582 persons with mental illness who were homeless were awarded. In

addition to assessment, meeting basic needs and attempting to move the person and the needed mental health services toward each other, the MHD asked rural counties to focus further on persons with mental illness at risk of homelessness as well as on homeless, mentally ill migrant workers, and urban areas to have more of their clients accept county mental health case management on an on-going basis.

c. description of problems encountered:

Promoting the major system changes mandated by the 1987 legislation with a minimal amount of start-up time has significantly increased the workload of the Division, counties and providers. It has also increased tensions between counties, providers and the state while new roles and responsibilities were being sorted out.

Children's Services: The amount of funding provided by the Legislature covered only one new position in State Fiscal Year (SFY) 1990, with a second position provided through salary savings in the second half of SFY 1990. The lack of staff, combined with the review of county biennial Children's Mental Health Plans, severely limited efforts to develop and implement services and to provide much-requested technical assistance to counties. It is also difficult to find parents and former consumers to participate in local advisory councils.

d. Outcomes from the accomplishment, and whether these were what the State expected:

- Counties have successfully completed the biennial adult and children's mental health planning processes.
- Eight older adult pilot projects were funded in rural areas.
- A compulsive gambling program was developed.
- Planning for children's services was initiated.
- Eight Children's Mental Health Service Demonstration Projects were continued with ADM block grant funds.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 14

3. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 3-A

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

b. description of whether the objective was accomplished during the past year:

New Federal Funding Resources: The Division obtained two new grants from the National Institute of Mental Health totaling over $600,000 for a three-year period: One for mental health statistics improvement and another for mental health human resource development. A third small grant ($5,000) obtained by the MHD and the Chemical Dependency Division is providing for a statewide conference on adolescent dual diagnosis (MI/CD) issues. The Mental Health Statistics Improvement Project is funded by a three-year NIMH grant to improve the State's mental health data system (see Requirement II, 3-B).

Special State Projects: The Legislature provided, for the first time, a one million dollar appropriation for specialized mental health needs and services, pilot projects and training which cannot be funded through other funding sources, but which are necessary to the implementation of the Comprehensive Mental Health Act. These funds have been used for: A state-wide public education campaign to reduce the stigma of mental illness; housing support services demonstration projects; technical assistance for counties and providers; mental health information system operating costs; a statewide community client assessment survey; State Mental Health Advisory Council expenses; rule development; and a legislatively mandated program to provide camping activities for persons with mental illness. Lottery funds were used for the development of a compulsive gambling program. Due to the State budget deficit, the 1990 Legislature cut $153,000 from the FY 1991 appropriation. These were funds that had been used for the continuing public education campaign.

ACTIVITY STATISTICS:	F.Y. 90	F.Y 91	F.Y. 92	F.Y. 93
Number of grants awarded by DHS	213	252	238	238
Federal grant applications submitted	7	7	7	7

Prevention: A proposal developed by the MHD, the Department's Community Resource Development Division, and several local organizations and school districts requests funding for a mentoring program for children. This program, if funded, will train and then pair adolescents with at-risk younger children in an attempt to prevent symptoms of emotional disturbance.

Downsizing Institutions for Mental Disease (IMDs): The MHD took part in several efforts to determine how to provide more normalized living arrangements for persons with mental illness more effectively. These include continued efforts to address federal regulations declaring some residential facilities Institutions for Mental Diseases (IMDs). (Persons living in

facilities with more than 16 beds that provide mental health care are not eligible for Medical Assistance). All Rule 36 (community residential) facilities with more than 16 beds have been classified as IMDs. All residents of IMDs under age 65 are ineligible for all Medical Assistance services, including doctor's visits, dental care, and drugs. Although the 1989 Legislature approved expanded General Assistance Medical Care (GAMC) coverage for such persons, the Mental Health Division is working with individual facilities to reduce their size to 16 beds or less. This change not only restores Medical Assistance benefits, but also has a positive impact on the facilities' program. Since January 1989, the Division has successfully assisted 6 counties in downsizing 9 facilities from a total of 187 beds down to 144 beds for the 9 facilities. The Division has also developed a long-term IMD downsizing plan which is expected to significantly decrease the number of nursing facility and residential treatment facilities classified as IMDs over the next two years.

Nursing Home Alternatives: The 1989 Legislature provided special funding for community alternatives for persons with mental illness who do not need nursing facility level of care and who are required to move from (or cannot be admitted to) nursing homes due to new federal requirements. These funds are intended to implement the mental health portion of the Nursing Home Reform Act in the federal Omnibus Budget and Reconciliation Act of 1987 (P.L. 100-203) by supplementing other available funding for community services. These changes were to be effective January 1, 1989 and were to have been completed by April 1, 1990. Minnesota submitted an Alternative Disposition Plan (ADP) which was approved, allowing phased relocation over a two and a half year period, ending June 30, 1992. A state appropriation is currently being utilized to assist counties in developing appropriate alternative services for individuals relocated from nursing facilities under OBRA regulations.

Anoka Alternatives: The 1990 Legislature provided a one-time appropriation of $500,000 for community alternatives for about 35 persons with mental illness who are ready for discharge from the Anoka Metro Regional Treatment Center, but for whom there are insufficient services in the community. Grants to counties utilizing the Anoka facility have been awarded and the first patients have been relocated to appropriate community alternatives.

Children's Services: The 1989 Legislature's appropriations for the 1990-91 biennium included $2.3 million in new state funds for children's mental health services. (These funds were subsequently cut to $900,000.) A study of mental health services provided to children under MA was undertaken to assist in implementing services through the Children's Health Plan. The outcome of this project and a mandated study of current mental

health funding to be completed over the next year will direct future funding requests. Additional funding will be necessary before the Comprehensive Children's Mental Health Act is 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. The Department has developed mechanisms to serve children with severe emotional disturbance who are not currently MA eligible through the TEFRA (Children's Health Care Option) MA option. Availability of that payment option was made known to counties in August, 1990.

Family Community Support Grants: The 1989 Legislature provided a new appropriation of $500,000 to begin family community support services, as mandated in the Comprehensive Children's Mental Health Act of 1989. The appropriation was intended to fund three months of service, from April 1991 through June 1991. Faced with a budget deficit in 1990, the 1990 Legislature reduced that appropriation to $300,000. The 1990 appropriation bill requires that the 1992-1993 biennial budget base funding level for this grant be a straight line annualization of the fiscal year 1991 appropriation.

Since the FY 1991 appropriation is for three months, $1,200,000 per year has been included in the budget base for FY 1992-1993. The Department has developed specific guidelines for these new funds in the form of a request for proposal sent to all counties in the fall of 1990. Applications from counties will be reviewed during February 1991, with grants awarded during March 1991. Counties are required to coordinate these funds with other available services and funding sources.

Community Support Program Reallocation: 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. Funding was approved for a minimum of $40,000 per county or $1.65 per capita.

State Grants Administered Directly by
the State Mental Health Department

Grant Type: (Dollars in thousands)	F.Y. 90	F.Y. 91
Adult Residential	$11,144	$11,445
Community Support	8,492	9,452
Nursing Home Alternatives	11	2,188
Special Projects	500	347
Anoka Alternatives	0	500
Family Community Support	0	300
Compulsive Gambling	300	300
TOTAL:	$20,447	$24,532

A total of $1,993,000 in new state funds for mental health services was approved for FY 90, and $6,552,000 in FY 91 (this includes some funds administered by other Divisions, e.g., as part of Medical Assistance). Increases over the two years are primarily due to increases in children's mental health funding, nursing home alternatives funding, and Rule 12/14 increases (including Rule 14 housing support projects, changes in the Rule 14 formula and others). (See Appendix D, Final Budget: New Funds for Mental Health Services)

Future Directions: The Division has awarded a contract for a wage equity study of community care providers. A problematic issue in this regard is the need to increase Rule 12 grants if pay increases are recommended. This issue was addressed in the Legislative Auditor's study of community residential facilities.

New services under discussion in the Division as of July 31, 1990, include: an MA option for state operated community services (SOCS) for children with severe emotional disturbance; case management services for children with severe emotional disturbance as a covered MA service; and mental health rehabilitation services as a covered MA service for both children and adults. This would provide ongoing federal participation in funding for components of certain services mandated by the Comprehensive Children's and Adult Mental Health Acts.

Human Resources

Public-Academic Liaison Initiative: A public/academic liaison is essential in improving the quality of services to persons with mental illness; therefore, the Comprehensive Mental Health Act was amended to include a Public Academic Liaison Initiative (PALI). The Department is charged with establishing "a

public/academic liaison initiative to coordinate and develop brain research and education and training opportunities for mental health professionals in order to improve the quality of staffing and provide state-of-the-art service to residents in Regional Treatment Centers and other state facilities (M.S. 245.4861 subd. 1)."

PALI is to include programs which:

--encourage and coordinate joint research efforts between academic research institutions and RTCs, community mental health centers, and other organizations conducting research on mental illness or working with individuals who are mentally ill;
--sponsor and conduct basic research on mental illness and applied research on existing treatment models and community support programs;
--seek to obtain grants for research on mental illness;
--develop and provide grants for training, internship, scholarship, and fellowship programs for mental health professionals in an effort to combine academic education with practical experience, and to increase the number of professionals working within the state.

No appropriation was made for the Public Academic Liaison Initiative in 1989. Therefore, no new activities could be started. However, many ongoing MHD activities, as well as new activities funded by the NIMH Human Resource Development (HRD) capacity building grant facilitate this public/academic liaison.

Many linkages already exist between the Department and higher education; these linkages can provide a model or basis for a more comprehensive approach to a public/academic liaison initiative. Examples of existing linkages that relate to the outcomes specified in the PALI legislation are:

- DHS's Institutional Review Board (IRB), with representatives from Minnesota's medical schools, DHS, and such organizations as the Institute for Disability Studies and the Minnesota Hospital Association, advocates for research within the RTCs. Its membership affords some liaison capacity between DHS and academic institutions interested in researching the biological origins of and treatment for mental illness.

- The DHS's Affirmative Action Office has developed recruiting relationships with colleges and universities with traditionally minority enrollees throughout the country. The Minority Recruitment Shortage Occupation Project has focused on the occupational roles in the areas of occupational therapy, physical therapy, and speech pathology. The Project has placed student interns in both Brainerd Regional Human Services Center and Fergus Falls Regional Treatment Center.

- University representatives are on a variety of advisory groups including the HRD Project; Compulsive Gambling; Case Management; and Rule 36 revision.
- During the past year there have been several efforts to link with the University of Minnesota in the area of research and research grants. A number of grant applications were submitted to NIMH which were joint efforts on the part of the University and the MHD; the DHS contracted with the University for a follow-up survey of gambling behaviors for the Division's compulsive gambling project and for assistance with gathering baseline and prevalence data on adolescents and adults at highest risk; and DHS has lent its support to other efforts on the part of the University or other academic institutions.

HRD Project: DHS received a grant from the National Institute of Mental Health (NIMH) for Capacity Building in Human Resource Development in October, 1989. This project has four main goals, one of which is to develop appropriate planning linkages with academic institutions, mental health service agencies and other related agencies. The expected outcomes of the Human Resource Development (HRD) Project are consistent with the goals of PALI.

Approximately one third of the project's advisory group is from the academic sector, with representatives from the University of Minnesota School of Nursing and Dept. of Social Work, and the Higher Education Coordinating Board. Although line items related to the public/academic collaboration aspects of the project at only 35% of requested levels, the funding is a start. These funds are to be used to engage faculty in planning, implementing, and evaluating the collaboration in education, services, and research.

DHS has received approval for assistance from the State/University Collaboration Project (SUCP), a joint effort of the Pew Memorial Trust and the American Psychiatric Association. The SUCP offers in-depth consultative services to states wishing to develop or enhance existing state/university collaborations. The SUCP also conducts regional workshops designed to assist in creating or expanding collaborative efforts between state mental health departments and departments of psychiatry. The Screening Committee held a regional workshop June 21-22, 1990 in Minneapolis. While the SUCP focus on psychiatry is far narrower in scope than the collaboration envisioned by either PALI or HRD, it may form the basis for more extensive collaboration with the academic system.

1) A human resource development (HRD) capacity building project has been initiated. The project is designed to develop the following resources:

- Administrative functions to oversee the process
- Data capacity to monitor the mental health service force

- Development of planning linkages with relevant academic institutions
- Development of an HRD plan, including a focal point for HRD administration

The following has been accomplished to date:

Administrative functions: A project director has been hired; this position will terminate at the end of the HRD grant funds. Preliminary discussions have been initiated by the project director with the relevant divisions involved in HRD (Personnel, Resident Program Management and Mental Health) in order to prepare for a mechanism which will establish administrative functions by spring, 1992.

Data capacity: An explicit data set which is part of the federal Mental Health Statistics Improvement Project (MHSIP, a subset of 23 basic data elements recommended by NIMH) exists to provide very basic HRD data. The research data capacity in the DHS is currently being assessed in order to determine the data which is usable and accessible in the system and that which is needed beyond the current information. For example, Rule 12 and Rule 14 data is collected by the Mental Health Division, Licensing collects Rule 29 outpatient clinic compliance data (which is not computerized in a manner usable to the MHD), Personnel collects county data on mental health workers, Medical Assistance has another system, and so forth.

Planning linkages: Planning linkages with relevant academic institutions in order to address common problems (e.g., rural staff shortages, graduates with little training in specific areas of mental health) have been developed with the Department of Health, Health Occupations area of the Health Systems Division. The Minnesota legislature mandated a study of rural health professionals in order to identify ways to encourage more rural health professionals and to identify areas of shortage by number and type of professional. The proposal was written with a primary medicine influence. The MHD has been encouraging inclusion of mental health areas as well. The results are to be available for the next legislative session.

HRD plan: The project Advisory Group, with representative from academic institutions, is currently doing the preliminary work required to develop an HRD plan. They have formed two sub-work groups, 1) education and training, and 2) standards and regulations (and how these affect the work force capability). A third subgroup on how to develop a focal point for HRD administration is being considered.

Currently, they are working on a survey of academic institutions on their capacity to prepare graduates in mental health-related service areas, the content of their curriculum, the kind of

practical experience included in the curriculum (internships, etc.), their openness to increased collaboration with the MHD, etc. These data and the linkages formed in obtaining these data will form the basis for inter-organizational linkages.

2) A PEW Memorial Trust Fund - American Psychiatric Association application for increased collaboration between the University of Minnesota, Department of Psychiatry and the State MHD was recently approved. This project is centrally concerned with increasing linkages between the MHD and academic training institutions. This application provides for in-depth consultation from experts from a state with greater experience with such collaborative efforts. The consultation will be used by project staff to develop a proposal for residency training in public psychiatry (e.g., Regional Treatment Centers, Community Mental Health Centers, or other CSPs). Approximately 20 persons will be involved in the all-day consultation, projected to be in October, 1990. The model adopted for increased collaboration with the Department of Psychiatry is similar to that which might be attempted on a broader scale with other departments' training staff in mental health areas, such as psychology, social work, nursing, occupational therapy and others.

c. description of problems encountered:

Budget: The Governor requested a total of $11,028,000 in new funding for mental health services for FY 90 and FY 91 combined. The Legislature approved only $8,545,000 due to the State budget deficit, with the cuts being primarily in children's services, Mental Health Division staff and expansion of the CSP program (Rule 14 formula change). Growth of CSPs in all 87 counties is proceeding at a slightly lower rate than expected because of the reduced funding levels in the appropriation. Development of an appropriate array of children's mental health services is also delayed due to concern over availability of state service funding.

HRD: Project funds were available in September, 1989. Delays in hiring staff have slowed the HRD project, but funds are available from the late start. The Project Director was not hired until December, 1989 and the second position, the Project Analyst, who is involved in developing a needs assessment to supplement planning, was not hired until August, 1990.

Establishing administrative oversight requires coordination between the Personnel Division, the Research Program Management Division and the Mental Health Division. An assigned focal point for responsibility within DHS is needed, but this probably will not be located within any of the individual Divisions involved, which complicates the establishment of this position. Development of a focal point is not due to be completed until spring, 1992.

Survey development is slightly behind schedule due to hiring delays. Development of an HRD plan is difficult prior to development of the data capability (this is not due until 1992).

d. Outcomes from the accomplishment, and whether these were what the State expected:

Both the HRD and the PEW/APA projects are in the initial stages, and hence there are no outcomes at this time. Implementation of CSPs statewide is proceeding. New funds have been procured for the new Children's Mental Health Act, but at far below the level requested. Funding across a variety of programs, both Federal and state, has been reduced, thus hampering program development, state funding of grants and technical assistance efforts.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 4

4. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 4-B

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

b. description of whether the objective was accomplished during the past year:

A significant amount of rule revision is in process at this time which is expected to have a major effect upon the way in which mental health services are delivered in the State. Current priorities and activities include:

Rule 14 (community services) revisions have been drafted as two rules, one encompassing funding and the other standards. These are expected to be promulgated in late spring, 1991.

Rule 36 (residential treatment) is currently under revision. It will be changed so that it will be a rule to look at rehabilitation services in residential settings which does not tie the service to a particular setting (services can be delivered in any residence with 24 hour supervision). Promulgation is expected by fall, 1991.

Rule 5 (licensing for children's residential treatment) was written in 1971, and does not reflect current standards. Revision of this rule is considered critical. The MHD is looking at incorporating JCAHO standards into the Rule, to the extent that this is feasible. Discussion at this point is preliminary, but revision is expected to take about two years from this date.

Rule 74 (adult case management) has not been opened for revision yet, but the Division has established a Rule 74 Implementation Committee, including county and provider staff. Some of the assumptions made in the original Rule with respect to billing and hours of services are being examined through surveys of county staff and providers of case management services to determine the extent and nature of the disparities between the Rule requirements and present realities. The focus is on the payment/billing system and the assumptions underlying them. For example, case managers spend more time in travel to reach the client than was anticipated, and, in urban counties, case managers are senior social workers, and hence the county is not reimbursed enough to hire new case managers, caseloads are very high, paperwork increases and client contact time decreases per worker. Issues regarding the case management model will be addressed later.

Rule 29 (approval for third party reimbursement of services provided by community mental health centers and clinics) revision is underway, with the assistance of an advisory group. Standards for approval are being revised to reflect contemporary professional standards. Promulgation is expected by April, 1991.

Mental Health Funding Integration: DHS recognizes that the current system of categorical funding may "push" clients towards certain services or certain living arrangements, sometimes contrary to clients' needs, and sometimes contrary to cost effective treatment. Minnesota Statutes, section 245.463, subdivision 3, requires DHS to review funding for mental health services and make recommendations to the Legislature for any changes needed by January 31, 1991. During the coming year, MHD plans to develop separate proposals for adult and children's funds, in recognition of the very different needs of adults and children, and the very different service systems involved. Pilot projects will probably be proposed for 1992, with potential statewide implementation in 1993.

c. description of problems encountered:

Under the Administrative Procedures Act (Minnesota legislation), Rule revision takes a minimum of 18 months. If the Rule is complex or if the Division is overloaded with other responsibilities, this period is longer. Work on a case management rule for children with serious emotional disturbance is delayed due to lack of staff within the MHD.

The integrated funding workplan is contingent on the Department's commitment of sufficient staff resources and on Departmental approval of the concept.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Two major rules have undergone revision and will be promulgated in the spring. Input has been extensive and the revised rules reflect current standards. Work on other rules is continuing.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 3

5. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 4-F

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

b. description of whether the objective was accomplished during the past year:

State Level Funding: The 1989 Legislature appropriated two staff positions for children's mental health planning within DHS. (This included replacement funding for an existing position originally financed by temporary federal funds.) Because the amount of funding provided covered only one position, the second position could only be filled through salary savings in the second half of SFY 1990.

Planning for Early Identification and Intervention: Minnesota Statutes require inclusion of recommendations to provide coordinated, interdepartmental efforts to ensure early identification and intervention (EI/I) for children with, or at risk of developing, emotional disturbance.

As a preliminary step in the development of an EI/I system, the MHD, in cooperation with the Minnesota Department of Education, sponsored a multi-agency collaborative planning effort to design a system of EI/I services which would identify children who are at risk of needing or who need mental health services; and offer prevention and treatment to each child who is identified as needing mental health services.

The objectives of this planning activity were to:

-- identify the agencies, systems, and programs currently conducting EI/I activities;
-- reach a consensus on a working definition of EI/I;
-- define the critical components of a system of EI/I; and
-- strategize the processes and methods to effectively reach and identify children at risk of emotional disturbance.

The group identified key principles underlying a comprehensive, quality system of EI/I. These included: Child and family centered; multidisciplinary in nature; varied in service setting;

community-based; flexible in design to meet the unique needs of individual children and families; accessible, affordable, and accountable; valid and reliable; and provided by competent individuals.

Twelve key issues or components were identified by the group as integral to the development of an EI/I system: Professional training/continuing education; resource information dissemination; service coordination; data privacy and data management; identification and screening; systems evaluation; funding; public education; geographical accessibility; administrative functions; intake functions and processes; and technical assistance.

Preliminary recommendations of the group included:

- The need to identify currently existing resources for early identification and intervention within the state and nationally, including existing agencies and programs which conduct screening activities as well as screening tools currently in use;
- The need to build capacity and child mental health professional expertise within and across systems;
- The need for continued collaborative planning to pursue resource identification, methods of service development, and a targeted schedule of service implementation; and
- The need for all communities to promote sound mental health as a top priority for its children.

Several members of the initial planning group are willing and interested in participating in an ongoing work group to carry out the next steps in system development.

In addition, MHD staff, with assistance from mental health professionals, published a handbook for use within children's systems of care for identification of children at risk of or exhibiting early symptoms of emotional disturbance.

State Level Coordination: Minnesota Statutes, section 245.4873, subdivision 1, directs the coordination of the development and delivery of children's mental health services on the state and local levels "...to assure the availability of services to meet the mental health needs of children in a cost-effective manner." Subdivision 2 requires the Departments of Human Services, Health, Education, State Planning, Corrections, and Commerce, along with a representative of the Minnesota District Judges Association Juvenile Committee, to meet at least quarterly through 1992 to:

. Educate each agency about the policies, procedures, funding, and services in all agencies represented for children with emotional disturbances;
. Develop mechanisms for interagency coordination on behalf of

children with emotional disturbances;
- Identify programmatic, policy or procedural barriers that interfere with delivery of mental health services for children with all agencies represented;
- Recommend policy and procedural changes needed to facilitate the development and effective delivery of mental health services for children in the agencies represented; and
- Identify mechanisms for better use of federal and state funding in the delivery of mental health services for children.

This interagency group met quarterly as planned to address these issues and make interdepartmental recommendations during state fiscal year 1990; during SFY 1991, meetings are scheduled monthly.

Local Coordinating Councils: (See Requirement I, Objective 6-B) These local councils have met to assess local needs and are working to assure that local services address the identified needs.

Assistance to Families: A new grant program for family community support services is being implemented in F.Y. 1991, as directed by the Legislature.

c. description of problems encountered:

In 1989, $2.3 million was allocated in new state funding for children's services. This was cut back to $900,000 in 1990. These budgetary cuts have had major implications for progress on this item. Four state level positions were recommended by the Governor, but only two positions were approved by the legislature. The family community support pilot project originally was funded for $500,000, but funds were reduced to $300,000; professional home-based family services was funded at $750,000, but is now $367,000; therapeutic support of foster care was $460,000 was eliminated; outpatient mental health coverage under the Children's Health Plan was cut from $500,000 to $200,000. The implications of budgetary and staffing constraints include postponement of case management services for children as well as delays in the development of therapeutic support of foster care programs. Overall, development of children's services has been seriously delayed due to minimal funding for both staff and services in this area.

Mental health professionals with training to address the treatment needs of children with emotional disturbance are lacking in many parts of the states.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Recommendations from the State Interagency Coordination group are being included in legislative proposals of the DHS and the Department of Education. These include strengthening EI/I functions of local coordinating councils and demonstration funding for service projects which have co-location as a goal. In addition, training recommendations have been included in the Division workplan for SFY 91. The first phase of a study of multi-system funding, to be conducted by the Department of Education, is currently underway.

The publication on symptoms and risk predictors of emotional disturbance has been widely distributed within the social services, mental health, health, corrections, and educational service systems. Due to acceptance of and demand for this publication, it has been reprinted twice since being made available in January, 1990. The volume will be extracted in a brochure to be published in spring, 1991.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 14

6. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 5-A

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

b. description of whether the objective was accomplished during the past year:

The array of services mandated for adults and children and how they are to be provided are described in the Comprehensive Adult and Children's Mental Health Acts (see Appendix E).

Children's Services: New legislation to meet the needs of children with emotional disturbance was introduced in the 1989 Legislature. The passage of that legislation has significantly increased the MHD's responsibilities for planning, standard setting, and technical assistance. Since January, 1988, four 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 to be in place by 1992.

The Act required counties to submit their first biennial children's mental health plans in November, 1989, and mandated a comprehensive set of services throughout the state, to be phased in over 2 1/2 years, so that all children and their families

receive services based upon their individual level of need. Finally, the DHS funded eight demonstration projects which are modeled after the CASSP (Child and Adolescent Service System Program of NIMH) framework of interagency coordination and service delivery. These four efforts form the foundation for future Department work on children's mental health.

c. description of problems encountered:

The reduction in funding for children's mental health services due to the state deficit has seriously hampered development efforts in this area (see Requirement I, Objective 4-B).

d. Outcomes from the accomplishment, and whether these were what the State expected:

Services for adults are well-defined and new models of implementation are underway, as exemplified by the Anoka Alternatives and State OBRA-87 services project (the latter funding is available statewide).

The Division worked with Children's Health Plan staff to set parameters and funding mechanisms for outpatient services which started 7-1-90. A task force finished preliminary definitions of early identification and intervention. MHD staff worked with staff from the Children's Services Division to include mental health services in a demonstration of family-based in-home crisis services. Funding for these one year projects has been awarded. Work continues on defining both professional Home-based Services and Family Community Support Services. The RFP for the latter will be available in the fall of 1990.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 1

7. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 6-A

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

b. description of whether the objective was accomplished during the past year:

Comprehensive Children's Mental Health Act: The 1989 legislation was designed to accomplish, among other goals, the establishment of mechanisms at the state, local and individual case levels for coordination among agencies serving children with mental health needs and their families; and the establishment of advisory

councils at the state and county levels, assuring input from former consumers, parents, providers, advocates, and others. State level coordination is provided by the required interagency group defined in Minnesota Statutes 245.4873.

Commissioners' representatives of the State Departments of Human Services, Education, Health, Corrections, State Planning, Commerce and others, along with a representative of the Minnesota District Judges Association, have met quarterly since the end of the 1989 legislative session in order to design a system which would identify children at risk or who need mental health services and offer prevention and treatment. Highlights of their recommendations include: Provision of training for multi-system service providers; establishment across Departments of commonly defined eligibility criteria for programs; studying of pooled funding to enhance access to resources and eliminate duplicative requirements; and state development of model interagency agreements to promote the provision of early identification and intervention services on the local level.

Other Coordination: The MHD has participated in numerous other efforts to ensure state-level coordination with affected parties. The employability component of community support services is closely coordinated with services available through the Department of Jobs and Training, Division of Rehabilitation Services (DRS). The MHD coordinated its efforts with the Department of Health on a study and report of methods of licensing and monitoring board and lodge facilities. The MHD expects to be able to link with the Health Department in licensing facilities requiring clinical oversight with respect to appropriate expectations regarding staff training, coordination of training and similar issues. The MHD has recently begun participating with representatives of other agencies and interest groups in the formal State Transition Interagency Council. This group addresses issues related to the transition of children with disabilities to adult service systems.

At the present time, there are a minimum of 21 task forces, advisory groups and/or committees in which the MHD is centrally involved. These involve a variety of state level inter- and intra-departmental coordination efforts for the development, implementation and funding of mental health services. In most cases, other agencies and organizations are also involved. These groups include the following:

The State Mental Health Advisory Council;
Children's Mental Health Subcommittee;
Case Management Implementation Group;
Rule 14 Advisory Committee;
Rule 36 Advisory Committee;
Rule 74 Implementation Committee;
Rule 29 Advisory Committee;

MHSIP Management Committee;
MHSIP Technical Committee;
Indian Mental Health Advisory Committee;
Refugee Mental Health Advisory Committee;
HRD Advisory Committee;
Compulsive Gambling Advisory Committee;
Home-Based Services Work Group;
Early Identification/Intervention Work Group;
Children's Case Management Work Group;
Adult Screening Task Force for Residential and Inpatient Treatment Services;
Children's Screening Task Force for Residential and Inpatient Treatment Services;
Training Subgroup on Children's Mental Health;
State Interagency Coordinating Group; and
State Transition Interagency Council

A new Children's Case Management Work Group is to be established in September of 1990.

Public/Academic Liaison Initiative: Although no appropriation was made for the Public/Academic Liaison Initiative (PALI), the MHD did receive in November 1989 a limited grant from the National Institute of Mental Health for Human Resource Development (HRD) capacity building. The HRD grant allows for some activities called for in the Minnesota PALI legislation. Because the HRD grant was received late in the year, initial efforts have focused upon the development of an advisory committee to the project and the initiation of ties to the state university system, Higher Education Coordinating Board, and professional societies and organizations. While the HRD project will, over three years, focus on issues related to the supply, education, and training of mental health professionals, these efforts will create opportunities to coordinate specific research efforts with the University of Minnesota.

Special Projects: Special projects in the area of aging and mental health have used collaborative mechanisms to extend demonstration projects to other counties. At the State level, the State Project Director, in collaboration with the Long Term Care Division and the Quality Assurance and Review Section of the Minnesota Health Departments, developed mental health screening components for incorporation to pre-existing instruments that were in compliance with the federal OBRA legislation. The State Project Director has also established linkages with the Long Term Care, Aging, and Social Service Divisions within the Department as well as the gero-psychiatric sections of national associations and organizations.

The MHD and the Refugee and Immigrant Assistance Division signed an agreement to share supervision and coordination of the state funds available for social adjustment/mental health programs

($150,000) in SFY 1991. The DHS funded eight demonstration projects which are modeled after the CASSP (Child and Adolescent Service System Program of NIMH) framework of interagency coordination and service delivery. The MHD funds a newsletter produced by the demonstration counties which assists in the coordination of efforts to develop children's mental health services.

c. description of problems encountered:

Coordination with other entities is generally time-consuming due to different terminology, expectations, levels of development, and agency rules.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Service development, including legislation, Rule revision, and specification of lines of responsibility, areas of service, target populations, service delivery methodologies, etc. has been a process which uses multidisciplinary perspectives, so that shared areas of responsibility, information and opportunity have been identified in the planning process. Funding opportunities have developed across systems for the provision of children's mental health services.

The collaborative work to develop the mental health portion of the nursing home screening instrument, as required by OBRA, was completed and implemented.

Proposals for mutually beneficial efforts were developed between the MHD and the University of Minnesota and submitted to NIMH. Unfortunately, these proposals were not funded.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 2

8. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 6-B

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

b. description of whether the objective was accomplished during the past year:

Case management: 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 for whom they are providing case management services. This regulation

ensures that the case manager continues to work with the client beyond a time-limited treatment period. Statewide implementation of case management services began January 1, 1989. The development of case management as an independent mental health service and not as a traditional social service offered by the county has necessitated restructuring and reorganizing internal administrative processes to accommodate to this change. In many cases, these adjustments have permitted the county to become a vendor of services in much the same way as other mental health providers in the overall system.

Children's Services: One of the goals of the Comprehensive Children's Mental Health Act was to establish mechanisms at the local level for coordination among agencies serving children with mental health needs and their families and to establish advisory councils at the county level, assuring input from parents, providers, advocates, and others.

By August 1, 1989, counties were required to 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 eligible children for services. Review of county biennial children's mental health plans (due in November, 1989) indicated variable compliance with this provision.

By January 1, 1990, counties were required to establish local coordinating councils (LCCs) 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, councils must also include representatives of juvenile court or the court responsible for juvenile issues and law enforcement. Members of councils must meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. Councils must provide written interagency agreements and report annually to the Commissioner about unmet children's needs, service priorities and the local system of care. These are present in all counties. Counties which have received Children's Demonstration grants appear to be the most advanced in the development of LCCs.

Special projects: Special projects have shown considerable coordination at the local level. For example, project staff from the Range Mental Health Center and St. Louis County Social Services collaborated with federal Alcohol, Drug Abuse and Mental Health (ADM) projects to incorporate mental health needs into the basic assessment instruments used for screening applicants for social and mental health services. The project staff have also been involved with coordinating a network of local service providers to respond to the needs of this target population.

c. description of problems encountered:

Problems in implementation of case management statewide are currently being assessed through surveys of case managers. Analysis of data from these surveys will test assumptions upon which the reimbursement system is based.

Insufficient numbers of mental health professionals to complete diagnostic assessments are available in some areas of the state, especially those trained to assess treatment needs of children.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Adult case management services have been implemented statewide.

Reviews of county biennial children's mental health plans indicated that local coordinating councils were being established as required, although a few counties were slow in appointing representatives.

Local mental health proposals from rural counties have shown improvement in addressing the mental health needs of older adults, but additional technical assistance is needed.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 21

9. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 7-C , 7-D

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; and

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

b. description of whether the objective was accomplished during the past year:

The MHD focused its efforts on a variety of special projects this year. Federal Alcohol, Drug Abuse, and Mental Health (ADM) Block Grant funds were used for services to Indians and underserved populations. Federal McKinney Act funds and state appropriations enabled ten projects serving homeless persons with mental illness to continue and focus their efforts. The MHD established mental health pilot projects around the state serving the unique needs of older adults. Projects focussing upon refugees and persons in

rural areas were terminated in 1989 as per the federal grants supporting the projects.

ADM Block Grant Provisions: The 13.75% of the Federal Alcohol, Drug Abuse and Mental Health Services Block Grant which supports mental health services in Minnesota are used to make grants to Indian tribal organizations for special Indian mental health services, to fund support costs of the State Indian Mental Health Advisory Committee, to award special statewide demonstration project grants for underserved populations and other special projects, and to provide statewide planning and evaluation activities.

Federal and state restrictions include: At least 10% must be used to initiate and provide new mental health services for children and adolescents with severe emotional disturbance and for unserved areas or underserved populations; not more than 25% for mental health services and advisory committees for Indian organizations; not more than 15% for statewide planning and evaluation and 5% on administration. Local grant recipients must provide 1) outpatient counseling; 2) 24-hour emergency services; 3) screening of individuals being considered for placement in state regional treatment centers; 4) day treatment; and 5) consultation and education services. In F.Y. 1990, 10 Indian tribal organizations and 17 demonstration projects for services to underserved populations were awarded grants.

ACTIVITY STATISTICS:	F.Y. 90	F.Y. 91	F.Y. 92	F.Y.93
Number of Indian tribal organizations receiving grants	10	10	10	10
Number of grants for demonstration projects for services to under-served populations	17	16	9	9

ACTIVITY STATISTICS: (Dollars in Thousands)	F.Y. 90	F.Y. 91	F.Y. 92	F.Y. 93
Financial assistance to political subdivisions and nonprofit agencies:				
Indian tribal organizations	$ 324.0	$ 308.7	$ 308.7	$ 308.7
Children, underserved and demonstration grants	1,186.4	679.2	679.2	679.2
SUBTOTAL:	1,510.4	987.9	987.9	987.9
State Agency Operations:				
Administration	72.3	61.7	61.7	61.7
Planning and Evaluation	164.0	185.2	185.2	185.2
SUBTOTAL:	$ 236.3	246.9	246.9	246.9
TOTAL:	$1,746.7	$1,235.0	$1,235.0	$1,235.0

Indian Mental Health Advisory Council: The Indian Mental Health Advisory Council has met quarterly. Membership includes representatives from all eleven reservations as well as from the urban communities. The Council advises the Multicultural Program Consultant on the use of federal grant set aside funds in the delivery of mental health services for Indian populations.

Refugee Mental Health: The NIMH funded Refugee Mental Health Program provided a state level focal point for addressing refugee mental health issues. The program was designed to improve/increase culturally sensitive services to an estimated 34,000 refugees in the state of Minnesota. It ended in August, 1989. The duties of three staff funded by this grant were taken on by existing MHD staff.

Legislation was enacted during the 1989 session which made $150,000 available for Social Adjustment/Mental Health Programs for SFY 1991. As a result of a signed agreement between the Refugee and Immigrant Assistance and Mental Health Divisions, supervision of the refugee mental health funds will be shared and coordinated between RIAD and MHD, including development of requests for proposals, proposal review and grant awards.

Mental Health Services for Homeless Persons: Federal McKinney Act homeless grant funds are used to help counties assess the need and develop appropriate specialized community based services for homeless persons with mental illness. Grants to counties are made in combination with state Rule 14 Community Support Program

funds to assure linkage and ongoing provision of local services to homeless persons with serious and persistent mental illness. The 1987 Legislature appropriated $350,000 for the biennium for delivery of mental health services to homeless individuals in Hennepin, Ramsey and St. Louis Counties. This money was used towards the required 3 to 1 match of the McKinney Block Grant. The 1989 Legislature appropriated an additional $400,000 for the next biennium.

The Mental Health Division used the Department of Jobs and Training quarterly shelter data to determine which counties would receive would receive funds and in what percentage. Minnesota's McKinney Mental Health Services for the Homeless (MHSH) allocation for FY 90 was $334,000. For SFY 90, the total Mentally Ill Homeless Grant program budget (state and federal dollars) was $724,000. In F.Y. 1990, 8 grants serving 2,582 homeless persons with mental illness were funded.

Special Projects for Older Adults: The three year NIMH demonstration project on community support program services for older adults ended in August, 1989, which was the first full year of ADM block grant funding for eight projects demonstrating different models of community-based mental health services for older adults. These projects extend the methodologies and instruments of the NIMH demonstration project. The project director developed the evaluation for the ADM projects.

Compulsive Gambling: The 1989 State Lottery Bill included a new appropriation of $300,000 per year to develop and implement prevention, public education and treatment services for compulsive gamblers and their families, and to conduct relevant research. The Lottery Bill directed the State Lottery Division to each year transfer $100,000 from state lottery proceeds to the General Fund for support of the Compulsive Gambling treatment program. This appropriation includes 1.75 positions to administer the program; it is the only part of the State MH Grants activity which includes the administrative costs related to the grant.

Federal Grants Administered by the Mental Health Division

Grants by Category: (Dollars in Thousands)	F.Y. 90	F.Y. 91	F.Y. 92	F.Y. 93
MH Block Grant	$1,747	$1,235	$1,235	$1,747
Refugee MH Program	15	0	0	0
MH for Homeless	454	391	350	350
Community Support Services for Older Adults	88	0	0	0
Planning Grant	75	0	0	0
Rural Mental Health	26	0	0	0
Statistics Improvement	41	195	142	142
Human Resource Dev.	27	150	104	104
TOTAL:	$2,473	$1,971	$1,831	$1,831

c. description of problems encountered:

Indian Mental Health and Underserved Populations and Areas: The amount of the Federal Mental Health block grant for Federal F.Y. 1989 was $200,000 less than Federal F.Y. 1988. The two-year spending provision delayed the immediate impact of the Federal reduction, but it is gradually requiring a significant cutback in both the demonstration projects and the state staffing during F.Y. 1990 and 1991. No significant increases are expected in this grant for F.Y. 1992 and 1993. State funding has been requested for one position now funded by the above funds.

Mental Health Services for the Homeless: The reduction in Federal funds will result in curtailment of the number of grants and persons served if funding is not restored to the initial level.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Special project grants have made possible numerous innovative projects for diverse populations. These projects have been well received locally. In some cases, they have provided the only funding option available.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 12

10. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 8-B

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

b. description of whether the objective was accomplished during the past year:

The Comprehensive Adult and Children's Mental Health Acts require input at both the state and local levels from consumers and their families, if appropriate, in the provision of mental health treatment services. For example, consumers and families are involved in treatment service development. The housing mission statement in the Adult Mental Health Act, the recently enacted appropriation for family community support services, task force recommendations on treatment services, program content of the annual CSP conference and projects promoting alternative, community based treatment are consistent with the emphasis throughout the system on consumer involvement and self-determination. In addition, consumer and family members are required as participants on Local Advisory Councils.

Service Development/Rule Revision: Consumers and families are involved in planning for service development. This includes involvement in Rule revision (e.g., consumers are involved in the revision of Rule 36 (Community Residential Treatment) and the revision of Rule 15 (CSP Program Rule), using their experiences with these systems to guide the revisions. Under the proposed revision of Rule 15, for example, counties and providers are expected to provide general information to families about mental illness, psychotropic medications, etc. and to provide specific information to families if the consumer has signed a release of information to enhance consumer and family involvement in the treatment process. This service expectation was added as a direct result of family and advocacy groups' recommendations. Consumers are also involved with a variety of other activities which can influence service development. Consumers are on every county's mental health advisory board. Consumers were involved from the beginning stages in the development of an NIMH proposal for a consumer-run supported housing program (not funded).

Task Force Recommendations: The children's and adult task forces on inpatient and residential treatment services recommended that, at a minimum, the person and the person's family (when appropriate) should be involved in screening decisions, and appeal mechanisms should be clear to them. Service consumers participated in task force activities.

Comprehensive Mental Health Acts: Both the child and adult Mental Health Acts require involvement of the consumer and families of child consumers in planning their program of mental health services. This is stated in the mission statement and

individual treatment planning sections of the Acts.

Anoka Alternative Treatment Plans: In July, the Anoka Alternatives Project, a one year pilot project aimed at developing alternatives for clients who would otherwise continue to reside in the Regional Treatment Center (RTC), started. A total of $500,000 was allocated for service development and implementation for SFY 1991 (7/1/90-6/30/91). In this project, consumers must be involved with developing and agree to their alternative treatment plan. Among other provisions, counties are expected to develop flexible, individually tailored treatment plans which provide the services needed for each person, including mechanisms for support, to the maximum extent feasible, for individual preference as to where services should be delivered, assertive intervention and support plans on behalf of the individual, and working with and supporting community members such as landlords, employers and family or friends as well as the individual who has mental illness.

Housing Support: Ten counties are in their second year of housing support pilot projects. The purpose of these projects is to assist individuals with mental illness in living in housing of their choice, with self-determination being considered part of the treatment. Services developed and provided with these funds must be based on the principle of an individual's right to self-determination and normalized housing.

Family Community Support Services: The 1989 Legislature provided a new appropriation of $500,000 to begin family community support services, as mandated in the Comprehensive Children's Mental Health Act of 1989. These services include outreach, medication monitoring, independent living skills development, parenting skills development, assistance with leisure and recreational activities, crisis assistance, foster care with therapeutic support, day treatment, assistance in locating respite care and special needs day care, and assistance in obtaining financial resources and benefits. These services are designed to assist children with severe emotional disturbance to function and remain within their family in the community. Consumers and, if appropriate, their families, are expected to be involved in developing Individual Family Community Support Plans.

Conferences and other participation: One consumer per county was given a stipend by the MHD to attend the annual statewide CSP conference, a major training/technical assistance event. Consumers were also the focus of many program offerings at the conference. For example, the program included sessions/roundtables on: gaining consumer participation; housing development based on values; consumer-run alternatives; employing consumers in mental health settings; consumer advocacy, consumer perspectives in CSP, and consumer empowerment. Special program sessions were oriented to consumers, including: telling your own

story; data privacy; consumer issues; and how to gain consumer participation in LACs. Consumers were among the many conference presenters and planners. The MHD funded five consumers, recommended by their Local Advisory Councils, as well as one staff member, to attend the Alternatives 90 Conference. The purpose of this national conference is to emphasize consumers' self-determination, choice and individual rights in treatment of and recovery from mental illness. Themes included consumer-run treatment programs, consumer self-advocacy organizations, employment alternatives, consideration of holistic perspectives as an alternative to medical models of treatment, and consumers as mental health professionals.

Consumers and their families were also involved in the development of materials for a major statewide anti-stigma campaign. (See Appendix F.)

c. description of problems encountered:

Many counties experienced difficulty in finding and maintaining consumer representation on their local advisory boards. Nevertheless, consumers have been increasingly involved in service planning, despite years in which their participation was neither sought nor valued.

Providers often plan services without the involvement of the consumer.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Consumers are increasingly involved on the local level in planning service development and are encouraged by local staff to participate fully in development of treatment plans. Input from consumers and families has challenged the service delivery system at the state, county and provider levels. The resulting system changes have made service provision more effective.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 11

12. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 8-C

To promote the employment of consumers.

b. description of whether the objective was accomplished during the past year:

Priority: Employability services are increasingly viewed as top priorities in the development of a community based system for persons with mental illness. With housing, employability was considered most important in a 1989 survey of consumer members of local mental health advisory councils. The 1989 Three Year Plan for Services for Persons with Mental Illness includes the objective of promoting the employment of consumers.

Background: Employability services have for some time been inadequate to meet the needs of persons with mental illness in Minnesota. Only recently has there been a recognition of the special job-related needs of persons with mental illness.

CSP Interagency Agreements: While DRS provides services such as job training, job placement and work evaluations, the CSPs assist persons with mental illness to improve their employability through activities such as medication management or assistance in developing social interaction skills in the context of employment or volunteer work. Although funding for employability services historically has been inadequate, many counties have created their own programs by using money allocated for community support 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.

Through an interagency agreement signed in 1987, the MHD and DRS have coordinated efforts to establish employability and work-related opportunities in all areas of the state. These services, designed to be a part of CSP services in all 87 counties, include:

--functional and situational employability assessments to determine the person's employability needs, strengths, and goals;
--habilitative services designed to prepare the person for employment in the community; and
--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.

In 1989, the MHD, DRS, and the Division for Persons with Developmental Disabilities conducted employability training programs in 10 sites around the state. Over 600 persons attended the sessions, which provided technical assistance on employability services as well as information on funding sources. A training manual was compiled from the sessions.

DRS and the MHD renewed their interagency agreement through December 31, 1991. The workplan of the two agencies includes:

--joint planning and participation on state and local advisory committees;
--joint development, review, and support for biennial budget requests;

--joint legislative initiatives and demonstration projects;
--joint site visits and technical assistance efforts;
--joint policy, fiscal and data analysis; and
--exchanges of Request for Proposals and reciprocal grant and program reviews.

The employability component of community support services is closely coordinated with services available through the DRS. As part of the budget process, the MHD is meeting with DRS to support DRS efforts to expand vocational services for persons with mental illness and to ensure there is not duplication between the two departments.

Mental Health Division Announcements: Consumers are actively sought in Division hiring efforts, and all Division grant announcements now indicate that applicants are encouraged to hire consumers. Grant announcements indicate the following:

> The Department recognizes the value of experiences gained by clients, former clients and family members of clients of mental health services. The Department believes that the experiences of such individuals make them a resource which can significantly contribute to the work and goals of the mental health service system. The Department recognizes that clients and former clients often have unique capabilities to work with, empathize and assist current clients, as well as insuring credibility and integrity in meeting the goals and objectives of the Comprehensive Mental Health Act. Therefore, the Department encourages the recruitment and consideration of qualified consumers and family members for positions funded under this grant. Applicants should include in the narrative portion of the grant methods of recruitment and means of identifying qualified consumers and/or family members.

Anti-stigma materials: The anti-stigma package distributed in June, 1990 includes employment themes (see Appendix F). These include: information about the effects of mental illness on business and the available programs for workers with mental illness (facts); common questions raised by employers about workers with mental illness; a literature review examining employer attitudes about mental illness; mutual strategies for successful job placement; examples of realistic working relationships benefiting Minnesota employers; tips for employers about successful employee transitions back to work after a mental health-related absence; proactive approaches to mental health in the workplace; steps to take if employment discrimination due to a disability occurs; educational materials on employment; and information about the services available from DRS.

Other employment efforts: The Division hires consumers and has contracted for services from consumer employment groups. The MHD

is exploring coordination with academic institutions and technical institutes to train additional vocational rehabilitation specialists, in coordination with the HRD effort. Employment themes were also part of the annual statewide CSP conference.

c. description of problems encountered:

Counties using their entire Rule 14 allocation to finance employability services were 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 were required to do so. As a result, the availability and quality of such services have been uneven.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Locally, employability services for persons with mental illness have increased. All counties are providing minimal employability and work related services through their CSPs. As these services become more stable, enhanced opportunities for consumer employment are expected to result. Counties and providers are beginning to hire consumers. DRS and MHD programs are becoming more distinct from each other as roles and responsibilities have been sorted out.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 13

13. Brief description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 9-A

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

b. description of whether the objective was accomplished during the past year:

An anti-stigma campaign program has been successfully completed. Approximately 300 kits were distributed to community organizations, consumers, and family members in June, 1990 (see Appendix F). The LAC liaison and another MHD staff member have provided technical assistance on the use of these kits.

The MHD contracted with the MN Department of Health, Division of Health Promotion to address the issue of stigma of mental illness, to research, plan, develop, create, promote and implement a project about stigma and mental illness, and to develop related media and materials. The advisory committee which assisted with the development of program recommendations

included the Alliance for the Mentally Ill, the State Advisory Council, the Mental Health Association, consumers and their families, and state, provider, county and University of Minnesota representatives. Literature in this area was reviewed, the experiences of other states and national organizations were solicited, and consumer and family opinions about how stigma affects their lives were gathered.

Additional input was gathered from potential users of the proposed kit, including local mental health advisory council members, county staff and other experts across the state about the target audiences for kit distribution, the overall message, whom the materials within the kit should address, and identification of stigma-related concerns. Materials included sections on organizing communities; mental illness and housing; mental illness and community-based treatment; mental illness and employment; mental illness and community responsiveness; mental illness in the public eye; and resources.

c. description of problems encountered:

Funding has been cut from the MHD budget by the State Legislature, forcing the curtailment of this program during the current State fiscal year.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Following development of the anti-stigma campaign materials, kits were distributed to a wide range of organizations. Local advisory councils are very optimistic about the impact of the campaign. Many are planning uses for the material.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 11

REQUIREMENT II. Specification of quantitative targets to be achieved

1. Brief Description of Initial Implementation Objective Identified in 9/89 Plan, under this Requirement.

a. The original milestone: 2-A

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

b. Description of whether the objective was accomplished during the past year:

Overview: Objective 2-A is one component of the broader goal of ensuring "statewide availability, accessibility, and provision of

services for children and adults as required by the Comprehensive Mental Health Act." The September 1989 State Mental Health Plan incorporated the service development mandates which were passed by the Minnesota Legislature. These mandates required the development of a broad array of children's and adult mental health services, based on a phase-in schedule. The dates indicate the deadlines by which each service was to be available in all 87 counties. A partial listing of services and the dates by which the services were to be available follows:

Education and prevention	Immediate
Emergency (hot-line) services for children and adults	Immediate
Outpatient services for children and adults	Immediate
Community Support Programs for adults and children with serious and persistent mental illness	July, 1989
Case management for adults and children with serious and persistent mental illness	January, 1989
Community support services and case management for children who do not quality as having serious and persistent mental illness, but meet the definition of severe emotional disturbance	July, 1991
Professional Home-Based Family Treatment for children with severe emotional disturbance	January, 1991
Community Residential Treatment for adults with serious and persistent mental illness and children with severe emotional disturbance	Immediate

Accomplishments:

Appendix G includes data from county mental health plans regarding the numbers of clients served and expenditures per service per county for 1988 (actual), 1990 (projected) and 1991 (projected). For this plan update, only those services are included which appear to be of primary concern in P.L. 99-660: case management, community support services, and state hospital inpatient (RTC) services. Data are available upon request regarding all of the other services mandated by the Minnesota Legislature.

The data in Appendix G indicates that, for the most part, services are being developed according to the original targets. The availability of case management and community support services is increasing significantly, while utilization of state institutions is remaining relatively stable. This may be

primarily an indication of the high level of unmet needs that previously existed.

The State's role in reviewing county Mental Health Plans and providing technical assistance to counties is described under Requirements III and V, 2-A.

c. Description of problems encountered:

Part of the state's review process for county Mental Health Plans included an evaluation of the adequacy of each county's proposed levels of service, especially for case management and community support services. The state withheld funding from eleven counties, primarily due to inadequate plans for case management. As a result, counties revised their plans to ensure at least a minimum level of service for adults and children with serious and persistent mental illness.

However, development of specialized services for children with severe emotional disturbance is behind schedule ("severe emotional disturbance" includes about twice as many children as "serious and persistent mental illness"). Most of these services were not planned to be developed until 1991. Due to funding constraints, it now appears that an expansion of pilot projects will be possible in 1991, but statewide availability of family community support and case management for children with severe emotional disturbance may not be feasible until 1993.

d. Outcomes from the accomplishment, and whether these were what the State expected:

The new community services have reduced hospitalization of their clients by over 50% (see full discussion under Requirement V, Objective 2-B). However, the RTCs (state hospitals) continue to serve the same number of clients. This may be primarily an indication of the high degree of unmet need that previously existed. It may also indicate an increasing need for mental health services, and an increasing willingness on the part of the general public to recognize mental illness and to seek treatment.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 14

2. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 3-B

To implement the new Community Mental Health Reporting System (CMHRS).

b. Description of whether the objective was accomplished during the past year:

Community Mental Health Reporting System: The Community Mental Health Reporting System (CMHRS) was implemented on a test basis on January, 1989, and on a fully operational basis in January, 1990. It provides the MHD with the capability of producing both routine semi-annual and annual reports, and ad hoc reports.

The CMHRS incorporates all publicly funded mental health services provided by counties and their contracted providers, a scope of service activity much broader than that covered by previous reporting systems. The data it contains include individual client characteristics and the type and amount of each service received by each client.

The CMHRS operates as a semiannual transfer of client-specific data from the recordkeeping systems of counties and their contracted providers directly to the State. This direct transfer process eliminates the burden on reporting agencies of producing statistical information at the local level. For most agencies, the transfers are automated, with the state receiving the data on electronic media.

This data transfer process provides the foundation for a statewide database from which most state mental health reports are being produced. This database will soon be made directly available to DHS management for rapid response to ad hoc inquiries.

As critical parts of the CMHRS, procedures for monitoring data quality and for providing technical support to counties and provider organizations were added during the past year.

A Summary of accomplishments in the development of the CMHRS is presented in the following table.

STATUS OF MENTAL HEALTH INFORMATION SYSTEM
as of August 31, 1990

DEVELOPMENT AND OPERATIONAL TASKS	COMPLETED	IN PROCESS	NOT STARTED
1. Develop and test procedures for collecting, storing, and processing data in the CMHRS	[ ]	[ ]	[X]
2. Develop and test procedures for correcting and updating data in the CMHRS	[X]	[ ]	[ ]
3. Develop and test procedures for producing reports for local agencies form the CMHRS	[X]	[ ]	[ ]

4.	Develop and test procedures for producing statewide and regional reports from the CMHRS database	[X]	[ ]	[ ]
5.	Develop and test procedures for extracting storing, and processing data from the MA/GAMC claims system	[X]	[ ]	[ ]
6.	Develop and test procedures for producing local and statewide reports from the MA/GAMC claims system	[X]	[ ]	[ ]
7.	Obtain CMHRS-compatible data from the RTC information system	[X]	[ ]	[ ]
8.	Redesign annual grant reports to integrate CMHRS data and continue monitoring program performance and accountability	[X]	[ ]	[ ]
9.	Study feasibility of coordinating mental health information systems with social services systems	[ ]	[X]	[ ]
10.	Study the data systems and information requirements of community support programs to determine the type of data to be collected and reported by these programs	[X]	[ ]	[ ]
11.	Conduct onsite quality assurance studies for CMHRS data	[ ]	[ ]	[X]

The MHD will continually evaluate the CMHRS on the basis of three criteria:

Performance: The ability of the system to meet the defined information requirements of the MHD, to provide information that is credible (based on complete and quality-assured data), and to replace more costly methods of reporting;

Capability: A measure of the system's content and data processing technology, which determine how well information requirements can be met and the "flexibility" of the overall system to meet unanticipated requirements; and

Decision-support: The extent to which information produced by the system is actually used in decision making, planning, and other functions of the Division.

Evaluation of the Information System

1. Performance: The CMHRS now meets 30% of the Division's information requirements (other information and data collection processes meet another 30%; about 40% will be met in the future with expansion of the CMHRS). Automated data error detection procedures in the CMHRS found that all data elements had error rates below 2%. However, data on client's race and type of mental illness (acute, serious and persistent, etc.) were found to be missing in a much higher percentage of cases. Data extracted from the MA/GAMC Claims system were found to deviate

from other sources of this information. The reasons for discrepancies are currently being studied.

The size and scope of grant reports have been reduced, allowing the CMHRS to produce some of the information previously reported in statistical form by counties and contracted providers.

The CMHRS has provided a means of reporting (automated data transfer) that greatly reduces the amount of effort required at service provider agencies. The Division has worked with Community Services Information System, operated by 74 counties, to incorporate this style of reporting, and has produced two microcomputer programs to assist small provider agencies in meeting CMHRS requirements. Efficiency of the system overall can still be improved through expansion of the CMHRS.

2. Capabilities: System capabilities are still limited to producing about 50% of information requirements that a reporting system could be expected to meet. Expansion of the CMHRS is seen as one means of improving capability. Additional staff are needed in the Division to operate the information system at its current level of technical capability.

Also important are incentives to county and provider agencies to increase automation and content of their data systems. A grant received from the National Institute of Mental Health allows the Division to work with providers to incorporate national data standards.

3. Decision-support: MIS staff have met with state staff to explain the types of information now being produced by the CMHRS, and to discuss how they can access and use this information.

A special report to counties on utilization of MA/GAMC services by their clients was distributed in February, 1990. Similar reports are now incorporated into routine semiannual reports to counties from the CMHRS.

Program staff and state staff have reviewed county plan statistical information and used this information to evaluate local service delivery systems.

c. Description of problems encountered:

A shortage of staff in the Division to maximize the capabilities of the information system has been the key problem. This has affected the MHD's ability to provide technical assistance and to reverse use of system-generated information.

d. Outcomes from the accomplishment, and whether these were what the State expected:

The CMHRS and data extract system are implemented and operating as expected.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 6

3. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 3-C

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

b. Description of whether the objective was accomplished during the past year:

A network of 30 personal computers and a minicomputer file server has been implemented in the MHD. This system provides E-mail, file transfer, and stored device functions to the MHD as well as providing access to budgetary and legislative processes. A student worker assists in the maintenance of this system.

c. Description of problems encountered: Systems continually have needed adaptation as new equipment became available and new users were added. The result is that stability was not possible.

d. Outcomes from the accomplishment, and whether these were what the State expected: Software use is standardized. Twenty people are accessing electronic mail functions. Clerical staff functioning has been improved as professional staff utilize word processing capabilities. Data is being made available for use by staff.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 6

4. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 3-D

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

b. Description of whether the objective was accomplished during the past year:

Progress on the Mental Health Information System, scheduled for implementation during the period from November, 1990 to March, 1991, has provided additional insights into the array of

reporting requirements to which providers and counties are now subject. Because programs have been established and funded at different points in time, the MHD now administers Rule 12 (for Rule 36 programs), Rule 14 (community support programs), federal block grant, and special projects grants separately.

Data Extracts: Starting in July 1989, the MHD became a direct user of the Minnesota Medicaid Information System (MMIS). As a direct user, the MHD extracts mental health client, services, and cost data from the MA/GAMC Claims database and stores it for processing. This has many advantages over the previous method of obtaining this information by requesting reports from the division that manages the MMIS. The detailed dataset now available specific to the individual MA/GAMC claim provides a very powerful and flexible source of information on the MA/GAMC client population.

The MHD is now able to extract mental health data directly from the regional treatment centers (RTC) state accounting system database. This system will provide data on services and clients receiving treatment in the RTCs.

Financial Reports: There are a large number of funding sources which can, under certain circumstances, be used to pay for mental health services. Most of these sources are not specific to mental health. The reporting for these programs, such as Medical Assistance, is determined by the overall program and mental health services information must be extracted from the larger system.

Family support and medical programs at DHS are in the midst of major systems developments. These new automated systems will provide the reporting functions needed, eliminating the need for county or provider based reporting for these programs.

There are also funding sources specific to mental health which are administered directly by the MHD. In these cases reporting is independent of larger systems, specific to the county and/or provider, and under direction of the MHD. RTC mental health units are administered by DHS, independent of the MHD. Reporting on these services is primarily a function of the state accounting system. Reporting does not include counties or providers as a source of information. The possibilities for simplification and integration of fiscal reports are constrained by the requirements of the various funding sources.

Mental Health Statistics Improvement Project (MHSIP): This project is funded by a three year NIMH grant to help organizations that provide mental health services make improvements in their data systems. Improvements include installation of national data standards, and use of these standards to serve local management decision making. Involved

organizations include county operated and county contracted community mental health centers and freestanding community support programs.

The grant covers the period from October 1989 through September 1992. These funds support one professional, one clerical and a half-time student position. Some grant funds are subcontracted to provider organizations to support changes to local data systems. The management analyst and clerk typist were hired in January, 1990, and the student technician in May, 1990. Project progress to date includes the following:

Describe information uses in local organizations. Twelve community mental health centers (CMHCs) were recruited to participate in the project. Intensive site visits were conducted with eight of these centers, collecting system documentation and management information requirements. Three meetings were held with management and technical committees composed of representatives of these centers, and techniques were developed for identifying management information requirements and key decisions in these organizations. A report to summarize findings is in process.

Implement MHSIP prototype in local systems. System documentation was collected from 8 CMHCs and from a software vendor who supplies a comprehensive data system to 10 CSP operators in Minnesota. The documentation was analyzed to identify the technical changes needed at each site for MHSIP implementation. Using this information, two contracts were prepared to support implementation work at two CMHCs and a third contract for the CSP system vendor. A report summarizing findings of the systems analyses of prototype sites has begun.

Design MIS and research program for the SMHA. Information and data requirements of the SMHA were defined to perform its role of supervising delivery of mental health services, and a set of key management indicators for evaluating service delivery in counties and other organizations providing community mental health services were identified.

c. Description of problems encountered:

Existing Databases: The RTC database was undergoing major revisions; the MHD worked with the Residential Programs Management Division to ensure that needs for data would be met with these revisions.

MHSIP: Staff recruiting for the MHSIP project was delayed due to the combination of skills needed for the key staff role, as well as by lengthy bureaucratic procedures. The result was a slow start for the project. The problem has been overcome through

hiring an individual with excellent technical skills, and the project has had more immediate implementation with less concept-selling than originally planned. Some counties have expressed concern that this project does not fit in with overall systems development plans. Counties have been reassured that this is part of the long-range plan to increase uniformity.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Existing Databases: The MHD became a direct user of the Minnesota Medicaid Information System. The MHD is now able to extract data on services and clients receiving treatment in the RTCs directly from the state accounting system database.

MHSIP: 12 CMHCs were recruited to participate in the Mental Health Statistics Improvement Project (MHSIP); requirements for system documentation and management information were collected; system documentation from 8 CMHCs was analyzed to identify technical changes needed; and information and data requirements, as well as a set of key management indicators have been defined.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 6

5. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 3-H

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

b. Description of whether the objective was accomplished during the past year:

Children's residential and inpatient facilities are required by state statute to submit annual reports about the number and types of persons admitted. This information provides the data base for planning, but is not summarized in one report. Statutory amendments are being proposed by the MHD to simplify this reporting process.

c. Description of problems encountered: Statutory data requirements do not necessarily match current planning needs.

d. Outcomes from the accomplishment, and whether these were what the State expected:

The MHD is proposing statutory modifications to make this data more useful for planning purposes. Children's services data are incorporated in the CMHRS.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 6

6. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 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.

b. Description of whether the objective was accomplished during the past year:

Overview: The process to identify the issues which need to be addressed has begun. The completed Plan is not due until near the end of the grant period (early 1992).

The Human Resource Development (HRD) Capacity Building Project aims to increase the Department's ability to address the human resource issues involved in implementing the Comprehensive Mental Health Act. Upon completion of the three year project (September 1989 to July 1992), DHS should have the capability to plan, monitor, and influence the size, quality, utilization, and distribution of the mental health services work force. One of the goals of the HRD Project is to develop a State Human Resource Development Plan, which is integrated with the State Mental Health Services Plan.

c. Description of problems encountered:

The HRD project is progressing behind schedule due to delays in hiring project staff. The Project is now fully staffed.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Funding for the HRD Project has been secured. It is too soon to evaluate the outcomes of the project itself.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 22

7. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 3-K

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

b. Description of whether the objective was accomplished during the past year:

One of the goals of the HRD Project is to create capacity and commitment to collect and analyze data on the mental health workforce. This goal will be accomplished primarily in the project's third year (1991-92). The HRD Project currently funds 1.6 FTE professional and .4 FTE clerical positions.

The Project has assessed current data collection efforts in mental health HRD by relevant state agencies. To date, little information has been obtained in a usable form.

c. Description of problems encountered:

Lack of usable existing information will necessitate the development of a data collection system from the initial stages.

d. Outcomes from the accomplishment, and whether these were what the State expected:

The Project is progressing on schedule.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 8

8. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 4-D

To enhance Division's capacity to evaluate service provision.

b. Description of whether the objective was accomplished during the past year:

Discussions initiated within the Division in May, 1990 have generated a proposal for restructuring the Division in order to enhance Division capacity to evaluate service provision. The process entailed reviewing the primary functions identified earlier and the values which the MHD believes must be maintained, then weighing a number of structural options against both the list of primary tasks and the identified values. As a result, four units were identified, as described below.

Primary functions identified included: standard setting; resource allocation/development; monitoring (compliance)/evaluation; technical assistance/consultation; and statewide planning.

Inherent values included: improved outcomes for clients; professional soundness; fiscal responsibility; staff

strengths/maximizing capacity; achievability; simplification; political feasibility; and personal contact with counties.

Three units focus primarily on the setting of standards, monitoring/evaluation, and technical assistance/consultation necessary for program development in each of the areas listed. Staff assigned to each of these units generally have more than one specialty area. Position descriptions have been rewritten to reflect the change from regional consultants to specialists, but reflect responsibility for regional and statewide training in specialty areas. A fourth unit remains the primary technical support unit for the Division.

c. Description of problems encountered:

Significant time has been required to develop new work plans based on the primary functions cited above.

d. Outcomes from the accomplishment, and whether these were what the State expected:

This reorganization was accomplished August 1, 1990. Evaluation of the effects of the new structure will be undertaken in the spring, 1991.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 2

9. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 6-A

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

b. Description of whether the objective was accomplished during the past year:

The MHD links with the Health Department in licensing facilities requiring clinical oversight with respect to appropriate expectations regarding staff training, coordination of training, and other common issues. The Division has participated in numerous inter-divisional and inter-agency work groups to ensure coordination of its efforts with other affected parties. These have included the Departments of Education, Jobs and Training, Housing Finance, Health, Corrections, State Planning, and others.

Children's Services: Three primary goals of the 1989 Comprehensive Children's Mental Health Act were to establish mechanisms at the state, local and individual case levels for

coordination among agencies serving children with mental health needs and their families; and to establish advisory councils at the state and county levels, assuring input from parents, providers, advocates, and others.

The DHS has lead responsibility at the state level to assure that the systems which serve children (i.e., Human Services, Health, Education, State Planning, Corrections, and District Judges' Juvenile Committee) identify barriers to the development and delivery of a coordinated, effective, and cost-efficient mental health system. This state interagency coordinating group is mandated to create interagency mechanisms which eliminate such barriers through the creation of policies and funding mechanisms which enable and promote intersystem collaboration and service coordination statewide.

By January 1, 1990, counties were required to establish local coordinating councils (LCCs) 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, councils must also include representatives of juvenile court or the court responsible for juvenile issues and law enforcement. Members of councils must meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. Councils must provide written interagency agreements and report annually to the Commissioner about unmet children's needs, service priorities and the local system of care. Initial reviews of proposed county biennial children's mental health plans indicate these councils are being established as required, although a few counties have been slow in appointing representatives. Case management service development is planned for the next year.

Special projects: Many special projects and programs for underserved persons or unserved areas, including Indian mental health programs, refugee mental health, programs for homeless persons with mental illness, and programs for older persons with mental illness have required state level coordination. For example, in the NIMH funded rural aging project, the State Project Director, in collaboration with the Long Term Care Division and the Quality Assurance and Review Section of the Minnesota Health Department, developed mental health screening components for incorporation to pre-existing instruments that were in compliance with the federal OBRA legislation.

Employability: With the passage of the 1987 Comprehensive Mental Health Act, all counties were required to provide employability services as part of a full array of CSP services. The Mental Health Division (MHD) and the Division of Rehabilitation Services (DRS) signed an interagency agreement in 1987 to

coordinate efforts to establish and maintain employability, including functional and situational employability assessments, habilitative services and ongoing supportive services. In 1989, the MHD, DRS and the Division for Persons with Developmental Disabilities conducted employability training programs in 10 sites around the state, attended by over 600 persons, and the DRS and the MHD renewed their interagency agreement through December 31, 1991. Legislative proposals are reviewed by the two divisions to assure coordinated approaches.

Public/Academic Liaison Initiative: The NIMH funded Human Resource Development (HRD) capacity building grant will allow for some activities called for in the Minnesota Public/Academic Liaison Initiative (PALI) legislation. Initial efforts have focussed upon the development of an advisory committee for the HRD project and the initiation of ties to the state university system, Higher Education Coordinating Board, and professional societies and organizations. The HRD project will, over three years, focus on issues related to the supply, education, and training of mental health professionals. Although this does not directly address the objective, it responds to the issue of the State coordinating with other bodies for the improvement of mental health services.

c. Description of problems encountered:

Development of Children's Case Management Services has been delayed due to lack of state staff.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Planning is underway with the Education Department on a risk prevention initiative which will assist children at risk of emotional disturbance. Joint funding mechanisms for services are being promoted for counties and school districts. A study of funding mechanisms has been undertaken.

Employability training programs were conducted in 10 sites around the state by the MHD, the Division of Rehabilitation Services and the Division for Persons with Developmental Disabilities.

The MHD participated in the development of housing support activities as a result of coordination with the Housing Finance Agency.

Coordinated rule development is underway with the Health Department on appropriate licensing of board and lodging facilities which provide special services for persons with mental illness.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 19

REQUIREMENT III. The description of services to be provided to enable these individuals to have access to mental health services, including treatment, prevention, and rehabilitation

1. Brief Description of Initial Implementation Objective Identified in 9/89 Plan, under this Requirement.

a. The original milestone: 2-A

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

b. Description of whether the objective has been accomplished during the past year:

Overview: The 1987 and 1989 Comprehensive Mental Health Acts for Adults and Children require counties to submit written plans biennially to indicate to DHS how they plan to comply with the requirements of the Acts. Initial instructions for the 1990-91 county biennial CSSA and mental health plans were sent to counties in February 1989; draft adult plans were due in August 1989 and final plans in November 1989. For the first time, the CSSA and the adult mental health plans followed the same schedule. Draft children's plans were due in November 1989 and final plans in the spring of 1990. Two plans (adult and child) were necessary because of passage of the new children's legislation.

Counties were sent county-specific information including: funds available, historical use of various programs, and prevalence of serious mental illness for adults and emotional disturbance for children.

Plans include both planning data and compliance data. Data available through the newly implemented mental health information system can be used for planning, monitoring, and evaluation. The plan format, at the request of county directors, was a fill-in-the-blank model. Instructions from DHS (including statutory definitions and requirements) made up about one-third of the plan document.

Plan Review Process: In addition to review and input by LACs, the county plan review process at the state level included a number of steps and was similar for both the adult and children's mental health plans. Each plan was compared to a standard program review checklist by the respective regional program staff person in the Mental Health Division and by Special Project staff (older adults, Indian, homeless persons, rural Human Resource Development). A parallel review was conducted by Mental Health

Division grants management staff based on a standard fiscal and data checklist.

Data from all plans were computerized and analyses prepared based on per capita and other measures. Counties were compared with one another and to measures of service adequacy established in national studies. Copies of these analyses are available from the Mental Health Division.

Mental Health Division staff also obtained input from the Regional Treatment Centers and the Social Services, Children's Services, and other departmental divisions. A number of external reviewers, including the state advisory council and major mental health advocacy groups, also reviewed the plans. Department staff were impressed by the level of interest shown by these groups and their willingness to spend long hours reviewing plans in detail. All comments from all reviewers were carefully evaluated regarding their statutory relevance.

Department staff prepared feedback letters summarizing the results of each plan review. The letters included:

- requests for additional clarification whenever county plans appears to be unclear or inaccurate;
- corrective action required for areas in which counties were clearly not in compliance with statute;
- recommendations for improvement.

In addition, Division staff provided most counties with individualized technical assistance to ensure development of plans that are in compliance with the Acts.

For both adult and children's mental health, the Division devoted a major portion of its staff resources during F.Y. 1990 to review and revision of the county mental health plans. A total of 84 Adult and 84 Children's Plans were reviewed, representing all 87 counties in Minnesota (some counties plan jointly with neighboring counties for service provision).

Adult Services: As a result of the review process, and after plan revisions, the Department identified eleven counties whose adult mental health plans were not in substantial compliance with the Act. The eleven counties were notified that payment of general social service funds would be delayed until substantial compliance was achieved. The key service areas on which the Department focused were the top priorities specified in the Mental Health Act:

Emergency services, locally available case management, and community support services for persons with serious and persistent mental illness.

Revision of County Plans: Counties (including the eleven mentioned above) have revised their adult and children's plans in compliance with statutes. Individual technical assistance was provided to counties to the extent of staff time available. In cases where compliance issues have related to inadequate levels of service availability, the Department considered the individual situation of each county. This included recognition of variations in need, funding availability, availability of qualified personnel, and the need for a phase-in period. The Department and the counties are making significant progress toward the statewide, comprehensive mental health system required by the Acts. However, it is important to recognize that progress cannot occur in exactly the same manner and at the same rate in every county due to differences in need, local funding, availability of trained staff, and the degree to which some services were previously in place.

Children's Services: The Comprehensive Children Mental Health Act required counties to 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 eligible children for services by August 1, 1989. Review of initial county biennial children's mental health plans (submitted November, 1989) indicates variable compliance with this provision.

The DHS has lead responsibility at the state level to assure that the systems which serve children identify barriers to the development and delivery of a coordinated, effective, and cost-efficient mental health system. This state interagency coordinating group is mandated to create interagency mechanisms which eliminate such barriers through the creation of policies and funding mechanisms which enable and promote intersystem collaboration and service coordination statewide. Counties, as the local mental health authority, must establish a local coordinating council with a similar mission.

The development of early identification and intervention services is a key responsibility of the County Board. The local coordinating council is the vehicle at the local level which addresses unmet service needs and service gaps, system barriers which interfere with service coordination, and strategies for resolution of these issues. Such intersystem coordination will only occur if there is sufficient knowledge and understanding by the various child-serving systems regarding: The Comprehensive Children's Mental Health Act; available early identification/ intervention services within each system; points of entry within each system; mechanisms for referral and intervention both within and across systems; and strategies for collaboration in service development and funding.

c. Description of problems encountered:

-- Most counties have made every possible effort, within available resources, to develop the service system envisioned in the Mental Health Acts. However, for most counties, additional technical assistance and additional state funding are still needed to comply with both the Adult and the Children's Mental Health Acts.

-- Counties are generally frustrated in meeting the needs of the Mentally Ill/Chemical Dependent and, to a lesser extent, the Mentally Ill/ Developmentally Disabled populations, although several addressed these issues creatively. Service development for dually diagnosed populations need to be addressed on the state level (e.g., training or special project grants to encourage program development).

--Some counties still have a great deal of difficulty in defining mental health services as distinct from social services (e.g., parenting services, services for battered women, and services for sexual offenders) as defined in the Mental Health Acts.

-- Some counties used their entire Rule 14 allocation to finance employability services, and were then faced with the need to provide all CSP services, rather than just one component. Others, which had not previously used Rule 14 funds for employability services, were now required to do so. This resulted in unevenness in the availability and quality of CSP services.

-- There are currently no resources to assist counties in acquiring the level of knowledge necessary to effectively implement a system of early identification and intervention.

d. Outcomes from the accomplishment, and whether these were what the State expected:

County plans: The combination of fiscal delays and technical assistance resulted in significant improvements in many county plans. Fiscal penalties included a $3 million delay in funding imposed on one county by the Department of Human Services for submitting a substandard plan for serving adults with mental illness. Funding to ten other counties was also delayed. The delays involved a portion of all social services funding supported by a block grant and Title XX, not just state mental health funding. The main problem identified in these 11 plans was the lack of emphasis given to case management services for persons with serious and persistent mental illness.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 8

2. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 9-A

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

b. Description of whether the objective was accomplished during the past year:

An anti-stigma campaign program has been successfully completed. Approximately 300 kits were distributed to community organizations, consumers, and family members in June, 1990 (see Appendix F). The LAC liaison and another MHD staff member have been providing technical assistance on use of these kits.

c. Description of problems encountered:

Unfortunately, this highly successful project will not be continued in the current fiscal year due to a cut in state funding for the project.

d. Outcomes from the accomplishment, and whether these were what the State expected:

The anti-stigma kit was distributed to 300 agencies and organizations in June, 1990. An evaluation form was sent to these agencies. Respondents included County Social Service Departments (35%), Mental Health Advisory Councils (30%), Community Mental Health Centers (14%), Mental Health Association Chapters (5%), and Alliance for the Mentally Ill Chapters (20%), for a total of 69 respondents. Over one-quarter (28%) indicated that few, if any, mental illness awareness activities had occurred in their community in the past year. Respondents were quite positive about the kit, with top ratings being given for the kit's quality, accuracy, comprehensiveness and usefulness by 77%, 84%, 78% and 68% respectively. A number of examples of how the materials, information and ideas in the kit will be used were provided, as well as a variety of highly positive comments, such as:

> "Best "I've seen as it is very comprehensive and covers all aspects of stigma and how to overcome it"; and "Glad to see the Department giving grass roots organization some help in our attempt to educate the general public about persons with mental illness. The materials are really fine. Thank You!"
>
> Plans are in process to increase the utilization of the kits by designating a week during the coming year

(anticipated in February) as Mental Illness Awareness Week. The focus would be on educating the general public about people with mental illness, with the method being to have the Local Advisory Councils select a particular issue and use the kit to plan events and/or activities for the particular week. Responses to the evaluations suggests that this would be a logical extension (statewide) of the direction that many LACs and/or advocacy groups are already taking. An outline for coordinating a statewide campaign has been developed.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 9

3. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 9-B

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

b. Description of whether the objective was accomplished during the past year:

All MHD communications have been changed to "person-first language" ("persons with mental illness", rather than "the mentally ill" or other, more stigmatizing descriptions). Reducing stigma and increasing sensitivity are an integral part of many projects announced and contracted by the Division. For example, projects in the area of community based mental health services for older adults include, as project goals, "to reduce the stigma and anxiety experienced by older adults in need of mental health services by providing in-home assessments and brief therapy (and) to increase the knowledge and sensitivity of (providers)"; "to improve access to and reduce the stigma of obtaining mental health services through the development of a peer counseling network"; "to reduce the stigma of seeking mental health services through the use of outreach and home visits"; and other similar goals.

The MHD also initiated numerous articles on mental health issues and editorials which were published in newspapers throughout the state.

Other Activities: Two projects funded by NIMH which terminated in 1989 have nevertheless continued to build upon their earlier efforts. Some of their continuing activities indirectly address the promotion of anti-stigma efforts by efforts to increase access to mental health services among populations which tend to be particularly sensitive to the issue of stigma. The NIMH Rural Mental Health Demonstration Project initiated a number of

activities likely to reduce stigma and increase access to mental health services in rural areas, such as attempting to facilitate clergy involvement in rural community support through a "caring week", providing materials and sermon ideas, an adolescent peer counseling program in several high schools, peer helping networks, and regular newspaper columns emphasizing rural mental health. This project's 26-member state advisory committee formulated recommendations to improve mental health services in rural areas following the grant period.

The NIMH Refugee Mental Health grant expired, but the Refugee Mental Health Advisory Council remains active and meets quarterly or as often as necessary with the subcommittees currently addressing broader refugee issues for problem identification and other purposes. One of the issues addressed which increased refugee access to mental health services has been the decision to permit refugee caseworkers with less than the usual qualifications to continue practicing as they obtain their credentials. The Indian Mental Health Advisory Council has met quarterly to advise the state Multicultural Program Consultant on the use of federal funds for this population. A majority of the Indian mental health projects utilize the services of traditional healers as well as the services of the community mental health providers, making mental health services more acceptable and accessible by community members.

c. Description of problems encountered:

None, other than curtailed funding for the project.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Stigma regarding mental illness is generated from many sources over a long period of time. While the anti-stigma efforts undertaken by the DHS were immediately successful, it is too early to judge their overall success. However, use of language descriptive of mental illness is changing within the Department and in Departmental publications, signifying a beginning of a movement to counteract stigma.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 13

REQUIREMENT IV. The description of services to be provided to enable these individuals to function outside of inpatient institutions

1. Brief Description of Initial Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 2-C

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

b. Description of whether the objective was accomplished during the past year:

OBRA-87: The Federal Nursing Home Reform Act (P.L. 100-203, also known as OBRA-87) requires that a Medicaid-certified nursing facility must not admit, on or after January 1, 1989, any new resident who is mentally ill, unless the state mental health authority has determined prior to admission that, because of the physical and mental condition of the individual, the person requires the level of services provided by a nursing facility. If the individual requires such level of services, it must be determined whether the individual requires active treatment for mental illness.

Objectives for DHS' efforts to implement P.L. 100-203 include screening all prospective applicants to Medicaid-certified nursing facilities who have or may have a mental illness to determine 1) if the applicant's physician and mental condition requires nursing facility care and 2) if the applicant has a mental illness and, if so, is in need of active treatment. Initial screenings (Level I) are conducted by county preadmission teams who then refer those applicants in need of further evaluation to the county local mental health authority. Applicants in need of diagnostic assessment are then referred to a mental health professional who is independent of the county. Final determination for admission rests with the local mental health authority.

DHS has also established an Annual Resident Review (ARR) process in order to: 1) assess the mental health service needs of all persons with mental illness currently residing in nursing facilities; and 2) determine the necessity and appropriateness of their current services. Persons determined to be inappropriately residing in the facility are then relocated. If needed, mental health services will be enhanced for persons with mental illness who require nursing facility care for physical reasons. The ARR process begins at the time of the annual Quality Assurance and Review of each nursing facility resident conducted by the Minnesota Department of Health. Persons who have or may have a mental illness are then referred to the state and local mental health authority for further evaluation (Level II assessment). Approximately 5,000 Level II Annual Resident Reviews have been conducted.

Progress and achievements during 1989 include:

--The MHD has disseminated information to counties through written materials, individual meetings and statewide or regional workshops to sensitize county staff about the needs of this population. The MHD is the mental health authority for OBRA, and provides ongoing technical assistance in the implementation of this process.

--The MHD obtained approval from the Legislative Audit Commission for 2.25 FTE positions within the MHD to plan, organize, implement and evaluate the mental health PASARR activities mandated by P.L. 100-203, and to ensure that the activities are coordinated with the mandates of the Minnesota Comprehensive Mental Health Act. The MHD provides monitoring of compliance to the nursing home screening sections of the law. The PASARR process has been implemented.

--MHD staff have conducted technical assistance sessions for Minnesota Department of Health Quality Assurance and Review (QAR) teams, local mental health authority staff, PASARR staff, RTC staff, nursing facility staff and other health and human service providers throughout the state.

Special Projects for Older Adults: A state-funded pilot project for older adults with mental illness in a rural area of the state provided assessments to 66 older adults, public information to these adults and their families, and training sessions for providers.

Screening for Inpatient and Residential Treatment Services: Initial recommendations by Adult and Children's Task Forces on Inpatient and Residential Treatment Services have been completed. These task forces have struggled with issues of screening adults and children for appropriateness of admission to such care, without adding yet another bureaucratic barrier to the availability of care. Legislative changes in requirements for screening are being proposed as a result of the recommendations by these groups. These recommendations include county assurance that appropriate admission, discharge, and continued stay criteria are included in contracts for residential services and that Medical Assistance Utilization Review criteria for inpatient hospital admission address availability and appropriateness of community services.

Anoka Alternative Treatment Plans: This one year pilot project is aimed at developing alternatives for clients who would otherwise continue to reside in the Anoka RTC (state hospital). The project started in July, 1990. Counties receive state grants so that the individual may live in their home community. Counties are expected to develop flexible, individually tailored treatment plans which provide the services needed for each person, including mechanisms for support, to the maximum extent feasible, for individual preference as to where services should

be delivered, assertive intervention and support plans on behalf of the individual, and working with and supporting community members such as landlords, employers and family or friends as well as the individual who has mental illness.

c. Description of problems encountered:

- Insufficient numbers of mental health professionals to complete the diagnostic assessments in a timely fashion; insufficient numbers of case managers who are mental health practitioners.

- Extensive training time on the part of MHD staff needed to change provider skills and attitudes from an institutionally based model to more community based approaches (e.g., to assist providers in determining how to provide the types of supervision and coordination needed outside of an institutional setting). Provider reluctance and lack of skill in working with an older adult population that has not historically been a high priority population.

- Lack of clear direction at the federal level (OBRA regulations are still not final; see 3-D).

d. Outcomes from the accomplishment, and whether these were what the State expected:

OBRA-87. The PASARR process has been implemented, and the population of people having a mental illness and not needing nursing facility care or active treatment for mental illness has been identified.

Older Adults Grants. Greater sensitivity to the mental health needs of older adults has resulted from this process.

Anoka Alternatives. The first patients have been discharged to alternative community settings.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 16

2. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 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.

b. Description of whether the objective was accomplished during the past year:

OBRA-87: In an effort to reach DHS' goal of full implementation of federal Public Law 100-203, requiring the arrangement of alternative housing and services for persons in nursing facilities who have a mental illness but are not in need of nursing facility level of care by April 1992, the MHD has begun to provide technical assistance and funding to counties from a 1989 legislative appropriation. As part of its technical assistance package, the MHD is encouraging counties to be creative in their delivery of alternative services.

The Minnesota Department of Health Quality Assurance and Review Section refers residents who have or may have mental illness and who do not need nursing facility care to the Mental Health Division (MHD) for further review. MHD staff then notify the county contact to ensure that thorough mental health diagnostic and functional assessments are completed and individual alternative disposition plans are developed, implemented and monitored.

Revised Schedule: The DHS submitted an Alternative Disposition Plan (ADP) to HCFA to request additional time to arrange for a safe and orderly discharge of an estimated 300 individuals determined to be inappropriately residing in a nursing facility. The approved schedule called for 50 persons to be relocated and provided appropriate services from January 1, 1990 to March 30, 1990, 100 additional persons from April 1, 1990 to March 30, 1991 and 150 additional persons from April 1, 1991 to June 30, 1992.

Implementation: The Division successfully began implementation of federal OBRA regulations requiring the relocation of persons with mental illness from nursing homes to community alternatives. This has required the involvement of all 87 county social service and public health departments, 98 community mental health programs and over 4,000 physicians, nursing facilities and hospitals. The latest available information indicates that up to 300 nursing home residents with mental illness may be required to relocate. Fifty persons have been discharged to independent living. By March, 1991, 100 additional persons will be discharged. State ADP grant funds, approved by the 1989 Legislature, are being used to help counties develop service packages for those persons and others who will be relocated in 1991-1992, and who are expected to need community based mental health services. Counties have begun to identify gaps, and are looking at ways to fill these needs through developing appropriate new or expanded services in the community. Thirteen counties have submitted proposals for alternative disposition grants (state funds) to assist with relocation of these residents from nursing facilities to community-based housing with a wide array of mental health, social, and medical services to transition and maintain these individuals in the community. The 13 counties have approximately 100 residents who will need to be relocated by March 31, 1991.

Technical assistance is being provided to enhance understanding of OBRA's requirements for alternative disposition plans, and to improve local awareness of how to increase this population's access to community-based housing and services. The MHD is reviewing and approving grant applications addressing specific ADPs for persons in need of relocation; providing supervision to county staff responsible for implementing ADP's, and tracking and evaluating reporting mechanisms on a quarterly basis. Plans have been developed for ongoing monitoring, including just prior to relocation, immediately following relocation, and a minimum of one year after relocation.

c. Description of problems encountered:

- Insufficient numbers of mental health professionals to complete the diagnostic assessments quickly, which delays the relocation process. Insufficient numbers of case managers who are mental health practitioners.

- Extensive training time on the part of MHD staff needed to change provider skills and attitudes from an institutionally based model to more community based approaches;

- As of July 1990, the federal government had proposed, but still not promulgated, over 30 pages of regulations to implement the mental health portion of OBRA-87.

d. Outcomes from the accomplishment, and whether these were what the State expected:

PASARR assessments have been completed and persons in need of relocations identified. Specific deadlines in federal statute and in Minnesota's approved ADP for OBRA relocations into the community are being met. Fifty persons have been discharged into the community.

Sensitivity to the needs of this population has increased, as well as awareness of community based service possibilities.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 13

3. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 4-E

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

b. Description of whether the objective was accomplished

during the past year:

Children: The 1989 Legislature, in Minnesota Statutes, section 245.4885, mandated a screening service for children being considered for residential or inpatient treatment services when public funding will be used to provide those services:

> The county board shall ensure that all children are screened upon admission for treatment of emotional disturbance to a residential treatment facility, an acute care hospital, or informally admitted to a Regional Treatment Center if public funds are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment of emotional disturbance or held for emergency care by a Regional Treatment Center under Section 253B.05, Subdivision 1, screening must occur within five working days of admission. Screening shall determine whether the proposed treatment:
>
> - is necessary;
> - is appropriate to the child's individual treatment needs; and
> - cannot be effectively provided in the child's home.
>
> In addition, it must be determined that:
>
> - the length of stay is as short as possible consistent with the individual child's needs; and
> - the case manager, if assigned, is developing an individual family community support plan.
>
> Screening shall be in compliance with Section 256F.07 or 257.071, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate. The screening process and placement decision must be documented in the child's record. An alternative review process may be approved by the Commissioner if the county board demonstrates that an alternative review process has been established by the county board and the items of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (3).

The Legislature also established a task force to report on and recommend changes in screening mechanisms. The purpose of the task force was to: examine and evaluate existing and available mechanisms that have as their purpose determination of and review of appropriate admission and need for continued care for all children with emotional disturbances who are admitted to residential treatment facilities or acute care hospital inpatient treatment.

The task force concluded that screening processes should be based on the following principles:

--Simplicity and consistency
--Capability to respond differentially to emergency and non-emergency situations.
--Effective and immediate linkage between counties and service providers to assure comprehensive planning and continuity of care

--Separate and distinct from ongoing case management services
--Primary focus on the clinical needs of the child and family; decisions based on clinical needs.

Recommendations

- The screening team should be comprised of, at minimum, the child, his/her family (unless clinically contraindicated), the referring agent, and a mental health professional.
- A well-publicized appeal process should be available to those families and children who believe the screening process has not met their needs. Such a process should be multidisciplinary in nature. - Rule 5 must be revised to include common admission and continued stay standards for all residential treatment facilities serving children. These standards should be linked with the Permanency Planning Process.
- Upon revision of the rule, DHS should monitor Rule 5 facilities randomly as part of its licensing process to assure that appropriate services and lengths of stay are being provided. Full scale reviews should be undertaken when facilities do not meet licensure guidelines.
- Rule 48, which governs Medical Assistance Utilization Review, should address the availability of community alternatives to inpatient hospitalization. If a lack of community alternatives for children is creating a clinical situation which otherwise might not exist, acute care admission should be approved.

Adults: The 1989 Legislature amended Minnesota Statutes, section 245.476, subdivision 1, as follows:

> No later than January 1, 1992, the county board shall screen all adults before they may be admitted for treatment of mental illness to a residential treatment facility, an acute care hospital, or informally admitted to an RTC if public funds are used to pay for the services. Screening prior to admission must occur within ten days. If an adult is admitted for treatment of mental illness on an emergency basis to a residential facility or acute care hospital or held for emergency care by a Regional Treatment Center under section 253B.05, subdivision 1, screening must occur within five days of the admission. Adults must be screened within ten days before or within five days after admission to

ensure that:

- an admission is necessary;
- the length of stay is as short as possible consistent with individual client need; and
- the case manager, if assigned, is developing an individual community support plan.

The same year the Legislature also required the appointment of a task force to examine and evaluate existing mechanisms that have as their purpose review of appropriate admission and need for continued care for clients admitted to residential treatment, acute care hospital inpatient treatment, and Regional Treatment Center inpatient treatment.

The Commissioner was required to review the statutory preadmission screening requirements for psychiatric hospitalization, both in the Regional Treatment Centers and other hospitals, to determine if changes in preadmission screening are needed and to deliver a report of the review to the Legislature by January 31, 1990. This report was combined with the task force reports on adult and children's screening.

The emphasis on screening gradually shifted between 1987 and 1989 from concern about whether or not the admission is appropriate to recognition that a "quality review" mechanism is needed to ensure that both the treatment provided and the length of stay are appropriate to the individual's needs. However, the statute clearly mandates that screening for adults must be accomplished prior to admission. The focus of screening can be on (1) the adequacy of preadmission screening and/or (2) a quality review mechanism which evaluates the adequacy of the treatment provided and the length of stay in the program. If emphasis is placed on preadmission screening, significant issues include whether a mental health professional should be required to conduct screening (as in the children's statute), whether screening in addition to that required for commitment and voluntary admission to RTCs is necessary at all, and the costs associated with preadmission screening.

Task force members made the following recommendations:

- Each entity providing mental health services under contract with a county should be required to have admission, continued stay, and discharge criteria as part of the service contract;
- The current revision of Rule 36 should address general admission, continued stay, and discharge criteria and all providers of licensed services should be required to adhere to these standards;
- Admission processes should have the capacity to respond differentially to emergency and non-emergency situations;
- The admission function must provide an effective and immediate

linkage between counties and service providers, to assure comprehensive planning and continuity of care between needed services, in accordance with data privacy requirements;
- Admission functions must be separate and distinct from ongoing case management services unless the case management model used for mental health services in Minnesota is changed;
- Screening functions must provide a structure which has as its primary focus the clinical needs of the adult and which results in decisions soundly based on clinical needs;
- The admission process must include an appeal mechanism which can be readily accessed by the individual or the individual's legal representative;
- Repeal of adult screening as a service should be sought.

c. Description of problems encountered:

Children's Screening Mechanisms:

-- Screening mechanisms currently being used are disjointed and separate, even though they may accomplish their intended individual goal;
-- In the absence of integration, balance is lost, and the result is that the focus of the screening activity becomes either the rationing of care (under-treatment) or the filling of beds (over-treatment);
-- Screening mechanisms tend not to be multidisciplinary in nature;
-- Rather than being based on clinical factors, admission to or denial of inpatient or residential program services may be based on administrative considerations; these non-clinical factors are believed to exclude children from needed programs as often as they result in admission to inappropriate programs.

Adult Screening Mechanisms:

--Mechanisms for, and logistics of, screening are inconsistent across services, systems, and counties. Currently, each facility and each clinician sets individual criteria for admission.
--Criteria for admission, especially to acute care hospital psychiatric programs, may focus more on administrative issues than on clinical factors or judgments.
--Screening can identify gaps within systems, but specific information on those gaps is hard to capture, especially if an individual is provided community services which do not require screening, rather than residential or inpatient services. Screening mechanisms should be broad enough to deal with whatever services are needed.
--Retrospective reviews by third party payers force hospitals to pick up costs of services after the fact, even when prior authorization has occurred. The state is directed to use both these review mechanisms to safeguard against unnecessary or inappropriate use of MA services. The result is that the burden

for screening out in advance anyone who might later be found to be inappropriately placed by the payer has fallen on hospitals, making them unwilling to take admissions.
--A unified screening system may be easier to implement in rural or small town areas; such systems may be logistically impractical for large metro areas in which there are multiple providers and numerous options for placement and community services.
-- The lack of community-based alternatives to residential and inpatient services, appropriate funding for community and residential and inpatient programs, and beds within residential and inpatient programs has an impact on admissions to residential/inpatient programs. An adequate array of both community based services and residential/inpatient services is a key to resolving inappropriate placement problems.
--Funding for the RTC system reduces the availability of funding for other service development.
--Delays in discharge are often necessary because the individual does not have adequate funds to pay for the costs of room and board outside the facility. No mechanism exists to address this issue.
--Multiple screenings are costly, yet the system sometimes encourages them.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Both Adult and Children's Task Force recommendations are complete. The DHS will propose legislative changes as a result of these recommendations which would repeal of screening for adults as a service. Precommitment screening will be continued and a mechanism for independent screening of voluntary admissions to RTCs will be proposed. Task Force members will work with Medical Assistance staff to revise Rule 48 (Medical Assistance Utilization Review) for children's inpatient hospitalizations. Task Force members also participated with DHS staff in developing admission criteria for the proposed State-operated Rule 5 facility in Willmar (adolescent SOCS) and in developing the contract for independent screening of persons under the age of 21 for inpatient psychiatric hospitalization.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 21

4. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 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.

b. Description of whether the objective was accomplished during the past year:

The MHD is moving toward development of State Operated Community Services (SOCS) for persons with mental illness, as directed by the 1989 Legislature in the Regional Treatment Center Act. Funding was provided by the 1990 Legislature in the State Bonding Bill for construction of one adolescent (Rule 5) facility in Willmar and an adult (Rule 36) facility in the Twin Cities metropolitan area. Development of a larger number of SOCS is dependent on resolution of several issues, including funding mechanisms for supervised apartments which will not create undesired facility-based programs, and development of resources to stimulate both housing availability and appropriate levels of service in the local community, to support individuals previously served with more institutional levels of treatment. Planning for the two MI SOCS is underway, a 10 bed residence for children with emotional disturbance, and a 16 bed residence for adults with mental illness.

The 1990 Legislature shifted $500,000 in funding to a new effort to provide community alternatives for 35 to 50 persons in the Anoka Metro Regional Treatment Center. Counties have been awarded these funds, and the first individuals have been relocated from the RTC.

Rule 36: The MHD took part in several efforts to determine how to provide normalized living arrangements for persons with mental illness more effectively. The MHD continued to investigate the feasibility of separating the Rule 36 service components from its housing components, in an effort to allow consumers of services to live in more normalized surroundings. The goal is the development of a rehabilitative service model which could be offered in multiple sites, depending on individual need. Such sites might include licensed adult foster care homes, board and lodging facilities, or even the individual's own home if such an option were economical. A separation of programming and housing also could conceivably make some services currently offered in Rule 36 facilities MA reimbursable, thus providing an approximate 50% federal match for those expenditures.

Activities to revise the rule were interrupted during the period of August 1989 to March 1990, as all available staff resources were diverted to the review of county biennial Children's and Adult's Mental Health Plans. This delay coincided with the release of a report by the Legislative Auditor ("Community Residences for Adults with Mental Illness"), and thus afforded an opportunity to incorporate some of the LAC's findings into the revision.

Three other studies also have impact on Rule 36 revision: the report on Inpatient and Residential Screening for Adults, a report on Board and Lodging Facilities with Supportive Services (submitted to the legislature by the DHS and the Department of Health), and a study of the needs of a sample of individuals of Rule 36 and CSP program, for which preliminary analysis has been conducted.

OBRA-87: The Division successfully began implementation of new federal OBRA-87 regulations which are requiring the relocation of about 300 persons with mental illness from nursing homes to community alternatives. State funds approved for this purpose by the 1989 Legislature are being allocated to counties, with appropriate new or expanded services being developed in the community, and 50 persons have been discharged to independent living.

c. Description of problems encountered:

Lack of human resources at the State level to accomplish both the extensive review of County Mental Health Plans (168 plans were reviewed together with extensive technical assistance by the MHD to counties) and to continue the Rule revision activities.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Planning for the two MI State Operated Community Services (SOCS) began in June, 1990, a 10 bed residence for children/adolescents with emotional disturbance, and a 16 bed residence for adults with mental illness.

The 1990 Legislature shifted $500,000 in funding to a new effort to provide community alternatives for 35 to 50 persons in the Anoka Metro Regional Treatment Center. Counties have been awarded these funds, and the first individuals have been relocated.

The MHD continued to investigate the feasibility of separating the Rule 36 service components from its housing components, in an effort to allow consumers of services to live in more normalized surroundings. A number of reports and special studies on community services, including a study of the needs of a sample of individuals of Rule 36 and CSP program, for which preliminary analysis has been conducted, have or will be incorporated into the final Rule 36 revision.

State funds approved for OBRA mandated relocations are being allocated to counties, with appropriate new or expanded services being developed in the community; 50 persons have been discharged to independent living.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 14

REQUIREMENT V. The reduction of the rate of hospitalization of these individuals

1. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 2-A

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

b. Description of whether the objective was accomplished during the past year:

Minnesota is a county-based human service system, in which the county provides local mental health services. The 1987 and 1989 Comprehensive Mental Health Acts for Adults and Children require counties to submit written plans biennially to indicate how they plan to comply with the requirements of the Acts. For both adult and children's mental health, the Division devoted a major portion of its staff resources during F.Y. 1990 to review and revision of the county mental health plans. This is one of the major vehicles by which the Division can promote county efforts to prevent and reduce rates of hospitalization by implementing appropriate screening programs and by developing and/or expanding community support programs which are adequate and appropriate to persons most at risk for hospitalization, or who are currently residing in hospitals. The development and implementation of the new mental health information system which permits comparisons of county's success in meeting this objective are also helpful in targeting resources for technical assistance as needed.

Adult Mental Health Plans were reviewed and eventually approved in all 87 counties. Funds were delayed for a few counties that had major areas of non-compliance with the law. Technical assistance was provided to improve plans. Two sets of plans were approved (Adult and Children's Mental Health Plans), resulting in a total of 168 plan reviews (some counties plan jointly for provision of services, see Requirements II and III, Objective 2-A).

Plan Review Process: The county plan review process at the state level included a number of steps and was similar for both the Adult and Children's Mental Health Plans. Each plan was compared to a standard program review checklist by the respective regional program staff person in the Mental Health Division and by Special Project staff (older adults, Indian, homeless persons, rural Human Resource Development). A parallel review was conducted by Mental Health Division grants management staff based on a

standard fiscal and data checklist.

Data from all plans were computerized and analyses prepared based on per capita and other measures. Counties were compared with one another and to measures of service adequacy established in national studies. Mental Health Division staff also obtained input from the Regional Treatment Centers and the Social Services, Children's Services, and other departmental divisions, the major mental health advocacy groups and others. This input from persons knowledgeable about both the RTCs and the community services, from both staff and consumer perspectives, was helpful in targeting means to reduce hospitalization through appropriate planning efforts.

Department staff prepared feedback letters summarizing the results of each plan review. In addition, Division staff provided most counties with individualized technical assistance to ensure development of plans that are in compliance with the Acts. Penalties for noncompliance were imposed. The key service areas on which the Department focused were the top priorities specified in the Mental Health Act: Locally available emergency services and locally available case management and community support services for persons with serious and persistent mental illness. These key areas are critical to reduction of hospitalization rates, since they support early intervention and secondary prevention efforts as well as an adequate array of community services to support living outside of a hospital setting. Following revisions, all counties have plans in compliance with statutes.

Other Activities: The Division conducted technical assistance workshops and site visits, many of which were aimed at improving community services and service coordination and developing preventive services, which are expected to reduce the rate of hospitalization. The Division conducted a total of 59 technical assistance workshops and 600 site visits to individual counties and providers in F.Y. 1990. In 1989, the MHD, DRS and the Division for Persons with Developmental Disabilities conducted employability training programs in 10 sites around the state, attended by over 600 persons. In August, 1990, the Division reorganized to focus more on regional workshops and less on site visits to individual providers, which may actually increase the total number of contacts and should improve the effectiveness of the Division's technical assistance.

The MHD also awarded funds to counties to 1) develop alternative disposition plans for persons in Regional Treatment Centers (Anoka Alternatives Program); 2) develop community service relocation plans for adults with mental illness inappropriately residing in nursing homes; and 3) continue supported housing pilot projects. A variety of special projects funded by state monies or federal Block Grant monies are intended to strengthen

community alternatives to hospitalization; these services are developed and delivered at the county level with state MHD supervision.

Some current areas of Rule revision are focused on a redefinition of services separate from residential settings (e.g. Rule 36 revision), which underscore the State's philosophy of minimizing non-normalized living environments. Work on consolidated funding mechanisms is aimed in part at the separation of eligibility requirements for services from RTC residential status, i.e., of providing services based on clinical need rather than administrative requirements. Anti-stigma campaign materials, which were distributed in June, 1990, are intended to reduce some of the stresses faced by clients in community settings by preventive educational efforts. Although these areas do not involve direct county supervision, they impact upon the county's ability to plan for and provide mental health services, and are aimed at strengthening community alternatives rather than hospitalization for adults with mental illness.

c. Description of problems encountered:

The congruence of two nearly simultaneous planning processes (for adults and children) brought into focus problems inherent in the processes themselves. Planning processes tended to juxtapose both planning and compliance data. Some of the compliance data was already available to DHS through other means, such as CMHRS reporting. In addition, the emphasis on developing (and then reviewing) complex workplans with objectives for each service was onerous for both county and state staff.

d. Outcomes from the accomplishment, and whether these were what the State expected:

County plans: The combination of fiscal delays and technical assistance resulted in significant improvements in many county plans. Fiscal penalties included a $3 million delay in federal aid imposed on one county by the Department of Human Services for submitting substandard plans for serving adults with mental illness. Funding to ten other counties was also delayed. The delay involved all social services supported by a block grant and Title XX, not just state mental health funding. The main problem was the lack of emphasis given to case management services for persons with serious and persistent mental illness.

State MHD staff are now meeting with other DHS Divisions and a work group of county representatives to redesign the planning process for the next biennium. Recommendations of the work group are to be provided to the Legislature in its 1991 session.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 16

2. Brief description of Another Implementation Objective Identified in 9/89 Plan under this objective.

a. The original milestone: 2-B

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

b. Description of whether the objective has been accomplished during the past year:

Overview of Rule 36 and Rule 12 grants: State grants are provided to counties to ensure that all community residential facilities for adults with mental illness meet and maintain compliance with program licensing standards. To implement this legislative requirement, promulgated in 1981, the Department promulgated Rule 36, which established licensing program standards and Rule 12, which established funding criteria and procedures. Major objectives of Rule 36 are to reduce hospitalization and assist persons with serious and persistent mental illness in achieving a higher level of independent living. Through Rule 12, the state pays for up to 75% of program costs (direct service costs only). County boards apply for Rule 12 funds on behalf of Rule 36 facilities by providing the Commissioner with a budget and program plan.

Accomplishments, Rules 12/36: Since 1981, the joint efforts of the Legislature, private sector, Division and counties to bring Rule 36 facilities into compliance with licensure standards has been highly successful. As of May, 1990, each facility met fire, safety and health standards, 79 facilities were licensed (compared with 7 in 1981), and funds were distributed about equally in the metropolitan and non-metropolitan areas of the state, closely paralleling the population distribution in these two areas (initially, 70% were in the metropolitan areas). Some of the newer facilities have specialized services for persons with dual diagnoses (mentally ill and hearing impaired, chemically dependent or behaviorally aggressive), and some older, larger facilities have closed. In FY 1990, there were 1,679 licensed beds in 79 licensed facilities, 76 of which received Rule 12 funds, and 1,447 beds were funded under Rule 12. The average per diem cost was $55.53, $28.71 of which was for program costs (Rule 12 and match).

Reduction of hospitalization. The Legislative Auditor's Report (December, 1989) analyzed Medical Assistance data on 300 persons who had been residing in Rule 36 facilities. They found that, on the average, clients spent about half as much time in the hospital in the six months following Rule 36 discharge as in the six months preceding admission. This was true for stays in both Regional Treatment Centers (state hospitals) and community hospitals. The total number of hospital stays were also fewer after residing in a Rule 36 facility than before.

Hospitalization Rates Before, During and After Rule 36 Stays

Total Hospital Days

	In Community Hospitals	In Regional Treatment Centers	Total Days in Hospital
Before Rule 36 Stay (6 mos.)	1,354	6,320	7,674
During Rule 36 Stay (Ave.: 10 mos.)	567	37	604
After Rule 36 Stay (6 mos.)	680	3,066	3,746

Total Hospital Stays

	In Community Hospitals	In Regional Treatment Centers	Total Stays in Hospital
Before Rule 36 Stay (6 mos.)	107	62	169
During Rule 36 Stay (Ave.: 10 mos.)	60	1	61
After Rule 36 Stay (6 mos.)	56	43	99

Downsizing. The MHD is working with individual facilities to reduce their size to 16 beds or less. This change not only restores Medical Assistance benefits lost under federal IMD requirements, but also has a positive impact on the facilities' program. Since January, 1989, the MHD has successfully assisted 6 counties in downsizing 9 facilities from a total of 187 beds to 144 beds. The Division has developed a long-term IMD downsizing plan. The Legislative Audit Commission conducted an extensive program audit of the Rule 12 grant program and Rule 36 facilities. The audit recommended additional staff in Rule 36 facilities serving "difficult" clients, rather than the funding of new Rule 36 beds, and that additional clients be served through expanded funding for non-facility-based case management and housing support services. The downsizing efforts and long-term plan respond in principle to the objective of reduction of hospitalization by reducing placements in larger, less "home-like" facilities.

Overview of Rule 14 Grants: Grants are awarded to counties under provision of Rule 14 for community support services to persons with serious and persistent mental illness. The purpose of the program is to provide services that will assist individuals to stay in or near their home community and function at their maximum ability level. To be eligible for grants, counties must

provide: Client outreach; medications management; assistance in independent living skills; employability and supportive work opportunities; crisis assistance; psychosocial rehabilitation; help in applying for government benefits; development, identification and monitoring of living arrangements; and case management.

Accomplishments, Rule 14: In FY 1990, all counties in the state were offered grants and a total of 86 (out of 87) submitted applications approved for funding. This program continues to be effective in stabilizing the lives of persons with serious and persistent mental illness. The program has proven effective in reducing the number of persons needing to be hospitalized for their mental illness and in increasing the number of clients obtaining employment. Recent data shows that 52% of Rule 14 clients who were in the program at least one year were hospitalized during the year before admission to the Rule 14 program, while only 21% were hospitalized after their Rule 14 admission. A total of 3,300 new admissions and 6,000 total during the year were served in Rule 14 programs.

The employability component of community support services is closely coordinated with services available through the Department of Jobs and Training, Division of Rehabilitation Services (DRS). As part of the budget process, the MHD is meeting with DRS to support DRS efforts to expand vocational services for persons with mental illness and to ensure there is no duplication between the two departments. It is notable that employment and housing were the top two concerns of consumers on a recent survey. It is expected that the increased emphasis on employability will result in more successful community placement and consequently reduced vulnerability to re-hospitalization.

A number of recommendations from the Legislative Auditor's Commission Report have been added to the Division's workplan for the next year, including revision of Rule 36 to consider the type of residential setting separately from the services offered and seeking additional funding for Rule 14 grants to counties.

Annual Grant Program Reports: Mental health services providers receiving Rule 12 or Rule 14 grants have traditionally submitted annual reports containing summary data on the amount of services provided, the types of clients receiving these services, and client outcomes. This statistical information is useful in assessing program performance and demonstrating accountability.

Grant programs funded under Rule 14 or Rule 12 have been required by the Department of Human Services (DHS) to submit an annual aggregate report for each year that receives funding. Until SFY 1989, these reports included the following components:

-counts of admissions and discharges;
-client characteristics at admission;
-county of financial responsibility of clients served;
-changes to clients who were discharged from the program during the year, including changes in psychiatric hospital use, income source, employment status and living arrangement;
-changes to clients who were in the program for at least one year at the end of the reporting period;
-follow up information on those clients who were discharged;
-information on waiting lists, unmet needs, etc.

These annual reports from each county were 11 pages in length. With implementation of the Community Mental Health Reporting System (CMHRS) in 1989 and a greater emphasis on individual client data, the annual reports were shortened to three pages. These reports now focus on client admission and discharge counts and on identifying counties of financial responsibility. Any information needed about client characteristics and outcomes not available through the CMHRS or annual statistical reports will be obtained through special studies of client samples. Such information will be collected directly from counties or providers as appropriate.

c. Description of problems encountered:

The shift to smaller facilities located closer to the client's own community has resulted in improved service but with a reduction in statewide beds and a higher cost per person. However, the shift to smaller facilities does improve the Federal share for the other services needed by facility residents, due to the recent Federal clarification of laws and rules relating to Institutions for Mental Diseases (IMDs). The effect of the latter is to enhance incentives for smaller facilities, since all residents of Rule 36 facilities larger than 16 beds (IMDs) under age 65 are ineligible for all Medical Assistance services, including doctor's visits, dental care and drugs.

d. Outcomes from the accomplishment, and whether these were what the State expected:

-On the average, clients spent about half as much time in the hospital (both RTCs and community hospitals) in the six months following Rule 36 discharge as in the six months preceding admission; the total number of hospital stays after residing in a Rule 36 facility was also less in the six months after than in the six months before living in Rule 36;
-Among clients participating in Rule 14 programs for at least one year, 52% were hospitalized in the year prior to Rule 14 participation, compared with 21% after;
-All Rule 36 facilities now meet fire, safety and health standards, and most are licensed;
-Rule 36 facilities are distributed proportionately in urban and

rural areas;
-Some newer Rule 36 facilities have specialized services for persons with dual diagnoses;
-Six counties have downsized 9 facilities;
-All but one of 87 counties submitted Rule 14 grant applications that were funded.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 16

3. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 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.

b. Description of whether the objective was accomplished during the past year:

The director of the MHD meets monthly with her counterpart in the Residential Program Management Division (the Division which hires and supervises the mental health work force in RTCs), and the director of the HRD project meets frequently with the Residential Program Management Division liaison. Issues addressed in the latter effort include: Development of an administrative focal point for human resource development efforts, areas of responsibility in training methods, salaries, data collection and others.

State Operated Community Services: The Department of Human Services Transition Team is limited to the development of State Operated Community Services (SOCS) for persons with developmental disabilities. The MHD is exploring new mechanisms to develop SOCS for persons with mental illness, which will differ substantially from SOCS for persons with developmental disabilities (the latter are residential facilities, while the mental health SOCS are attempting to create a model which is more community-based and which reflects the MHD emphasis on normal living environments and separation of treatment from residential requirements). The MHD has the authority to plan, with the Residential Program Management Division, for two SOCS, one adolescent unit (Willmar) and one adult unit (metro area). Work groups have been formed, including MHD staff as well as staff from Licensing, Personnel, Residential Program Management, union representatives, State and local advisory councils, Minnesota Alliance for the Mentally Ill, the Mental Health Association, and MAMHRF, a provider organization.

Progress on the adolescent SOCS is substantial: two possible sites have been selected; it has been determined that it will not be a permanent residence, but rather a treatment facility; and it will be a Joint Commission accredited children's residential facility licensed under Rule 5. Discussions are also underway on the adult SOCS. The work group has just agreed on the program emphasis, but the location and and funding issues remain to be resolved. The work group is attempting to avoid duplication of existing services as well as to avoid developing a mini-RTC, and to develop a model which is consistent with MHD housing (maximizing choice) and least restrictive alternative philosophies. The resulting SOCS are expected to be steps forward in promoting an alternative model to state hospitals (RTCs) as residences for persons with serious and persistent mental illness.

Out-of-State Placement for Children: Although this does not directly address the issue of reduction of hospitalization, given the directions currently being considered and developed in Minnesota favoring treatment in the natural environment to the extent feasible rather than residential placement, the issue of out-of-state placement for children may be indirectly germane. That is, the State is better able to assure reduction of hospitalization for children if the numbers of children placed outside the state are reduced.

Following discussion of out-of-state placements of Minnesota children for mental health treatment, the 1989 Minnesota Legislature required that the Department present a plan to the Legislature by February 15, 1990, on methods of increasing the use of staff and resources at the Willmar Regional Treatment Center to serve children with severe emotional disturbances who would otherwise be placed in treatment in other states. A work group comprised of DHS and Willmar RTC personnel focused on this issue. Two questionnaires were developed to determine the reasons for out-of-state placement. One was sent to directors of all Minnesota counties or to specific social workers within those counties who were most knowledgeable about the placement of children. Responses were received from all 87 counties. The second was sent to 25 out-of-state facilities that were listed by counties as receiving Minnesota children for placement.

Over the course of one year, counties place between 125-160 children in out-of-state facilities for mental health treatment. These numbers do not include children who are placed by their parents without county involvement or public funding. Reasons for using out-of-state facilities include: Proximity, emergencies, specific treatment needs best met in out-of-state facilities, cost, reputation, or difficult to place (dual diagnosis, long histories of treatment failure). A recommendation of the work group was the establishment of a SOCS for adolescents.

c. Description of problems encountered:

Adolescents: Limited availability of professionals with specialized experience working with adolescents with mental illness. Willmar Regional Treatment Center has recently hired a child psychiatrist, however.

Adults: Retraining personnel to develop skills in service delivery separate from a residential facility.

d. Outcomes from the accomplishment, and whether these were what the State expected:

One adolescent SOCS is being planned with significant input from the MHD. Awareness of out-of-state placement issues with respect to adolescents has been heightened. Several policies related to RTCs have been clarified with MHD input. A new five year planning process for the removal of adolescents from RTC campuses is being undertaken. Planning for an adult SOCS is also moving forward.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 16

4. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 5-C

To assess current rules to determine the degree to which these promote increasing individual's levels of functioning and safety.

b. Description of whether the objective was accomplished during the past year:

Several rules are under revision or are in the preliminary stages of discussion. These state rules promote reduction of hospitalization by offering alternatives to hospitalization, by encouraging more community-based treatment, and/or by (proposing) alterations in the way in which mental health funds are distributed which may result in greater emphasis upon community-based service delivery options.

Rule 36: The MHD took part in several efforts to determine how to provide normalized living arrangements for persons with mental illness more effectively. These included consideration of alternative ways of providing Rule 36 (community residential services to adults) services. As it currently stands, Rule 36 is inconsistent with current law and philosophy. A draft of a proposed revision to the Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 36) governing provision of residential treatment services to adults with mental illness was developed, and

numerous advisory committee meetings were held during 1989. The latest draft rule has been made available to advisory committee members.

Departmental decisions were made to attempt separation of treatment/program components and costs from those associated with housing, to assure as much flexibility as possible in order to facilitate individual consumer choice and attention to treatment needs. The goal is the development of a rehabilitative service model which could be offered in multiple sites, depending on individual need. Such sites might include licensed adult foster care homes, board and lodging facilities, or even the individual's own home if such an option were economical. This philosophical underpinning and a subsequent separation of programming and housing also could conceivably make some services currently offered in Rule 36 facilities Medical Assistance reimbursable under the Rehabilitation Option, thus providing an approximate 50% federal match for those expenditures.

Activities to revise the rule were interrupted during the period of August 1989 to March 1990, as all available staff resources were diverted to the review of county biennial children's and adult's mental health plans. This delay coincided with the release of reports by the Legislative Auditor ("Community Residences for Adults with Mental Illness"), a report on Inpatient and Residential Screening for Adults, and a report on Board and Lodging Facilities with Supportive Services, and thus afforded an opportunity to incorporate some of their findings into the revision.

An assessment of a sample of individuals living in community settings (Rule 36) and/or receiving community services (Rule 14) has recently been completed. Data from this survey will assist in determining the changes which may be needed to successfully implement a program which will encourage community based, normalized living with coordinated service provision. Presumably, attempts to encourage treatment separate from choice of residence might free up scarce space in Rule 36 facilities for persons currently in hospital settings.

Rule 14 (community services) revisions have been drafted as two rules, one encompassing funding and the other standards. These are expected to be promulgated in late spring, 1991.

Rule 5 (licensing for children's residential treatment) is considered critical to revise. The MHD is looking at incorporating JCAHO standards into the Rule, to the extent that this is feasible. Discussion at this point is preliminary, but the recently enacted Comprehensive Children's Mental Health Act, which will affect Rule revision, emphasizes increasing family and community involvement, which in effect promotes alternatives to hospitalization.

Rule 74 (adult case management): The Division has established the Rule 74 Implementation Committee, which is examining some of the assumptions made in the original Rule through surveys of county staff and providers of case management services. This has clear implications for reduction of hospitalization, in that: 1) the current Rule assumes that case management would occur primarily from a central location, with only one hour/month of transportation built in to reach the client. (At the present time, case managers spend more time than this per client.) With increased emphasis on community-based services and separating funding for service provision from residential placement funding, services may be even more "decentralized", and case managers may spend more time for transportation; 2) The previously mentioned problem (see 4-B) of low county reimbursements which do not match salary levels for case managers in urban counties, resulting in fewer case managers hired in these counties and higher caseloads, will need to be addressed in order to effectively reduce hospitalization rates.

Rule 29: (Approval for third party reimbursement of services provided by community mental health centers and clinics). The revision of this rule is underway with the assistance of an advisory group. Standards for approval are being revised to reflect contemporary professional standards. Promulgation is expected by April 1, 1991.

c. Description of problems encountered:

Under the Administrative Procedures Act (Minnesota legislation), rule revision takes a minimum of 18 months. If the rule is complex or if the Division is overloaded with other responsibilities, this period can be longer.

Revision of rules was interrupted during the period of August, 1989 to March, 1990, since all available staff resources were diverted to the review of county biennial children's and adult Mental Health Plans.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Rule 14 and Rule 29: Two major rules have undergone revision and will be promulgated in the spring. Others are in the process of revision or in the early stages of discussion. Revisions and proposed changes reflect current standards and promote community based treatment, based on the individual's clinical needs. These should promote reduction of hospitalization.

Findings from several recent reports (on community residences, inpatient and residential screening, and board and lodging facilities with supportive services for adults) were incorporated into a draft of a proposed revision to Rule 36 (community residential treatment services to adults with mental illness). An assessment of a sample of individuals living in community settings (Rule 36) and/or receiving community support services (Rule 14) was completed, and data from this survey will assist in determining the changes which may be needed to successfully implement community based living with coordinated service provision. Surveys of county staff and providers of case management services are in process; these will be used to assist in revision of Rule 74 (case management).

e. Cross-reference to 1 of 22 topics listed in Attachment B: 3

REQUIREMENT VI. The provision of case management to each individual with severe, disabling mental illness who receives substantial amounts of public funds

1. Brief Description of Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 6-C

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

b. Description of whether the objective was accomplished during the past year:

Description and Philosophy: Case management is one of the key services required by the Comprehensive Adult Mental Health Act to ensure the provision of services in the least restrictive environment which increases the level of functioning and safety of adults needing 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. According to statute, case management services are to be coordinated with community support programs, also mandated in each of the 87 counties in Minnesota. Implementation of case management services statewide began January 1, 1989.

The underlying philosophy of case management in Minnesota is based on the idea that adults with serious and persistent mental illness:
- are often involved with more than one service provider;
- have difficulty managing multiple systems, e.g., mental health, financial, social services, education; and
- are unable to access necessary mental health services.

The primary goal and responsibility of the case manager is to develop an individual community support plan which is based on diagnostic and functional assessments. The case manager then refers the person to needed mental health and other services identified in this plan, providing the coordination, ongoing monitoring and evaluation of these services. The responsibility for providing the service rests with the county or local agency. 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 for whom they are providing case management services. This regulation ensures that the case manager continues to work with the client beyond a time-limited treatment period.

Utilization of Case Management: Between January 1, 1989 and December 31, 1989, a total of 10,754 mental health clients used case management services, for a total of 123,456 hours. Of this number, 6,781 clients with serious and persistent mental illness saw case managers for a total of 84, 494 hours. (This report does not exclude clients duplicated in counts across providers, and many county systems were not able to exclude non-Rule 74 case management activities.)

Children's Mental Health Act: The Minnesota Comprehensive Children's Mental Health Act of 1989 mandated that mechanisms be established at the state, local and individual case levels for coordination among agencies serving children with mental health needs and their families. Continued case management availability was mandated for children meeting the criteria of serious and persistent mental illness. Children qualifying under the criteria of severe emotional disturbance are to have the service available at a later date.

County Mental Health Plans: In the county mental health plans for adult and children's mental health services submitted to the MHD for approval, counties are required to answer questions about coordination of services for individuals and between programs. One of the top priority areas of both the adult and children's Mental Health Acts, and a key service area on which the Department focussed and imposed penalties for noncompliance, was the adequacy of locally available case management services for persons with serious and persistent mental illness. One county's Plan was cited as deficient and nearly three million dollars in grant funds delayed in part because the Department felt that it had "seriously underestimated" the number of people with serious and persistent mental illness needing case management services and had not provided adequate staff for those clients identified.

1989 Refugee Amendment: A 1989 amendment 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.

Revision of Rule 74: Currently, the MHD is conducting a survey of counties about case management activities in order to define the extent of the case management problems cited below and to assist in developing solutions. The results are expected in the next 1-2 months. Following the results, the MHD will then work on revision of the case management rule (Rule 74). The Legislative Auditor's Reports of 1987 and 1989, which the DHS participated in preparing, reviewed caseload sizes in Minnesota. In 1987, the average caseload was about 49, whereas in 1989, it was about 40, suggesting some improvement in this regard.

c. Description of problems encountered:

In the past year, some counties have experienced difficulties providing case management, partly due to the development of case management as an independent mental health service and not as a traditional social service offered by the county. Counties have needed to restructure and reorganize internal administrative processes to accommodate the provision of case management as defined in Rule 74.

MA reimbursements are not adequate to cover the true cost of case management services in metro counties, which tend to use experienced social workers and service providers as case managers who often earn significantly more than the reimbursement rate allows (Rule 74 requires case managers only to have a bachelor's degree and one year of experience) or the cost of travel time, which is critical if services are to be delivered outside of the office.

Counties having fewer than 50% of their clients MA eligible find it difficult to fund case management.

Development of case management for children with severe emotional disturbance, as distinct from those eligible under current Rule 74, is delayed due to lack of state staff.

d. Outcomes from the accomplishment, and whether these were what the State expected:

The issues noted in (c) will be examined in the next year to determine whether any changes should be made in Minnesota's case management system. To the extent possible, work on developing and implementing a distinct children's case management model is continuing.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 17

REQUIREMENT VII. The provision of a program of outreach to persons who are mentally ill and homeless

1. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 7-A

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

b. Description of whether the objective was accomplished during the past year:

Federal McKinney Act funds and state appropriations were used to help counties assess the need for and develop appropriate specialized community based services for homeless persons with mental illness. Grants to counties were made in combination with state Rule 14 Community Support Program funds to assure linkage and ongoing provision of local services to homeless persons with serious and persistent mental illness. In F.Y. 1990, 8 grants serving 2,582 homeless were awarded. Specialized technical assistance and program consultation were provided to the counties that received these grants.

Each project has an assessment process to determine homelessness, at risk of homelessness and mental illness. The definition of mental illness for this federal program includes acute mental illness as well as serious and persistent mental illness as defined by M.S. 245.462, subd. 20. If staff determine that an individual has mental illness and is homeless, they attempt to link the person to needed mental health services, although much of the initial activity involves meeting basic needs of food and shelter.

All of the eight projects provided outreach as well as five other essential services (see 7-B).

Combining all programs, outreach consisted of 41% of the total program. Urban and suburban counties, however, typically had considerably less outreach (20-25% in the metropolitan counties in or near Minneapolis-St. Paul, and 40% in Duluth), and, with one exception, rural areas typically considered outreach a major focus of the grant, ranging between 60-65%. For example, the staff person in one of the rural areas in which there were no other services specifically for homeless persons traveled over 16,000 miles providing outreach and provided face-to-face training to over 14 local law enforcement agencies.

Overall, 50% were known to have serious and persistent mental illness, 12% acute, 18% were unknown, 16% "other", and 4% none.

Only 18% were taking prescribed psychotropic medications.

This year, the rural counties receiving grants have been asked to focus further on those at risk of homelessness and mental illness as well as on migrant workers who are homeless and also have mental illness. Outreach and referrals are two of the five major services all local programs are required to provide. (See 7-B and 7-C under this Requirement for further information).

c. Description of problems encountered:

Current federal McKinney Act funds have not kept up with the initial funding for F.Y. 1989. A two-year spending provision has delayed the impact of the federal reduction, but the number of grants and persons served will be reduced if funding is not restored to the initial level.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Federal McKinney Act funds and state appropriations awarded 8 grants to counties serving 2,582 homeless persons in SFY 90 to assess the need for and develop appropriate specialized community based services for homeless persons with mental illness.

Each project has an assessment process to determine homelessness, at risk of homelessness and mental illness. This year, the rural counties receiving grants have been asked to focus further on those at risk of homelessness and mental illness as well as on migrant workers who are homeless and also have mental illness.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 12

2. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 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.

b. Description of whether the objective was accomplished during the past year:

Objective 7-B specifically focuses on the mandate, under federal McKinney Act homeless grant funds, to help counties develop appropriate specialized community based services for homeless persons with mental illness. Grants to counties are made in combination with state Rule 14 Community Support Program funds to assure linkage and ongoing provision of local

services to homeless persons with serious and persistent mental illness. (see 7-A and 7-C for further detail about the program).

The Mental Health Division is the administrative agent for the Mental Health Services for the Homeless (MHSH) Block Grant. The State agency distributes money to local programs to provide mental health services; outreach; case management; referrals; and substance abuse treatment to homeless persons who have mental illness. Money is also available for project staff. Funding to each state is based on the proportion of a state's urban population relative to the nation's urban population.

Minnesota's FY 90 allocation was $334,000; the SFY 90 budget was $724,000. A total of 8 grants were funded, representing 7 different counties. No single county is expected to meet all the federal requirements for the McKinney program; but the state as a whole must provide for each program area. Hennepin and Blue Earth Counties provide services directly through their own county staff, while the other six counties either contract with the community mental health center, community support program or a private agency.

The Mental Health Division has hired a Program Advisor for .4 FTE to provide technical assistance, training and networking for each project and to other MHD staff. Grants management and administration is conducted by the grants manager from the MHD Technical Support Unit.

McKinney Act funding has been used by grantees to hire 18 FTE local staff. They provide direct services to homeless individuals. All project staff work closely with homeless shelters and drop-in providers in their area and they also have training and networking meetings with local law enforcement personnel. If the assessment process indicates that an individual has mental illness and is homeless, an attempt is made to link the person and the needed mental health services, following satisfaction of the basic needs of food and shelter.

This past year, Minnesota's program has continued eight projects. The urban area projects are focusing on encouraging more of their clients to accept county mental health case management on an on-going basis.

c. Description of problems encountered:

Current federal McKinney Act funds have not kept up with the initial funding for F.Y. 1989. A two-year spending provision has delayed the impact of the federal reduction, but the number of grants and persons served will be reduced if funding is not restored to the initial level.

In addition, the definition of case management as required by the McKinney Act is much broader than that provided by state law and federal requirements for targeted case management under Medical Assistance.

d. Outcomes from the accomplishment, and whether these were what the State expected:

A total of 8 homelessness grants were funded, representing 7 different counties. Urban area projects are focusing on encouraging more of their clients to accept county mental health case management on an on-going basis this year.

McKinney Act funding has been used by grantees to hire 18 FTE local staff who provide direct services to homeless individuals. All project staff work closely with homeless shelters and drop-in providers in their area and they also have training and networking meetings with local law enforcement personnel.

The MHD hired a Program Advisor for .4 FTE to provide technical assistance, training and networking for each homelessness project and to other MHD staff.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 12

3. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 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.

b. Description of whether the objective was accomplished during the past year:

Funding History: The 1987 Legislature appropriated $350,000 for the biennium for delivery of mental health services to homeless individuals in Hennepin, Ramsey and St. Louis Counties (Minneapolis, St. Paul and Duluth areas). This money was used toward the required 3 to 1 match of the McKinney Block Grant. The 1989 Legislature appropriated an additional $400,000 for the next biennium.

Congress allocated $32,200,000 in 1987. Minnesota received $396,190 (1.23%). In 1988, Congress allocated an additional $11,489,000 and Minnesota received $176,083 (1.53%). The initial federal notification of available funds was received in November 1987 (FY 88) and federal approval for the State plan was received in March 1988. The first state spending began in June, 1988.

The Mental Health Division used the Department of Jobs and Training quarterly shelter data to determine which counties would receive funds and in what percentage. Six counties were selected on the basis of their percentage of the total number of sheltered homeless persons. With the additional 1988 federal funds two counties received money because they were representative of either rural homelessness or suburban homelessness. Funding to each state is based on the proportion of a state's urban population relative to the nation's urban population.

Minnesota's McKinney Mental Health Services for the Homeless (MHSH) allocation for FY 89 was $267,000 (1.89% of the $14,100,000 Congress allocated), and the FY 90 allocation was $334,000. For SFY 89, the total Mentally Ill Homeless Grant program budget (state and federal dollars) was $740,000. The SFY 90 budget is $724,000.

Other Efforts: In addition to federal programs directly addressing the issue of homelessness, there are other state-funded programs which are aimed at developing community-based housing for persons who are scheduled for discharge from institutional settings (state hospitals or nursing homes). The Anoka Alternatives Project, funded by a one-time appropriation of $500,000 by the 1990 Legislature, provides grants to counties utilizing the Anoka RTC for relocation of about 35 persons to appropriate community alternatives in their home communities. The 1989 Legislature appropriated special funding to assist counties in developing appropriate alternative services for individuals relocated from nursing facilities under OBRA-87 regulations.

c. Description of problems encountered:

Current federal McKinney Act funds have not kept up with the initial funding for F.Y. 1989. A two-year spending provision has delayed the impact of the federal reduction, but the number of grants and persons served will be reduced if funding is not restored to the initial level.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Minnesota's McKinney Mental Health Services for the Homeless (MHSH) allocation for FY 90 was $334,000, and the total Mentally Ill Homeless Grant program budget (state and federal dollars) was $724,000. Funding has been made available to provide a range of services to homeless persons with mental illness. A Legislative appropriation has permitted the use of state funds to relocate inappropriately placed nursing facility residents and to provide a creative array of services for approximately 35 residents of the Anoka RTC.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 12

REQUIREMENT VIII. The provision of consultation with representatives of employees of various long-term care facilities

This requirement crosses components of several objectives which have been previously described. In brief, planning for State Operated Community Services (SOCS), an alternative to the RTCs, has involved RTC staff at Anoka and Willmar (adult and adolescent treatment centers, respectively); Regional Treatment Center staff provided input into the county Mental Health Plan reviews, Rule 36 revision, the Anoka Alternatives Project, and others. Union representatives have been involved as appropriate. Staff of Rule 36 facilities have been involved in the Adult Screening Task Force and Rule 36 Revision Advisory Committee. A work group comprised of DHS and Willmar RTC personnel focused on the issue of out-of-state placement of children. OBRA-87 legislation implementation has involved extensive consultation with nursing home employees and others involved with the identification and/or relocation of older persons inappropriately placed in nursing facilities.

The following section discusses a different type of collaboration, the collaborative efforts forged between the MHD and academic institutions, mental health service agencies and other agencies in Minnesota. This type of collaboration is multifaceted, but one of its aims is to coordinate training efforts so that the workforce in long-term care settings as well as other settings is appropriately prepared to apply current concepts of care in working with persons with mental illness. Other efforts involve research collaborations that not infrequently involve long-term care facilities, and/or consumers of such facilities.

1. Brief Description of Initial Implementation Objective Identified in 9/89 Plan, under this Requirement.

a. The original milestone: 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.

b. Description of whether the objective has been accomplished during the past year:

1) The HRD project has an advisory group with representatives from academic institutions which will form the basis for building linkages. Currently, they are working on a survey of academic

institutions on their capacity to prepare graduates in mental health-related service areas, the content of their curriculum, the kind of practical experience included in the curriculum (internships, etc.), their openness to increased collaboration with the MHD, etc. These data and the linkages formed in obtaining these data will form the basis for inter-organizational linkages. Planning linkages have been developed to address common problems. For example, the Legislature mandated a study of rural health professionals to identify ways to encourage more rural health professionals and to identify areas of shortage by number and type of professional. The MHD has met with the Health Occupations area of the Department of Health to encourage inclusion of mental health areas. [Refer to Requirement 1, Objective 3-A, HRD project]

2) The PEW/APA project is centrally concerned with increasing linkages between the MHD and academic training institutions. The model adopted for increased collaboration with the Department of Psychiatry is similar to that which might be attempted on a broader scale with other departments training staff in mental health areas, such as psychology, social work, nursing, occupational therapy and others. The MHD was recently approved for an in-depth consultation from experts from other states which will be used to develop a proposal for residency training in public psychiatry, including Regional Treatment Centers and others [Refer to Requirement 1, Objective 3-A, PEW/APA project].

3) The MHD has lent support to the University of Minnesota Departments of Nursing and Social Work proposals for NIMH clinical training (in mental health). Research proposals have been developed with the collaboration of the MHD and a professor in the Department of Sociology to study organizational relationships which evolved from the implementation of the Children's Mental Health Act, as well as with the University's Institute for Community Integration and the MHD to evaluate consumer-run supported housing.

4) <u>Public-Academic Liaison Initiative:</u> A public/academic liaison is essential in improving the quality of services to persons with mental illness; therefore, the Comprehensive Mental Health Act was amended to include a Public Academic Liaison Initiative (PALI). The Department is charged with establishing "a public/academic liaison initiative to coordinate and develop brain research and education and training opportunities for mental health professionals in order to improve the quality of staffing and provide state-of-the-art service to residents in Regional Treatment Centers and other state facilities (M.S. 245.4861 subd. 1)." PALI is to include programs which:

--encourage and coordinate joint research efforts between academic research institutions and RTCs, community mental health centers, and other organizations conducting research on mental

illness or working with individuals who are mentally ill;
--sponsor and conduct basic research on mental illness and applied research on existing treatment models and community support programs;
--seek to obtain grants for research on mental illness;
--develop and provide grants for training, internship, scholarship, and fellowship programs for mental health professionals in an effort to combine academic education with practical experience, and to increase the number of professionals working within the state.

No appropriation was made for the Public Academic Liaison Initiative in 1989. Therefore, no new activities could be started. However, many ongoing MHD activities, as well as new activities funded by the NIMH Human Resource Development (HRD) capacity building grant facilitate this public/academic liaison.

Existing linkages that relate to the outcomes specified in the PALI legislation are:

- DHS's Institutional Review Board (IRB) advocates for research within the RTCs. It included representatives from Minnesota's medical schools, DHS, the Institute for Disability Studies, the Minnesota Hospital Association, and others. Its membership affords some liaison capacity between DHS and academic institutions interested in researching the biological origins of and treatment for mental illness.
- The DHS's Affirmative Action Office has developed recruiting relationships with colleges and universities with traditionally minority enrollees throughout the country. The Minority Recruitment Shortage Occupation Project has focused on the occupational roles in the areas of occupational therapy, physical therapy, and speech pathology. The Project has placed student interns in both Brainerd Regional Human Services Center and Fergus Falls Regional Treatment Center.
- DHS received a grant from the National Institute of Mental Health (NIMH) for Capacity Building in Human Resource Development in October, 1989. This project has four main goals, one of which is to develop appropriate planning linkages with academic institutions, mental health service agencies and other related agencies. The expected outcomes of the Human Resource Development (HRD) Project are consistent with the goals of PALI.

c. Description of problems encountered:

HRD/PALI: The project was delayed in its inception, and hence is in the preliminary stages of development. State PALI legislation had no funds attached.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Planning for the adult and adolescent SOCS program is well underway. Persons with mental illness inappropriately residing in nursing homes have been identified, 50 have been relocated into the community, and counties have received grants for implementing community service plans for others needing relocation. The Anoka Alternatives Project is underway, up to 50 people are targeted for relocation, and grants have been awarded to their home communities for implementation.

The MHD was approved for an in-depth consultation from experts from other states which are more familiar with collaborative academic/state MHD liaisons. Out of this day-long consultation, planned for fall, 1990, a proposal for residency training in public psychiatry, including Regional Treatment Centers and others, will be developed.

The MHD has met with the Health Occupations area of the Department of Health to encourage inclusion of mental health areas in the state mandated study of rural health professionals to identify ways to encourage more rural health professionals and to identify areas of shortage by number and type of professional. This potentially affects RTCs, since they are predominantly located in rural areas.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 7

REQUIREMENT IX. The use of state mental health planning councils for advice on the development of the mental health services plan

1. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 1-C

To enhance leadership of state and local advisory councils.

b. Description of whether the objective was accomplished during the past year:

The MHD has funded an additional position to staff the state advisory council. That position is involved in the MHD and Department-wide supervisory and other policy planning bodies/committees. The State Advisory Council has been directly involved in:

- Reviewing and providing direction for the MHD's ongoing work plan;

- All MHD and State agency biennial budget requests affecting persons with mental illness;
- The review of all grant applications submitted to the State; and
- Participation in the Minnesota Health Care Access Commission as an alternate member.

The MHD has hired an individual full-time to work with the local advisory councils (LACs). He has attended meetings and provided technical assistance in 57 of Minnesota's 87 counties during the last nine months. The visits provide advisory council members with the opportunity to present concerns directly to the MHD and the State Mental Health Advisory Council. Technical assistance has been provided through presentations at these visits and in an ongoing way by telephone contacts and regular mailings. In addition, an annual CSP conference in May had a regular track of sessions solely for Local Advisory Council (LAC) members. The Division funded attendance for one LAC and one consumer member per county. Attendance was very high, and evaluations revealed positive remarks about the sessions designed for LAC members. He has also developed a quarterly newsletter for local advisory councils, containing information written by and for LAC members. The goal of the newsletter and other mailings is to inform LACs of developments at the State Mental Health Advisory Council and the MHD, to increase their knowledge, and to contribute to the system on the State level. The newsletter also aids in providing educational and background information for consumers and families on LACs.

c. Description of problems encountered:

Local advisory councils function in individual counties, and, as a result, are dependent on local county staff for support. Counties vary in their willingness to staff councils and to consider recommendations of these councils.

Termination of federal planning grant funding has jeopardized continuation of these vital functions. State funding has thus far not been available to replace lost federal dollars which have supported staff for the State Advisory Council.

d. Outcomes from the accomplishment, and whether these were what the State expected:

The State Mental Health Advisory Council meets monthly and provides regular input for MHD planning efforts. LACs participate in policy-making, are informed of developments in their early stages, and link directly to the MHD and the State Advisory Council.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 7

2. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 3-G

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

b. Description of whether the objective was accomplished during the past year:

Counties and Local Advisory Councils: In preparing their biennial plans, the MHD asks counties to indicate county program goals and objectives for adults with mental illness and children with emotional disturbance, to identify local needs, including needs obtained through input from the local mental health advisory council, to identify barriers to services and accessibility, to identify access and service problems for special populations, to address coordination of services for individuals and between programs; and to indicate membership and activities of the local mental health advisory councils (for children only, the membership and activities of the local coordinating committee, a group with representatives of agencies providing services). These needs are then to be addressed in the county's mental health plan. This provides a means of obtaining formal input about needs and barriers as a basis for planning.

State Advisory Council: The State Advisory Council has been involved in reviewing county and state plans for service development and in all county mental health plans and grants. State Advisory Council members and advisory groups are currently involved in the process of developing the program for the adolescent and adult State Operated Community services. Subcommittees from the State Advisory Council are dealing with children's issues and others. Advisory Council members, family members, providers and others are involved in the development of the children's service system, and the former play a very active role.

Consumers: Consumers are usually directly involved in either providing input about services and needs or in the planning process itself. Surveys conducted by a state provider group (MAMHRF) assessed consumer satisfaction with various aspects of Rule 36 facilities, and formed the basis for revision of this rule. In the process of revising Rule 36 (adult residential treatment), there were two focus groups, one with providers and another with current and former consumers of Rule 36 to see what worked and did not work. In planning the next CSP conference, consumers will be participants in the planning and delivery process.

Public Hearings: In the last Legislative session, public hearings were held with the Governor, the DHS Commissioner and the State Advisory Council on the Children's Mental Health Act in order to assist in its development. Hearings were held in several sites with a great deal of consumer and family involvement. In 1990, the Governor will hold hearings on both adult and child mental health issues, coordinated with the State Advisory Council and the DHS to hear about the current service system. Based on this information, they will plan for changes which are needed in the system. Five meetings are planned from September 7 to October 9, 1990. The Governor's presence underscores his commitment to these issues, and public hearings allow a wide variety of perspectives to be heard in order to base changes needed on such input.

Studies and Related Information: In redirecting adult social services from facility based services to services not linked with facilities, many national as well as state surveys were reviewed which indicated consistent consumer preferences for normal housing. These formed the basis for a change in adult service policy. NIMH information about national directions in service provision, data collection and other issues is also used to incorporate best practices information into the planning process. The entire State Mental Health Act was based on research indicating the parameters of a basic mental health service system needed in communities.

c. Description of problems encountered:

Short timelines for implementation of new services of the Mental Health Act as well as grant and county Plan reviews have created some difficulties in promoting thoughtful service development.

Data on unmet needs of clients is sometimes difficult to obtain on the state level. Counties vary in their ability and willingness to plan service development with input from local advisory councils.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Efforts to review, revise and promulgate state rules and to develop new services solicit a wide variety of input through broad-based work groups/task forces including consumers and their families, local and state advisory councils, and staff at various levels and types of services, as well as make ample use of research results (e.g., a statewide survey of case managers is being conducted to define the extent of the problems with the present rule and to suggest solutions; the experiences of consumers has been used to guide directions for change in Rule 36 revision; early identification/intervention services are being developed with the assistance of a multidisciplinary interagency

group established for that purpose, state and national surveys have been used to guide directions in both service development and rule revision.).

e. Cross-reference to 1 of 22 topics listed in Attachment B: 10

3. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 8-A

To provide active outreach in order to elicit consumer input.

b. Description of whether the objective was accomplished during the past year:

The Division has made special efforts to empower consumers in all phases of service planning and implementation. Staff working with state and local advisory councils have emphasized the input of consumers. Staff have also conducted consumer satisfaction and consumer assessment surveys, which have been incorporated into the process of rule revision. Surveys conducted by a state provider group (MAMHRF) assessed consumer satisfaction with various aspects of Rule 36 facilities, and formed the basis for revision of this rule. In the process of revising Rule 36 (adult residential treatment), there were two focus groups, one with providers and another with current and former consumers of Rule 36 to see what worked and did not work.

One consumer per county was funded by the MHD to attend the last CSP statewide conference in May. Special sessions were oriented to consumers, and consumers were among the presenters. In planning the next CSP conference, consumers will be invited into the planning process. Local Advisory Committees nominated consumers for participation in the Alternatives '90 Conference. Five consumers were funded by the MHD to attend the Alternatives '90 conference. Consumers and their families were involved in the development of the anti-stigma campaign materials. Consumers have also been involved in reviewing and developing grants, and all Division grant announcements encourage hiring consumers.

c. Description of problems encountered:

Because of the stigma attached to mental illness, some consumers are unwilling to participate openly. There is no statewide organization or network of consumers.

d. Outcomes from the accomplishment, and whether these were what the State expected:

Consumers are frequently involved in providing input or in the planning process itself. This tends to focus attention on the

consumer as an important focal point for service decisions. For example, existing screening mechanisms were reviewed by the children's and adult task forces, who evaluated their current status and effectiveness and developed recommendations for change, which included that the person and the person's family (when appropriate) should be involved in screening decisions, and appeal mechanisms should be clear to them. In preparation for the State Advisory Committee meetings to assist with the anti-stigma campaign, consumer and family opinions about how stigma affects their lives were gathered.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 11

4. Brief Description of Another Implementation Objective Identified in 9/89 Plan, under this Objective.

a. The original milestone: 9-C

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

b. Description of whether the objective was accomplished during the past year:

An anti-stigma campaign program was successfully completed, with approximately 300 kits distributed to community organizations, consumers, and family members in June, 1990 (see Appendix F). An advisory committee was selected to assist with the development of recommendations for the campaign. The committee included representatives from the Alliance for the Mentally Ill, the State Advisory Council, the Mental Health Association, consumers and family members. This advisory committee discussed options and made recommendations that a kit be developed and distributed to counties and local advisory councils for their use in building coalitions and proactively educating segments of their communities about mental illness. The proposed kit would contain a variety of materials, tips, and tools for community organization and public education.

Additional input was gathered from mental health advisory council members and other potential users of the proposed kit about the target audience for distribution of the proposed kits, the overall message of the campaign, the individuals to be addressed by the kit materials, and identification of stigma-related concerns. They recommended that the materials reach a variety of groups within communities, including local advisory councils, county agencies, local advocacy organizations and consumers of mental health services.

Respondents were extremely enthusiastic about the attention given to the stigma issue and the possibility of the kit. They supported the use of the kit by local advisory councils, county agencies, and/or local advocacy organizations.

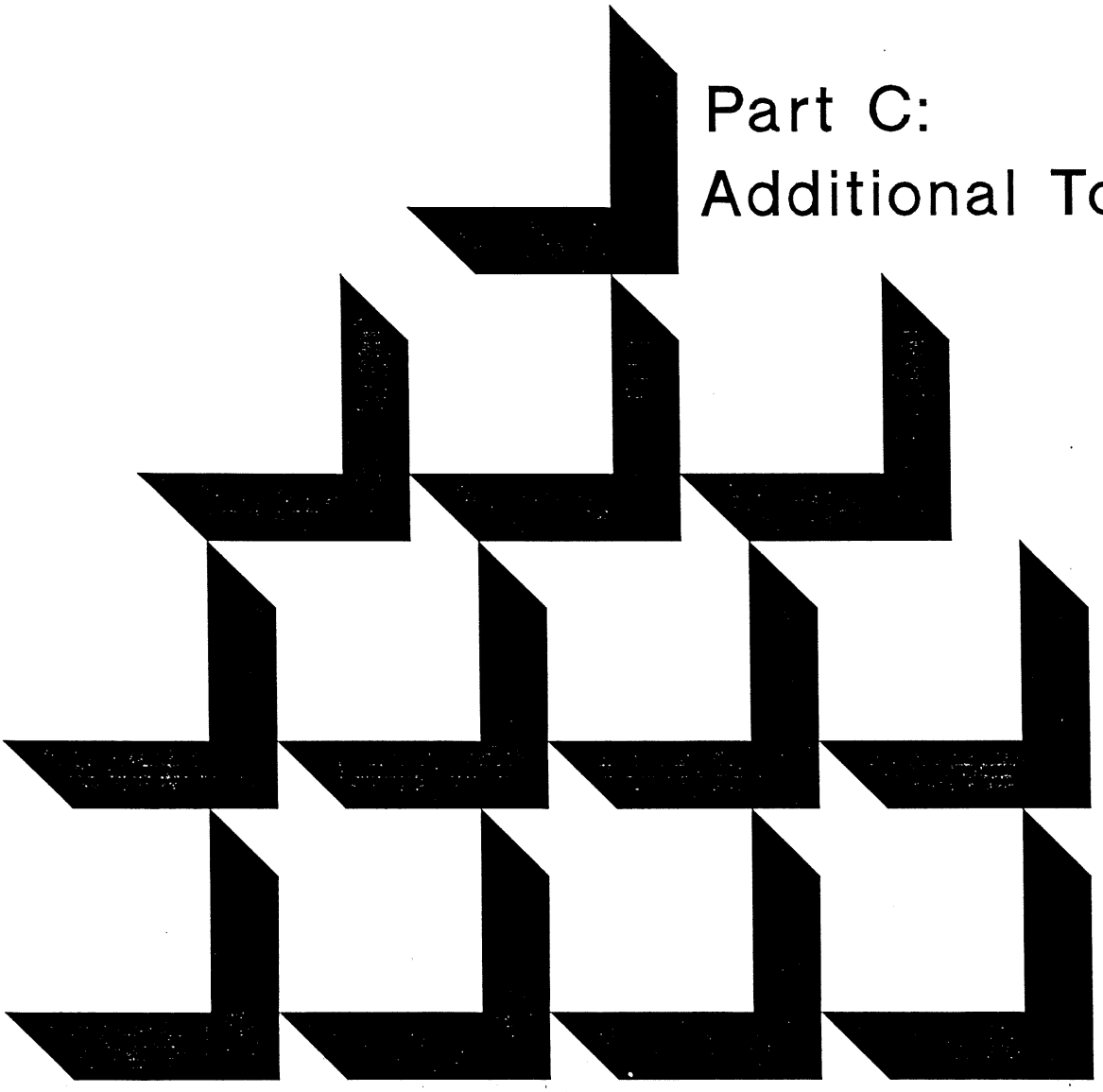
Reducing stigma and increasing sensitivity are an integral part of many projects announced and contracted by the Division. For example, project goals in many of the state funded projects for older adults with mental illness directly addressed the issue of stigma (see 9-B), such as "to improve access to and reduce the stigma of obtaining mental health services through the development of a peer counseling network".

c. Description of problems encountered:

d. Outcomes from the accomplishment, and whether these were what the State expected:

Three hundred anti-stigma kits were distributed to relevant organizations, with significant input from consumers. LACs are planning use of anti-stigma materials in their local communities.

e. Cross-reference to 1 of 22 topics listed in Attachment B: 13



Part C:
Additional Topics

PART C: ADDITIONAL TOPICS:

1. Overall Profile of Mental Health Services, Prior to 1987

Overview of policy, mission and rights issues: On June 14, 1985, the Governor announced the formation of the Governor's Commission on Mental Health and a list of specific issues to be addressed by the Commission. That commission met between September and November of 1985, during which time it developed recommendations and established priorities for the future. This was a highly significant step in the development of a comprehensive, community-based mental health system in Minnesota.

The Commission concluded that the system of mental health services was a "nonsystem", since services, policies and funding did not work together as a whole to perform a vital function or to achieve a goal. There were no mission statements in state statutes with reference to services for people with mental illness comparable to those addressing chemical dependency or developmental disabilities. Mission statements existed within the Department of Human Services, and the Mental Health Division, but the commission concluded that they were not sufficient to guide and stimulate the development and operation of a mental health service system which was responsive to the needs of Minnesota's citizens and the communities in which they lived. They also concluded that there was a considerable discrepancy between the rights of people with mental illness, the recognition of those rights in state statute, and the protection of those rights in practice.

The federal Mental Health Systems Act included a patient's bill of rights which was recommended to states for their adoption in statute. A review of state statutes to determine the extent to which these rights were accepted in states (Lyon, Levine, & Zusman, 1982) determined that Minnesota had substantially complied in nine areas, partially complied in six areas, and had not complied or contradicted the recommendations in nine areas. Fourteen states exceeded Minnesota in statutory protection of rights at that time.

a. Percent of Needs Met:

There were no known studies at the time of the Commission deliberations documenting the individual needs of all people with mental illness in Minnesota. Although some studies (cited below) had been conducted, the Commission concluded that there was little comprehensive information about the actual needs of Minnesotans with mental illness.

The DHS collected information in 1984 on the services provided by counties under the Community Social Services Act to people with mental illness, and the views of counties regarding the

accessibility, adequacy and quality of those services. This study indicated that counties were providing an array of services to people with mental illness, and that many essential services were either not available in all counties, or not available to the extent that they were needed. The major areas of services identified as needed were: Housing, employment, case management, patient follow-up and aftercare, crisis care/emergency services, transportation, day treatment programs, social and recreational activities, prevention and education services, and services for special population.

Services identified by 75% or more of the counties involved in the study as essential for mentally ill persons were then recommended by the Department to be included in the description of minimal capability. These included: Adult protection, child protection, assessment, case management, emergency services/24-hour emergency service, pre-petition screening, assistance in meeting basic human needs, outpatient services, community residential services, diagnosis, and inpatient psychiatric services.

In 1984, The Mental Health Advocates Coalition of Minnesota, Inc., surveyed between 686 and 812 consumers and their families across the state about three issues - availability, accessibility, and quality of services. Among people who had been involved in services or the Coalition, only 48% reported having adequate access to mental health services, with 42% reporting having no access and 10% reporting being unaware of services accessible to them. Approximately one in five individuals thought they were restricted in their access to hospitalization, and approximately one-half did not have basic information about mental illness, about ways to cope, or about services available. The services which allow people to live close to home and family (housing/residential services in the community) and reduce hospitalization (outpatient services) were seen as inaccessible by 60% and 40% respectively. Only 37% reported access to vocational/rehabilitation services, and only 24% reported access to respite care (N=519).

b. Geographic Distribution of Services:

In FY 85, the average daily census in the six state hospitals and the Minnesota Security Hospital was 1,197 persons with mental illness; this was expected to rise to 1,251 in FY 86. (Prior to the deinstitutionalization movement of the 1960s and 1970s), there were over 10,000 beds in the state hospital system for people with mental illness). Many elderly persons with mental illness, however, were moved into nursing homes during that time. For example, from 1978 to 1982, the number of Medicaid funded persons with mental illness in nursing homes increased from 6,281 to 9,948. By 1985, the DHS reported 15,200 people with mental illness living in nursing homes (this represented all types of

funding in all nursing homes, including state-operated nursing homes for persons with mental illness). Most of the people with mental illness in nursing homes are elderly people with organic mental disorders, probably a different population than the people who used to be in state hospitals.

As of January, 1986, there were 1,918 beds licensed or in the process of being licensed under Rule 36, excluding state hospitals (i.e., group homes), involving a total of 81 facilities. A total of 7 5 facilities received Rule 12 grants (grants to counties to help pay for services required by Rule 36), with a capacity of 1,676 beds, distributed over 29 of Minnesota's 87 counties. The Department estimated that there were about 22,000 people with mental illness in Minnesota's 300 to 350 residential facilities at any one time. It was estimated that 69% of these persons were in nursing homes, 6% in state hospital units for persons with mental illness, 5% in psychiatric hospital units, 10% in Rule 36 community facilities, and another 10% in non-Rule 36 facilities. The number of persons with mental illness estimated to be residing in nursing homes exceeded 15,000; it was estimated that over 1,000 of these persons, or approximately 7%, were under the age of 65 years.

At that time, the DHS estimated that approximately 4,000 to 5,000 persons had mental health needs appropriate for placement in a Rule 36 facility, a semi-independent living arrangement, or a supportive living residence, but these alternatives were not available to meet the projected need.

Funding for community support programs (Rule 14) was provided to 36 of 87 counties, serving 2,750 clients in FY 84. Lack of long-term funding and fiscal disincentives to counties resulted in less than statewide distribution of community support programs.

In 1985, there were 39 mental health center and county program boards. Only seven facilities in the state ever qualified for support under P.L. 88-164, Title II in 1963. The funding of mental health centers was not consistent throughout the state, and the range and nature of services offered by the centers differed significantly.

In 1983, there were 62 Rule 29 centers (Rule 29 governs eligibility for insurance reimbursement for outpatient mental health clinics). The Commission concluded that very little was known or required to be known about outpatient services, in contrast to inpatient psychiatric services.

The DHS reported 1,100 licensed beds in community hospitals for psychiatric care in FY 84. In FY 84, 6,054 patients were covered under MA/GAMC for general hospital psychiatric care. Quality assurance activities and utilization review were subcontracted to

Blue Cross/Blue Shield of Minnesota. Several problems noted included poor or nonexistent discharge planning, poor or nonexistent physician involvement, and a lack of crisis intervention and seclusion areas within facilities which would prevent the need to transfer people to inpatient care.

c. Distribution of Funding Resources:

A report prepared for the Commission indicated that total expenditures for people with mental illness in FY 85 were $565,250,000. Nursing homes accounted for 47% of expenditures (for nursing home care), general hospitals for 20%, state hospitals for 8%, Rule 36/12 (community residential settings, including room and board) for 8%, Rule 14 (community support services) for 6%, special education/vocational for 5%, .3% for community mental health, and 5% for other. The public sector accounted for the majority of funds, with 30% paid by state funds, 27% by federal funds and 9% by local funds. Insurance and private pay accounted for 34% of expenditures.

The Commission concluded that systematic information was unavailable about 1) precisely how much is spent on services for persons with mental illness; 2) who is receiving services; 3) what services are received and to what effect, and 4) who pays for services. They also concluded that Minnesota's funding sources required people with mental illness receive funded services, rather than permitting funding to be used to purchase needed services, and that policies favored the placement of individuals in more restrictive, but not necessarily more effective, environments. In addition, the absence of a vigorous case management and individual service planning approach, and of uniform placement criteria, increased the risk that services would be offered based on the costs to the unit of government making the placement rather than the needs of people. E.g., the costs to counties of placement is often lower for a state hospital placement than for a community Rule 36 facility placement. The CSSA requirement for at least 50% county funding made less restrictive options such as halfway houses, extended care and crisis homes more expensive, less attractive options.

Despite these findings, Minnesota's State Mental Health Agency per capita expenditures for community-based programs were 12th in the nation (FY 83), compared with 33rd in the nation for per capita expenditures for state hospitals.

d. Consumer Involvement:

There were virtually no mechanisms for ensuring consumer involvement in 1985, except that Rules 14 and 36 provided requirements for consumer involvement in individual planning.

2. Signs of "Substantial" Progress:

Progress toward a more effective and accountable community based mental health system has occurred on multiple fronts. The combined effect has been a highly significant change in the way in which the mental health system of Minnesota is organized, and progress on these issues is continuing at the present time in a very tangible fashion. Since the Commission report in 1985, detailing the absence of a system and the lack of or very uneven distribution of many important services, the following has occurred:

. Development and implementation of the Adult Comprehensive Mental Health Act in 1987, revised in 1989, specifying a full range of basic services which counties must provide to adults with mental illness, among other requirements.

. Development of the Children's Comprehensive Mental Health Act in 1989, specifying a full range of basic services which counties must provide to children with mental illness, among other requirements.

. Extensive state-level reviews of county plans, coupled with technical assistance and delay of funding in cases of serious deficiencies, in order to ensure that plans are adequate to respond to the needs of persons with mental illness statewide. Plans have been reviewed and approved for both adult and children's services in most of Minnesota's counties.

. Expansion of Rule 36 community residential service programs to include proportional representation in urban and rural areas, approximately doubling the number available statewide since 1985.

. Continued efforts to downsize larger facilities in the community (IMDs).

. Statewide implementation of case management services.

. Implementation of OBRA requirements to identify and relocate persons with mental illness inappropriately placed in nursing homes. The state has provided funding and technical assistance to counties to assist in developing and implementing relocation plans which return persons to their home communities.

. Consumer involvement throughout the mental health system, including mandatory involvement in state and local advisory councils, in Rule revision, in the annual CSP statewide meeting, both as participants and speakers, and other activities.

. Implementation of CSPs in all 87 counties. Statewide annual 3-day Community Support Program meetings provide extensive

networking opportunities, and technical assistance efforts have also been extensive to implement these services.

. Full involvement of local advisory councils in Plan reviews and other activities affecting mental health service provision at the local level.

. Greater emphasis on community alternatives and normalized living environments. Special supported housing projects (state funded), work in progress on State Operated Community Services (SOCS) for adults and adolescents, the Anoka Alternatives Project (a state-funded project designed to relocate 35 persons in the Anoka Metro RTC [state hospital]) into the community, OBRA community relocation (state) grants all emphasize community alternatives to institutionalization. Homeless services include basic food and shelter needs and attempts to link the person with the mental health system as well as preventive services.

. Increased collaboration with other state agencies to coordinate efforts at the state level for persons with mental illness, including collaboration on issues such as chemical dependency, employment, and housing.

. Development of and work in progress on uniform screening mechanisms for adults and children.

. Development and implementation of a Comprehensive Mental Health Reporting System, so that accurate information may be accessed for planning and evaluation purposes. Work is in progress on various components of the computer-based system for both services and funding.

. Extensive Rule revision to update Rules to reflect current standards, based on national and state data regarding needs and standards in the various areas. Rules being revised or under discussion include Rule 36 community residential services, Rule 14 community support services, Rule 29 outpatient services, Rule 74 case management services, and others.

. Increased emphasis on employment for persons with mental illness, as demonstrated by a variety of programs.

. Expansion of programs for underserved populations, including American Indians, older persons, refugees, and homeless persons with mental illness. A variety of programs in urban and rural areas have been developed, with creative methods frequently being used to increase access and decrease the stigma associated with mental health services.

. Initiation of a program for human resource development in mental health. Various Division activities, including extensive technical assistance at the county and provider level, and

involvement with other agencies impacting upon training, are ongoing.

. Expansion of funding for mental health programs and priorities. In the past year, two new grants, totaling over $600,000, were received from NIMH. The state legislature appropriated new funds (one million dollars) for specialized mental health needs and services to implement the Comprehensive Children's Mental Health Act. Another $1,200,000 will be allocated in 1991 for family community support services as part of the Comprehensive Children's Mental Health Act of 1989. A total of $8,545,000 was allocated in new state funding for mental health.

. Activities to reduce stigma. An anti-stigma campaign has been successfully completed and materials distributed to counties, advocacy organizations, and local advisory councils.

Progress on each of these activities during the past year and others is described more fully in Part B. Overall, it is clear that the state is currently operating with a mental health system based on recent legislation for adult and children's services, that all counties are being held accountable for providing a full range of critical services, that mental health plans are in place in most counties, that the system for accounting for services and funding has been coordinated so that access to critical information is possible, that many new areas of focus have been added to the prior mental health system, that the emphasis is increasingly on community-based, normalized living environments, with coordinated, supportive services, and that funding has been procured to support most of these activities. The effect is that Minnesota is just entering into a phase of planned, coordinated, consumer-responsive and statewide mental health services.

3. Anticipated Problems for "Full" Implementation.

Children's Services: The significant reduction in funding is seriously delaying the development of programs and services in this area.

Homeless Services: The reduction in federal McKinney Act funding is straining state resources to continue existing programs at the current level.

Special Populations: Reductions in federal block grant funding have resulted in reductions in initiatives in this area. For example, basic programs are being continued in Indian Mental Health, but new initiatives are not possible with current funding levels.

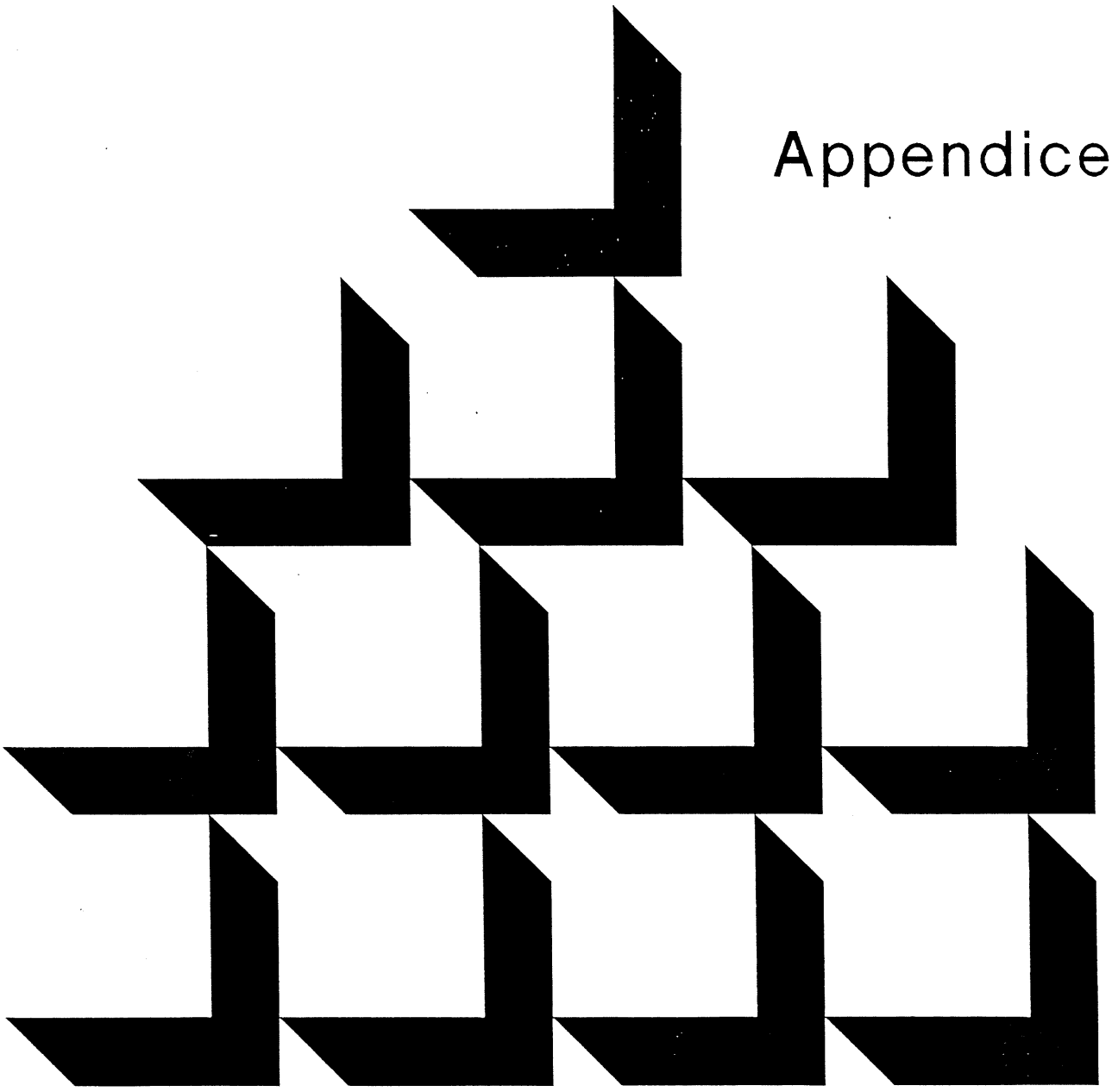
Review of County Plans: Revision of guidelines so as to streamline the process for both counties and state staff in the future will occur.

4. Reconsideration of Plan.

MHD goals or implementation objectives are substantially unchanged (See Appendix H). They have been organized differently for work planning proposed under the five major functions of the reorganized Mental Health Division: Planning, standard setting, monitoring and evaluation, technical assistance, and resource development. Items which were viewed as being somewhat vague were further defined. Some objectives have been altered somewhat to reflect accomplishments to date (e.g., some tasks were accomplished, and the current tasks and objectives reflect this accomplishment and proceed from this point), whereas others reflect changes in fiscal realities or other issues, but essentially the objectives are largely the same.

For example, in the area of data reporting systems, State Objective 3-B, "To implement the new community mental health reporting system (CMHRS)", is more accurately stated as "To enhance the state reporting capacity and data quality of the Community Mental Health Reporting System" for the coming year, since the CMHRS has been implemented. Objective 3-D, "To implement effective methods to utilize available mental health data from MA/GAMC, RTCs and other information systems" is restated as "To incorporate mental health data from the Minnesota Medicaid Information System, RTCs, and other information systems into state mental health reporting", since progress has been made on the original objective. Objective 3G, "To maximize opportunities to plan service development systematically, based on client needs", has been modified to "To update techniques for local and state planning for service delivery, in order to incorporate new services and more effective planning methodologies", and a new objective has been added, "To enhance the data systems of mental health provider organizations, including incorporation of national data standards". Both of these reflect greater specificity in the objectives, based on the experience of the past year.

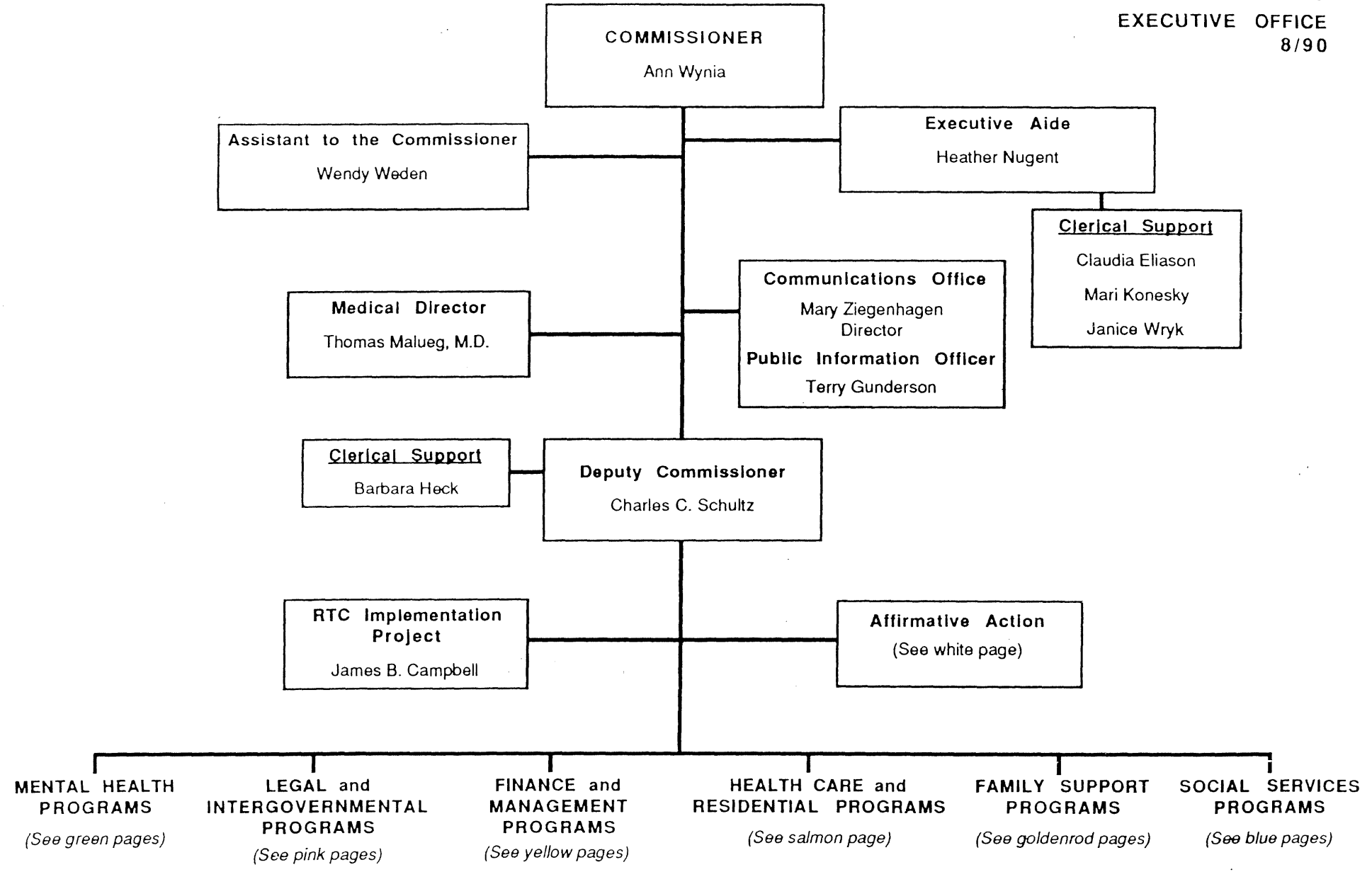
Appendices



MINNESOTA DEPARTMENT OF HUMAN SERVICES

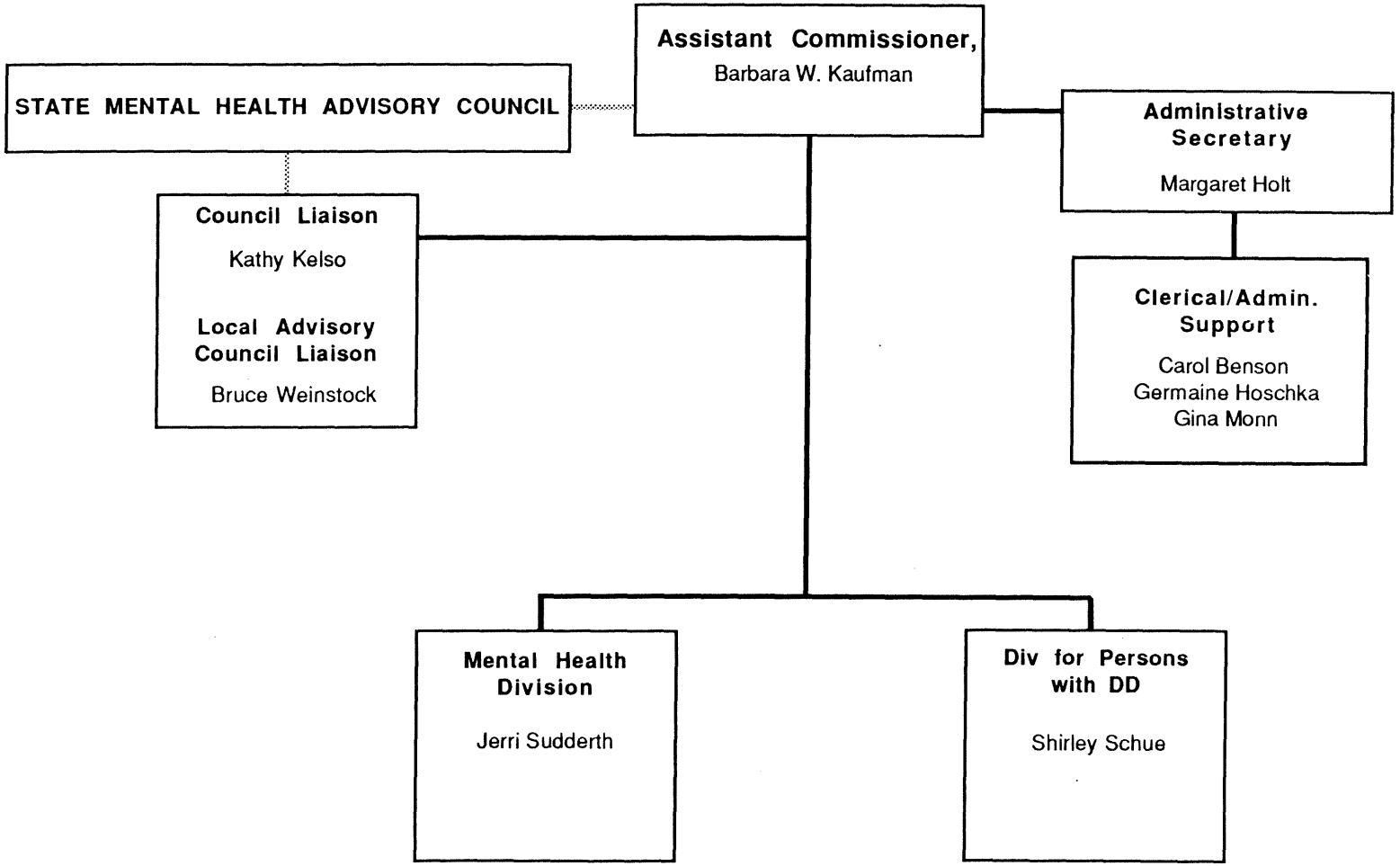
EXECUTIVE OFFICE

8/90

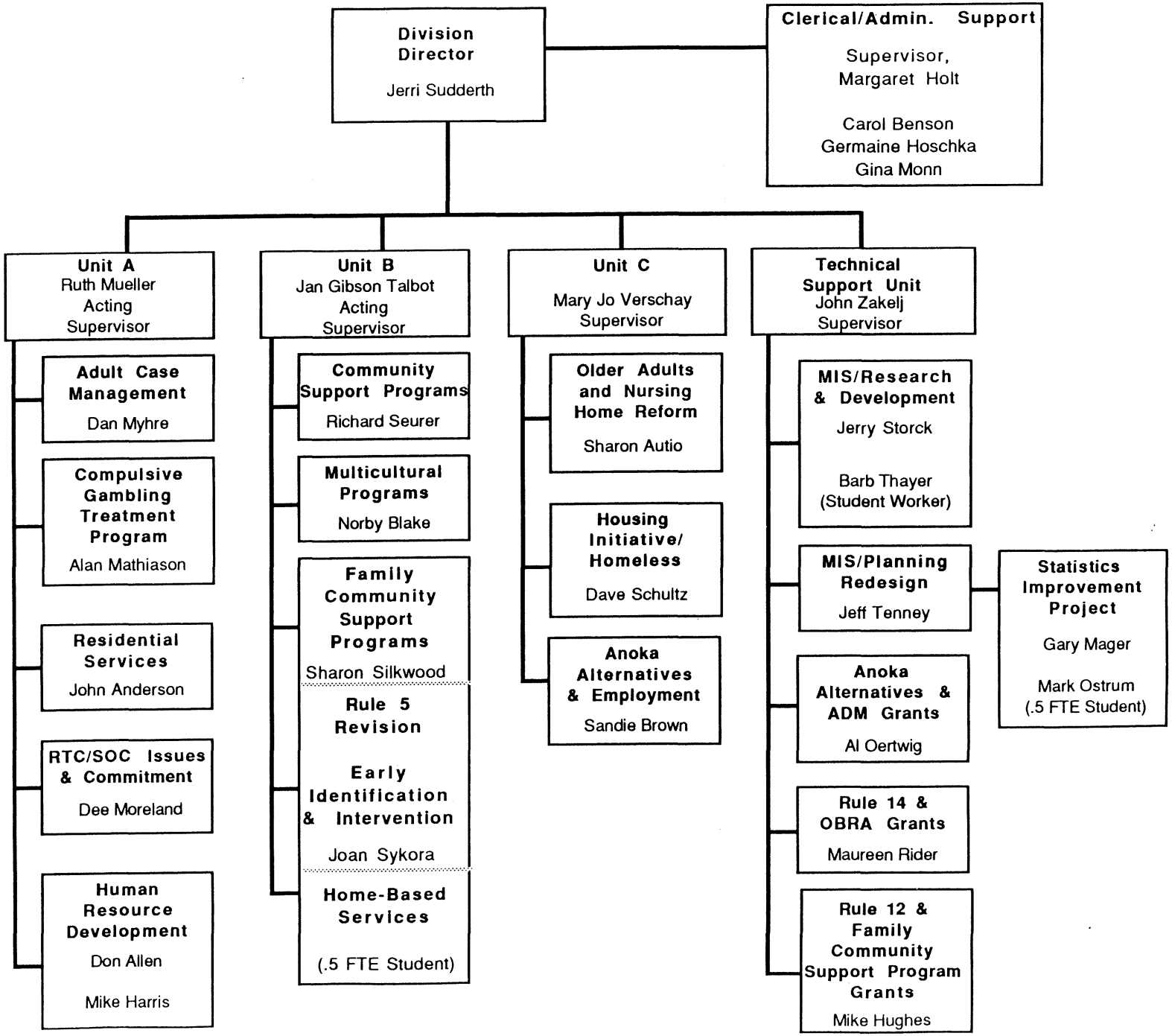


APPENDIX A

MENTAL HEALTH PROGRAMS
9/90



APPENDIX B-1


Division Director
Jerri Sudderth
Clerical/Admin. Support
Supervisor, Margaret Holt
Carol Benson
Germaine Hoschka
Gina Monn
Unit A
Ruth Mueller
Acting Supervisor
Adult Case Management
Dan Myhre
Compulsive Gambling Treatment Program
Alan Mathiason
Residential Services
John Anderson
RTC/SOC Issues & Commitment
Dee Moreland
Human Resource Development
Don Allen
Mike Harris
Unit B
Jan Gibson Talbot
Acting Supervisor
Community Support Programs
Richard Seurer
Multicultural Programs
Norby Blake
Family Community Support Programs
Sharon Silkwood
Rule 5 Revision
Early Identification & Intervention
Joan Sykora
Home-Based Services
(.5 FTE Student)
Unit C
Mary Jo Verschay
Supervisor
Older Adults and Nursing Home Reform
Sharon Autio
Housing Initiative/ Homeless
Dave Schultz
Anoka Alternatives & Employment
Sandie Brown
Technical Support Unit
John Zakelj
Supervisor
MIS/Research & Development
Jerry Storck
Barb Thayer
(Student Worker)
MIS/Planning Redesign
Jeff Tenney
Statistics Improvement Project
Gary Mager
Mark Ostrum
(.5 FTE Student)
Anoka Alternatives & ADM Grants
Al Oertwig
Rule 14 & OBRA Grants
Maureen Rider
Rule 12 & Family Community Support Program Grants
Mike Hughes

APPENDIX B-2

STATE ADVISORY COUNCIL ON MENTAL HEALTH (9/20/90)

MEMBER	AFFILIATION
Monte Aaker	rep. of MN Housing Finance Agency
Howard Agee	rep. of MN Alliance for the Mentally Ill
Barbara Amram	school social worker, Bloomington Public Schools
Lee Beecher, M.D.	rep. of Minnesota Psychiatric Society
Sen. Linda Berglin	rep. of MN State Senate
Craig Brooks, Director	County social services director (rural)
Bonnie Brysky	(ex-officio) rep. of SE Asian refugees
Susan Carey	rep. of consumers of mental health services
William Conley	rep. of Mental Health Assoc. of Minnesota
Miller Friesen	rep. of community mental health centers
Peter Glick	provider of mental health services
Cynthia Hart	rep. of parent/family member of persons with mental illness
Ron Hook	rep. of state Medical Assistance program
Jim House	rep. of state vocational services agency
Karen Johnson	rep. of consumers of mental health services
Steve Johnson	rep. of family member/relative of persons with mental illness

Barbara Kaufman	rep. of state mental health and social services agency
Kathy Kosnoff	rep. of Minnesota Mental Health Law Project
Patricia Lamppa	rep. of family member/relative of persons with mental illness
Susan Lentz	public member
Paul McCarron	County Commissioner (urban)
Susan Moore	rep. of family member/relative of persons with mental illness
Larry Olson, M.D.	rep. of Regional Treatment Center mental health programs
Jo Rohady	rep. of Minnesota Nurses Assoc.
Robert Roufs, Jr.	County Commissioner (rural)
Norma Schleppegrell **Chair of Advisory Council**	rep. of community support programs; family member of person with mental illness
Rep. Gloria Segal	rep. of Minnesota House of Representatives
Zigfrids Stelmachers, Ph.D.	Director, Hennepin County Crisis Unit; rep. of Minnesota Psychological Association
Michael Weber, Director	county social services director (urban)

STATE SUBCOMMITTEE ON CHILDREN'S MENTAL HEALTH (9/20/90)

MEMBER	AFFILIATION
Barbara Amram	school social worker for Bloomington Public Schools
Bonnie Bray	rep. of state department of education
Louise Brown	rep. of family services organization
Patricia Carlson	county social services director (rural)
Ruth Curwen Carlson	rep. of state health department
Susan Carstens	rep. of juvenile justice
Paula Childers **Chair of Subcommittee**	rep. of parent/family member of children with emotional disturbance
William Dikel, M.D.	rep. of Minnesota Society of Child and Adolescent Psychiatry
Denise Dodson	rep. of parent/family member of children with emotional disturbance
Vern Dorschner	rep. of parent/family member of children with emotional disturbance
Susan Erbaugh, Ph. D.	provider of children's mental health services
Louise Farnham	provider of children's mental health services
Elsie Groth	rep. of parent/family member of child with emotional disturbance
Jo Gundry	provider of children's mental health services

Laura Hansen	rep. of consumers of child/adolescent mental health services
Ron Hook	rep. of state Medical Assistance program
Ann Jaede	rep. of State Planning Agency
Dixie Jordan	rep. of parent/family member of children with emotional disturbance
Barbara Kaufman	rep. of state mental health and social services agency
John Langworthy	rep. of DHS Children's Services Division
Decorah Mach	rep. of Minnesota Nurses Association
Judge Allen Oleisky	rep. of Minnesota District Judges Association Juvenile Justice Committee
Brenda Otto	rep. of county social services agency
Thomas Papin	county social services director (rural)
Liz Prebich	County Commissioner (rural)
Richard Quick	rep. of state juvenile corrections agency
Deidre Richards	rep. of parent/family member of child with emotional disturbance
Tom Rice	rep. of Department of Finance
Lisa Rotenberg	rep. of state agency regulating private insurance
David Sanders	rep. of Minnesota Psychological Association
Rep. Gloria Segal	rep. of Minnesota House of Representatives

Edwin Swenson	rep. of community mental health centers
Kathleen Trihey	rep. of juvenile community corrections agency
Michael Weber	rep. of county social services directors (urban)
Gordon Wrobel	rep. of educators of emotionally disturbed children
Cas Zantek	rep. of state juvenile corrections agency

Comprehensive Adult and Children's Mental Health Acts

(With 1990 Revisions)

245.461 POLICY AND CITATION.

Subdivision 1. **Citation.** Sections 245.461 to 245.486 may be cited as the "Minnesota comprehensive adult mental health act."

Subd. 2. **Mission statement.** 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 adults 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.

Subd. 3. **Report.** By February 15, 1988, and annually after that until February 15, 1990, the commissioner shall report to the legislature on all steps taken and recommendations for full implementation of sections 245.461 to 245.486 and on additional resources needed to further implement those sections.

Subd. 4. **Housing mission statement.** 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.

History: *1989 c 282 art 4 s 1*

245.462 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to 245.486.

Subd. 2. **Acute care hospital inpatient treatment.** "Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the community support services program as defined in subdivision 6 and are designed to help adults 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 a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Subd. 4. **Case manager.** "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in sections 245.471 and 245.475. A case manager must have a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and have at least 2,000 hours of supervised experience in the

delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client. The case manager shall meet in person with a mental health professional at least once each month to obtain clinical supervision of the case manager's activities. Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must complete 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness and must receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of supervised experience is met. Clinical supervision must be documented in the client record.

Until June 30, 1991, a refugee who does not have the qualifications specified in this subdivision may provide case management services to adult refugees with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person: (1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university; (2) completes 40 hours of training as specified in this subdivision; and (3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Community support services program.** "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 adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related 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 community support services program must be coordinated with the case management services specified in section 245.4711.

Subd. 7. **County board.** "County board" means the county board of commissioners or board established pursuant to the joint powers act, section 471.59, or the human services board act, sections 402.01 to 402.10.

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to an adult in: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4711, subdivision 7, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least one day a week for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. The services are aimed at stabilizing the adult's mental health status, providing mental health

services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services.

Subd. 9. **Diagnostic assessment.** "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.

Subd. 10. **Education and prevention services.** "Education and prevention services" means services designed to educate the general public or special high-risk target populations about mental illness, to increase the understanding and acceptance of problems associated with mental illness, to increase people's awareness of the availability of resources and services, and to improve people's skills in dealing with high-risk situations known to affect people's mental health and functioning. The services include the distribution of information to individuals and agencies identified by the county board and the local mental health advisory council, on predictors and symptoms of mental disorders, where mental health services are available in the county, and how to access the services.

Subd. 11. **Emergency services.** "Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency.

Subd. 11a. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the adult's:

(1) mental health symptoms as presented in the adult's diagnostic assessment;

(2) mental health needs as presented in the adult's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the adult's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Subd. 12. **Individual community support plan.** "Individual community support plan" means a written plan developed by a case manager on the basis of a diagnostic assessment and functional assessment. The plan identifies specific services needed by an adult with serious and persistent mental illness to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships, financial management, housing, transportation, and employment.

Subd. 13. **Individual placement agreement.** "Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of an individual adult to provide residential treatment services.

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness.

Subd. 15. **Local mental health proposal.** "Local mental health proposal" means the proposal developed by the county board, reviewed by the commissioner, and described in section 245.463.

Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under sections 256D.06 and 256D.37 to facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

Subd. 17. **Mental health practitioner.** "Mental health practitioner" means a person providing services to persons with mental illness who is qualified 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 and is formally assigned by an accredited college or university to an agency or facility for clinical training; or

(4) holds 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 mental illness.

Subd. 18. **Mental health professional.** "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 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 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 post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: a psychologist licensed under 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 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.

Subd. 19. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to adults with mental illness and are described in sections 245.461 to 245.486.

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects 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.

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the clinical supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 22. **Regional treatment center inpatient services.** "Regional treatment center inpatient services" means the 24-hour-a-day comprehensive medical, nursing, or psychosocial services provided in a regional treatment center operated by the state.

Subd. 23. **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 inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under Minnesota Rules, parts 9520.0500 to 9520.0690 or other rules adopted by the commissioner.

Subd. 24. **Service provider.** "Service provider" means either a county board or an individual or agency including a regional treatment center under contract with the county board that provides adult mental health services funded by sections 245.461 to 245.486.

Subd. 25. [Repealed, 1989 c 282 art 4 s 64]

History: *1989 c 282 art 4 s 2*

245.463 PLANNING FOR A MENTAL HEALTH SYSTEM.

Subdivision 1. **Planning effort.** Starting on the effective date of sections 245.461 to 245.486 and ending June 30, 1988, the commissioner and the county agencies shall plan for the development of a unified, accountable, and comprehensive statewide mental health system. The system must be planned and developed by stages until it is operating at full capacity.

Subd. 2. **Technical assistance.** The commissioner shall provide ongoing technical assistance to county boards to develop local mental health proposals as specified in section 245.478, to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of adults with mental illness residing in the county and extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Subd. 3. The commissioner of human services shall, in cooperation with the commissioner of health, study and submit to the legislature by February 15, 1991, a report and recommendations regarding (1) plans and fiscal projections for increasing the number of community-based beds, small community-based residential programs, and support services for persons with mental illness, including persons for whom

nursing home services are inappropriate, to serve all persons in need of those programs; and (2) the projected fiscal impact of maximizing the availability of medical assistance coverage for persons with mental illness.

Subd. 4. **Review of funding.** The commissioner shall complete a review of funding for mental health services and make recommendations for any changes needed. The commissioner shall submit a report on the review and recommendations to the legislature by January 31, 1991.

History: *1989 c 282 art 4 s 3,4; art 6 s 3*

245.464 COORDINATION OF MENTAL HEALTH SYSTEM.

Subdivision 1. **Coordination.** The commissioner shall supervise the development and coordination of locally available adult mental health services by the county boards in a manner consistent with sections 245.461 to 245.486. The commissioner shall coordinate locally available services with those services available from the regional treatment center serving the area. The commissioner shall review local mental health service proposals developed by county boards as specified in section 245.463 and provide technical assistance to county boards in developing and maintaining locally available mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's adult mental health proposals and other information as required by sections 245.461 to 245.486.

Subd. 2. **Priorities.** By January 1, 1990, the commissioner shall require that each of the treatment services and management activities described in sections 245.469 to 245.477 are developed for adults with mental illness within available resources based on the following ranked priorities:

(1) the provision of locally available emergency services;

(2) the provision of locally available services to all adults with serious and persistent mental illness and all adults with acute mental illness;

(3) the provision of specialized services regionally available to meet the special needs of all adults with serious and persistent mental illness and all adults with acute mental illness;

(4) the provision of locally available services to adults with other mental illness; and

(5) the provision of education and preventive mental health services targeted at high-risk populations.

History: *1989 c 282 art 4 s 5*

245.465 DUTIES OF COUNTY BOARD.

The county board in each county shall use its share of mental health and community social service act funds allocated by the commissioner according to a biennial local mental health service proposal approved by the commissioner. The county board must:

(1) develop and coordinate a system of affordable and locally available adult mental health services in accordance with sections 245.461 to 245.486;

(2) provide for case management services to adults with serious and persistent mental illness in accordance with sections 245.462, subdivisions 3 and 4; 245.4711; and 245.486;

(3) provide for screening of adults specified in section 245.476 upon admission to a residential treatment facility or acute care hospital inpatient, or informal admission to a regional treatment center;

(4) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.461 to 245.486; and

(5) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract with the county to provide mental health services have experience and training in working with adults with mental illness.

History: *1989 c 282 art 4 s 6*

245.466 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision 1. **Development of services.** The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable adult mental health services. The county board may provide some or all of the mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward full implementation of sections 245.461 to 245.486 during the period July 1, 1987, to January 1, 1990. County boards must develop fully each of the treatment services and management activities prescribed by sections 245.461 to 245.486 by January 1, 1990, according to the priorities established in section 245.464 and the local mental health services proposal approved by the commissioner under section 245.478.

Subd. 2. **Adult mental health services.** The adult mental health service system developed by each county board must include the following services:

(1) education and prevention services in accordance with section 245.468;

(2) emergency services in accordance with section 245.469;

(3) outpatient services in accordance with section 245.470;

(4) community support program services in accordance with section 245.4711;

(5) residential treatment services in accordance with section 245.472;

(6) acute care hospital inpatient treatment services in accordance with section 245.473;

(7) regional treatment center inpatient services in accordance with section 245.474;

(8) screening in accordance with section 245.476; and

(9) case management in accordance with sections 245.462, subdivision 3; and 245.4711.

Subd. 3. **Local contracts.** Effective January 1, 1988, the county board shall review all proposed county agreements, grants, or other contracts related to mental health services for funding from any local, state, or federal governmental sources. Contracts with service providers must:

(1) name the commissioner as a third party beneficiary;

(2) identify monitoring and evaluation procedures not in violation of the Minnesota government data practices act, chapter 13, which are necessary to ensure effective delivery of quality services;

(3) include a provision that makes payments conditional on compliance by the contractor and all subcontractors with sections 245.461 to 245.486 and all other applicable laws, rules, and standards; and

(4) require financial controls and auditing procedures.

Subd. 4. **Joint county mental health agreements.** In order to provide efficiently the services required by sections 245.461 to 245.486, counties are encouraged to join with one or more county boards to establish a multicounty local mental health authority pursuant to the joint powers act, section 471.59, the human service board act, sections 402.01 to 402.10, community mental health center provisions, section 245.62, or enter into multicounty mental health agreements. Participating county boards shall establish acceptable ways of apportioning the cost of the services.

Subd. 5. **Local advisory council.** The county board, individually or in conjunction with other county boards, shall establish a local adult mental health advisory council or mental health subcommittee of an existing advisory council. The council's members must reflect a broad range of community interests. They must include at least one consumer, one family member of an adult with mental illness, one mental health professional, and one community support services program representative. The local adult mental health advisory council or mental health subcommittee of an existing advisory council shall meet at least quarterly to review, evaluate, and make recommendations regarding the local mental health system. Annually, the local adult mental health advisory council or mental health subcommittee of an existing advisory council shall:

(1) arrange for input from the regional treatment center's mental illness program unit regarding coordination of care between the regional treatment center and community-based services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.462, subdivision 10; and

(3) coordinate its review, evaluation, and recommendations regarding the local mental health system with the state advisory council on mental health.

The county board shall consider the advice of its local mental health advisory council or mental health subcommittee of an existing advisory council in carrying out its authorities and responsibilities.

Subd. 6. **Other local authority.** The county board may establish procedures and policies that are not contrary to those of the commissioner or sections 245.461 to 245.486 regarding local adult mental health services and facilities. The county board shall perform other acts necessary to carry out sections 245.461 to 245.486.

History: *1989 c 282 art 4 s 7-10*

245.467 QUALITY OF SERVICES.

Subdivision 1. **Criteria.** Mental health services required by this chapter must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical needs, cultural and ethnic needs, and other special needs of individuals being served;

(3) provided in the most appropriate, least restrictive setting available to the county board;

(4) accessible to all age groups;

(5) delivered in a manner that provides accountability;

(6) provided by qualified individuals as required in this chapter;

(7) coordinated with mental health services offered by other providers; and

(8) provided under conditions which protect the rights and dignity of the individuals being served.

Subd. 2. [DIAGNOSTIC ASSESSMENT.] All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of outpatient and day treatment services must complete a diagnostic assessment within ~~ten~~ five days after the adult's second visit or within 30 days ~~of admission~~ after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within ~~90~~ 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the adult's current mental health status and service needs. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance or general assistance medical care reimbursement under chapters 256B and 256D.

Subd. 3. [INDIVIDUAL TREATMENT PLANS.] All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan ~~must be developed~~ within ten days of client intake and ~~reviewed~~ must review the individual treatment plan every 90 days ~~thereafter~~ after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.

Subd. 4. **Referral for case management.** Each provider of emergency services, day treatment services, outpatient treatment, community support services, residential treatment, acute care hospital inpatient treatment, or regional treatment center inpatient treatment must inform each of its clients with serious and persistent mental illness of the availability and potential benefits to the client of case management. If the client consents, the provider must refer the client by notifying the county employee designated by the county board to coordinate case management activities of the client's name and address and by informing the client of whom to contact to request case management. The provider must document compliance with this subdivision in the client's record.

Subd. 5. **Information for billing.** Each provider of outpatient treatment, community support services, day treatment services, emergency services, residential treatment, or acute care hospital inpatient treatment must include the name and home address of each client for whom services are included on a bill submitted to a county, if the client has consented to the release of that information and if the county requests the information. Each provider shall attempt to obtain each client's consent and must explain to the client that the information can only be released with the client's consent and may be used only for purposes of payment and maintaining provider accountability. The provider shall document the attempt in the client's record.

Subd. 6. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of persons receiving mental health services are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; and

(2) staff who provide treatment services or case management and their clinical supervisors.

Release of mental health data on individuals submitted under subdivisions 4 and 5, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 4 and 5, results in civil or criminal liability under the standards in section 13.08 or 13.09.

History: *1987 c 403 art 2 s 22; 1988 c 689 art 2 s 78-80*

History: *1989 c 282 art 4 s 11-13*

245.468 EDUCATION AND PREVENTION SERVICES.

By July 1, 1988, county boards must provide or contract for education and prevention services to adults residing in the county. Education and prevention services must be designed to:

(1) convey information regarding mental illness and treatment resources to the general public and special high-risk target groups;

(2) increase understanding and acceptance of problems associated with mental illness;

(3) improve people's skills in dealing with high-risk situations known to have an impact on adults' mental health functioning;

(4) prevent development or deepening of mental illness; and

(5) refer adults with additional mental health needs to appropriate mental health services.

History: *1989 c 282 art 4 s 14*

245.469 [EMERGENCY SERVICES.]

Subdivision 1. [AVAILABILITY OF EMERGENCY SERVICES.] By July 1, 1988, county boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further 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 in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

Subd. 2. [SPECIFIC REQUIREMENTS.] The county board shall require that all service providers of emergency services to adults with mental illness 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. The commissioner may waive the requirement that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

Whenever emergency service during nonbusiness 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.

M.S. 245.470 Subdivision 1. [AVAILABILITY OF OUTPATIENT SERVICES.] (a) ~~By July 1, 1988,~~ County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; or by contract with a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (4). Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

History: *1989 c 282 art 4 s 16*

Subd. 2. **Specific requirements.** The county board shall require that all service providers of outpatient services:

(1) meet the professional qualifications contained in sections 245.461 to 245.486;

(2) use a multidisciplinary mental health professional staff including at a minimum, arrangements for psychiatric consultation, licensed consulting psychologist consultation, and other necessary multidisciplinary mental health professionals;

(3) develop individual treatment plans;

(4) provide initial appointments within three weeks, except in emergencies where there must be immediate access as described in section 245.469; and

(5) establish fee schedules approved by the county board that are based on a client's ability to pay.

History: *1987 c 403 art 2 s 25*

245.471 [Repealed, 1989 c 282 art 4 s 64]

245.4711 [CASE MANAGEMENT ~~AND COMMUNITY SUPPORT~~ SERVICES.]

Subdivision 1. [AVAILABILITY OF CASE MANAGEMENT SERVICES.] (a) By January 1, 1989, the county board shall provide case management ~~activities~~ services for all adults with serious and persistent mental illness ~~residing in~~ who are residents of the county and who request or consent to the services and to each adult for whom the court appoints a case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.462, subdivision 4.

(b) Case management services provided to adults with serious and persistent mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

Subd. 2. [NOTIFICATION AND DETERMINATION OF CASE MANAGEMENT ELIGIBILITY.] (a) The county board shall notify the ~~client~~ adult of the ~~person's~~ adult's potential eligibility for case management services within five working days after receiving a request from an individual or a referral from a provider under section 245.467, subdivision 4. The county board shall send a written notice to the ~~client~~ adult and the ~~client's~~ adult's representative, if any, that identifies the designated case management providers.

(b) The county board must determine whether an adult who requests or is referred for case management services meets the criteria of section 245.462, subdivision 20, paragraph (c). If a diagnostic assessment is needed to make the determination, the county board shall offer to assist the adult in obtaining a diagnostic assessment. The county board shall notify, in writing, the adult and the adult's representative, if any, of the eligibility determination. If the adult is determined to be eligible for case management services, the county board shall refer the adult to the case management provider for case management services. If the adult is determined not to be eligible or refuses case management services, the local agency shall offer to refer the adult to a mental health provider or other appropriate service provider and to assist the adult in making an appointment with the provider of the adult's choice.

Subd. 3. [DUTIES OF CASE MANAGER.] ~~(a) The case manager shall promptly arrange for a diagnostic assessment of the applicant when one is not available as described in section 245.467, subdivision 2, to determine the applicant's eligibility as an adult with serious and persistent mental illness for community support services. The county board shall notify in writing the applicant and the applicant's representative, if any, if the applicant is determined ineligible for community support services.~~

~~(b)~~ Upon a determination of eligibility for ~~community support~~ case management services, and if the adult consents to the services, the case manager shall complete a written functional assessment according to section 245.462, subdivision 11a. The case manager shall develop an individual community support plan for ~~an~~ the adult according to subdivision 4, paragraph (a), review the ~~client's~~ adult's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

Subd. 4. 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 service;

(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.

Subd. 5. Coordination between case manager and community support services. The county board must establish procedures that ensure ongoing contact and coordination between the case manager and the community support services program as well as other mental health services.

[245.4712] [COMMUNITY SUPPORT AND DAY TREATMENT SERVICES.]

Subdivision 1. [AVAILABILITY OF COMMUNITY SUPPORT SERVICES.] County boards must provide or contract for sufficient community support services within the county to meet the needs of adults with serious and persistent mental illness who are residents of the county. Adults may be required to pay a fee according to section 245.481. The community support services program must be designed to improve the ability of adults with serious and persistent mental illness to:

(1) work in a regular or supported work environment;

(2) handle basic activities of daily living;

(3) participate in leisure time activities;

(4) set goals and plans; and

(5) obtain and maintain appropriate living arrangements.

The community support services program must also be designed to reduce the need for and use of more intensive, costly, or restrictive placements both in number of admissions and length of stay.

Subd. 2. [DAY TREATMENT SERVICES PROVIDED.] (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Subd. 3. [BENEFITS ASSISTANCE.] The county board must offer to help adults with serious and persistent mental illness in applying for state and federal benefits, including supplemental security income, medical assistance, Medicare, general assistance, general assistance medical care, and Minnesota supplemental aid. The help must be offered as part of the community support program available to adults with serious and persistent mental illness for whom the county is financially responsible and who may qualify for these benefits.

245.472 RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. Availability of residential treatment services. By July 1, 1988, county boards must provide or contract for enough residential treatment services to meet the needs of all adults with mental illness residing in the county and needing this level of care. Residential treatment services include both intensive and structured residential treatment with length of stay based on client residential treatment need. Services must be as close to the county as possible. Residential treatment must be designed to:

(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs;

(2) help clients achieve the highest level of independent living;

(3) help clients gain the necessary skills to function in a less structured setting; and

(4) stabilize crisis admissions.

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under applicable rules adopted by the commissioner and must be clinically supervised by a mental health professional. Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0690, may be allowed to continue providing clinical supervision within a facility until July 1, 1991, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

History: *1987 c 403 art 2 s 27; 1988 c 689 art 2 s 84*

Subd. 3. **Transition to community.** Residential treatment programs must plan for and assist clients in making a transition from residential treatment facilities to other community-based services. In coordination with the client's case manager, if any, residential treatment facilities must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the residential treatment facility must notify the client's case manager; so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

History: *1989 c 282 art 4 s 18,19*

245.473 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. **Availability of acute care inpatient services.** By July 1, 1988, county boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for adults with mental illness residing in the county. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible; and

(3) facilitate appropriate referrals for follow-up mental health care in the community.

History: *1989 c 282 art 4 s 20*

Subd. 2. **Specific requirements.** Providers of acute care hospital inpatient services must meet applicable standards established by the commissioners of health and human services.

History: *1987 c 403 art 2 s 28*

245.474 [REGIONAL TREATMENT CENTER INPATIENT SERVICES.]

Subdivision 1. [AVAILABILITY OF REGIONAL TREATMENT CENTER INPATIENT SERVICES.] By July 1, 1987, the commissioner shall make sufficient regional treatment center inpatient services available to adults with mental illness throughout the state who need this level of care. Services must be as close to the patient's county of residence as possible. Regional treatment centers are responsible to:

(1) provide acute care inpatient hospitalization;

(2) stabilize the medical and mental health condition of the adult requiring the admission;

~~(2)~~ (3) improve functioning to the point where discharge to community-based mental health services is possible;

~~(3)~~ (4) strengthen family and community support; and

~~(4)~~ (5) facilitate appropriate discharge and referrals for follow-up mental health care in the community.

Subd. 2. [QUALITY OF SERVICE.] The commissioner shall biennially determine the needs of all adults with mental illness who are served by regional treatment centers by administering a client-based evaluation system. The client-based evaluation system must include at least the following independent measurements: behavioral development assessment; habilitation program assessment; medical needs assessment; maladaptive behavioral assessment; and vocational behavior assessment. The commissioner shall propose staff ratios to the legislature for the mental health and support units in regional treatment centers as indicated by the results of the client-based evaluation system and the types of state-operated services needed. The proposed staffing ratios shall include professional, nursing, direct care, medical, clerical, and support staff based on the client-based evaluation system. The commissioner shall recompute staffing ratios and recommendations on a biennial basis.

Subd. 3. [TRANSITION TO COMMUNITY.] Regional treatment centers must plan for and assist clients in making a transition from regional treatment centers to other community-based services. In coordination with the client's case manager, if any, regional treatment centers must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the regional treatment center must notify the client's case manager, so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

245.475 [Repealed, 1989 c 282 art 4 s 64]

245.476 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subdivision 1. **Screening required.** No later than January 1, 1992, the county board shall screen all adults before they may be admitted for treatment of mental illness to a residential treatment facility, an acute care hospital, or informally admitted to a regional treatment center if public funds are used to pay for the services. Screening prior to admission must occur within ten days. If an adult is admitted for treatment of mental illness on an emergency basis to a residential facility or acute care hospital or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within five days of the admission. Adults must be screened within ten days before or within five days after admission to ensure that:

(1) an admission is necessary,

(2) the length of stay is as short as possible consistent with individual client need, and

(3) the case manager, if assigned, is developing an individual community support plan.

The screening process and placement decision must be documented in the client's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards specified in clauses (1) to (3).

Subd. 2. **Qualifications.** Screening for residential and inpatient services must be conducted by a mental health professional. Mental health professionals providing screening for inpatient and residential services must not be financially affiliated with any acute care inpatient hospital, residential treatment facility, or regional treatment center. The commissioner may waive this requirement in sparsely populated areas.

Subd. 3. **Individual placement agreement.** The county board shall enter into an individual placement agreement with a provider of residential treatment services to an adult eligible for services under this section. The agreement must specify the payment rate and terms and conditions of county payment for the placement.

Subd. 4. **Task force on residential and inpatient treatment services for adults.** The commissioner of human services shall appoint a task force on residential and inpatient treatment services for adults. The task force must include representatives from each of the mental health professional categories defined in section 245.462, subdivision 18, the Minnesota mental health association, the Minnesota alliance for the mentally ill, the Minnesota mental health law project, the Minnesota association of mental health residential facilities, the Minnesota hospital association, department of human services staff, the department of education, the department of corrections, the ombudsman for mental health and mental retardation, and counties. The task force shall examine and evaluate existing mechanisms that have as their purpose review of appropriate admission and need for continued care for clients admitted to residential treatment, acute care hospital inpatient treatment, and regional treatment center inpatient treatment. These mechanisms shall include at least the following: precommitment screening, licensure and reimbursement rules, county monitoring, technical assistance, nursing home preadmission screening, hospital preadmission certification, and hospital retrospective reviews. The task force shall report to the legislature by February 15, 1990, on how existing mechanisms may be changed to accomplish the goals of screening as described in subdivision 1.

Subd. 5. **Report on preadmission screening.** The commissioner shall review the statutory preadmission screening requirements for psychiatric hospitalization, both in the regional treatment centers and other hospitals, to determine if changes in preadmission screening are needed. The commissioner shall deliver a report of the review to the legislature by January 31, 1990.

History: *1989 c 282 art 4 s 22-24; art 6 s 4*

245.477 APPEALS.

Any adult who requests mental health services under sections 245.461 to 245.486 must be advised of services available and the right to appeal at the time of the request and each time the individual community support plan or individual treatment plan is reviewed. Any adult whose request for mental health services under sections 245.461 to 245.486 is denied, not acted upon with reasonable promptness, or whose services are suspended, reduced, or terminated by action or inaction for which the county board is responsible under sections 245.461 to 245.486 may contest that action or inaction before the state agency as specified in section 256.045. The commissioner shall monitor the nature and frequency of administrative appeals under this section.

History: *1989 c 282 art 4 s 25*

245.478 LOCAL MENTAL HEALTH PROPOSAL.

Subdivision 1. **Time period.** The first local mental health proposal period is from July 1, 1988, to December 31, 1989. The county board shall submit its first proposal to the commissioner by January 1, 1988. Subsequent proposals must be on the same two-year cycle as community social service plans. If a proposal complies with sections 245.461 to 245.486, it satisfies the requirement of the community social service plan for the mental illness target population as required by section 256E.09. The proposal must be made available upon request to all residents of the county at the same time it is submitted to the commissioner.

Subd. 2. **Proposal content.** The local adult mental health proposal must include:

(1) the local adult mental health advisory council's or adult mental health subcommittee of an existing advisory council's report on unmet needs of adults and any other needs assessment used by the county board in preparing the local adult mental health proposal;

(2) a description of the local adult mental health advisory council's or the adult mental health subcommittee of an existing advisory council's involvement in preparing the local adult mental health proposal and methods used by the county board to ensure adequate and timely participation of citizens, mental health professionals, and providers in development of the local mental health proposal;

(3) information for the preceding year, including the actual number of clients who received each of the mental health services listed in sections 245.468 to 245.476, and actual expenditures for each mental health service and service waiting lists; and

(4) the following information describing how the county board intends to meet the requirements of sections 245.461 to 245.486 during the proposal period:

(i) specific objectives and outcome goals for each adult mental health service listed in sections 245.461 to 245.486;

(ii) a description of each service provider, including county agencies, contractors, and subcontractors, that is expected to either be the sole provider of one of the adult mental health services described in sections 245.461 to 245.486 or to provide over $10,000 of adult mental health services per year, including a listing of the professional qualifications of the staff involved in service delivery for the county;

(iii) a description of how the adult mental health services in the county will be unified and coordinated;

(iv) the estimated number of clients who will receive each adult mental health service; and

(v) estimated expenditures for each adult mental health service and revenues for the entire proposal.

Subd. 3. **Proposal format.** The local adult mental health proposal must be made in a format prescribed by the commissioner.

Subd. 4. **Provider approval.** The commissioner's review of the local mental health proposal must include a review of the qualifications of each service provider required to be identified in the local mental health proposal under subdivision 2. The commissioner may reject a county board's proposal for a particular provider if:

(1) the provider does not meet the professional qualifications contained in sections 245.461 to 245.486;

(2) the provider does not possess adequate fiscal stability or controls to provide the proposed services as determined by the commissioner; or

(3) the provider is not in compliance with other applicable state laws or rules.

Subd. 5. **Service approval.** The commissioner's review of the local mental health proposal must include a review of the appropriateness of the amounts and types of mental health services in the local mental health proposal. The commissioner may reject the county board's proposal if the commissioner determines that the amount and types of services proposed are not cost effective, do not meet client needs, or do not comply with sections 245.461 to 245.486.

Subd. 6. **Proposal approval.** The commissioner shall review each local mental health proposal within 90 days and work with the county board to make any necessary modifications to comply with sections 245.461 to 245.486. After the commissioner has approved the proposal, the county board is eligible to receive an allocation of mental health and community social service act funds.

Subd. 7. **Partial or conditional approval.** If the local mental health proposal is in substantial, but not in full compliance with sections 245.461 to 245.486 and necessary modifications cannot be made before the proposal period begins, the commissioner may grant partial or conditional approval and withhold a proportional share of the county board's mental health and community social service act funds until full compliance is achieved.

Subd. 8. **Award notice.** Upon approval of the county board proposal, the commissioner shall send a notice of approval for funding. The notice must specify any conditions of funding and is binding on the county board. Failure of the county board to comply with the approved proposal and funding conditions may result in withholding or repayment of funds as specified in section 245.483.

Subd. 9. **Plan amendment.** If the county board finds it necessary to make significant changes in the approved local proposal, it must present the proposed changes to the commissioner for approval at least 30 days before the changes take effect. "Significant changes" means:

(1) the county board proposes to provide a mental health service through a provider other than the provider listed for that service in the approved local proposal;

(2) the county board expects the total annual expenditures for any single mental health service to vary more than ten percent or $5,000, whichever is greater, from the amount in the approved local proposal;

(3) the county board expects a combination of changes in expenditures per mental health service to exceed more than ten percent of the total mental health services expenditures; or

(4) the county board proposes a major change in the specific objectives and outcome goals listed in the approved local proposal.

History: *1987 c 403 art 2 s 33; 1988 c 689 art 2 s 89-91*

History: *1989 c 282 art 4 s 26,27*

245.479 COUNTY OF FINANCIAL RESPONSIBILITY.

For purposes of sections 245.461 to 245.486 and 245.487 to 245.4887, the county of financial responsibility is determined under section 256G.02, subdivision 4. Disputes between counties regarding financial responsibility must be resolved by the commissioner in accordance with section 256G.09.

History: *1989 c 282 art 4 s 28*

245.48 MAINTENANCE OF EFFORT.

Counties must continue to spend for mental health services specified in sections 245.461 to 245.486 and 245.487 to 245.4887, according to generally accepted budgeting and accounting principles, an amount equal to the total expenditures shown in the county's approved 1987 Community Social Services Act plan under "State CSSA, Title XX and County Tax" for services to persons with mental illness plus the comparable figure for Rule 5 facilities under target populations other than mental illness in the approved 1987 CSSA plan.

History: *1989 c 282 art 4 s 29*

245.481 FEES FOR MENTAL HEALTH SERVICES.

A client or, in the case of a child, the child or the child's parent may be required to pay a fee for mental health services provided under sections 245.461 to 245.486 and 245.487 to 245.4887. The fee must be based on the person's ability to pay according to the fee schedule adopted by the county board. In adopting the fee schedule for mental health services, the county board may adopt the fee schedule provided by the commissioner or adopt a fee schedule recommended by the county board and approved by the commissioner. Agencies or individuals under contract with a county board to provide mental health services under sections 245.461 to 245.486 and 245.487 to 245.4887 must not charge clients whose mental health services are paid wholly or in part from public funds fees which exceed the county board's adopted fee schedule. This section does not apply to regional treatment center fees, which are governed by sections 246.50 to 246.55.

History: *1989 c 282 art 4 s 30*

245.482 REPORTING AND EVALUATION.

Subdivision 1. **Reports.** The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (17).

Subd. 2. **Fiscal reports.** The commissioner shall develop a unified format for quarterly fiscal reports that will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486, 245.487 to 245.4887, and section 256E.08. The county board shall submit a completed fiscal report in the required format no later than 30 days after the end of each quarter.

Subd. 3. **Program reports.** The commissioner shall develop unified formats for reporting, which will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486, 245.487 to 245.4887, and section 256E.10. The county board shall submit completed program reports in the required format according to the reporting schedule developed by the commissioner.

Subd. 4. **Provider reports.** The commissioner may develop formats and procedures for direct reporting from providers to the commissioner to include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4887. In particular, the provider reports must include aggregate information by county of residence about mental health services paid for by funding sources other than counties.

Subd. 5. **Commissioner's consolidated reporting recommendations.** The commissioner's reports of February 15, 1990, required under sections 245.461, subdivision 3, and 245.487, subdivision 4, shall include recommended measures to provide coordinated, interdepartmental efforts to ensure early identification and intervention for children with, or at risk of developing, emotional disturbance, to improve the efficiency of the mental health funding mechanisms, and to standardize and consolidate fiscal and program reporting. The recommended measures must provide that client needs are met in an effective and accountable manner and that state and county resources are used as efficiently as possible. The commissioner shall consider the advice of the state advisory council and the children's subcommittee in developing these recommendations.

Subd. 6. **Inaccurate or incomplete reports.** The commissioner shall promptly notify a county or provider if a required report is clearly inaccurate or incomplete. The commissioner may delay all or part of a mental health fund payment if an appropriately completed report is not received as required by this section.

Subd. 7. **Statewide evaluation.** The commissioner shall use the county and provider reports required by this section to complete the statewide report required in sections 245.461 and 245.487.

History: *1989 c 89 s 1; 1989 c 282 art 4 s 31*

NOTE: Subdivision 1 was also amended by Laws 1989, chapter 89, section 1. The amendment renumbered it to subdivision 2 to read as follows:

"Subd. 2. **Fiscal reports.** The commissioner shall develop a unified format for quarterly fiscal reports that will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and section 256E.08."

245.483 TERMINATION OR RETURN OF AN ALLOCATION.

Subdivision 1. **Funds not properly used.** If the commissioner determines that a county is not meeting the requirements of sections 245.461 to 245.486 and 245.487 to 245.4887, or that funds are not being used according to the approved local proposal, all or part of the mental health and community social service act funds may be terminated upon 30 days notice to the county board. The commissioner may require repayment of any funds not used according to the approved local proposal. If the commissioner receives a written appeal from the county board within the 30-day period, opportunity for a hearing under the Minnesota administrative procedure act, chapter 14, must be provided before the allocation is terminated or is required to be repaid. The 30-day period begins when the county board receives the commissioner's notice by certified mail.

Subd. 2. **Use of returned funds.** The commissioner may reallocate the funds returned.

Subd. 3. **Delayed payments.** If the commissioner finds that a county board or its contractors are not in compliance with the approved local proposal or sections 245.461 to 245.486 and 245.487 to 245.4887, the commissioner may delay payment of all or part of the quarterly mental health and community social service act funds until the county board and its contractors meet the requirements. The commissioner shall not delay a payment longer than three months without first issuing a notice under subdivision 2 that all or part of the allocation will be terminated or required to be repaid. After this notice is issued, the commissioner may continue to delay the payment until completion of the hearing in subdivision 2.

Subd. 4. **State assumption of responsibility.** If the commissioner determines that services required by sections 245.461 to 245.486 and 245.487 to 245.4887 will not be provided by the county board in the manner or to the extent required by sections 245.461 to 245.486 and 245.487 to 245.4887, the commissioner shall contract directly with providers to ensure that clients receive appropriate services. In this case, the commissioner shall use the county's community social service act and mental health funds to the extent necessary to carry out the county's responsibilities under sections 245.461 to 245.486 and 245.487 to 245.4887. The commissioner shall work with the county board to allow for a return of authority and responsibility to the county board as soon as compliance with sections 245.461 to 245.486 and 245.487 to 245.4887 can be assured.

History: *1989 c 282 art 4 s 32*

245.484 RULES.

The commissioner shall adopt permanent rules as necessary to carry out sections 245.461 to 245.486 and Laws 1989, chapter 282, article 4, sections 1 to 53.

History: *1989 c 282 art 4 s 33*

245.485 NO RIGHT OF ACTION.

Sections 245.461 to 245.484 and 245.487 to 245.4887 do not independently establish a right of action on behalf of recipients of services or service providers against a county board or the commissioner. A claim for monetary damages must be brought under section 3.736 or 3.751.

History: *1989 c 282 art 4 s 34*

245.486 LIMITED APPROPRIATIONS.

Nothing in sections 245.461 to 245.485 and 245.487 to 245.4887 shall be construed to require the commissioner or county boards to fund services beyond the limits of legislative appropriations.

History: *1989 c 282 art 4 s 35*

245.4861 PUBLIC/ACADEMIC LIAISON INITIATIVE.

Subdivision 1. **Establishment of liaison initiative.** The commissioner of human services, in consultation with the appropriate post-secondary institutions, shall establish a public/academic liaison initiative to coordinate and develop brain research and education and training opportunities for mental health professionals in order to improve the quality of staffing and provide state-of-the-art services to residents in regional treatment centers and other state facilities.

Subd. 2. **Consultation.** The commissioner of human services shall consult with the Minnesota department of health, the regional treatment centers, the post-secondary educational system, mental health professionals, and citizen and advisory groups.

Subd. 3. **Liaison initiative programs.** The liaison initiative, within the extent of available funding, shall plan, implement, and administer programs which accomplish the objectives of subdivision 1. These shall include but are not limited to:

(1) encourage and coordinate joint research efforts between academic research institutions throughout the state and regional treatment centers, community mental health centers, and other organizations conducting research on mental illness or working with individuals who are mentally ill;

(2) sponsor and conduct basic research on mental illness and applied research on existing treatment models and community support programs;

(3) seek to obtain grants for research on mental illness from the National Institute of Mental Health and other funding sources;

(4) develop and provide grants for training, internship, scholarship, and fellowship programs for mental health professionals, in an effort to combine academic education with practical experience obtained at regional treatment centers and other state facilities, and to increase the number of mental health professionals working in the state.

Subd. 4. **Private and federal funding.** The liaison initiative shall seek private and federal funds to supplement the appropriation provided by the state. Individuals, businesses, and other organizations may contribute to the liaison initiative. All money received shall be administered by the commissioner of human services to implement and administer the programs listed in subdivision 3.

Subd. 5. **Report.** By February 15 of each year, the commissioner of human services shall submit to the legislature a liaison initiative report. The annual report shall be part of the commissioner's February 15 report to the legislature required by section 245.487, subdivision 4.

History: *1989 c 282 art 4 s 36*

245.487 CITATION; DECLARATION OF POLICY; MISSION.

Subdivision 1. **Citation.** Sections 245.487 to 245.4887 may be cited as the "Minnesota comprehensive children's mental health act."

Subd. 2. [FINDINGS.] The legislature finds there is a need for further development of existing clinical services for emotionally disturbed children and their families and the creation of new services for this population. Although the services specified in sections 245.487 to 245.4887 are mental health services, sections 245.487 to 245.4887 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for continuity of care with other community agencies. At the same time, sections 245.487 to 245.4887 emphasize the importance of developing special mental health expertise in children's mental health services because of the unique needs of this population.

Nothing in this act shall be construed to abridge the authority of the court to make dispositions under chapter 260 but the mental health services due any child with serious and persistent mental illness, as defined in section 245.462, subdivision 20, or with severe emotional disturbance, as defined in section 245.4871, subdivision 6, shall be made a part of any disposition affecting that child.

Subd. 3. **Mission of children's mental health service system.** As part of the comprehensive children's mental health system established under sections 245.487 to 245.4887, 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.

Subd. 4. **Implementation.** (a) The commissioner shall begin implementing sections 245.487 to 245.4887 by February 15, 1990, and shall fully implement sections 245.487 to 245.4887 by January 1, 1992.

(b) Annually until February 15, 1992, the commissioner shall report to the legislature on all steps taken and recommendations for full implementation of sections 245.487 to 245.4887 and on additional resources needed to further implement those sections.

Subd. 5. [CONTINUATION OF EXISTING MENTAL HEALTH SERVICES FOR CHILDREN.] Counties shall make available case management, community support services, and day treatment to children eligible to receive these services under Minnesota Statutes 1988, section 245.471. No later than August 1, 1989, the county board shall notify providers in the local system of care of their obligations to refer children eligible for case management and community support services as of January 1, 1989. The county board shall forward a copy of this notice to the commissioner. The notice shall indicate which children are eligible, a description of the services, and the name of the county employee designated to coordinate case management activities and shall include a copy of the plain language notification described in section 245.4881, subdivision 2, paragraph (b). Providers shall distribute copies of this notification when making a referral for case management.

245.4871 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.487 to 245.4887.

Subd. 2. **Acute care hospital inpatient treatment.** "Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 3. [CASE MANAGEMENT SERVICES.] "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with severe emotional disturbance and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include ~~obtaining a comprehensive diagnostic assessment,~~ assisting in obtaining a comprehensive diagnostic assessment, if needed, developing a functional assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of ~~these~~ services over time.

Subd. 4. Case manager. (a) "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family. A case manager must have experience and training in working with children.

(b) A case manager must:

(1) have at least a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university;

(2) have at least 2,000 hours of supervised experience in the delivery of mental health services to children;

(3) have experience and training in identifying and assessing a wide range of children's needs; and

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families.

(c) The case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) The case manager must meet in person with a mental health professional at least once each month to obtain clinical supervision.

(e) Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of experience is met.

(f) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(g) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(h) Until June 30, 1991, a refugee who does not have the qualifications specified in this subdivision may provide case management services to child refugees with severe emotional disturbance of the same ethnic group as the refugee if the person:

(1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Subd. 5. **Child.** "Child" means a person under 18 years of age.

Subd. 6. **Child with severe emotional disturbance.** For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

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

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

The term "child with severe emotional disturbance" shall be used only for purposes of county eligibility determinations. In all other written and oral communications, case managers, mental health professionals, mental health practitioners, and all other providers of mental health services shall use the term "child eligible for mental health case management" in place of "child with severe emotional disturbance."

Subd. 7. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision does not include authority to make or terminate court-ordered placements of the child. Clinical supervision must be accomplished by full-time or part-time employment of or contracts with mental health professionals. The mental health professional must document the clinical supervision by cosigning individual treatment plans and by making entries in the client's record on supervisory activities.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 9. **County board.** "County board" means the county board of commissioners or board established under the joint powers act, section 471.59, or the human services board act, sections 402.01 to 402.10.

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4881, subdivision 7, and Minnesota Rules, parts 9505.0170 to 9505.0475; or

(4) an entity that operates a program that meets the requirements of section 245.4881, subdivision 7, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services. Day treatment services for a child are an integrated set of education, therapy, and family interventions.

A day treatment service must be available to a child at least five days a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Subd. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written evaluation by a mental health professional of:

(1) a child's current life situation and sources of stress, including reasons for referral;

(2) the history of the child's current mental health problem or problems, including important developmental incidents, strengths, and vulnerabilities;

(3) the child's current functioning and symptoms;

(4) the child's diagnosis including a determination of whether the child meets the criteria of severely emotionally disturbed as specified in subdivision 6; and

(5) the mental health services needed by the child.

Subd. 12. **Early identification and intervention services.** "Early identification and intervention services" means services that are designed to identify children who are at risk of needing or who need mental health services and that arrange for intervention and treatment.

Subd. 13. **Education and prevention services.** (a) "Education and prevention services" means services designed to:

(1) educate the general public and groups identified as at risk of developing emotional disturbance under section 245.4872, subdivision 3;

(2) increase the understanding and acceptance of problems associated with emotional disturbances;

(3) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning; and

(4) refer specific children or their families with mental health needs to mental health services.

(b) The services include distribution to individuals and agencies identified by the county board and the local children's mental health advisory council of information on predictors and symptoms of emotional disturbances, where mental health services are available in the county, and how to access the services.

Subd. 14. **Emergency services.** "Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for each child having a psychiatric crisis, a mental health crisis, or a mental health emergency.

Subd. 15. **Emotional disturbance.** "Emotional disturbance" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III; and

(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.

"Emotional disturbance" is a generic term and is intended to reflect all categories of disorder described in DSM-MD, current edition as "usually first evident in childhood or adolescence."

Subd. 16. **Family.** "Family" means a child and one or more of the following persons whose participation is necessary to accomplish the child's treatment goals: (1) a person related to the child by blood, marriage, or adoption; (2) a person who is the child's foster parent or significant other; (3) a person who is the child's legal representative.

Subd. 17. **Family community support services.** "Family community support services" means services provided under the clinical supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis assistance, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4881, subdivision 10.

Subd. 18. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the child's:

(1) mental health symptoms as presented in the child's diagnostic assessment;

(2) mental health needs as presented in the child's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the child's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Subd. 19. **Individual family community support plan.** "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.

Subd. 20. **Individual placement agreement.** "Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of a child to provide residential treatment services.

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention, treatment, and services for a child with an 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 individuals responsible for providing treatment to the child with an emotional disturbance.

Subd. 22. **Legal representative.** "Legal representative" means a guardian, conservator, or guardian ad litem of a child with an emotional disturbance authorized by the court to make decisions about mental health services for the child.

Subd. 23. **Local mental health proposal.** "Local mental health proposal" means the proposal developed by the county board, reviewed by the commissioner, and described in section 245.4872.

Subd. 24. **Local system of care.** "Local system of care" means services that are locally available to the child and the child's family. The services are mental health, social services, correctional services, education services, health services, and vocational services.

Subd. 25. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under sections 256D.06 and 256D.37 to facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a person providing services to children with emotional disturbances. 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) 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 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) holds 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.

Subd. 27. **Mental health professional.** "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 sections 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 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 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 sections 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.

Subd. 28. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to children with emotional disturbances and are described in sections 245.487 to 245.4887.

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the clinical supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 30. **Parent.** "Parent" means the birth or adoptive mother or father of a child. This definition does not apply to a person whose parental rights have been terminated in relation to the child.

Subd. 31. **Professional home-based family treatment.** "Professional home-based family treatment" means intensive mental health services provided to children (1) who are at risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement because of an emotional disturbance. Services are provided to the child and the child's family primarily in the child's home environment or other location appropriate to the child. Examples of appropriate locations include, but are not limited to, the child's school, day care center, home, and any other living arrangement of the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed to meet the specific mental health needs of the child and the child's family. Services include family and individual therapy and family living skills training and must be coordinated with other service providers.

Subd. 32. **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 inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 9545.0900 to 9545.1090, or other rules adopted by the commissioner.

Subd. 33. **Service provider.** "Service provider" means either a county board or an individual or agency including a regional treatment center under contract with the county board that provides children's mental health services funded under sections 245.487 to 245.4887.

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and clinical

supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning.

History: *1989 c 282 art 4 s 38*

245.4872 PLANNING FOR A CHILDREN'S MENTAL HEALTH SYSTEM.

Subdivision 1. **Planning effort.** Starting on the effective date of sections 245.487 to 245.4887 and ending January 1, 1992, the commissioner and the county agencies shall plan for the development of a unified, accountable, and comprehensive statewide children's mental health system. The system must be planned and developed by stages until it is operating at full capacity.

Subd. 2. **Technical assistance.** The commissioner shall provide ongoing technical assistance to county boards to develop local mental health proposals, as specified in section 245.4887, to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of children with emotional disturbances residing in the county and the extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Subd. 3. **Information to counties.** By January 1, 1990, the commissioner shall 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.

History: *1989 c 282 art 4 s 39*

245.4873 COORDINATION OF CHILDREN'S MENTAL HEALTH SYSTEM.

Subdivision 1. **State and local coordination.** Coordination of the development and delivery of mental health services for children shall occur on the state and local levels to assure the availability of services to meet the mental health needs of children in a cost-effective manner.

Subd. 2. [STATE LEVEL; COORDINATION.] The commissioners or designees of commissioners of the departments of human services, health, education, state planning, and corrections, and a representative of the Minnesota district judges association juvenile committee, in conjunction with the commissioner of commerce or a designee of the commissioner, shall meet at least quarterly ~~through 1992~~ to:

(1) educate each agency about the policies, procedures, funding, and services for children with emotional disturbances of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with emotional disturbances;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent;

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children; and

(6) until February 15, 1992, prepare an annual report on the policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.

This report shall be submitted to the legislature and the state mental health advisory council annually ~~until February 15, 1992,~~ as part of the report required under section 245.487, subdivision 4. The report shall include information from each department represented on:

(1) the number of children in each department's system who require mental health services;

(2) the number of children in each system who receive mental health services;

(3) how mental health services for children are funded within each system;

(4) how mental health services for children could be coordinated to provide more effectively appropriate mental health services for children; and

(5) recommendations for the provision of early screening and identification of mental illness in each system.

Subd. 3. **Local level coordination.** (a) Each agency represented in the local system of care coordinating council, including mental health, social services, education, health, corrections, and vocational services as specified in section 245.4875, subdivision 6, is responsible for local coordination and delivery of mental health services for children. The county board shall establish a coordinating council that provides at least:

(1) written interagency agreements with the providers of the local system of care to coordinate the delivery of services to children; and

(2) an annual report of the council to the local county board and the children's mental health advisory council about the unmet children's needs and service priorities.

(b) Each coordinating council shall collect information about the local system of care and report annually to the commissioner of human services on forms and in the manner provided by the commissioner. The report must include a description of the services provided through each of the service systems represented on the council, the various sources of funding for services and the amounts actually expended, a description of the numbers and characteristics of the children and families served during the previous year, and an estimate of unmet needs. Each service system represented on the council shall provide information to the council as necessary to compile the report.

Subd. 4. **Individual case coordination.** The case manager designated under section 245.4881 is responsible for ongoing coordination with any other person responsible for planning, development, and delivery of social services, education, corrections, health, or vocational services for the individual child. The family community support plan developed by the case manager shall reflect the coordination among the local service system providers.

Subd. 5. **Duties of the commissioner.** The commissioner shall supervise the development and coordination of locally available children's mental health services by the county boards in a manner consistent with sections 245.487 to 245.4887. The commissioner shall review local mental health service proposals developed by county boards as specified in section 245.4872 and provide technical assistance to county boards in developing and maintaining locally available and coordinated children's mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's children's mental health proposals and other information as required by sections 245.487 to 245.4887.

Subd. 6. **Priorities.** By January 1, 1992, the commissioner shall require that each of the treatment services and management activities described in sections 245.487 to 245.4887 be developed for children with emotional disturbances within available resources based on the following ranked priorities:

(1) the provision of locally available mental health emergency services;

(2) the provision of locally available mental health services to all children with severe emotional disturbance;

(3) the provision of early identification and intervention services to children who are at risk of needing or who need mental health services;

(4) the provision of specialized mental health services regionally available to meet the special needs of all children with severe emotional disturbance, and all children with emotional disturbances;

(5) the provision of locally available services to children with emotional disturbances; and

(6) the provision of education and preventive mental health services.

History: *1989 c 282 art 4 s 40*

245.4874 [DUTIES OF COUNTY BOARD.]

The county board in each county shall use its share of mental health and community social service act funds allocated by the commissioner according to a biennial local children's mental health service proposal required under section 245.4887, and approved by the commissioner. The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

(2) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

(3) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost effectiveness of their delivery;

~~(3)~~ (4) assure that mental health services delivered according to sections 245.487 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

~~(4)~~ (5) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

~~(5)~~ (6) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

~~(6)~~ (7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

~~(7)~~ (8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4887;

~~(8)~~ (9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871; and

~~(9)~~ (10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age.

245.4875 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision 1. **Development of children's services.** The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable children's mental health services. The county board may provide some or all of the children's mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward fully implementing sections 245.487 to 245.4887 during the period July 1, 1989, to January 1, 1992. County boards must develop fully each of the treatment services prescribed by sections 245.487 to 245.4887 by January 1, 1992, according to the priorities established in section 245.4873 and the local children's mental health services proposal approved by the commissioner under section 245.4887.

Subd. 2. **Children's mental health services.** The children's mental health service system developed by each county board must include the following services:

(1) education and prevention services according to section 245.4877;

(2) early identification and intervention services according to section 245.4878;

(3) emergency services according to section 245.4879;

(4) outpatient services according to section 245.488;

(5) family community support services according to section 245.4881;

(6) day treatment services according to section 245.4881, subdivision 7;

(7) residential treatment services according to section 245.4882;

(8) acute care hospital inpatient treatment services according to section 245.4883;

(9) screening according to section 245.4885;

(10) case management according to section 245.4881;

(11) therapeutic support of foster care according to section 245.4881, subdivision 9; and

(12) professional home-based family treatment according to section 245.4881, subdivision 9.

Subd. 3. **Local contracts.** The county board shall review all proposed county agreements, grants, or other contracts related to children's mental health services from any local, state, or federal governmental sources. Contracts with service providers must:

(1) name the commissioner as a third party beneficiary;

(2) identify monitoring and evaluation procedures not in violation of the Minnesota government data practices act, chapter 13, which are necessary to ensure effective delivery of quality services;

(3) include a provision that makes payments conditional on compliance by the contractor and all subcontractors with sections 245.487 to 245.4887 and all other applicable laws, rules, and standards; and

(4) require financial controls and auditing procedures.

Subd. 4. **Joint county mental health agreements.** To efficiently provide the children's mental health services required by sections 245.487 to 245.4887, counties are encouraged to join with one or more county boards to establish a multicounty local children's mental health authority under the joint powers act, section 471.59, the human services board act, sections 402.01 to 402.10, community mental health center provisions, section 245.62, or enter into multicounty mental health agreements. Participating county boards shall establish acceptable ways of apportioning the cost of the services.

Subd. 5. [LOCAL CHILDREN'S ADVISORY COUNCIL.] (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with severe emotional disturbance; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with emotional disturbance in the local area and services needed by families of these children, and shall meet ~~at least quarterly~~ monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services; and

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2).

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Subd. 6. **Local system of care; coordinating council.** The county board shall establish, by January 1, 1990, a council representing all members of the local system of care including mental health services, social services, correctional services, education services, health services, and vocational services. The council shall include a representative of 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 coordinating council shall meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. A county may use an existing child-focused interagency task force to fulfill the requirements of this subdivision if the representatives and duties of the existing task force are expanded to include those specified in this subdivision and section 245.4873, subdivision 3.

Subd. 7. **Other local authority.** The county board may establish procedures and policies that are not contrary to those of the commissioner or sections 245.487 to 245.4887 regarding local children's mental health services and facilities. The county board shall perform other acts necessary to carry out sections 245.487 to 245.4887.

History: *1989 c 282 art 4 s 42*

245.4876 QUALITY OF SERVICES.

Subdivision 1. **Criteria.** Children's mental health services required by sections 245.487 to 245.4887 must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;

(3) delivered in a manner that improves family functioning when clinically appropriate;

(4) provided in the most appropriate, least restrictive setting available to the county board to meet the child's treatment needs;

(5) accessible to all age groups of children;

(6) appropriate to the developmental age of the child being served;

(7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;

(8) provided by qualified individuals as required in sections 245.487 to 245.4887;

(9) coordinated with children's mental health services offered by other providers;

(10) provided under conditions that protect the rights and dignity of the individuals being served; and

(11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Subd. 2. [DIAGNOSTIC ASSESSMENT.] All residential treatment facilities and acute care hospital inpatient treatment ~~services~~ facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of outpatient and day treatment services for children must complete a diagnostic assessment within ~~ten working days of admission~~ five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within ~~90~~ 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance or general assistance medical care reimbursement under chapters 256B and 256D.

Subd. 3. [INDIVIDUAL TREATMENT PLANS.] All providers of outpatient services, day treatment services, ~~family community support services,~~ professional home-based family treatment, residential treatment ~~facilities~~, and acute care hospital inpatient treatment ~~facilities~~, and all regional treatment centers that provide mental health ~~facilities~~ services for children must develop an individual treatment plan for each child client. The individual treatment plan

must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan ~~must be developed~~ within ten working days of client intake or admission and ~~reviewed~~ must review the individual treatment plan every 90 days after ~~that date~~ intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in section 257.071, subdivisions 2 and 4. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.

Subd. 4. [REFERRAL FOR CASE MANAGEMENT.] Each provider of emergency services, outpatient treatment, community support services, family community support services, day treatment services, screening under section 245.4885, professional home-based family treatment services, residential treatment facilities, acute care hospital inpatient treatment facilities, or regional treatment center services must inform each child with severe emotional disturbance, and the child's parent or legal representative, of the availability and potential benefits to the child of case management. The information shall be provided as specified in subdivision 5. If consent is obtained according to subdivision 5, the provider must refer the child by notifying the county employee designated by the county board to coordinate case management activities of the child's name and address and by informing the child's family of whom to contact to request case management. The provider must document compliance with this subdivision in the child's record. The parent or child may directly request case management even if there has been no referral.

Subd. 5. **Consent for services or for release of information.** (a) Although sections 245.487 to 245.4887 require each county board, within the limits of available resources, to make the mental health services listed in those sections available to each child residing in the county who needs them, the county board shall not provide any services, either directly or by contract, unless consent to the services is obtained under this subdivision. The case manager assigned to a child with a severe emotional disturbance shall not disclose to any person other than the case manager's immediate supervisor and the mental health professional providing clinical supervision of the case manager information on the child, the child's family, or services provided to the child or the child's family without informed written consent unless required to do so by statute or under the Minnesota government data practices act. Informed written consent must comply with section 13.05, subdivision 4, paragraph (d), and specify the purpose and use for which the case manager may disclose the information.

(b) The consent or authorization must be obtained from the child's parent unless: (1) the parental rights are terminated; or (2) consent is otherwise provided under sections 144.341 to 144.347; 253B.04, subdivision 1; 260.133; 260.135; and 260.191, subdivision 1, the terms of appointment of a court-appointed guardian or conservator, or federal regulations governing chemical dependency services.

Subd. 6. **Information for billing.** Each provider of outpatient treatment, family community support services, day treatment services, emergency services, professional home-based family treatment services, residential treatment, or acute care hospital

inpatient treatment must include the name and home address of each child for whom services are included on a bill submitted to a county, if the release of that information under subdivision 5 has been obtained and if the county requests the information. Each provider must try to obtain the consent of the child's family. Each provider must explain to the child's family that the information can only be released with the consent of the child's family and may be used only for purposes of payment and maintaining provider accountability. The provider shall document the attempt in the child's record.

Subd. 7. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of children receiving mental health services and their families are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; and

(2) staff who provide treatment services or case management and their clinical supervisors.

Release of mental health data on individuals submitted under subdivisions 5 and 6, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 5 and 6, results in civil or criminal liability under section 13.08 or 13.09.

History: *1989 c 282 art 4 s 43*

245.4877 EDUCATION AND PREVENTION SERVICES.

Education and prevention services must be available to all children residing in the county. Education and prevention services must be designed to:

(1) convey information regarding emotional disturbances, mental health needs, and treatment resources to the general public and groups identified as at high risk of developing emotional disturbance under section 245.4872, subdivision 3;

(2) at least annually, distribute to individuals and agencies identified by the county board and the local children's mental health advisory council information on predictors and symptoms of emotional disturbances, where mental health services are available in the county, and how to access the services;

(3) increase understanding and acceptance of problems associated with emotional disturbances;

(4) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning;

(5) prevent development or deepening of emotional disturbances; and

(6) refer each child with emotional disturbance or the child's family with additional mental health needs to appropriate mental health services.

History: *1989 c 282 art 4 s 44*

245.4878 EARLY IDENTIFICATION AND INTERVENTION.

By January 1, 1991, early identification and intervention services must be available to meet the needs of all children and their families residing in the county, consistent with section 245.4873. Early identification and intervention services must be designed to identify children who are at risk of needing or who need mental health services. The county board must provide intervention and offer treatment services to each child who is identified as needing mental health services. The county board must offer intervention services to each child who is identified as being at risk of needing mental health services.

History: *1989 c 282 art 4 s 45*

M.S. 245.4879

Subdivision 1. [AVAILABILITY OF EMERGENCY SERVICES.] County boards must provide or contract for enough mental health emergency services within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;

(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;

(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs.

Subd. 2. [SPECIFIC REQUIREMENTS.] The county board shall require that all service providers of emergency services to the child with an emotional disturbance 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. The commissioner may waive the requirement that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

When emergency service during nonbusiness 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.

M.S. 245.488 OUTPATIENT SERVICES

Subdivision 1. [AVAILABILITY OF OUTPATIENT SERVICES.] (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; or by contract with a licensed mental health professional as defined in section 245.4871, subdivision 27, clauses (1) to (4). A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Subd. 2. **Specific requirements.** The county board shall require that a service provider of outpatient services to children:

(1) meets the professional qualifications contained in sections 245.487 to 245.4887;

(2) uses a multidisciplinary mental health professional staff including, at a minimum, arrangements for psychiatric consultation, licensed consulting psychologist consultation, and other necessary multidisciplinary mental health professionals;

(3) develops individual treatment plans; and

(4) provides initial appointments within three weeks, except in emergencies where there must be immediate access as described in section 245.4879.

History: *1989 c 282 art 4 s 47*

245.4881 CASE MANAGEMENT

Subdivision 1. [AVAILABILITY OF CASE MANAGEMENT SERVICES.] (a) By July 1, 1991, the county board shall provide case management ~~activities~~ services for each child with severe emotional disturbance ~~residing in~~ who is a resident of the county and the child's family who request or consent to the services. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Case management services provided to children with severe emotional disturbance eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

Sec. 20. Minnesota Statutes 1989 Supplement, section 245.4881, subdivision 2, is amended to read:

Subd. 2. [NOTIFICATION AND DETERMINATION OF CASE MANAGEMENT ELIGIBILITY.] (a) The county board shall notify, as appropriate, the child, child's parent, or child's legal representative of the child's potential eligibility for case management services within five working days after receiving a request from an individual or a referral from a provider under section 245.4876, subdivision 4.

(b) The county board shall send a notification written in plain language of potential eligibility for case management and family community support services. The notification shall identify the designated case management providers and shall contain:

(1) a brief description of case management and family community support services;

(2) the potential benefits of these services;

(3) the identity and current phone number of the county employee designated to coordinate case management activities;

(4) an explanation of how to obtain county assistance in obtaining a diagnostic assessment, if needed; and

(5) an explanation of the appeal process.

~~The county board shall send a written notice that identifies the designated case management providers.~~ The county board shall send the notice, as appropriate, to the child, the child's parent, or the child's legal representative, if any.

(c) The county board must promptly determine whether a child who requests or is referred for case management services meets the criteria of sections 245.471 or 245.4871, subdivision 6. If a diagnostic assessment is needed to make the determination, the county board must offer to assist the child and the child's family in obtaining one. The county board shall notify, in writing, the child and the child's representative, if any, of the eligibility determination. If the child is determined to be eligible for case management services, and if the child and the child's family consent to the services, the county board shall refer the child to the case management provider for case management services. If the child is determined not to be eligible or refuses case management services, the county board shall notify the child of the appeal process and shall offer to refer the child to a mental health provider or other appropriate service provider and to assist the child in making an appointment with the provider of the child's choice.

Subd. 3. [DUTIES OF CASE MANAGER.] (a) ~~The case manager shall promptly arrange for a diagnostic assessment of the child when one is not available as described in section 245.4876, subdivision 2, to determine the child's eligibility as a child with severe emotional disturbance for family community support services. The county board shall notify in writing, as appropriate, the child, the child's parent, or the child's legal representative, if any. if the child is determined ineligible for family community support services.~~

~~(b)~~ Upon a determination of eligibility for ~~family support~~ case management services, the case manager shall complete a written functional assessment according to section 245.4871, subdivision 18. The case manager shall develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall ~~perform a functional assessment and~~ note in the ~~client's~~ child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and ~~family's unmet needs~~ child's family. The information required under section 245.4886 shall be provided in writing to the child and the child's family. The case manager shall note this provision in the ~~client~~ child's record.

Subd. 4. [INDIVIDUAL FAMILY COMMUNITY SUPPORT PLAN.] (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan every 90 calendar days after it is developed. To the extent appropriate, the child with severe emotional disturbance, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of ~~a~~ an individual family community support plan, the case manager shall assist the child and child's family in accessing the needed services listed in subdivision 6.

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

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(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 family community support plan.

Subd. 5. Coordination between case manager and family community support services. The county board must establish procedures that ensure ongoing contact and coordination between the case manager and the family community support services as well as other mental health services for each child.

245.4882 RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. [AVAILABILITY OF RESIDENTIAL TREATMENT SERVICES.] County boards must provide or contract for enough residential treatment services to meet the needs of each child with severe emotional disturbance residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be subject to the six-month review process established in section 257.071, subdivisions 2 and 4. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs;

(2) help the child improve family living and social interaction skills;

(3) help the child gain the necessary skills to return to the community;

(4) stabilize crisis admissions; and

(5) work with families throughout the placement to improve the ability of the families to care for children with severe emotional disturbance in the home.

Subd. 2. Specific requirements. A provider of residential services to children must be licensed under applicable rules adopted by the commissioner and must be clinically supervised by a mental health professional.

Subd. 3. Transition to community. Residential treatment facilities and regional treatment centers serving children must plan for and assist those children and their families in making a transition to less restrictive community-based services. Residential treatment facilities must also arrange for appropriate follow-up care in the community. Before a child is discharged, the residential treatment facility or regional treatment center shall provide notification to the child's case manager, if any, so that the case manager can monitor and coordinate the transition and make timely arrangements for the child's appropriate follow-up care in the community.

History: *1989 c 282 art 4 s 49*

245.4883 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. [AVAILABILITY OF ACUTE CARE HOSPITAL INPATIENT SERVICES.] County boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for children with severe emotional disturbances residing in the county

needing this level of care. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible;

(3) facilitate appropriate referrals for follow-up mental health care in the community;

(4) work with families to improve the ability of the families to care for those children with severe emotional disturbances at home; and

(5) assist families and children in the transition from inpatient services to community-based services or home setting, and provide notification to the child's case manager, if any, so that the case manager can monitor the transition and make timely arrangements for the child's appropriate follow-up care in the community.

[245.4884] [FAMILY COMMUNITY SUPPORT SERVICES.]

Subdivision 1. [AVAILABILITY OF FAMILY COMMUNITY SUPPORT SERVICES.] By July 1, 1991, county boards must provide or contract for sufficient family community support services within the county to meet the needs of each child with severe emotional disturbance who resides in the county and the child's family. Children or their parents may be required to pay a fee in accordance with section 245.481.

Family community support services must be designed to improve the ability of children with severe emotional disturbance to:

(1) handle basic activities of daily living;

(2) improve functioning in school settings;

(3) participate in leisure time or community youth activities;

(4) set goals and plans;

(5) reside with the family in the community;

(6) participate in after-school and summer activities;

(7) make a smooth transition among mental health services provided to children; and

(8) make a smooth transition into the adult mental health system as appropriate.

In addition, family community support services must be designed to improve overall family functioning if clinically appropriate to the child's needs, and to reduce the need for and use of placements more intensive, costly, or restrictive both in the number of admissions and lengths of stay than indicated by the child's diagnostic assessment.

Subd. 2. [DAY TREATMENT SERVICES PROVIDED.] (a) Day treatment services must be part of the family community support services available to each child with severe emotional disturbance residing in the county. A child or the child's parent may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placements that are more intensive, costly, or restrictive than necessary to meet the child's need;

(4) coordinate with or be offered in conjunction with the child's education program;

(5) provide therapy and family intervention for children that are coordinated with education services provided and funded by schools; and

(6) operate during all 12 months of the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) alternative services exist through the county's family community support services for each child who would otherwise need day treatment services; and

(2) county demographics and geography make the provision of day treatment services cost ineffective and unfeasible.

Subd. 3. [PROFESSIONAL HOME-BASED FAMILY TREATMENT PROVIDED.] (a) By January 1, 1991, county boards must provide or contract for sufficient professional home-based family treatment within the county to meet the needs of each child with severe emotional disturbance who is at risk of out-of-home placement due to the child's emotional disturbance or who is returning to the home from out-of-home placement. The child or the child's parent may be required to pay a fee according to section 245.481.

The county board shall require that all service providers of professional home-based family treatment set fee schedules approved by the county board that are based on the child's or family's ability to pay. The professional home-based family treatment must be designed to assist each child with severe emotional disturbance who is at risk of or who is returning from out-of-home placement and the child's family to:

(1) improve overall family functioning in all areas of life;

(2) treat the child's symptoms of emotional disturbance that contribute to a risk of out-of-home placement;

(3) provide a positive change in the emotional, behavioral, and mental well-being of children and their families; and

(4) reduce risk of out-of-home placement for the identified child with severe emotional disturbance and other siblings or successfully reunify and reintegrate into the family a child returning from out-of-home placement due to emotional disturbance.

(b) Professional home-based family treatment must be provided by a team consisting of a mental health professional and others who are skilled in the delivery of mental health services to children and families in conjunction with other human service providers. The professional home-based family treatment team must maintain flexible hours of service availability and must provide or arrange for crisis services for each family, 24 hours a day, seven days a week. Case loads for each professional home-based family treatment team must be small enough to permit the delivery of intensive services and to meet the needs of the family. Professional home-based family treatment providers shall coordinate services and service needs with case managers assigned to children and their families. The treatment team must develop an individual treatment plan that identifies the specific treatment objectives for both the child and the family.

Subd. 4. [THERAPEUTIC SUPPORT OF FOSTER CARE.] By January 1, 1992, county boards must provide or contract for foster care with therapeutic support as defined in section 245.4871, subdivision 34. Foster families caring for children with severe emotional disturbance must receive training and supportive services, as necessary, at no cost to the foster families within the limits of available resources.

Subd. 5. [BENEFITS ASSISTANCE.] The county board must offer help to a child with severe emotional disturbance and the child's family in applying for federal benefits, including supplemental security income, medical assistance, and Medicare.

245.4885 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subdivision 1. [SCREENING REQUIRED.] The county board shall ~~ensure that~~, upon admission, screen all children ~~are screened upon admission~~ admitted for treatment of severe emotional disturbance to a residential treatment facility, an acute care hospital, or informally admitted to a regional treatment center if public funds are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment of emotional disturbance or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within five working days of admission. Screening shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) ~~the~~ provides a length of stay ~~is~~ as short as possible consistent with the individual child's need; ~~and~~.

~~(5) the case manager. if assigned. is developing an~~ During the screening process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and that an individual family community support plan is being developed by the case manager, if assigned.

Screening shall be in compliance with section 256F.07 or 257.071, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.

The screening process and placement decision must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to ~~(3)~~ (5).

Subd. 2. [QUALIFICATIONS.] No later than ~~January~~ July 1, ~~1992~~ 1991, screening of children for residential and inpatient services must be conducted by a mental health professional. Mental health professionals providing screening for inpatient and residential services must not be financially affiliated with any acute care inpatient hospital, residential treatment facility, or regional treatment center. The commissioner may waive this requirement for mental health professional participation ~~in sparsely populated areas~~ after July 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service; and

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional.

Subd. 3. Individual placement agreement. The county board shall enter into an individual placement agreement with a provider of residential treatment services to a child eligible for county-paid services under this section. The agreement must specify the payment rate and terms and conditions of county payment for the placement.

Subd. 4. Task force on residential and inpatient treatment services for children. The commissioner of human services shall appoint a task force on residential and inpatient treatment services for children that includes representatives from each of the mental health professional categories defined in section 245.4871, subdivision 27, the Minnesota mental health association, the Minnesota alliance for the mentally ill, the children's mental health initiative, the Minnesota mental health law project, the Minnesota district judges association juvenile committee, department of human services staff, the department of education, local community-based corrections, the department of corrections, the ombudsman for mental health and mental retardation, residential treatment facilities for children, inpatient hospital facilities for children, and counties. The task force shall examine and evaluate existing and available mechanisms that have as their purpose determination of and review of appropriate admission and need for continued care for all children with emotional disturbances who are admitted to residential treatment facilities or acute care hospital inpatient treatment. These mechanisms shall include at least the following: precommitment screening, preplacement screening for children, licensure and reimbursement rules, county monitoring, technical assistance, hospital preadmission certification, and hospital retrospective

reviews. The task force shall report to the legislature by February 15, 1990, on how existing mechanisms may be changed to accomplish the goals of screening as described in section 245.4885, subdivision 1.

History: *1989 c 282 art 4 s 51*

245.4886 APPEALS.

A child or a child's family, as appropriate, who requests mental health services under sections 245.487 to 245.4887 must be advised of services available and the right to appeal as described in this section at the time of the request and each time the individual family community support plan or individual treatment plan is reviewed. A child whose request for mental health services under sections 245.487 to 245.4887 is denied, not acted upon with reasonable promptness, or whose services are suspended, reduced, or terminated by action or inaction for which the county board is responsible under sections 245.487 to 245.4887 may contest that action or inaction before the state agency according to section 256.045. The commissioner shall monitor the nature and frequency of administrative appeals under this section.

History: *1989 c 282 art 4 s 52*

245.4887 CHILDREN'S SECTION OF LOCAL MENTAL HEALTH PROPOSAL.

Subdivision 1. **Time period.** The county board shall submit its first complete children's section of its local mental health proposal to the commissioner by November 15, 1989. Subsequent proposals must be on the same two-year cycle as community social service plans. If a proposal complies with sections 245.487 to 245.4887, it satisfies the requirement of the community social service plan for the emotionally disturbed target population as required by section 256E.09. The proposal must be made available upon request to all residents of the county at the same time it is submitted to the commissioner.

Subd. 2. **Proposal content.** The children's section of the local mental health proposal must include:

(1) a report of the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council on unmet needs of children and any other needs assessment used by the county board in preparing the local mental health proposal, including the report of the local coordinating council or local interagency task force specified in section 245.4875, subdivision 6;

(2) a description of the involvement of the local children's mental health advisory council or the children's mental health subcommittee of the existing local mental health advisory council in preparing the local mental health proposal and methods used by the county board to ensure adequate and timely participation of citizens, mental health professionals, and providers in development of the local mental health proposal;

(3) information for the preceding year, including the actual number of children who received each of the mental health services listed in sections 245.487 to 245.4887, and actual expenditures for each mental health service and service waiting lists; and

(4) the following information describing how the county board intends to meet the requirements of sections 245.487 to 245.4887 during the proposal period:

(i) specific objectives and outcome goals for each mental health service listed in sections 245.487 to 245.4887;

(ii) a description of each service provider, including county agencies, contractors, and subcontractors, that is expected to either be the sole provider of one of the mental health services described in sections 245.487 to 245.4887 or to provide over $10,000 of mental health services per year, including a listing of the professional qualifications of the staff involved in service delivery for the county;

(iii) a description of how the mental health services in the county will be unified and coordinated, including the mechanism established by the county board providing for interagency coordination as specified in section 245.4875, subdivision 6;

(iv) the estimated number of children who will receive each mental health service; and

(v) estimated expenditures for each mental health service and revenues for the entire proposal.

Subd. 3. **Proposal format.** The children's section of the local mental health proposal must be made in a format prescribed by the commissioner.

Subd. 4. **Provider approval.** The commissioner's review of the children's section of the local mental health proposal must include a review of the qualifications of each service provider required to be identified in the children's section of the local mental health proposal under subdivision 2. The commissioner may reject a county board's proposal for a particular provider if:

(1) the provider does not meet the professional qualifications contained in sections 245.487 to 245.4887;

(2) the provider does not have adequate fiscal stability or controls to provide the proposed services as determined by the commissioner; or

(3) the provider is not in compliance with other applicable state laws or rules.

Subd. 5. **Service approval.** The commissioner's review of the children's section of the local mental health proposal must include a review of the appropriateness of the amounts and types of children's mental health services in the children's section of the local mental health proposal. The commissioner may reject the county board's proposal if the commissioner determines that the amount and types of services proposed are not cost-effective, do not meet the child's needs, or do not comply with sections 245.487 to 245.4887.

Subd. 6. **Proposal approval.** The commissioner shall review each children's section of the local mental health proposal within 90 days and work with the county board to make any necessary modifications to comply with sections 245.487 to 245.4887. After the commissioner has approved the proposal, the county board is eligible to receive an allocation of mental health and community social service act funds.

Subd. 7. **Partial or conditional approval.** If the children's section of the local mental health proposal is in substantial compliance, but not in full compliance with sections 245.487 to 245.4887, and necessary modifications cannot be made before the proposal period begins, the commissioner may grant partial or conditional approval and withhold a proportional share of the county board's mental health and community social service act funds until full compliance is achieved.

Subd. 8. **Award notice.** Upon approval of the county board proposal, the commissioner shall send a notice of approval for funding. The notice must specify any conditions of funding and is binding on the county board. Failure of the county board to comply with the approved proposal and funding conditions may result in withholding or repayment of funds according to section 245.483.

Subd. 9. **Plan amendment.** If the county board finds it necessary to make significant changes in the approved children's section of the local mental health proposal, it must present the proposed changes to the commissioner for approval at least 30 days before the changes take effect. "Significant changes" means:

(1) the county board proposes to provide a children's mental health service through a provider other than the provider listed for that service in the approved local proposal;

(2) the county board expects the total annual expenditures for any single children's mental health service to vary more than ten percent or $5,000, whichever is greater, from the amount in the approved local proposal;

(3) the county board expects a combination of changes in expenditures per children's mental health service to exceed more than ten percent of the total children's mental health services expenditures; or

(4) the county board proposes a major change in the specific objectives and outcome goals listed in the approved local children's mental health proposal.

History: *1989 c 282 art 4 s 53*

Mental Health Related Amendments in Laws of 1990, Chapter 568

	1990	1991
	$	$
Art. 1, Sec. 1, Subd. 5		
Subd. 5. Mental Health	-0-	(813,000)

Notwithstanding Laws 1989, chapter 282, article 1, section 2, subdivision 5, $102,000 is transferred in fiscal year 1991 from state mental health grants to state mental health administration, and 2.25 positions are authorized to implement federal requirements relating to nursing homes and people with mental illness.

The $10,000 appropriated for camping activities for persons with mental illness by Laws 1989, chapter 282, article 1, section 2, subdivision 5, shall be used for adults with mental illness from across the state, for a camping program which utilizes the BWCA and is cooperatively sponsored by client advocacy, mental health treatment, and outdoor recreation agencies.

$500,000 may be transferred from the appropriation in Laws 1989, chapter 282, article 1, section 2, subdivision 5, in fiscal year 1990 for state mental health grants to fiscal year 1991 for state mental health special projects. These funds are to be used for alternative placements for people being discharged from the Metro Regional Treatment Center.

Notwithstanding the rider relating to the family-based community support pilot project in Laws 1989, chapter 282, article 1, section 2, subdivision 5, the base funding level for the project for the 1992-1993 biennial budget must be a straight line annualization of the fiscal year 1991 appropriation.

245.73 GRANTS FOR RESIDENTIAL SERVICES FOR ADULT MENTALLY ILL PERSONS.

Subdivision 1. **Commissioner's duty.** The commissioner shall establish a statewide program to assist counties in ensuring provision of services to adult mentally ill persons. The commissioner shall make grants to county boards to provide community-based services to mentally ill persons through programs licensed under sections 245A.01 to 245A.16.

Subd. 2. [APPLICATION; CRITERIA.] County boards may submit an application and budget for use of the money in the form specified by the commissioner. The commissioner shall make grants only to counties whose applications and budgets are approved by the commissioner for residential programs for ~~adult mentally ill persons~~ adults with mental illness to meet licensing requirements pursuant to sections 245A.01 to 245A.16. ~~Funds shall not be used to supplant or reduce local, state, or federal expenditure levels supporting existing resources unless the reduction in available money is the result of a state or federal decision not to refund an existing program.~~ State funds received by a county pursuant to this section shall be used only for direct service costs. Both direct service and other costs, including but not limited to renovation, construction or rent of buildings, purchase or lease of vehicles or equipment as required for licensure as a residential program for ~~adult mentally ill persons~~ adults with mental illness under sections 245A.01 to 245A.16, may be paid out of the matching funds required under subdivision 3. Neither the state funds nor the matching funds shall be used for room and board costs.

Subd. 2. **Application; criteria.** County boards may submit an application and budget for use of the money in the form specified by the commissioner. The commissioner shall make grants only to counties whose applications and budgets are approved by the commissioner for residential programs for adult mentally ill persons to meet licensing requirements pursuant to sections 245A.01 to 245A.16. Funds shall not be used to supplant or reduce local, state, or federal expenditure levels supporting existing resources unless the reduction in available money is the result of a state or federal decision not to refund an existing program. State funds received by a county pursuant to this section shall be used only for direct service costs. Both direct service and other costs, including but not limited to renovation, construction or rent of buildings, purchase or lease of vehicles or equipment as required for licensure as a residential program for adult mentally ill persons under sections 245A.01 to 245A.16, may be paid out of the matching funds required under subdivision 3. Neither the state funds nor the matching funds shall be used for room and board costs.

Subd. 2a. **Special programs.** Grants received pursuant to this section may be used to fund innovative programs in residential facilities, related to structured physical fitness programs designed as part of a mental health treatment plan.

Subd. 3. **Formula.** Grants made pursuant to this section shall finance 75 percent of the county's costs of expanding or providing services for adult mentally ill persons in residential facilities as provided in subdivision 2.

Subd. 4. **Rules; reports.** The commissioner shall promulgate an emergency and permanent rule to govern grant applications, approval of applications, allocation of grants, and maintenance of service and financial records by grant recipients. The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (17). The commissioner shall require collection of data for compliance, monitoring and evaluation purposes and shall require periodic reports to demonstrate the effectiveness of the services in helping adult mentally ill persons remain and function in their own communities. As a part of the report required by section 245.461, the commissioner shall report to the legislature as to the effectiveness of this program and recommendations regarding continued funding.

History: *1989 c 89 s 3; 1989 c 282 art 2 s 55,56; art 4 s 60*

253B.03 RIGHTS OF PATIENTS.

Subdivision 1. **Restraints.** A patient has the right to be free from restraints. Restraints shall not be applied to a patient unless the head of the treatment facility or a member of the medical staff determines that they are necessary for the safety of the patient or others. Restraints shall not be applied to patients with mental retardation except as permitted under section 245.825 and rules of the commissioner of human services. Consent must be obtained from the person or person's guardian except for emergency procedures as permitted under rules of the commissioner adopted under section 245.825. Each use of a restraint and reason for it shall be made part of the clinical record of the patient under the signature of the head of the treatment facility.

Subd. 2. **Correspondence.** A patient has the right to correspond freely without censorship. The head of the treatment facility may restrict correspondence on determining that the medical welfare of the patient requires it. For patients in regional facilities, that determination may be reviewed by the commissioner. Any limitation imposed on the exercise of a patient's correspondence rights and the reason for it shall be made a part of the clinical record of the patient. Any communication which is not delivered to a patient shall be immediately returned to the sender.

Subd. 3. **Visitors and phone calls.** Subject to the general rules of the treatment facility, a patient has the right to receive visitors and make phone calls. The head of the treatment facility may restrict visits and phone calls on determining that the medical welfare of the patient requires it. Any limitation imposed on the exercise of the patient's visitation and phone call rights and the reason for it shall be made a part of the clinical record of the patient.

Subd. 4. **Special visitation; religion.** A patient has the right to meet with or call a personal physician, spiritual advisor, and counsel at all reasonable times. The patient has the right to continue the practice of religion.

Subd. 5. **Periodic assessment.** A patient has the right to periodic medical assessment. The head of a treatment facility shall have the physical and mental condition of every patient assessed as frequently as necessary, but not less often than annually. If a person is committed as mentally retarded for an indeterminate period of time, the three-year judicial review must include the annual reviews for each year as outlined in Minnesota Rules, part 9525.0075, subpart 6.

Subd. 6. **Consent for medical procedure.** A patient has the right to prior consent to any medical or surgical treatment, other than the treatment of mental illness or chemical dependency. A patient with mental retardation or the patient's guardian or conservator has the right to give or withhold consent before:

Subd. 6a. [ADMINISTRATION OF NEUROLEPTIC MEDICATIONS.] (a) Neuroleptic medications may be administered to persons committed as mentally ill or mentally ill and dangerous only as described in this subdivision.

(b) A neuroleptic medication may be administered to a patient who is competent to consent to neuroleptic medications ~~only~~ if the patient has given written, informed consent to administration of the neuroleptic medication.

(c) A neuroleptic medication may be administered to a patient who is not competent to consent to neuroleptic medications ~~only~~ if a court approves the administration of the neuroleptic medication ~~or~~:.

(d) A neuroleptic medication may be administered without court review to a patient who is not competent to consent to neuroleptic medications if:

(1) the patient does not object to or refuse the medication;

(2) a guardian ad litem appointed by the court with authority to consent to neuroleptic medications gives written, informed consent to the administration of the neuroleptic medication; and

(3) a multidisciplinary treatment review panel composed of persons who are not engaged in providing direct care to the patient gives written approval to administration of the neuroleptic medication.

(e) A neuroleptic medication may be administered without judicial review and without consent in an emergency situation for so long as the emergency continues to exist if the treating physician determines that the medication is necessary to prevent serious, immediate physical harm to the patient or to others. The treatment facility shall document the emergency in the patient's medical record in specific behavioral terms.

~~(d)~~ (f) A person who consents to treatment pursuant to this subdivision is not civilly or criminally liable for the performance of or the manner of performing the treatment. A person is not liable for performing treatment without consent if written, informed consent was given pursuant to this subdivision. This provision does not affect any other liability that may result from the manner in which the treatment is performed.

~~(e)~~ (g) The court may allow and order paid to a guardian ad litem a reasonable fee for services provided under paragraph (c), or the court may appoint a volunteer guardian ad litem.

(h) A medical director or patient may petition the committing court, or the court to which venue has been transferred, for a hearing concerning the administration of neuroleptic medication. A hearing may also be held pursuant to section 253B.08, 253B.09, 253B.12, or 253B.18. The hearing concerning the administration of neuroleptic medication must be held within 14 days from the date of the filing of the petition. The court may extend the time for hearing up to an additional 15 days for good cause shown.

Subd. 7. **Program plan.** A person receiving services under this chapter has the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further custody, institutionalization, or other services unnecessary. The treatment facility shall devise a written program plan for each person which describes in behavioral terms the case problems, the precise goals, including the expected period of time for treatment, and the specific measures to be employed. Each plan shall be reviewed at least quarterly to determine progress toward the goals, and to modify the program plan as necessary. The program plan shall be devised and reviewed with the designated agency and with the patient. The clinical record shall reflect the program plan review. If the designated agency or the patient does not participate in the planning and review, the clinical record shall include reasons for nonparticipation and the plans for future involvement. The commissioner shall monitor the program plan and review process for regional centers to insure compliance with the provisions of this subdivision.

Subd. 8. **Medical records.** A patient has the right to access to personal medical records. Notwithstanding the provisions of section 144.335, subdivision 2, every person subject to a proceeding or receiving services pursuant to this chapter shall have complete access to all medical records relevant to the person's commitment.

Subd. 9. **Right to counsel.** A patient has the right to be represented by counsel at any proceeding under this chapter. The court shall appoint counsel to represent the proposed patient if neither the proposed patient nor others provide counsel. Counsel shall be appointed at the time a petition is filed pursuant to section 253B.07. Counsel shall have the full right of subpoena. In all proceedings under this chapter, counsel shall: (1) consult with the person prior to any hearing; (2) be given adequate time to prepare for all hearings; (3) continue to represent the person throughout any proceedings under this charge unless released as counsel by the court; and (4) be a vigorous advocate on behalf of the client.

Subd. 10. **Notification.** All persons admitted or committed to a treatment facility shall be notified in writing of their rights under this chapter at the time of admission.

253B.17 RELEASE; JUDICIAL DETERMINATION.

Subdivision 1. [PETITION.] Any patient, except one committed as mentally ill and dangerous to the public, or any interested person may petition the committing court or the court to which venue has been transferred for an order that the patient is not in need of continued institutionalization or for an order that an individual is no longer mentally ill, mentally retarded, or chemically dependent, or for any other relief as the court deems just and equitable. A patient committed as mentally ill or mentally ill and dangerous may petition the committing court or the court to which venue has been transferred for a hearing concerning the administration of neuroleptic medication. A hearing may also be held pursuant to sections 253B.08, 253B.09 ~~and~~, 253B.12, and 253B.18.

Subd. 2. **Notice of hearing.** Upon the filing of the petition, the court shall fix the time and place for the hearing on it. Ten days' notice of the hearing shall be given to the county attorney, the patient, patient's counsel, the person who filed the initial commitment petition, the head of the treatment facility, and other persons as the court directs. Any person may oppose the petition.

Subd. 3. **Examiners.** The court shall appoint an examiner and, at the patient's request, shall appoint a second examiner of the patient's choosing to be paid for by the county at a rate of compensation to be fixed by the court.

Subd. 4. **Evidence.** The patient, patient's counsel, the petitioner and the county attorney shall be entitled to be present at the hearing and to present and cross-examine witnesses, including examiners. The court may hear any relevant testimony and evidence which is offered at the hearing.

Subd. 5. **Order.** Upon completion of the hearing, the court shall enter an order stating its findings and decision and mail it to the head of the treatment facility.

260.151 INVESTIGATION; PHYSICAL AND MENTAL EXAMINATION.

Subdivision 1. Upon request of the court the county welfare board or probation officer shall investigate the personal and family history and environment of any minor coming within the jurisdiction of the court under section 260.111 and shall report its findings to the court. The court may order any minor coming within its jurisdiction to be examined by a duly qualified physician, psychiatrist, or psychologist appointed by the court. With the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case. Adoption investigations shall be conducted in accordance with the laws relating to adoptions. Any funds received under the provisions of this subdivision shall not cancel until the end of the fiscal year immediately following the fiscal year in which the funds were received. The funds are available for use by the commissioner of corrections during that period and are hereby appropriated annually to the commissioner of corrections as reimbursement of the costs of providing these services to the juvenile courts.

Subd. 2. The court may proceed as described in subdivision 1 only after a petition has been filed and, in delinquency cases, after the child has appeared before the court or a court appointed referee and has been informed of the allegations contained in the petition. However, when the child denies being delinquent before the court or court appointed referee, the investigation or examination shall not be conducted before a hearing has been held as provided in section 260.155.

Subd. 3. [JUVENILE TREATMENT SCREENING TEAM.] (a) The county welfare board, at its option, may establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team, which may be the team constituted under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655, shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability. The team shall involve parents or guardians in the screening process as appropriate.

(b) This paragraph applies only in counties that have established a juvenile treatment screening team under paragraph (a). If the court, prior to, or as part of, a final disposition, proposes to place a child for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A, the court shall notify the county welfare agency. The county's juvenile treatment screening team must either: (1) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or (2) elect not to screen a given case, and notify the court of that decision within three working days.

(c) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

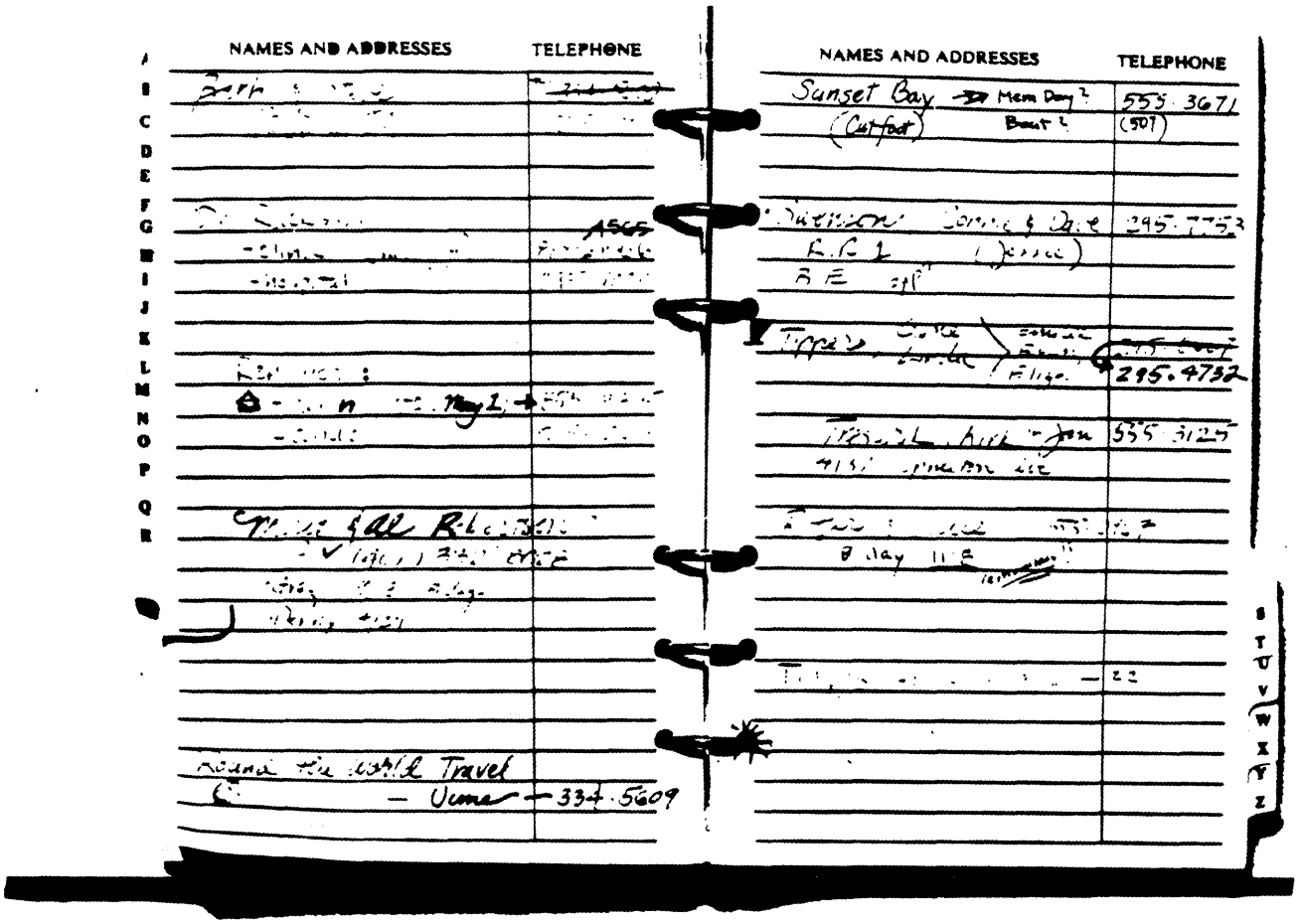
(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

APPENDIX E

FINAL BUDGET
NEW FUNDS FOR MENTAL HEALTH SERVICES

"MH Initiative" - Adults	Budget Page	Final FY 90	Final FY 91	Final Total	Governor Request
MH Division:	144				
Staff (Gov. request 5, final 2)	144	$66,239	$88,839	$155,078	$312,000
Support Cost	144	$8,000	$8,000	$16,000	$24,000
State Advisory Council - travel	144	$0	$0	$0	$30,000
State Advisory Council - per diems	N/A	$25,000	$25,000	$50,000	$0
Rules promulgation	144	$0	$0	$0	$100,000
Information System	144	$0	$0	$0	$120,000
Local advisory councils	N/A	$50,000	$50,000	$100,000	$0
Undesignated	N/A	$42,761	$38,161	$80,922	$0
Sub-total	144	$192,000	$210,000	$402,000	$586,000
Enhance community services:	148				
Rule 14 inflation (Gov. 3%, final 2.7%)	148	$200,000	$399,000	$599,000	$654,000
Rule 14 formula (Gov $1.80/50,000, final ?)	148	$586,000	$1,514,000	$2,100,000	$3,100,000
Rule 14 housing support projects	148	$343,000	$343,000	$686,000	$686,000
Rule 12 inflation (Gov. 3%, final 2.7%)	148	$300,000	$601,000	$901,000	$986,000
Sub-total Rule 12 and 14	148	$1,429,000	$2,857,000	$4,286,000	$5,426,000
Transfer outpat. commit. to R14	148	($120,000)	($120,000)	($240,000)	($240,000)
Net sub-total	148	$1,309,000	$2,737,000	$4,046,000	$5,186,000
Nursing Home Alternative Placements:	151				
New MH grant funds	151	$721,000	$2,290,000	$3,011,000	$3,011,000
Reduced Med. Assist. state share	151	($306,000)	($974,000)	($1,280,000)	($1,280,000)
Sub-total	151	$415,000	$1,316,000	$1,731,000	$1,731,000
Total "MH Initiative" - Adults		$1,916,000	$4,263,000	$6,179,000	$7,503,000
Children's Mental Health					
MH Division:	143				
Staff (Gov. request 4, final 2)	143	$79,693	$82,698	$162,391	$234,000
Support Cost	143	$8,000	$8,000	$16,000	$41,000
Local training	143	$0	$0	$0	$100,000
Deficit	N/A	($45,693)	($6,698)	($52,391)	$0
Sub-total	143	$42,000	$84,000	$126,000	$375,000
Therapeutic Foster Care Pilot	150	$0	$460,000	$460,000	$700,000
Family Community Support Pilot	N/A	$0	$500,000	$500,000	$0
Children's Health Plan - study and add MH	N/A	$20,000	$480,000	$500,000	$950,000
Med. Assist. Prof. Family-based Treatment	271	$0	$750,000	$750,000	$1,500,000
Early intervention - add MH to EPSDT	N/A	$15,000	$15,000	$30,000	$0
Total State Funds - Children MH		$77,000	$2,289,000	$2,366,000	$3,525,000
Med. Assist. Federal Funds	271	$15,000	$921,977	$936,977	$1,813,953
Total State and Federal - Child MH		$92,000	$3,210,977	$3,302,977	$5,338,953
Total New State Funds for Adult and Children's Mental Health Initiatives		$1,993,000	$6,552,000	$8,545,000	$11,028,000

Pick Any Five Friends.



Now Guess Which One Will Be Affected By Mental Illness.

Mental illness isn't nameless or faceless.
It affects one in five, including people close to you.
But mental illness isn't hopeless either.
With help and understanding, people lead fulfilling, productive lives.
So be a friend. Learn more about mental illness
through your local and state mental health organizations.

Understand mental illness

EVERY MIND MATTERS

Simons Allyn Marketing Communications for the Minnesota Department of Hum... June 1990

6 7 16" (3 columns) x 10 5" Newspaper Ad

About the Mental Illness and Anti-Stigma Project
Background and Goals

Project Background

Creation of the Mental Illness and Anti-Stigma Project
In August, 1989, the Department of Human Services (DHS) - Mental Health Division contracted with the Minnesota Department of Health - Division of Health Promotion (MDH), to address the issue of stigma of mental illness, to research, plan, develop, create, promote, and implement a project about stigma and mental illness, and to develop related media and materials.

Selection of advisory committee
An advisory committee was selected to assist with the development of program recommendations. The committee included representatives from the following organizations: DHS, MDH, Alliance for the Mentally Ill, State Advisory Council, Mental Health Association, county social services, regional treatment facility, community mental health centers, Children's Mental Health Initiative, community-based programs, University of Minnesota, consumers and family members.

Preparation and presentation of background research
In preparation for the advisory committee meetings, background research was gathered, including a review of the literature and and the experiences of other states and national organizations. Consumer and family opinions, regarding how stigma affects their lives, were also gathered.

Development of recommendations
The advisory committee discussed options and made recommendations that a kit be developed and distributed to counties and local advisory councils for their use in building coalitions and pro-actively educating segments of their communities about mental illness. The proposed kit would contain a variety of materials, tips, and tools for community organization and public education.

Additional input was gathered from potential users of the proposed kit, including mental health advisory council members, county social workers and other experts across the state. These interviews assessed opinions on who the proposed kits should be distributed to, what the overall message should be, who the materials within the kit should address, and identification of stigma-related concerns.

Respondents were extremely enthusiastic about the attention given to the stigma issue and the possibility of the kit. They recommended that the kit's materials communicate a message that mental illness is an illness and not a personal weakness, that mental illness is prevalent, that people can recover from mental illness with help, and that the community can play a role in reaching out, understanding, and accepting persons with mental illness. They also recommended that the materials conveying those messages reach a variety of groups within communities. They supported the use of the kit by local advisory councils, county agencies, and/or local advocacy organizations.

Based on the opinions from these key informant interviews, in conjunction with the input from the project's advisory committee, final recommendations were developed and goals were established. Those goals follow.

Project Purpose, Goals, and Objectives

Project Purpose

The purpose of the Mental Illness and Anti-Stigma Project is to enable mental health consumers and providers in each Minnesota county:

1) to easily *attract the attention of community leaders and institutions*;
2) to easily provide those community leaders and institutions with *relevant information* about mental illness;
3) to easily provide community leaders and institutions with *specific actions for improving community acceptance* of persons with mental illness.

Project Goals

The goals of the Mental Illness and Anti-Stigma Project are:

1) *to increase public awareness* and understanding of mental illness;
2) *to reduce the stigma* and misperceptions associated with mental illness;
3) *to improve community acceptance* of persons with mental illness.

Project Objectives

The specific objectives of the Mental Illness and Anti-Stigma Project are:

1) to decrease instances of *housing discrimination*, including lack of availability of affordable housing and access to existing housing and support services;
2) to decrease instances of *employment discrimination*, including lack of availability of transitional employment and lack of access to available positions for qualified applicants;
3) to increase the number of instances of community *responsiveness to needs of mentally ill persons*;
4) to increase instances where the media promote *accurate information* about mental illness, diminishing community misperceptions, fear, and lack of compassion for persons with mental illness.

Project Methods

The specific methods with which to accomplish the objectives of the project are:

1) *to distribute a kit* of information to mental health advisory councils, social service departments or education/prevention coordinating agency in each Minnesota county, as well as other interested consumer and provider organizations;
2) *to provide information within the kit regarding skills for community organizing*;
3) *to provide educational materials* within the kit that address specific areas related to stigma, including housing, community treatment, employment, community responsiveness, and the promotion of accurate information;
4) *to target those educational materials within the kit to specific audiences* whose actions and attitudes may promote stigma, such as neighbors, employers, schools, churches, and other community organizations, media, the general public, and consumers, families, and providers;
5) *to provide written education materials within the kit, addressing the target audiences* with specific information;
6) *to provide mass media materials within the kit*, including scripts for presentations and interviews, public service announcements, posters, and print ads;
7) *to produce a high-quality, visually appealing, and user-friendly kit*, containing attractively designed materials that invite use by the mental health consumers and providers, and attract the attention of the target audiences.

Introduction

This section presents an overview of the project, background information and goals, and a summary of the kit contents. The target audiences for these materials include all mental health consumer and provider groups, agencies, and organizations. Materials in this section include:

Introducing the Mental Illness and Anti-Stigma Kit
A brief overview of the stigma issue and ways communities can respond in order to increase awareness of mental illness

Project Background and Goals
The history of the Mental Illness and Anti-Stigma Project and its goals

Kit Contents Guide
A brief description of all kit materials

Understanding Mental Illness: A Community Issue
A statement of the key issues promoted throughout the kit

"The Stigma of Mental Illness"
A reprinted article from the National Institute of Mental Health

Acknowledgements
Thanks to the many contributors to this project

Dear Mental Health Advocate,

On behalf of the Department of Human Services and the Mental Health Division, I am pleased to give you the Mental Illness and Anti-Stigma Kit, a collection of ideas and materials for promoting public awareness and community acceptance of mental illness and those who suffer from it.

Inside the kit you will find:

Ideas to help you get organized, including tips for involving community leaders, ideas for creating awareness, and suggestions for program promotion,

Handouts on a variety of stigma-related issues, such as housing, employment, and community-based services,

Information for you to share with organizations throughout the community on ways they can be more responsive to the needs of persons with mental illness,

Materials to help you work effectively with the media to provide more accurate public information about mental illness,

Tools for public awareness, like posters, print ads, public services announcements, and logos,

Resources on seeking help and further information about mental illness

In short, the kit provides you with many important tips and tools you need in order to promote a public information campaign in your area. But any anti-stigma effort will only be effective with your involvement.

Make stigma an important part of your community mental health agenda.

Work closely with other consumers and providers in your area to set goals, develop strategies, and implement mental illness awareness campaigns.

Involve people and organizations outside of your "mental health circles", to make your program most effective.

Use the materials in some way to educate the public.

And please share information about your activities with us. We want to know how what you are doing has reduced the effects of stigma in your community. No anti-stigma effort is too small. One changed mind, one improved attitude, one person's increased understanding, will benefit all people with mental illness.

Sincerely,

Barbara W. Kaufman, MSW
Assistant Commissioner for Mental Health

Understand mental illness
EVERY MIND MATTERS

Introducing the Mental Illness and Anti-Stigma Kit for your community-based public information campaign

Mental Illness: A Community Issue

Mental Illness is an issue throughout our communities. Whether or not individuals are personally affected by mental illness in their lives or in their families, mental illness impacts nearly every segment and institution within the community. Yet despite its prevalence in our lives, families, and/or communities, mental illness is often misunderstood and persons with mental illness are often feared, rejected, or denied the compassion afforded others with chronic illness.

The stigma of mental illness takes on many forms. It may mean denial of opportunities for adequate housing or employment. It may mean lack of advocacy, support, or responsiveness from family and community. It may mean negative and inaccurate stereotypes of mental illness. In any case, to persons with mental illness, it means trying to overcome one of the most difficult challenges in their recovery.

Mental Illness: A Community Response

In response to the prevalence of mental illness and the reality of stigma in our communities, the Department of Human Services, in conjunction with the Department of Health and a host of mental health experts including providers, consumers, families, and community leaders, created the Mental Illness and Anti-Stigma Project. The project's theme, "*Understand Mental Illness. Every Mind Matters*", communicates the project's goals to increase awareness and understanding of mental illness, reduce the stigma and misperceptions associated with mental illness, and improve acceptance of mentally ill persons.

Introducing the Mental Illness and Anti-Stigma Kit

In order to accomplish these broad goals, this public information kit has been developed. The kit provides tips and tools for communities to use to create locally-directed public awareness and anti-stigma efforts. Included in the kit are suggestions for *organizing your community*, specific *campaign and event ideas*, tips for most effectively *reaching target audiences*, educational *materials for handouts* for any public information activity, tools to enhance the campaign, including *PSAs, print ads, posters, and more.* (A list of the kit contents is included on the backside of this page.)

Creating a Mental Illness Awareness Campaign in your Community

- Review Getting Organized for tips for organizing your community and for campaign ideas.
- Set goals, including the issues you will focus on and when you will kick off the campaign.
- Identify which materials in the remaining sections of the kit will help you reach those goals. For example, you may want to educate segments of the community on how they can be most responsive to community mental health, using the materials in Mental Illness and Community Responsiveness. Or instead you may narrow your focus to the issues of community-based treatment, housing, or employment, consulting Mental Illness and Community-based Treatment, Housing, Employment. Perhaps you will eradicate myths and misperceptions of mental illness, utilizing the materials and tools in Mental Illness in the Public Eye. Or, simply create your own campaign, drawing on materials from all sections of the kit.
- Plan and implement your campaign.

For More Information

For more information about the kit or how to establish a community-based mental illness awareness campaign in your community, contact the Minnesota Department of Human Services *Mental Health Division at 612-296-7908* or *Communications Office at 612-296-4416.*

Understand mental illness

EVERY MIND MATTERS

MENTAL ILLNESS AND ANTI-STIGMA PROJECT: Summary of Kit Contents

Getting Organized
- Steps for organizing your community
- How to involve community leaders and groups in your campaign
- Keys for successful campaigns
- Mental illness awareness ideas from Minnesota communities
- More ideas for mental illness awareness
- Promoting your program, project, or event

Mental Illness and Housing
- Minnesota's Comprehensive Mental Health Act
- Housing-as-Housing
- Housing in Minnesota
- Resources for Mental Illness and Housing
- Understanding the Fair Housing Amendments Act
- What to do if you are a victim of housing discrimination

Mental Illness and Community-based Residential Treatment
- Fact Sheets on Mental Illness and Community-based Residential Treatment
- Alleviating Neighborhood Concerns
- Strategies for Community Acceptance
- Undoing the Myth of Property Devaluation
- Resources for Mental Illness and Community-based Residential Treatment

Mental Illness and Employment
- Fact Sheets on Mental Illness and Employment
- Alleviating Employers' Concerns
- Strategies for Successful Job Placement
- Real Life Examples of Successful Working Relationships
- Returning to Work-tips for employers and for employees
- How to Create a Healthy Workplace
- What to do if you are a victim of employment discrimination
- Resources for Mental Illness and Employment

Mental Illness and Community Responsiveness
- Fact Sheets on Mental Illness in Adults and in Children
- Understanding mental illness as a community issue
- What community organizations can do
- What business organizations can do
- What churches, synagogues, and service organizations can do
- What schools, colleges, and community education programs can do
- What physicians, hospitals, and health care organizations can do
- What families can do
- Ways to get legislators and community officials involved
- Tips for consumers helping consumers
- Seeking help: Where to go and what to do
- Resources for community education on mental illness

Mental Illness in the Public Eye
- Making your pitch to the news media
- Story ideas on mental health issues
- How to write a press release
- Avoiding stigmatizing language: tips for writers and speakers
- Sorting the myths from the facts about mental illness
- How to do a media watch
- Samples scripts for presentations and interviews on mental illness
- Tips for interviews or presentations
- Attitude Exploration Exercises
- Creative expression on life with mental illness, by consumers
- Public Service Announcements, Print Ads, Posters, and Logos
- Videotapes for use in presentations on mental health and stigma topics

Resources for Education and Community Service

Using the Mental Illness and Anti-Stigma Kit: A Guide to the Kit Contents

Introduction

This section presents an overview of the project, background information and goals, and a summary of the kit contents. The target audiences for these materials include all mental health consumer and provider groups, agencies, and organizations. Materials in this section include:

Introducing the Mental Illness and Anti-Stigma Kit
An overview of the stigma issue and ways communities increase mental illness awareness
Project Background and Goals
The history of the Mental Illness and Anti-Stigma Project and its goals
Kit Contents Guide
A brief description of all kit materials
Understanding Mental Illness: A Community Issue
A statement of the key issues promoted throughout the kit
"The Stigma of Mental Illness"
A reprinted article from the National Institute of Mental Health

Organizing your Community

This section describes the process of, and some techniques for, organizing your community. The target audiences for these materials include all mental health consumer and provider organizations. Materials in this section include:

Organizing for Change: Community Organization Steps and Strategies
Five major steps and strategies for organizing your community
Involving Community Leaders in your Campaign
Ways to involve community leaders and an illustration of community organization in action
Creating a Successful Community Coalitions
Identification of success factors for community coalition-building
Keys to Success: A Checklist for Community Organizers
Identification of success factors for any community activity
How Minnesota Communities are Organizing
More than 25 examples of ways communities are promoting awareness mental illness
More Ideas for Mental Illness Awareness
Additional public information ideas for mental illness awareness
Promoting your Program, Project, or Event
General tips for audience selection and program promotion

Mental Illness and Community-based Residential Treatment

This section provides information about, and support for, community-based treatment for people with mental illness, as well as ways treatment program managers, neighbors, and communities can work together toward greater community acceptance. The target audiences for materials in this section include neighborhood associations, program providers, and consumers. Materials include:

Facts about Mental Illness and Community-based Residential Treatment
The need for community-based treatment and the options available
Community-based Residential Treatment Options
Types of community-based residential treatment available for adults and children
Alleviating Neighborhood Concerns
Common questions and answers about mental illness and residential treatment

Undoing the Myth of Property Devaluation
Effect of residential treatment programs on property values and community attitudes
Strategies for Cooperation and Acceptance
Ways that people with mental illness and their neighbors enhance community relations
Resources for Mental Illness and Residential Treatment Programs
Educational materials on residential treatment, including pamphlets and videotapes

Mental Illness and Housing

This section provides information about, and need for, housing and housing support services for people with mental illness. The target audiences for materials in this section include neighborhood associations, landlords/realtors, program providers, and consumers. Materials in this section include:

The Concept of Housing-as-Housing
Describes the concept of housing-as-housing
Housing in Minnesota
How Minnesota is responding to housing needs of persons with mental illness
Minnesota's Comprehensive Mental Health Act
A summary of the Act's mandates for housing and support services
Understanding the Fair Housing Amendments Act
The Fair Housing Amendments Act and what it means for people with disabilities
What to Do if You are a Victim of Housing Discrimination
Steps to take if you or a family member are denied housing due to a disability
Resources for Mental Illness and Housing
Educational materials and housing resources available in Minnesota

Mental Illness and Employment

This section provides information about, and support for, mainstream employment for persons with mental illness, as well as strategies for successful job placement. The target audiences for materials in this section include employers, business and professional organizations, chambers of commerce, rehabilitation counselors, and consumers. Materials in this section include:

Facts about Mental Illness and Employment
The effect of mental illness on business and the available programs for workers
Alleviating Employers' Concerns
Common questions, raised by employers, about workers with mental illness
Mental Illness and Employment: A Research Review
A literature review examining employer attitudes about mental illness
Strategies for Successful Job Placement
How employers, counselors, and employees can effectively work together
Real Life Examples of Successful Working Relationships
Examples of realistic working relationships benefiting Minnesota employers
Returning to Work: Employers helping Employees Make the Transition
Tips for employers for successful employee transitions back to work after an absence due to mental illness or a mental health need
Returning to Work: Employees Making the Transition Back to Work
Tips for employees for successful employee transitions back to work after an absence due to mental illness or a mental health need
How to Create a Healthy Workplace
Ways that employers can take a pro-active approach to mental health in the workplace
What to Do if You are a Victim of Employment Discrimination
Steps to take if you or a family member are denied employment due to a disability
Mental Health Educational Materials for Worksites
Educational materials on employment, including pamphlets, booklets, and tapes
Seeking Employment Services
Employment services available through the Division of Rehabilitation Services

Using the Mental Illness and Anti-Stigma Kit: A Guide to the Kit Contents (continued)

Mental Illness and Community Responsiveness

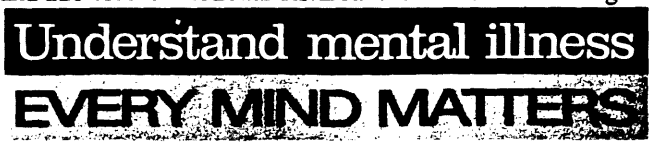
This section provides information regarding mental illness and ways to understand mental illness as a community issue, including tips for increased community responsiveness. The target audiences for this section include businesses, churches leaders and members, teachers, principals, librarians, police, social and public health services, physicians, health care organizations, community officials, families, consumers, and other groups and organizations. Materials in this section include:

Understanding Mental Illness: A Community Approach
The key issues, important to understanding mental illness
Facts about Child and Adolescent Mental Health
Child and adolescent emotional disturbances and the services available for their care
Understanding Mental Illness: Signs and Symptoms
A summary of the different types of mental illness
Understanding Child and Adolescent Emotional Disturbance
A summary of the different types of child and adolescent emotional disturbances
What Health Care Organizations Can Do
Ways that health care organizations can promote health and respond to mental health needs
What Business Organizations Can Do
Ways that businesses can promote employee health and encourage greater employee understanding and responsiveness to people with mental illness
What Churches, Synagogues, and Service Organizations Can Do
Ways that churches can respond most effectively to people with mental illness.
What Schools, Colleges, and other Education Programs Can Do
Ways that schools can promote information about mental health and can respond more effectively to students' mental health needs
What Community Organizations Can Do
Ways that other community organizations, like law enforcement, social and public health services, libraries, etc. can contribute to and benefit from public education on mental illness
What Families Can Do
Ways that families can promote mental health and address family mental health needs
Ways to Get Legislators and Community Officials Involved
Tips for educating community officials and addressing legislative issues
Tips for Consumers Helping Consumers
Tips for consumers living in the community
Seeking Help: Where to Go and What to Do
General guidelines and first steps to take in seeking mental health assistance
Mental Health Education Materials for Community Education
General mental health materials, including pamphlets, videos, and curricula

Mental Illness in the Public Eye and Tools for Public Awareness

This section addresses ways to bring accurate information regarding mental illness to the public, particularly via the media. The target audiences for materials in this section include media, general public, and mental health consumer and provider organizations. Materials in this section include:

Understanding Mental Illness: Signs and Symptoms
A summary of the different types of mental illness for use in educating the media
Understanding Child and Adolescent Mental Health
Child and adolescent emotional disturbances to use in educating the media



Sorting the Myths from the Facts about Mental Illness
Common myths about mental illness and the real story
Avoiding Stigmatizing Language: Tips for Writers and Speakers
Important suggestions for people who write or speak about mental illness
How to Do a Media Watch
Steps for organizing a media watch and ways to respond to an ad or program that inaccurately portrays mental illness
Making your Pitch to the News Media
Tips for effectively working with the newspaper, radio, and TV reporters
Story Ideas on Mental Health Issues
Suggestions for positive stories on mental health and mental illness
How to Write a Press Release
Tips for getting mental illness information in the news
Samples Scripts for Presentations and Interviews
Suggested mental health areas to cover and questions you may be asked in presentations
Tips for Interviews or Presentations
Tips for effectively presenting information about mental illness to the public
Attitude Exploration Exercises
Thought provoking questions to raise awareness about stigma and mental illness
Creative Expression on Life with Mental Illness, by Consumers
Thoughts about mental illness and the ways that stigma impacts lives

This section also provides tools for increasing public awareness and understanding of mental illness. Target audiences include media and general public. Materials in this part of the section include:

Radio PSA Script
Sample script for radio announcers to read on the air
TV PSA
Television PSA to share with your local stations
Newspaper/Magazine Print Ad
Public service ads for inclusion in local papers or magazines
Posters
Mental illness awareness posters to post in any community location
Logos
Logos to use when printing other communication tools
Videotapes for use in presentations
"Bridge to Understanding" from the Mental Health Association of Minnesota, and "Silent No More" from the Alliance for the Mentally Ill in Minnesota

Resources

This section provides resources for mental health education and mental health services. The target audiences for the materials in this section include all audiences discussed in this kit, the general public, and all mental health consumer and provider organizations. Materials in this section include:

Mental Health Education Materials for Community Education
General mental health materials, including pamphlets, videos, and curricula
Seeking Help: Where to Go and What to Do
General guidelines and first steps to take in seeking mental health assistance
Seeking Help in the Metropolitan Area
General mental health services in the Twin Cities
Seeking Help in Greater Minnesota
General mental health services around the state
Seeking Help: Support Groups and Advocacy/Education Organizations
General state-wide resources for support, education, and advocacy

Understanding Mental Illness:
A Community Approach

Mental illness is prevalent.

One in five persons are affected in some way by mental illness. They may be directly affected through a personal experience with a mental illness. They may be indirectly but significantly affected, helping a family member or close friend cope with a mental illness. There are people throughout our communities, whose lives are challenged by mental illness.

Mental illness is diverse.

There are a variety of kinds, and a variety of degrees, of mental illness. The most common types of mental illness include depression, manic depression, schizophrenia, and anxiety disorders.

Mental illness can affect anyone.

Mental illness can affect children, adolescents, adults, and elderly people.

Mental illness can be devastating to individuals and families.

The effects of mental illness can be worse than the effects of other illnesses. A Rand Corporation Study showed that depressed persons had significantly more social difficulties than all other chronic disease groups. And untreated mental illness is a powerful risk factor for suicide.

Persons with mental illness are people first.

People with mental illness are *people* with capabilities and talents. It is important to focus attention and compassion on *people*, not on their symptoms.

Mental illness *is* an illness. Mental illness *is not* a choice.

Mental illness is not a personal weakness. It is an illness, just as diabetes is an illness, with different degrees of chronicity, symptoms, and effectiveness of treatment. People with mental illness are experiencing something over which they have no control; in most instances an illness caused by a biochemical disturbance in the brain or another physiological basis. And just as with other illnesses, people with mental illness deserve understanding and compassion.

With proper treatment, many people manage their mental illness.

Help is available for successfully treating people with mental illnesses. However, not all people with mental illness do recover, as is true with all types of illness. It is unfortunate that many people do not receive the treatment they need, due to lack of affordable services, lack of understanding, or the stigma associated with mental illness.

Mental illness is a community issue.

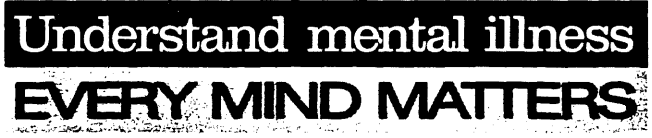
Mental illness indirectly impacts nearly every part of the community. Mental illness is an issue in our neighborhoods, where housing and residential treatment programs are greatly needed. It is an issue in our workplaces, where co-workers are coping with the mental illness of a loved one or making a transition back to work after their own challenges with mental illness. It is an issue in our schools and churches, where persons with special needs are in need of help and compassion.

In 1987, the Minnesota Legislature passed the Minnesota Comprehensive Mental Health Act, outlining mental health services that must be available to all adults with *severe and persistent* mental illness, and all children with emotional disturbances, in every Minnesota county.

We must work together for greater understanding of mental illness.

In order to deal with mental illness as a community, we must educate ourselves about mental illness and accept persons with it as community members. As a community, we cannot close our doors, our minds, or our hearts, to those whose lives are affected by mental illness.

"Understand Mental Illness. Every Mind Matters."



The Department of Human Services, Mental Health Division, gratefully acknowledges the following contributors to the Mental Illness and Anti-Stigma Project:

Thank you to the following individuals and organizations who served on the Mental Health and Anti-Stigma Advisory Committee, providing recommendations and overall direction for the project:

Cynthia Wainscott, Mental Health Association of Minnesota (Committee Chair)
Howard Agee, Alliance for the Mentally Ill / State Mental Health Advisory Council
Norby Blake, Indian/Minority Mental Health, Department of Human Services
Maureen Heaney, Dakota County Social Services
Barbara Koropchak, Anoka Regional Treatment Center
Don Mockenhaupt, Ramsey County Mental Health Center
Sheryl Neibuhr, Wilder Community Care Programs
Nadine Phillips, Hennepin County Mental Health Association
David Sanders, Hennepin County Mental Health Center
Carolyn Williams, University of Minnesota School of Public Health
Pat Young, 26th Street Project, Mental Health Association of Minnesota

Thank you to the following individuals and organizations who acted as key informants in helping to define the target audiences and content of the project:

Alice Adamson, St. Olaf Mental Health Center
Barbara Amram, State Advisory Council on Mental Health
Judith Anderson, Children's Mental Health Initiative
Jim Auron, Mental Health Division, Department of Human Services
Jean Brown, Dakota County Mental Health Advisory Council
Laurie Brown, Ramsey County Mental Health Advisory Council
Louise Brown, Family and Childrens Services
Bonnie Brysky, Refugee Mental Health Advisory Council
Susan Carey, State Mental Health Advisory Council
George Carr, Mental Health Association of Minnesota
Jan Check, Carver County Community Support Project
Carolyn Curti, Hennepin County Mental Health Advisory Council
Reverend Arthur Dale, St. Louis County Mental Health Advisory Council
Mary Davies, Dakota County Mental Health Center
John Dinsmore, Grant/Ottertail County Mental Health Advisory Council
Vern Dorschner, State Subcommittee on Children's Mental Health
Barbara Flanagin, League of Women Voters
Rebecca Fink, RISE Inc.
John Finnegan, University of Minnesota School of Public Health
Roxie Granite
John Haines, Kandiyohi County Social Services
Eileen Herbert, Washington County Mental Health Advisory Council
Marjorie Hobenicht, Refugee Mental Health Program
Mary Huggins, Hennepin County Community Support Project
Julie Johnson, therapist and author
Roger Israel
Manic Depressive Association of Minnesota
Ruth Mueller, Alliance for the Mentally Ill
Tim Olson, Anoka County Social Services
Nadine Phillips, Hennepin County Mental Health Association
Loa Porter, Indian Mental Health Advisory Council
Schizophrenia Association of Minnesota
Steve Scott, Mental Health Law Project
Norma Schleppegrell, State Advisory Council on Mental Health

(continued on back of page)

Ed Swenson, Northern Pines Mental Health Center
Barb Thomas
Cynthia Wainscott, Mental Health Association of Minnesota
Dolly Wood, Lake County Mental Health Advisory Council
Mary Ziegenhagen, Communications Office, Department of Human Services

Thank you to the following individuals and organizations who provided information and assistance in development of specific materials in this kit:

Karen Abrahamson, Mental Health Association of Minnesota
Anoka County Mental Health Consortium
Jean Brown, Dakota County Mental Health Advisory Council
Center for Community Change, University of Vermont
Children's Mental Health Initiative
Claire Courtney, Division of Rehabilitation Services, Department of Jobs and Training
Carolyn Curti, Mental Health Association of Minnesota
D/ART Program, Mental Health Association of Minnesota
Terri Gunderson, Public Information Office, Department of Human Services
Michael Hughes, Division of Mental Health, Department of Human Services
Lee Kingsbury, Minnesota Department of Health
Chuck Krueger, Alliance for the Mentally Ill
Jim Just, Welcome Home
League of Women Voters
Mental Health Law Project
Minnesota Department of Human Rights
Dave Morin, Oasis House
National Alliance for the Mentally Ill
Nadine Phillips
RISE, Inc.
Dave Schultz, Division of Mental Health, Department of Human Services
Dr. Karen Torkelson
26th Street Project
Vail Place
Mary Jo Verschay, Mental Health Divison, Department of Human Services
Bruce Weinstock, Mental Health Division, Department of Human Services
Marge Wherley,.Hennepin County Community Services
John Wills
Kevin Wilson, Minnesota Office, U.S. Department of Housing and Urban Development
Mary Ziegenhagen, Communications Office, Department of Human Services

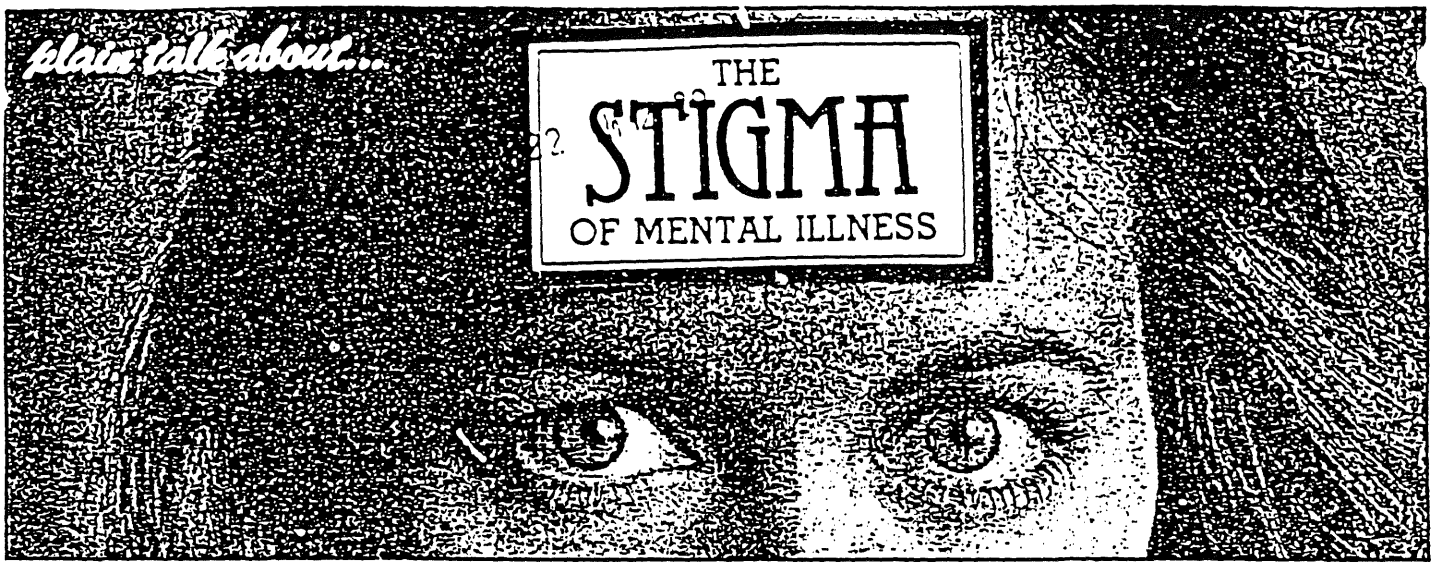
Thank you to Simons Allyn Marketing Communications for their creative expertise in the development and design of the creative materials in this kit. Also thank you to CJ Olson Market Research for providing message testing.

Thank you to the Mental Health Association for the inclusion of their video, "Bridge to Understanding," and to the Alliance for the Mentally Ill for the inclusion of their video, "Silent No More", in this kit.

Thank you to the Creative Living Center for the assembly of this kit.

Thank you to the 1989 Minnesota Legislature for providing the funding for this project.

Thank you to Susan Kripke Byers and the Minnesota Department of Health for the coordination of this project and the development of the written materials in this kit.



NATIONAL INSTITUTE OF MENTAL HEALTH

COMBATING THE STIGMA OF MENTAL ILLNESS

Among people who have been treated for mental illness, what is the biggest problem they face when trying to resume life in the community?

Most will say it is simply their inability to be accepted by other people. They have difficulty finding friends, housing, and work. They feel the sting of discrimination in almost everything they attempt. Many times they feel old friends are uncomfortable in their presence. They feel cut off from society.

They are the victims of the stigma that still surrounds mental illness. Numerous scientific studies have shown that stigma, often overt, is directed toward former mental patients by society. It becomes their most debilitating handicap.

Since 1980, the National Institute of Mental Health has been a leader in a nationwide attempt to remove the stigma associated with mental illness through an effort to encourage employers to hire people who have come through such illness and who are now able and eager to work. It has been proven that the dignity of work provides stability and meaning to these people as much as to those who have never experienced mental illness.

By forming a partnership with the private sector, the Institute has inaugurated an information program for employers that is paying dividends. Employers have learned that former mental patients, including the chronically mentally ill, comprise a valuable labor pool for American business.

But, employer knowledge and acceptance are not enough. The problems of stigma are everywhere. They affect all of us. We have found, also, that as the general public learns more about the devastating problems caused by stigma, even greater understanding and help will follow.

One in five families in the United States knows the devastating impact of mental illness. But its effects are far-reaching as family, friends, and co-workers suffer by the changes inflicted on them by another's mental illness.

Thirty percent of the population will suffer from cancer during their lifetimes, while 15 percent will be touched by mental illness. However, victims who have suffered both mental illness and cancer report that the mental illness caused them the greater pain.

In truth—the obstacles faced by recovering mental patients following treatment for their illness are often as difficult to overcome as was the illness.

Here, the question must be asked, "What is mental illness?" To begin with, mental illness is not a homogeneous entity which a general discussion of mental illness seems to imply. However, included under the rubric of mental illness are symptoms and problems that affect many persons but which may not be evident in others. These symptoms may not seriously—or even markedly—impair personal or social functioning. On the other hand, there are persons who may suffer from more serious, obvious, and incapacitating degrees of illness. These latter persons may well require hospitalization and intensive care and treatment.

Since the passage of the National Mental Health Act by Congress in 1946, care and treatment of mentally ill people has improved dramatically, assisted immeasurably by improvement in the use of psychoactive drugs (such as tranquilizers) and the development and use of other new therapies.

Improving Treatment

Today, research has unraveled many of the mysteries about the origins of mental illness. It has revealed that many mental illnesses are actually

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • [illegible]
Alcohol, Drug Abuse, and Mental Health Administration • [illegible]
Rockville, Maryland 20857 • DHHS Publication No. (ADM) [illegible]

caused by biochemical imbalances, as is the case with many physical illnesses.

The mentally ill should not be blamed for their condition any more than diabetics should be blamed for having diabetes. Uncovering many of the biochemical imbalances has led to treatments restoring the needed chemical balances, just as insulin controls the balances for diabetes. As long as a diabetic person takes the proper dosage of insulin, that person can live a normal life. It is much the same with mental illness. As long as the victim follows prescribed treatments, that person, too, can lead as normal a life as possible.

As care has been upgraded, so, too, have the settings in which treatment is given. For many decades, the usual responses to the mentally ill were to hide them away at home or to relegate them to asylums. As the number of admissions increased, care in the asylum became mostly custodial.

Problems of Deinstitutionalization

The populations of public mental hospitals grew until, about 30 years ago, more than 550,000 were housed in State and county facilities. Since then, deinstitutionalization—the process of releasing mental patients to communities—has lowered the number to fewer than 150,000.

At first, deinstitutionalization was hailed as a momentous advance by those who advocated treatment and services in community-based facilities—community mental health centers, halfway houses, psychosocial rehabilitation programs, and the like.

However, practice outpaced practicality; where the mentally ill were once caged as animals, chained to walls, mistreated, and even beaten, new understanding of mental illness has given many of them freedom. But the price of that freedom has often been aimless wandering through the streets, without homes or jobs. And, in too many instances, Americans who have had the misfortune to suffer mental illness—even those who approach a societal definition of normal—daily face an unsympathetic, unfair, and hostile society.

Historical physical abuse or neglect has been replaced by a less visible but no less damaging psychic cruelty.

Generally, in these enlightened days, we do not physically remove from our midst those we do not wish to have around; and we no longer send them to a far-away asylum. Instead, we isolate them socially, a much more artful though equally debilitating form of ostracism. A paradox now exists. In a time of vastly increased medical sophistication, which virtually guarantees greater numbers of restored mental patients, discrimination against them continues. Although we as a society have come far in the way we respond to those with mental illness, there is still a great distance to go.

For example, research studies have found that most Americans think the two worst things that can happen to a person are leprosy and insanity. In American society, ex-convicts stand higher on the ladder of acceptance than former mental patients. Asked to rank 21 categories of disability, from the least offensive to the most, respondents placed mental illness at the bottom of the list.

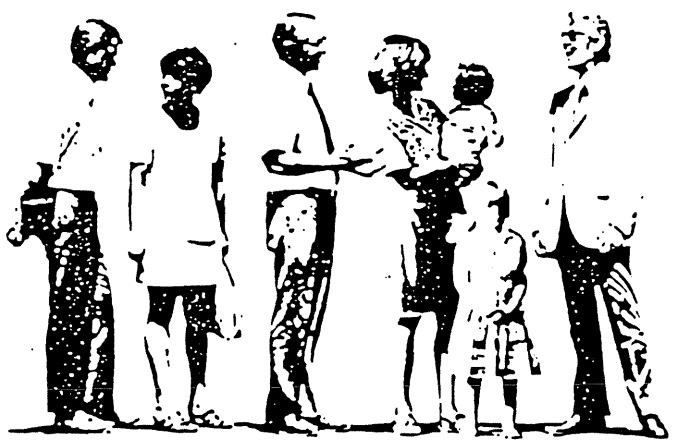
Attitude Changes

Public attitudes toward the mentally ill have changed in the past few decades, but the changes appear to be minimal. A 1979 study updating an earlier attitudes survey found "no noteworthy changes in attitudes toward the mentally ill 23 years later."

People continue to discriminate against the mentally ill, although it may be less socially acceptable to admit it openly. Discrimination crosses all boundaries of society and exists among people of all ages, socioeconomic levels, intelligence, education, and places. Nearly everyone, it seems, regards victims of mental disorders as "fundamentally tainted and degraded."

Even more astounding, mental patients sometimes face rejection from professionals who are paid to treat and help them. A key finding of a 1980 forum on stigma was that many health-care professionals harbor unconscious, unstated negative feelings about their mental patients. A 1980 survey found some psychiatric nurses showed prejudice toward their patients. Other studies have shown that it is not unusual for some staff members in psychiatric facilities to abuse their patients physically.

What is behind the stigma directed at mental patients? Some researchers think the term stigma is itself the problem. Too strong a word to be useful in describing the full range of reactions toward the mentally ill, they believe, it discourages objective



thinking about the problem it encompasses. That is, they believe simply talking about stigma may cause it.

Other investigators suggest that behavior, not a label, is what evokes negative response. For example, relatively well-adjusted and well-educated people who develop a psychiatric disorder but recover are unlikely, in this view, to suffer extensively from the problems of the stigma. It is the more or less permanently disabled persons who tend to be the objects of fear and avoidance.

Fears of Dangerousness

One of the reasons for this view, perhaps, is that people fear the mentally ill because they are thought to be unpredictable. But the truth is that the behavior of former mental patients is, on nearly every occasion, no different from the rest of society.

Thus, it should be said clearly: The vast majority of mentally ill persons are not dangerous. Here as elsewhere it is unfair to stigmatize the many of the acts of the few. The unfairness is apparent when danger from former mental patients is compared with the danger from drunk drivers. Some of the most predictably and demonstrably dangerous persons in our society are drunk drivers who account for about half of all fatal automobile accidents (about the same number as all criminal homicides each year), but Americans demonstrate a truly astonishing tolerance for this group of dangerous persons.

Then compare this to the record of former mental patients. Fewer than 2 percent of them pose any kind of danger to society. The reality is that persons who have been through emotional disturbances are typically anxious, passive, and fearful.

But the myth of dangerousness is perpetuated through a lack of knowledge by most members of the public. The belief that mentally ill persons are to be feared has been described in the research literature as a "core belief of the American public." Further, a recent California survey found only 17 percent of respondents agreed with the statement that mental patients are not dangerous.

The facts belie these beliefs. There has been an increase in the arrest rates of former mental patients over the past 29 years, but this increase pertains to former patients who had arrest records *prior* to being hospitalized.

Though there have also been a few studies showing *higher* rates of violent crimes by mentally ill persons, those who do not have prior arrest records have post-discharge arrest rates *equal to or lower* than those of the general population.

Why then the continuing public perception of them as dangerous individuals to be feared and shunned?

Role of the Media

Many observers fix a large share of the blame on the communications media. Newspapers in particular stress a history of mental disorder when they find it in the backgrounds of people who commit crimes of violence. Television news programs also sustain this view with their sensationalization of crimes where former mental patients are involved.

In television dramas, mentally ill persons are often portrayed as violent or victims of violence. Such stereotyping illustrates one of the many uses of mental illness by television producers or directors—to excite fear in the audience. One critic has pointed out that, on television, mental illness is synonymous with danger. Although that idea cannot be supported by known facts, it lends authenticity to the myth.

In this respect, the media—in the interests of fairness and in recognition of their power to influence public opinion—have a responsibility to provide a broader perspective on the mentally ill. A leading scientific investigator in this area has commented,

"That the mass media can condition a subtle set of attitudes which influences the behavior of society toward those who have been hospitalized for mental disorder is unequivocal."

The media usually reflect the beliefs of the public. Thus, it follows that when a majority of Americans are convinced that there are benefits in helping to change beliefs about mental illness, these beliefs will be positively altered. And the media must be convinced that at least some of the credit for helping change beliefs would accrue to them.

Possibility of Change

A summary of several studies indicates important areas where change is likely: in increased positive images of mental patients, in decreased fear ratings of them, in decreased fear of becoming insane, and (by patients themselves) in increased positive self-attribution. This likelihood is borne out by university-based studies which show that negative and stigmatizing images of mental patients can be altered.

For example, a Minnesota mental health education program informs the public in a straightforward way of the struggles of real people with emotional problems. Early indications are that awareness of such people's experiences and perceptions results in increased resistance to negative mass media images of current and former mental patients.

There are other encouraging signs of greater public understanding and acceptance of mental illness. Women, for example, have been found to be far more accepting of mental patients than are men. Recent Canadian and U.S. studies have shown positive acceptance of community mental health residential facilities, even in situations where residents have been labeled "mentally disordered offenders."

A survey by the National Restaurant Association, the first ever to investigate employment of the mentally restored in a single industry, produced solid evidence of the value of former mental patients to employers. The most outstanding result of the survey concerned work performance. More than 75 percent of employers who had hired mentally restored people rated them "as good as or better" than their co-workers in motivation, quality of work, attendance, job punctuality, and job tenure.

Fellow employees were described as cooperative and helpful toward their mentally restored coworkers, supporting the findings of another study of a shift toward understanding and acceptance when mental patients are given a chance to fill normal roles in work and other activities.

However, despite these impressive gains and the continued progress in unraveling its mysteries, mental illness remains one of the most frightening illnesses of all and consequently one of the hardest to be objective about. Depression, one of its most prevalent manifestations, currently affects an estimated 8 million to 20 million Americans. Over a lifetime, perhaps 25 percent of the U.S. population will experience at least one significant depression.

But if no one is immune, neither are the afflicted doomed to a lifetime of suffering. The ancients believed that persons who suffered from mental illness could not feel pain and were incurable. We have learned that mental patients are people from all walks of life who have sustained setbacks and need help in restoring their lives. Many of them can, if given that help, recover fully enough to lead productive and satisfying lives.

Since 1980, the National Institute of Mental Health has been engaged in a nationwide effort to combat the problems of stigma, with an emphasis on stimulating employment of recovered mental patients. The following materials are currently available, at no charge, to the public:

Brochures

- "Hiring the Mentally Restored Makes Dollars and Sense," a packet containing the following three brochures: "The Mentally Restored and Work: A Successful Partnership" (ADM 81-1071), "Affirmative Action to Employ Mentally Restored People" (ADM 81-1073), and "Eight Questions Employers Ask About Hiring the Mentally Restored" (ADM 81-1072).
- "The 14 Worst Myths About Recovered Mental Patients" (ADM 85-1391).

Videotape Programs

1. *"A Roundtable Discussion"* - Serves as an introduction to the NIMH Anti-Stigma Program. A panel discussion among officials of the National Restaurant Association, a director of a psychosocial rehabilitation program, and a practicing psychiatrist—himself a former mental patient.
2. *"Making It Back: A Doorway to the Community"* - Shows the daily operations of Green Door, a psychosocial rehabilitation program for the mentally restored in Washington, D.C.
3. *"Just Like You and Me"* - Features former mental patients who have made the successful transition from hospitalization into the workforce. Describes the operation of a Transitional Employment Program and the Projects With Industry Program.

Write or call for additional information: Office of Special Projects • National Institute of Mental Health, Room 15C-05, 5600 Fishers Lane, Rockville, Maryland 20857 • Phone: (301) 443-4536

U.S. GOVERNMENT PRINTING OFFICE: 1986—491-995/40048

Organizing your Community

This section describes the process of, and some techniques for, organizing your community. The target audiences for these materials include all mental health consumer and provider groups, agencies, and organizations. Materials in this section include:

Organizing for Change: Community Organization Steps
This overview of the process for community organization provides five major steps and strategies for organizing your community

Involving Community Leaders in your Campaign
Brief review of ways to involve community leaders and an illustration of successful community organization in action

Creating Successful Community Coalitions
Identification of success factors for community coalition-building

Keys to Success: A Checklist for Community Organizers
Identification of success factors for any community activity

How Minnesota Communities are Organizing
More than 25 examples of ways communities are promoting awareness and acceptance of mental illness

More Ideas for Mental Illness Awareness
Additional public information ideas for mental illness awareness

Promoting your Program, Project, or Event
General tips for audience selection and program promotion

Organizing for Change:
Community Organization Steps and Strategies

As your community prepares a mental illness awareness program, it is important to start by "getting organized." Communities who have successfully tackled tough social change issues have done so by setting goals, following a step-by-step process for achieving those goals, working together with others committed to their cause, and using creative strategies to gain the attention of key members of their communities. These activities are all important parts of the community organization process.

Chances are that your community has already completed some important steps for getting organized around mental health. Many Minnesota communities have very active advisory councils, addressing a variety of community mental health issues, including stigma. Others may have active social services agencies or mental health centers working on education/prevention activities. Still, many communities, though strongly committed to improving public awareness and attitudes about mental illness, have lacked the time and resources to actively pursue their public education goals.

Whether your group is a veteran or a newcomer to community organizing, it may be useful to look at the following steps of community organization. All steps require active citizen involvement for effectiveness.

Definition of Community Organization

> "Community Organization is a planned process to activate a community to use its own social structures and any available resources (internal or external) to accomplish community goals, decided primarily by community representatives and consistent with local values. Purposive social change interventions are organized by individuals, groups, and organizations from within the community to attain and then sustain community improvements and/or new opportunities."*

Stages of Community Organization

Community Analysis: In this stage, community needs, resources, social structures, and values are assessed. Broad community participation and ownership is encouraged. Important steps include:

1. *Defining your community* geographically
2. *Collecting data* regarding perceived needs, issues of concerns, and general demographics.
3. *Assessing existing or potential driving forces* for change in your community, such as human and financial resources, key community leaders, current level of interest, etc.
4. *Assessing existing or potential barriers* to change in your community, such as history of unsuccessful organizing, relentless negative attitudes, cultural barriers, etc.
5. *Assessing community readiness for change*, such as awareness or urgency of the problem, receptivity to change, current events impacting attitudes regarding the issue, etc.
6. *Synthesizing data and setting priorities*, through review of data, selection of the issue(s) to address, and preparation of information for presenting to others invested in the topic

Design and Initiation: In this stage, interested citizens are identified, groups are structured, and working relationships are established with existing organizations. Important steps include:

1. *Establishing a planning group* of 5-8 community leaders, consumers and providers, and a coordinator with community history, and communication and organizational skills

2. *Choosing an organizational structure* for your group

3. *Identifying and recruiting members*, representing various community organizations and ethnic groups who can address challenging issues and make creative decisions

4. *Defining mission statements, goals, and objectives* that clarify the group's purpose and communicate them in a clear, concise, and specific manner

5. *Clarifying roles and responsibilities* so the group can operate effectively and efficiently

6. *Providing training and recognition* for participants, to increase their commitment

Implementation: In this stage, ideas are translated into action, and design into programs. Important steps include:

1. *Generating broad citizen participation*, including interested advocates and outside representatives of the target audiences, to broaden the group and expand its influence

2. *Developing a workplan*, where priorities are set, interventions planned, resources and support obtained, and evaluation mechanisms designed, before program is launched

3. *Using comprehensive, integrated strategies*, to create synergy and maximize efforts

4. *Integrating community values* into programs, materials, and messages, as well as identifying relevant spokespersons

Program Maintenance: By this stage, experience has been gained and programs, modified. Important steps include:

1. *Integrating* your intervention activities into ongoing systems in the community

2. *Establishing a positive culture* of cooperation, and ownership, where growth can occur

3. *Establishing an ongoing recruitment* plan, in order to involve new and enthusiastic people

4. *Maintaining visibility* in the community, through promotion of programs and results

Reassessment: In this stage, results are evaluated, programs are modified, and future directions are determined. Important steps within this stage of community organization include:

1. *Updating the original community analysis*, making note of changes in leadership, resources, and relationships

2. *Assessing the effectiveness of your programs*, through program evaluation, ongoing monitoring, and record keeping of program participation, volunteer involvement, and attitude change

3. *Charting future directions*, including rewriting goals and reformulating strategies, based on results of community re-analysis and program evaluation

4. *Summarizing and disseminating evidence of program impact* to retain high visibility and positive image in the community

** from the 5 stage model of Bracht and Kingsbury, "Community Organization Principles in Health Promotion: A Five Stage Model", in Health Promotion at the Community Level, edited by Neil Bracht, Sage Publications Inc., in press, 1990*

Involving Community Leaders and Groups in your Mental Illness Awareness Project

An overview of community organization steps

Start by setting a goal and choosing target audience.

Involve community leaders and important representatives of your target audience in the planning process of a program or event, in order to meet your goal.

Some examples of activities to raise awareness include: speaker's bureaus, briefing sessions with legislators and local officials, media coverage via public service announcements, feature stories, and media events, and a variety of other techniques as broad as your imagination.

Some examples of community leaders include: *clergy*; *school personnel,* county personnel such as *social workers and public health nurses*; *community education directors*; *hospitals*; *health professionals*; *political leaders*; *media representatives*; *service clubs*, who may be interested in taking on your cause as a specific project; *cultural community leaders*, and *community members* with a connection with mental illness.

Assign tasks to committee members, with a timeline for action. Accountability is important if you want to get things accomplished. Work as a team.

Foster a sense of enthusiasm. If you are not excited about your issue, your target audiences will not be interested and will not participate in your effort.

Stay committed to your efforts for the long-term. People may not give an immediate response, but important seeds may be planted for their future reference.

An illustration of successful community organization in action

Meetings of the Mower County Mental Health Advisory Council were held to discuss the D/ART depression awareness program. Tasks were assigned and timeline determined for depression awareness events.

A kick-off event was planned to raise awareness and promote upcoming programs for Mental Health Month.

The media was contacted, including two TV station, 4 radio stations, and several newspapers, and interviews were scheduled on depression topic.

Presentations on depression were planned for various organizations.

The two-day kick-off event included seminars at a hospital for staff and the general public, a senior center, local high schools, and a church.

The Mental Health Month three-day event included presentations for all county staff, employee assistance program staff, high schools, hospitals, rehabilitation centers, and service clubs.

Information prepared by the D/ART program at the Mental Health Association of Minnesota

Creating Successful Community Coalitions

As you prepare to work together with others in your community to plan mental illness awareness activities, you are likely to encounter the challenges of managing a group of diverse people with different strategies for how goals should be accomplished. Though your group may disagree on specifics, it is imperative that the group establish a mutually agreeable goal, and encourage active involvement and good communication

According to A Practical Guide to Creating and Managing Community Coalitions by Daniel Merenda, the following characteristics are important to effective collaboration:

A common, unified, and highly-focused purpose
This occurs when participants agree on a purpose and focus on specific objectives. Without this, it is difficult to get things accomplished or measure if goals were met.

Active involvement of members
Make sure your goals and objectives are developed with the input of the majority of members. This assures that your activity will reflect the group's identified concerns. It also establishes commitment to the cause.

Clearly defined operating procedures and roles
In order to function effectively, all participating members must understand the ground rules of the group and its expectations of them.

Involvement of key community leaders from the beginning
Your coalition will benefit from the support and influence of community leaders, whether formal or informal. These leaders bring to your group contacts, notoriety, credibility, visibility, and access to decision makers and media sources.

A common vocabulary for effective communication
Clear, effective communication should be a priority, flowing freely between members and toward target audiences. Information is a source of power for your coalition, whether you obtain or share the information.

Atmosphere of collaboration and shared leadership
By sharing the responsibility (and the burden) for organizing and maintaining the coalition, both the group and its individual members are strengthened.

Good time management
Time is the most precious resource of each of your members. Be careful to keep meetings and activities focused and well-organized.

Evaluation of efforts
Monitor your progress in meeting your group's established goals and alter activities if goals aren't being adequately met. It is also important to make your progress known, demonstrating that your coalition is responsible and accountable.

Assignment of staff for optimal effectiveness
Whether paid, loaned, or volunteered; whether part- or full-time, it is important that someone is giving regular attention to your project.

Keys to Success:
A Checklist for Community Organizers

When following the five stages of community organization, there are some important things to keep in mind, regardless of which stage you are in or which specific step you are on.

Use these keys to success as a quick checklist as you begin or maintain mental health education and/or anti-stigma activities in your community.

Keep it simple

It is the simplest activities that are often the most easily implemented, most recognized by your target audiences, and most successful

Be enthusiastic and persistent

Enthusiasm is contagious so communicate your enthusiasm at all stages of development of your activity. When your project suffers setbacks and your enthusiasm wanes (as is typical in any long-term process), persist.

Recognize that you cannot do it alone

To be successful, your project requires multiple perspectives, input, and involvement. Don't burn yourself out by trying to manage tough issues on your own.

Believe in the process

Successful community organization requires careful planning and a step-by-step process of implementation

Find a specific hook for your community

There must be something about your community, whether it is something inherent to your community or timely in relation to a current issue or event, that will provide a foundation for your campaign and will capture the attention of the citizens in your area

Know your community's uniqueness

Develop your project focus, based on your community attitudes and values. Then you can adapt relevant materials from within or outside of this kit to best meet the needs of your community

adapted from information presented by Lee Kingsbury, Minnesota Department of Health, at the Minnesota Heart Health Program Dissemination Conference, June 1989

How Minnesota Communities are Organizing to Promote Awareness and Acceptance of Mental Illness

Across Minnesota, consumers, families, providers, and advocates are organizing to improve understanding of mental illness and its impact on individuals and families in their community. Representing local mental health advisory councils, Alliance for the Mentally Ill (AMI) or the Mental Health Association (MHA) chapters, county agencies, and other committed service organizations, these groups are making the public aware of mental illness issues and concerns. *The following are some examples of the many innovative ways that Minnesota communities are organizing to promote mental illness awareness:*

Anoka County established a *Mental Health Consortium.* They have developed a resource directory for providers, policy makers, consumers, families, and allied health professionals in the county.

Two Carver County newspapers ran a story featuring information about the local AMI chapter and its efforts to help families cope with mental illness. In addition to *interviewing an AMI member about myths about mental illness*, the papers ran a *sidebar presenting facts about mental illness.*

The Dakota County AMI chapter has held fundraisers, including *a style show and raffle drawing, a garage sale, a quilt raffle, inventory night at a local department store, and a community theater benefit.* Through ticket sales, publicity, and donation efforts, members have educated merchants, media, neighbors, and community leaders.

In order to establish relationships and make connections with community leaders, Dakota County Advisory Council members serve on a number of boards and committees, including *mental health center board, residential facility board, church board, and American Legion event committees.*

An important part of any community awareness activity is educating public officials. The Dakota County Advisory Council *keeps their County Board of Commissioners informed about mental illness* while the Dakota County AMI stays *visible at public hearings* to present priorities.

Presentations to local churches, service clubs, and other community organizations help keep mental health and mental illness visible to the community and improve community understanding. Dakota County AMI members participated in a *"Breakfast with the Experts"* for county employees.

The Dakota County AMI received a *proclamation from the county board, declaring May as Mental Health Month.* They kicked it off with an *ice cream social.* They also sponsored a local residential facility for *community night at a sporting event.*

The Duluth Area AMI sponsored a *series of free community seminars through their Community Education program* entitled "Mental Illness/Mental Wellness." The presentations included a video, followed by a panel discussion by a professional, consumer, and family member.

The Goodhue County AMI chapter *distributed information* to *key city and county officials.*

The Grant and Ottertail County Advisory Council, in conjunction with the Lakeland Mental Health Center, have *provided church and service groups with mental health information.*

The Hennepin County Mental Health Advisory Council has been active in *media watch activities, including opinion/editorial letters* to a major newspaper, in response to offensive stories or ads.

In addition, Hennepin County Social Services has coordinated *mental health roundtables, bringing together county officials in areas of recreation, law enforcement, housing, education, etc. to address mainstreaming issues and provide ideas for adapting programs* for citizens with mental illness.

Understand mental illness

EVERY MIND MATTERS

The Hennepin County MHA chapter created a *videotape,"Bridge to Understanding" to increase understanding about residential treatment facilities* for persons with mental illness.

Isanti County Advisory Council *trained law enforcement about mental illness,* and provided a resource guide.

In Kandiyohi County, MHA members have presented *information through "sandwich boards."*

The Koochiching County Advisory Council educates the community, via a *newspaper column.*

The Mental Health Association of Minnesota's *D/ART program has presented information on depression to schools, churches, libraries, and media* in communities across Minnesota. In addition, local chapters hold community awareness activities for Mental Health Month each May.

The Children's Mental Health Initiative has *organized parents of children with emotional disabilities* for identification of needs and organization of support and advocacy networks. In addition, the Children's Mental Health Subcommittee of the State Advisory Council advises on service needs and promotes understanding of the mental health needs of children and families.

Mower County's local advisory council has distributed *information to churches.*

In Ramsey County, the local Advisory Council has held *presentations on mental illness and stigma, and broadcast them on cable TV.* These presentations focus on the strengths and capabilities of people with mental illness.

The Refugee Mental Health Program of the Community University Health Care Center in Minneapolis has *interfaced with leadership of the Hmong community* to create awareness of refugee mental health needs.

Rice County coordinated a variety of public information activities, including *media coverage* concerning depression in elderly people, presentations on *mental illness and the church community,* and educational *programs for therapists and for families.*

In Rochester, local AMI members *contacted members of the Appropriations Sub-Committee of Congress* to urge their approval of a $500 million dollar budget for mental illness research.

The Range Mental Health Center in St. Louis County, has utilized the area's *community education, park and recreation, and vocational institutes to promote information about mental illness.*

The St. Louis County Mental Health Advisory Council has held *"Mental Illness Awareness Sundays" at local churches to promote information and understanding* about mental illness. Pastors give workshops to clergy, and consumers and families share their stories.

The 26th Street Project, a community-based program of the Mental Health Association of Minnesota, has held an *"art fair" and display of the original poetry and art work, created and sold by consumers.* Focusing on their creative abilities, the program helped raise awareness of the abilities of "disabled" people.

In Washington County, AMI members held a *meeting with area legislators* to discuss issues which affect people with mental illness. In addition, local Advisory Council members have maintained visibility at county fairs and health fairs.

Contributors to list include Jean Brown -Dakota County Mental Health Advisory Council Chair, Chuck Krueger-Alliance for the Mentally Ill of Minnesota, Bruce Weinstock-DHS-Mental Health Division Local Advisory Council Liaison, and other local advisory council chairs, consumers, providers, and advocates across Minnesota

More Ideas for Mental Illness Awareness

Creating Mental Illness Awareness in Business

Contact your local chamber of commerce. Educate them about the prevalence of mental illness and the effect on the business community. Encourage their support in organizing a breakfast meeting for local businesses to discuss mental health issues of interest to business: win-win opportunities for business and disabled workers, prevention, early intervention, and rehabilitation for workers with emotional problems or mental illness, ways that business can support the needs of persons with mental illness in the community, etc. Provide them with materials to support employee education about mental health and mental illness at their workplaces. Ask for their support in planning other public awareness activities.

Creating Mental Illness Awareness in Education

Contact your local school district. Educate them about the prevalence of children with emotional disturbance. Encourage their support in planning a workshop for teachers on recognizing and supporting children with special emotional needs in the classroom. Or suggest a mental illness awareness program for students during Mental Illness Awareness Week or Mental Health Month. Provide them with resources, and tools that they can use to implement mental illness education programs. Ask for their support in planning other community awareness activities.

Creating Mental Illness Awareness in Health and Human Service Professionals

Contact professional associations for various professions in your community, such as doctors, nurses, social workers, emergency workers, etc. Educate them on the prevalence of mental illness. Remind them of the likelihood of their being the first professional that a family or individual approaches for care for mental health concerns. Offer to provide a symposium about mental illness. Ask for their support, sponsoring an ad in a local publication or other activities.

Creating Mental Illness Awareness in Churches

Contact your local council of churches. Educate them about the prevalence of mental illness and encourage them to make mental illness awareness a priority in church worship, activities, and education. Suggest a "Mental Illness Awareness Sunday" to educate and support families community-wide. Provide them with materials to support a community-wide or single church effort, including the videotapes within this kit. Ask for their support in providing volunteers to offer support to persons with mental illness living in the community.

Creating Mental Illness Awareness in the Media

Contact your local media, advertising, or public relations organizations. Educate them about the prevalence of mental illness and ask their help in creating greater public awareness about mental health and mental illness. Suggest a series of reports on mental illness. Offer story ideas and interview subjects. Ask for their support in planning creative campaigns in your community.

Building Mental Illness Awareness:
Tips for Promoting your Project or Event

The success of your public awareness efforts depend on your ability to utilize the communication resources in your community. *The following include suggestions to help you identify your community's public relations resources, as well as to help stimulate other creative ideas to reach the public.*

Building public awareness on an individual level

Networking is one of the important ways to promote your project. The goal of networking is to make connections with people and to maintain and foster those connections to establish relationships. By establishing those relationships, you will open up opportunities to make even more connections.

When networking, in business or social situations, share information about your activities in mental illness awareness. Chances are the person that you are talking to knows or cares about someone with an emotional problem or a mental illness.

Identify key community leaders and determine ways to get them involved in your project. Invite them to serve as advisors on your committees or as honorary chair-persons for a special event. Ask them to identify other key people that may have an interest in the subject.

Watch how other organizations are creating awareness for their causes. Meet with them to share ideas and explore opportunities for collaboration on disability awareness or health promotion.

Get involved in other types of voluntary organizations, service clubs, or community activities. This is an important way to meet people, make connections, and identify additional resources to help your project.

Building awareness at the group level

Get the word out by speaking to small or large groups. Identify people within your group that are good speakers and can effectively present. Identify topics, using the *"Samples scripts for presentations and interviews"*, to get you started. Also use the materials or videos in this kit as supplemental handouts.

Identify speaking opportunities in your area. Many organizations are looking for good speakers on relevant topics for their monthly meetings. Potential audiences include service clubs, social clubs, churches, business associations, schools, etc.

Promote the availability of your speakers bureau on mental health topics. Send a letter and follow-up with the organizations to whom you are interested in speaking.

Building awareness through the use of community organizations

Add expertise to your project by involving business or community organizations to help get information out to the public.

Ask professional associations, particularly those in the advertising and public relations fields, for their expertise with your public awareness efforts.

Ask a local business or corporation for the voluntary use of their employees from relevant departments to assist with specific expertise or tasks.

Involve schools in your project. Ask to have your issue discussed as a class project. Involve a public relations class to consult on your campaign development. Invite an interested intern to participate in your project for school credit.

Building awareness through the use of the media

Make use of the time available on radio and TV talk shows and cable programs to share information with the public. Also involve newspaper reporters and editors.

As with group presentations, identify good spokespeople from your group or organization who are capable of being interviewed on mental health topics.

Identify the media opportunities in your market. Check radio stations, TV news and talk shows, and cable programs that provide information on similar topics. Also call the stations and ask about their formats and who to contact.

Make a pitch to the media, using some of the ideas listed in this kit, under *"Story Ideas on Mental Health Issues."* Write a personal letter to the program director or reporter, or send a news release, using the information on *"How to write a press release"* or *"Making your pitch to the news media."* Follow-up to discuss your idea personally.

Be prepared to provide a some background information to the reporter or producer, if desired. Use materials from this kit, particularly in the section on Mental Illness in the Public Eye.

Stay visible in the media, through community calendars, letters to the editor, and other services available through radio, TV, cable, and newspaper media.

Keep in touch with the media periodically to remind them of your availability.

Create a media event by inviting a celebrity to speak at your event. Utilize sports, news, or entertainment personalities in your area, or invite a non-local celebrity who is performing in the area, or a famous person who is from your community.

Other ways to gain visibility in your community

Utilize the tools in this kit to gain public awareness. Post the *posters* in key locations, with the support of the sponsoring organizations. Ask for public service space in local publications, utilizing the enclosed *print ads*. Ask local television and cable stations to air the *public service announcement* (described in this kit) and suggest to radio stations that they have their announcers read the *radio public service announcement*. Use the logos to create visibility on buttons, bumper stickers, grocery bags, and other communication tools.

Keep a scrapbook recording all presentations, news clippings, articles, media coverage, and other results from your program promotion.

Mental Illness and Housing

This section provides information about, and need for, housing and housing support services for people with mental illness. The target audiences for materials in this section include neighborhood associations, landlords/realtors, program providers, and consumers. Materials in this section include:

The Concept of Housing-as-Housing
Describes the concept of housing-as-housing, recognizing that persons with mental illness have the same desire as all people to live in decent, safe, affordable, and independent housing

Housing in Minnesota
What Minnesotans with mental illness want in terms of housing and how Minnesota is responding to their housing needs

Minnesota's Comprehensive Mental Health Act
A summary of the Act and its mandates for housing and support services for persons with mental illness

Understanding the Fair Housing Amendments Act
The Fair Housing Amendments Act and what it means for people with disabilities

What to Do if You are a Victim of Housing Discrimination
Steps to take if you or a family member are denied housing due to a disability

Resources for Mental Illness and Housing
Educational materials and housing resources available in Minnesota

The Concept of "Housing-as-Housing": Separating Housing from Treatment Services for Persons with Mental Illness

In the past, community mental health professionals and the community at large have held the view that mental health residential treatment services offer a continuum of treatment for persons with mental illness, whereby individuals progress from one type of treatment facility to the next, but with little opportunity for independent living. This view falsely suggests that persons with mental illness are simply clients, and that housing for persons with mental illness is limited to community-based residential treatment facilities.

A more recent model changes the concept of housing, away from its tie to a treatment regime, and to the concept of "housing-as-housing". The housing-as-housing approach states that people with mental illness should be able to select and obtain the same ranges and types of living situations available to the general public; decent, stable, safe, and affordable housing.

The housing-as-housing approach recognizes people with mental illness as members of the community, and increases opportunity for their acceptance in the community. *The following explains housing-as-housing and the principles suggested by this approach.*

Understanding the concept of housing-as-housing (1)

Housing-as-housing is the provision of permanent, individual housing that is not inherently a treatment or services setting, but a place to live rather than a place to be treated.

Individual dignity, the right to privacy, individual choice, and community integration are important to everyone, including persons with mental illness. Group living situations in residential treatment settings have both an internal lack of privacy and an external conspicuousness. In addition, residential settings do not necessarily provide individuals with mental illness the opportunity for community integration and companionship.

Housing-as-housing emphasizes scattered-site, mixed-site design, meaning that *people with mental illness have the right and ability to live in locations throughout the community, and the freedom to live side by side the general community.*

Although housing-as-housing separates housing from treatment services, *support services must be available, if needed or desired* by people with mental illness living in housing in the community, in order to help them sustain in a natural, homey environment. Services may include case management, crisis response, or vocational/employment opportunities. It is noted that some persons may need or desire many services, while others may need or desire only a few, if any, services, and that the intensity of type of services needed may be modified over time as the person changes. *The choice to live in one's own home should not be contingent on the level and frequency of one's needs.*

Not all persons with mental illness need or can benefit from residential treatment programs. *Many people with mental illness simply need safe, affordable, and*

independent housing located in the community with the availability of support services. Many people with mental illness do not need a community-based residential treatment facility.

The principles of housing-as-housing (2)

People with mental illness choose their own living situation

Consumers of mental health services should have the opportunity to make their own decisions regarding their lifestyle and the services they need.

In order for consumers to have these choices, they need a variety of real options, the knowledge of those options, and the support for their choice to become a reality. And by taking a risk and pursuing their choice, they will have greater opportunity for gaining increased self-confidence.

Mental health providers and the general community must learn that people with mental illness are aware of their own preferences, have the skills to make trade-offs, and are aware of their own special needs and have access to the services to meet those needs.

People with mental illness live in normal, stable housing, not in mental health programs

Existing and future housing opportunities must be assessed and liaisons should be established with public housing agencies, landlords, etc.

People with mental illness have the services and supports required to enable them to remain in the living situation they have chosen

Support services may include mental health crisis response, medication monitoring, supportive treatment, skills training, income entitlements, employment, housing, legal services, protection and advocacy, health services, needs assessment, support for their families, and information for their landlords and employers.

Individuals with severe and disabling mental illness should choose their own living situations; should live in normal, decent, stable housing, not in mental health programs; and should have the services and supports required to enable them to remain in the living situation they have chosen.

1 *from the Ohio Department of Health "Housing-as-Housing" Discussion Paper*
2 *from the Center for Community Change through Housing and Support, University of Vermont*

Housing in Minnesota:
Opportunities for Persons with Mental Illness

Housing in Minnesota: The Governor's Commission on Affordable Housing (1)

In response to concerns about the provision of decent and affordable housing in Minnesota, Governor Perpich appointed a Commission on Affordable Housing for the 1990's. Three factors have resulted in the need for state action on housing: 1) decreases in federal support for housing, 2) changes in Minnesota demographics, increasing the need for low income housing, and 3) more pronounced housing needs of special populations including people with mental illness, people with physical disabilities, families, and homeless people.

The Commission adopted principles to guide the development of recommendations:

1) All Minnesotans have the right to decent, affordable housing.
2) The state should first assist those most in need of help and who are most at risk of suffering from a lack of decent and affordable housing.
3) The state must recognize the needs of both renters and homeowners.
4) Communities in all parts of Minnesota must be helped with new programs, as needs differ and local communities can best determine their own needs.
5) Long-term affordability should be an objective of all activity.

As a result of the Commission, the Governor appropriated $2.75 million dollars for low-income housing, of which a portion is designated for use by people with mental illness. Such housing is coordinated with the provision of support services.

Housing in Minnesota: Department of Human Services Pilot Projects (2)

The Minnesota Department of Human Services, Mental Health Division, funds a number of qualified pilot projects for housing support services for persons with severe and persistent mental illness. Pilot projects are located in Blue Earth, Carver, Clay, Hennepin, Itasca, Kandiyohi, Olmstead, Ottertail, Ramsey, and St. Louis Counties.

These projects provide an array of housing support services for people with mental illness when they are discharged from treatment facilities, and for those already living in the community. They also help people obtain and maintain long-term housing, and maximize their dignity, so that they can develop their lives and skills in the most appropriate housing available.

Types of projects in operation include those that provide assistance with *locating and maintaining housing of choice*; *independent living skills, social and recreational activities, and the use of community resources*; 24-hour per day *response mechanism in case of emergency*; *additional support services*, such as personal care, transportation, money management, housekeeping, etc.; and *applying for government assistance* and benefit programs, particularly housing assistance.

These projects are in accordance with the Division's mission statement:

All people with mental illness should live in decent, stable, affordable housing, in settings that maximize community integration and opportunities for acceptance. People should actively participate in the selection of their housing from those living

environments available to the general public. Necessary support services should be available regardless of where people choose to live.

Housing in Minnesota: Other programs available for persons with mental illness (2) (3)

The Mental Health Division is the administrative agent for the Stewart B. McKinney Block Grant for Mental Health Services for Homeless People. The grant is federally administered by the Alcohol, Drug Abuse, and Mental Health Administration and the United States Department of Health and Human Services. The Minnesota Department of Human Services distributes money to local programs to provide outreach, mental health services, referrals, case management, supportive services, and housing services to homeless persons with mental illness. The following counties have funded projects: Anoka, Blue Earth, Clay, Hennepin, Polk, Ramsey, St. Louis (in Duluth and in the Range area) Counties.

In addition, the United States Department of Housing and Urban Development (HUD) has several housing programs that can provide low-rent housing for disabled persons, including those persons with mental illness. These programs include low-rent public housing (owned and managed by the Public Housing Authorities), Section 8 certificates and vouchers (administered by a local Public Housing Authority) Section 202 Housing (owned and managed by private non-profit organizations), and other programs.

Housing in Minnesota: Consumer attitudes about housing (2)

A survey of hospital staff and client perceptions about post-hospital placement found that *65% of clients were most satisfied with independent living settings*, while 53% were satisfied with Rule 36 program settings and 47% with living with relatives. Staff on the other hand had different perceptions: most were satisfied with client placements in Rule 36 facilities, but were less favorable of client's living with relatives or independently. (Office of the Legislative Auditor, 1989)

The *percentage of Minnesotans with mental illness indicating they were living where they wished to be living was the highest (72%) for those living independently*, while only 30% of persons living in residential treatment settings indicated that they were living where they wanted. (Ernst and Whinney, 1988)

A consumer survey conducted at the University of Vermont (Tanzman and Yoe, 1989) found that *the majority of consumers (70%) preferred subsidized rental housing*. This reflects both their preference and their income level, which is typically far below that which would permit them to rent or buy on the open market.

In a meeting between the Minnesota Department of Human Services and consumers to identify the most pressing needs in the area of residential services, *consumers requested more options beyond Rule 36 facilities, which are highly structured and offer little privacy, and complete independence. They further requested the availability of additional support services*, ranging from someone to chat with to crisis assistance, transportation services, and independent living skills training. In addition, they urged that *skills training be offered by consumers, to help build confidence among those providing services, and in turn to build a network of knowledgeable, involved consumers.*

1 *from Recommendations from the Governor's Commission on Affordable Housing for the 1990's, 1989*
2 *from the Minnesota Department of Human Services, Mental Health Division*
3 *from the Minnesota Office of the United States Department of Housing and Urban Development*

Minnesota's Comprehensive Mental Health Act

In 1987, the Minnesota Legislature passed the Minnesota Comprehensive Mental Health Act, ensuring a unified, accountable, and comprehensive mental health service system that recognizes the rights of people with mental illness, promotes the independence and safety of people with mental illness, reduces the chronicity of mental illness, and provides quality services to stabilize, support, and improve the functioning of people with mental illness.

The Act mandates that housing services be provided as part of a comprehensive mental health services system:

> *All people with mental illness should live in decent, stable, affordable housing, in settings that maximize community integration and opportunities for acceptance. People should actively participate in the selection of their housing from those living environments available to the general public. Necessary support services should be available regardless of where people choose to live.*

The Act also mandates the availability of community support services.

> "County boards must *provide or contract for sufficient community support services* within the county to meet the needs of adults with serious and persistent mental illness residing in the county."
>
> "The community support program must be designed *to improve the ability* of adults with serious and persistent mental illness; *to work in a regular or supported work environment, to handle basic activities of daily living, to participate in leisure time activities, to set goals and plans, to obtain and maintain appropriate living arrangements, to reduce use of more intensive, costly, or restrictive placements both in number of admissions and lengths of stay as determined by client need.*"

Proposed rule language further defines the community support program component for housing:

> "The county board shall *develop, identify and monitor community living arrangements services* for adults The services shall:
>
> - assist the adult *to obtain and maintain a living arrangement that is least restrictive and most appropriate* to the adult's needs, including if needed, referrals to housing services such as the Minnesota Housing Finance Agency, local housing authorities, subsidized housing programs, realtors, or private apartment rental services;
>
> - *include periodic visits to the adult's living arrangement* to ensure that the adult's health and safety are being maintained;
>
> - *not include the direct provision of, subsidization of, or payment for home care, homemaker services, or shelter*, except as provided under crisis assistance placements. "

Understanding the Fair Housing Amendment Act of 1988: What it means for people with mental illness

The Fair Housing Amendments Act of 1988

In 1968, Congress enacted Title VIII of the Civil Rights Act of 1968, popularly called the Fair Housing Act, to end racial discrimination in housing. Twenty years later, Congress amended the law to extend fair housing to persons with disabilities, including mental disabilities. It is now unlawful to discriminate against persons for desired housing on the basis of their race, color, national origin, sex, *as well as* handicap. Discrimination includes a variety of unlawful activities, such as coercion, intimidation, threats, interference, steering, blockbusting, limiting accessibility, or falsely representing a dwelling.

Purpose of the Act

The Fair Housing Amendments Act is a pronouncement of a national commitment to end the unnecessary exclusion of persons with handicaps from mainstream America. Thus, the views of hostile or uncomfortable neighbors, landlords, or legislators can no longer control the housing choices of people with mental illness.

Key Definitions

"Handicap" is defined with respect to a person's 1) physical or mental impairment which substantially limits one or more of such person's major life activities, 2) a record of having such an impairment, and/or 3) being regarded as having such an impairment.

"Steering" refers to practices designed to discourage or direct a person who is seeking housing in a particular community.

"Blockbusting" refers to any effort to induce or attempt to induce a person, for profit, to sell or rent a dwelling.

Discriminatory housing practices has been expanded to include coercion, intimidation, threats, or interference with any individual in the exercise or enjoyment of any right granted or protected by these fair housing amendments.

Description of Discriminatory Housing Practices

Whenever possible, Congress simply amended the Fair Housing Act to include "handicap" in the list of prohibited reasons for engaging in a particular housing activity. Thus discrimination in printed advertisements, representations of availability of housing, and blockbusting activities is unlawful.

In addition, Congress expanded upon the original provisions of the Fair Housing Act with additional disability specific provisions. These include:

It is unlawful to discriminate in the sale or rental, or to otherwise make unavailable or deny a dwelling to any buyer or renter because of a handicap

of (1) the buyer or renter, (2) a person residing in or intending to reside in the dwelling, or (3) any person associated with the buyer or renter.

It is unlawful to discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with such dwelling, because of a handicap of (1) that person, (2) a person residing in or intending to reside in that dwelling, or (3) any person associated with that person

It is unlawful to refuse to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling. Therefore, handicapped tenants cannot be barred individual access to recreation facilities, parking, cleaning services, use of premises, and any other benefits and privileges made available to other tenants, residents, and owners. As an example, recreational activities must be held in an accessible space, though it is not necessary to hire a special recreation or social service worker to provide services for the tenant.

It is unlawful for state and local health, safety, land-use and zoning regulations to exclude or restrict people with disabilities from living in group homes or other community-based residential treatment programs. Therefore, negative attitudes, prejudices, or fears on the part of neighbors cannot keep a program out of a neighborhood, nor be used to restrict the housing options of people with mental illness.

Another statute assures that extending civil rights protections to all people with disabilities will not limit property owners' rights to maintain a safe property. Therefore, a dwelling does not need to be made available to an individual whose tenancy would constitute a direct threat to the health or safety of other tenants or of property.

The Act also limits the questions that a property owner may ask of a prospective tenant to those asked of all applicants. The owner may ask an individual questions asked of other tenants that relate directly to tenancy, such as rental history, but may not ask if the prospective tenant has a disability or ask for information regarding medical history. The only exception is that a property owner may ask whether an individual is a current illegal abuser or addict of a controlled substance.

In addition, the Act establishes standards for accessibility and adaptability for new multi-family construction, such as accessible space in common use areas, doorways designed for passage, and adaptive design throughout the dwelling, in kitchens, bathrooms, and appliances or outlets.

<u>How to handle violations</u>

Complaints are to be submitted in writing to the Department of Housing and Urban Development in Washington, or the regional HUD office or a local agency (State Department of Human Rights). Complaints must contain the name and address of the aggrieved person, the name and address of the respondent, description and address of the dwelling, and a concise statement of pertinent dates and facts.

What To Do If You Are A Victim of Housing Discrimination

What is Illegal Housing Discrimination?

Under the Minnesota Human Rights Act, and the Fair Housing Amendments Act, illegal discrimination in housing occurs if:

Owners or agents refuse to sell or rent, advertise, or use applications which express discrimination or include terms which discriminate on the basis of race, color, creed, religion, national origin, sex, marital status, disability, public assistance status, and in most situations familial status.

Financial institutions or lenders refuse financial assistance, or use applications which limit or discriminate on the basis of race, color, creed, religion, national origin, sex, marital status, disability, public assistance status, and in most situations familial status.

What can you do if you believe you are victim of housing discrimination?

The Department of Human Rights advises that any person who experiences discrimination as defined by the Human Rights Act may file a discrimination charge, through the following process:

The party who is alleging discrimination may call for information or file a discrimination charge with:

Minnesota Department of Human Rights
500 Bremer Tower
7th Place and Minnesota Street
St. Paul, MN 55101
612-296-5663 / Toll Free 1-800-652-9747 / TTY 612-296-1283

The Department will conduct an investigation into the charge in an attempt to uncover evidence to support the allegation.

If the findings support the charge, the department issues a determination of probable cause, and becomes an advocate for the charging party.

If the findings indicate that there was not enough information or material to support the allegation, and thus no probable cause is determined, the charging party may appeal the decision.

Attempts at settlement are made throughout the process. When attempts fail, the case is referred to a special assistant attorney general who prepares the department's position for a public hearing. The hearing involves the review of all evidence and facts by the administrative law judge who then issues an order. The order of the administrative law judge may then be appealed to the Court of Appeals and then to the Minnesota Supreme Court.

from the Minnesota Department of Human Rights

Resources for Mental Illness and Housing

Educational Materials on Housing and Mental Illness

Dr. Paul Carling on Housing
A 74 minute video by a nationally recognized expert on housing talks about the housing needs of persons with mental illness and strategies for meeting those needs (available from the Alliance for the Mentally Ill/Minnesota, 612-645-2948)

A variety of additional materials and articles about mental illness and housing are available from the Minnesota Department of Human Services-Mental Health Division. For more information, call 612-296-2307.

Additional information on mental illness and housing is available from the Center for Community Change through Housing and Support, University of Vermont, 802-656-0000

General housing information can be obtained from the Minnesota Office of the United States Department of Housing and Urban Development. For more information, call 612-370-3000

Housing Resources and Services

A number of HUD programs are provided by local housing authorities, whose jurisdiction is in either your city or county. *For more information, contact:*

- *United States Housing and Urban Development, 612-370-3000*
- *Minnesota Housing and Finance Agency, 612-296-7608*
- *Your City or County's Housing and Redevelopment Authority, listed in your phone book's government listings under your county or city*

Mental Illness and Community-based Residential Treatment

This section provides information about, and support for, community-based residential treatment for people with mental illness, as well as ways programs, neighbors, and communities can work together toward greater community acceptance. The target audiences for materials in this section include neighborhood associations, landlords/realtors, program providers, and consumers. Materials in this section include:

Facts about Mental Illness and Community-based Residential Treatment
: The need for community-based residential treatment for persons with mental illness, the options (and gaps) available, and the ways that neighborhoods are responding

Community-based Residential Treatment Options
: A summary of the types of community-based treatment available for adults and children in Minnesota

Alleviating Neighborhood Concerns
: Common questions and answers raised about mental illness and community-based residential treatment

Undoing the Myth of Property Devaluation
: A literature review examining the effect of community treatment programs on property values and community attitudes

Strategies for Cooperation and Acceptance
: Suggestions of ways that people with mental illness and their neighbors can work together to enhance community relations

Resources for Mental Illness and Community-based Residential Treatment
: Educational materials on residential treatment, including pamphlets, booklets, and videotapes

Facts about Mental Illness and Community-based Residential Treatment

Mental Illness in Minnesota

Approximately one percent of the adult population, or approximately 29,000 people in Minnesota, has serious and persistent mental illness. (1)

Approximately 3000 Minnesota children were admitted to residential treatment centers for treatment for emotional disturbances in 1987. (2)

Contrary to long-standing assumptions, there is real potential for improvement and recovery among many of the most seriously disabled people. Some symptoms go into remission, while other people learn effective ways of coping with their illness. (3)

Much of the success of treatment and recovery for persons with mental illness depends on helping them learn to become more comfortable and less isolated in handling the stresses of daily living. Community-based residential treatment can assist persons with mental illness in developing skills for independent living or for returning home, and improving their chances for recovery. (4)

Community-based residential treatment options for persons with mental illness are a more cost-effective investment, in relation to long-term hospital placement. (4)

Community-based Residential Treatment Options, Needs, and Availability

Adult persons with mental illness live in a variety of types of treatment, residential treatment, and independent living settings in Minnesota: (3)

- Inpatient psychiatric units, providing short term care, either in community hospitals or regional treatment centers
- Treatment programs or "Rule 36" facilities, with professional staff and educational and therapeutic programming
- Respite care homes for temporary residence
- Supported apartment living, where persons live semi-independently in apartments and receive regular community support services
- Boarding homes, providing room and board and, in some cases, care and supervision
- Independent living (*this is the most common living arrangement for persons with mental illness in Minnesota*)

In addition, adolescents with emotional and behavioral disorders live in shelters, group homes, and residential treatment centers, though most live with their families. (4)

Persons with mental illness comprise an estimated 20-30 percent of Minnesota's homeless population. (5)

Many adults with mental illness must live with their families (5)

The nearly 2000 beds in "Rule 36" residential treatment facilities are inadequate to serve persons with mental illness, partly because clients who are ready to leave cannot find alternative housing. (5)

Few supported or transitional apartments for semi-independent living exist in Minnesota. (5)

Many of the treatment programs for persons with mental illness are concentrated in high crime areas, rather than spread evenly throughout metropolitan areas (5)

Persons with mental illness must compete for a declining supply of decent, affordable, low income housing. (5)

Low income housing units are diminishing. New subsidized housing units in the metropolitan area decreased from over 2000 in 1980 to 135 in 1983-1986. (5)

Rents in the Twin Cities metropolitan area increased by 66 percent from 1980 to 1986 (5)

Neighborhood Acceptance of Housing for Persons with Mental Illness

Neighbors living within one block of a treatment program indicated that they have good or neutral impressions of the residents. (3)

74% said the program was a good neighbor, 13% said the program was somewhat of a good neighbor, and 11% said that the program was not a good neighbor.

27% said that there have been program-related problems or incidents in the past two years. Of those, nearly half indicated that the staff have been very willing to listen to the neighborhood's concerns.

14% said that the program makes them more likely to move out of the neighborhood, while 82% said that it does not.

Few neighbors had negative comments regarding their treatment program neighbors. (3)

1 *from "A Report to the Legislature re: Community Residential Treatment Programs in Minnesota", 1989*
2 *from Children's Mental Health Initiative Fact Sheets, 1988*
3 *from "Community Residences for Adults with Mental Illness", 1989*
4 *from "Not in My Backyard", Hennepin County Community Services, 1988*
5 *from the League of Women Voters Study on "Mental Illness in Minnesota", 1988-89*

Community-Based Residential Treatment Programs: Options for Persons with Mental Illness

There are a variety of different types of treatment programs in communities across Minnesota. As a close or distant neighbor to some of these types of programs, you may have questions about the various types of programs, as well as the kinds of people that are served by these programs.

Residential programs are generally classified by the particular licensing regulations which govern their building, services, and client populations. Each program must have a health licensee or certification from the city or state health department, which establishes standards for food preparation, nutrition, hygiene, and/or health care services. In addition, each community-based residential program also holds a program license from the Minnesota Department of Human Services, which includes requirements for treatment and rehabilitation services, staffing, client records, etc.

Funding for these programs varies widely and may be provided through any combination of federal, state, county, insurance, or private sources. Counties may contract directly with some program operators and closely monitor their funding and programs. Referrals may be handled through the county social services system or privately.

The following is a list of the types of community-based residential treatment programs in many Minnesota communities, serving mentally ill adults or emotionally disturbed children:

Adult Programs

Residential Treatment Program for Mentally Ill Adults (DHS Rule 36)
Residential Treatment Programs provide transitional (2-18 months), intensive (18-36 months), or supportive (over 3 years) living for adults. These programs offer training in independent living skills, medication supervision, and counseling to adults with emotional disabilities. Programs provide many services on-site, but clients are also involved with recreational or vocational resources in the community.

Board and Lodging Programs/Rooming Houses with Meals (licensed by the Department of Health)
Board and Lodging Programs offer semi-independent living to adults on a short- or long-term basis. Residents are provided with a room, three meals a day, laundry services, and a room for TV or socializing. A few offer recreational activities, but unless they also have a DHS program license, they provide no rehabilitation services and little supervision. Clients are generally low income and single. They are often vulnerable due to age and emotional problems

Boarding Care Programs (licensed by the Department of Health)
Boarding Care Programs provide 24-hour supervision, limited nursing services, medication distribution, and recreational activities, usually on a relatively long-term basis. Clients have *physical or medical needs*, in addition to emotional problems. Some may move to more independent living settings, others with serious and persistent medical needs may eventually move to nursing homes.

Children and Adolescent Programs

Treatment Group Homes for Adolescents (DHS Rule 8)
Group Homes provide relatively short-term (3 months to one year) counseling support and supervision to teens with emotional, behavioral, and/or family problems that require treatment, but are not so severe as to prohibit living in an open community setting and attending community schools.

Residential Treatment Centers for Children and Adolescents (DHS Rule 5
Residential Treatment Centers serve clients 5-18 years old, who have more serious emotional problems that necessitate treatment setting for 12-18 months. Most services are provided on-site.

Other Types of Community Residential Programs serving non-mentally ill persons

There are other types of community residential programs that serve children and adults with other disabilities or health problems.

Residential Programs for Mentally Retarded Children or Adults (DHS Rule 34)
Rule 34 programs may provide short-term or lifelong care to mentally retarded persons who need assistance with developing independent living skills. Residents also may attend specialized day programs, such as school, training, or sheltered employment.

Residential Programs for Physically Disabled Children and Adults (DHS Rule 80)
Programs for persons with physical disabilities may provide short-term rehabilitative services, to enable clients to learn to cope or compensate for their handicaps, or they may provide longer term care and support. Physical handicaps may include cerebral palsy, epilepsy, or mental retardation.

Residential Programs for Chemically Dependent Persons (DHS Rule 35)
Chemical dependency residences may offer treatment for 3-6 months for persons engaged in harmful chemical use, or short- or long-term halfway houses programs for persons in the early stages of recovery. Vocational training and other counseling is provided.

Mental Illness and Community-based Treatment: Alleviating Neighborhood Concerns

When residential treatment programs or group homes for persons with mental illness move into a neighborhood, neighbors often have questions or concerns regarding how the new program will impact their area. Typically, these concerns are based on lack of information about mental illness and persons with mental illness. *The following addresses some of the common questions raised about mental illness and community-based treatment.*

"What can I expect of people with mental illness living in my neighborhood?

Most of us know someone with a mental illness, because mental illness strikes one in four families.

You can expect things of your new neighbors that you would expect from any neighbor, such as mutual respect of property and privacy. Some residents have been placed at the residential program to help them in developing or improving independent living skills, and may at times seem to have some difficulty with their social skills. One of the reasons why community placement is so valuable to persons with mental illness is that people can learn or relearn important skills for independent living.

Will my family and I be safe? Are people with mental illness dangerous? Will there be more crime in the neighborhood?

Unfortunately, movies and television often portray persons with mental illness as unpredictable and violent. This promotes a negative and inaccurate stereotype of mental illness.

In reality, persons with mental illness are no more likely to commit criminal acts than persons without mental illness. In a study of people who had been treated for mental illness, only one tenth of one percent were arrested for violent crimes. In each of those few cases, all had a criminal record before their treatment for mental illness. In other words, a person who has been treated for mental illness and does not have a previous criminal record, is considered to be less likely to be arrested than the average citizen. In addition, because mental illness often makes people more passive, persons with mental illness are more likely to be victims, not perpetrators, of aggressive acts.

People placed in residential programs have been carefully screened and selected for community placement, based on their readiness for community living.

How will the residential program fit into my neighborhood? What do others have to say about programs in their area?

In Minnesota, neighbors living near residential programs have had good or neutral impressions of them. In a survey of 65 people living within one block of a program, 74% said that the program is a good neighbor. Many said that they had initial apprehensions about the program, but have not experienced any significant problems. Most said they prefer a smaller program to a larger one.

The following are comments made by Minnesota residents about what is has been like living near a residential treatment program for persons with mental illness. (1)

"Because there are many problems in the city, I'm happy to have this residence making good use of a big house and providing a service to the clients. They are basically quiet and present no problems. They keep the outside neat. I'm pleased with their location in this area."

"We make it a point to visit the program because we like to know what is going on there. We're glad that the program is there. The previous owner didn't keep the place up real well."

"Sometimes the residents behave strangely. But these people who have to live somewhere and have to learn to deal w

How are residential programs supervised? Who can go to if I have concerns?

All programs are staffed according to the needs of the people who live there. Some clients may need intensive structure and support, while others will need only occasional assistance. Therefore, staffing may be full-time and intensive in some settings, while others provide more general, less structured support services

Each residence has staff who are there to provide monitoring of residents, support and programming for residents, and assurance that all problems are identified and resolved. It is best if neighborhoods establish open and positive communication between staff, residents, and neighbors from the beginning, so that realistic and mutual expectations can be discussed, and problems, if any, can be openly addressed and resolved.

How will my property value be affected? Will there be high turnover in the neighborhood ?

Research has demonstrated that the presence of a residential treatment program has no negative effect on property value, time for re-sale, or neighborhood turnover. In addition, residences are often perceived as good neighbors in terms of property maintenance and upkeep.

A recent study assessed the impact of community placement on property value. It compared neighborhoods with group homes with controls and revealed:

No significant increase in property turnover.
No adverse effect on average selling price, but an actual increase in property value.
Sale price as a percentage of the list price increased.
Properties did not take longer to sell.

Thus, it seems that the presence of a group home in a neighborhood may even indicate an upgrading effect on the neighborhood, since improvements are frequently made prior to the opening of the program. (2)

Why my neighborhood?

Persons with mental illness have the same rights as other members of the community to live within the community without neighborhood screening and approval. That right is guaranteed to all citizens, including those with physical or mental disabilities.

A person with mental illness needs the same things as a person without mental illness, in order to live a fulfilled life. These needs include need for community, home, job, hobbies, and family and friends.

How neighbors and treatment programs can live together in mutual harmony

Sometimes the perception or anticipation of a problem, even when no problem or evidence of problems exist, can have a more negative impact than actual facts. In these cases, neighbor's lack of information or understanding about residential treatment or about mental illness can create unnecessary concern.

It is important that both neighbors and residences take time to get to know each other. Neighbors should ask questions about the program and its staffing, criteria for placement, and how the neighbors can help to welcome the program into the area. They should be provided with information to help increase their understanding of mental illness. The program should ask questions about how they can best fit into the neighborhood. They should provide names of contact persons and phone numbers from both the program itself and from local organizations that can respond to questions regarding mental illness and community-based residential treatment.

1 from "Community Residences for Adults with Mental Illness", 1989
2 from Boydell, Trainor, and Pierri, "The Effect of Group Homes for the Mentally Ill on Residential PropertyValues", Hospital and Community Psychiatry, September 1989, 40(9)

Mental Illness and Community-based Residential Treatment
Undoing the Myth of Property Devaluation

One of the most frequently asked questions regarding community placement of persons with mental illness is how will such programs affect property values, housing turnover, and property maintenance and upkeep. *The following is a review of the literature examining the effect of community-based treatment programs on property values and the responses of neighbors in residential areas.*

Property Values, Turnover, and Maintenance

A recent study assessed the impact of community placement on property value. It compared neighborhoods with group homes with controls and revealed: *No significant increase in property turnover. No adverse effect on average selling price, but an actual increase in property value. Sale price as a percentage of the list price increased. Properties did not take longer to sell.* Thus, it seems that the presence of a group home in a neighborhood may even indicate an upgrading effect on the neighborhood, since improvements are frequently made prior to the opening of the program. (Boydell, Trainor, Pierri, 1989)

In a statistical analysis of real estate transactions that occurred before and after the location of eight group homes in Ohio, researchers found *no difference in the measures of property values*, based on length of time on the market and the sale price as a percentage of the list price. (Wagner and Mitchell, 1980)

Over a ten year study of 38 group homes and their impact in the Ottawa area, there was *no evidence that property values or marketability was adversely affected* by the presence of group homes. (Goodale and Wickware, 1981)

A study examining the effect of the introduction of a mental health program on the volume of sales and the selling price revealed that the *introduction of the group home had no effect on neighborhood property values.* (Dear and Taylor, 1982)

Selling prices and turnover rate in areas with residential treatment programs were compared with prices and turnover in areas without such programs. *The presence of mental health programs did not affect sales price, sales activity, or property values.* (Boekh, Dear, Taylor, 1980)

The city planning department of Lansing Michigan compared five neighborhoods with group homes to similar neighborhoods without group homes to determine effect on property values. In four of the five homes in the test area, the *average sales price ratio was equal to or higher than the ratio for homes in the control area.* The presence of the group homes did not have any apparent affect on the number of homes sold. (City of Lansing, 1976)

Using comparable market analyses, professional realtors in two Iowa communities studied the impact of group homes on the value of surrounding property. They found *no negative property value in six of eight cases, and actual increases in property values in the two remaining cases.* (Weiner, Anderson, and Nietupski, 1982)

A study of community residential programs in a New York suburb indicated that the programs have no downgrading effect on the neighborhood. Programs were found to be in the *same or better condition than their surrounding neighbors*. In all but one case, property value increased. (Breslow, 1976)

In Louisiana, studies shown that group homes had no appreciable effect on property value and on the turnover rate of housing in the neighborhood, and that establishment of a group home in the neighborhood did not change the character of the neighborhood. (Louisiana Center for the Public Interest, 1981)

Neighborhood Acceptance

In an assessment of social impact of five community residential programs on the surrounding neighborhoods in an Illinois community, neighbors of programs expressed a *significantly higher degree of approval for the programs than did citizens in the general area.* (Caulkins, Noak, and Wilkerson, 1976)

A study examining public opposition to community programs for persons with mental illness confirmed that *authoritarian personalities tend to be most opposed to community housing, while younger, better educated, and more economically secure persons have more favorable attitudes.* However, parents of young children in both groups were somewhat wary of having a residential program as a neighbor. The study also concludes that stigmatizing false beliefs about mental illness are often effectively used by opponents to rally their neighbors against treatment programs in their neighborhood. (Dear and Taylor, 1982)

In a survey of more than 25,000 residents of Minnesota and Wisconsin, assessments were made of neighbors' awareness and acceptance of group homes, residential turnover, and property values. Researchers concluded that *group homes have a negative impact on 20 percent of the immediate neighbors but that rate decreases after the first block*, that the proportion of homes sold before and after the group home was established remained the same, and that the house nearest the group home sold for 1.53 the assessed value. (Knowles and Baba, 1973)

A New York State community studied the prices of homes sold and the number of sales made before and after the establishment of a group home. They noted average increases of 9% one year after the group home opened. They *recommend that the crucial time to inform, reassure, educate, and support neighbors is three months prior to the opening of a group home.* (Lindauer and Tung, 1980)

Forty-three community residences were studied to examine community opposition. Researchers found that residences whose sponsors had conducted public education were more likely to encounter opposition than residences that opened with little or no advance notice to neighbors. *Opposition was found to be less likely either after it has opened or more than six months before occupancy.* (Seltzer, 1984)

Community opposition to the establishment of residential treatment programs is often grounded in misconceptions and stereotypes. According to one study, *when information was presented to dispel myths of increased crime rates, decreased property values, and diminished neighborhoods, neighbors became more favorably inclined toward the idea of community housing* for persons with mental illness and, over time, more positive about individual residents. (Sigelman et al, 1979)

Mental Illness and Community-based Residential Treatment: Strategies for Cooperation and Acceptance

A positive relationship between communities and the treatment programs they provide for their citizens with mental illness requires a commitment to cooperation by all involved. Whether you are a neighbor, a landlord or a realtor, a manager of a residential program, a community official, or a resident, you have an opportunity to play a positive role in creating harmony in your neighborhood.

The following is a list of tips for communities interested in enhancing relations with their neighbors with mental illness. Specific examples of community cooperation are italicized.

What Neighbors Can Do

Treat residents as equals. Recognize each of them as an individual with problems, not as a collective group of "the disabled".

Include residents in neighborhood activities.

Set a good example for your children; they will learn about acceptance by your actions and attitudes.

Greet residents, and engage them in neighborly communication.

Give yourself a chance to get to know a person with mental illness as a person: *A neighbor in suburban Minneapolis remarks that the residents of a nearby group home have been good neighbors. He also remarked that the property has greatly improved since the program moved in.*

Share accurate information regarding mental illness with family and friends.

What Landlords and Realtors Can Do

Take the time to get to know a person with mental illness as a person: *A landlord for a drop-in center in Fergus Falls encourages being spontaneous and open in conversation with residents, and not being overly concerned about saying the wrong thing.*

Respect residents privacy, including privacy about their mental illness: *A landlord remarks that people with mental illness do not want to be on display. Welcome individuals to be a part of your community, but respect their decision when they choose not to be involved, often due to the stigma many have experienced in the past.*

Sponsor events that support persons living in community-based programs in your community. *A board of realtors in central Minnesota solicit funds from local realtors for an annual holiday party for persons with mental illness living in the community. In addition, county officials, clergy, realtors, and other government, business, and community leaders attend.*

Understand mental illness

EVERY MIND MATTERS

What Program Managers Can Do

Be open to answering their questions about the program.

Stay visible to and become active with city officials and neighborhood leaders.

Get involved in neighborhood activities, whether community-wide campaigns, park board events or informal social gatherings: *A clubhouse and drop-in center in Hopkins takes a leadership role in a community-wide clean-up day.*

Educate neighbors, by example, on ways they can both support the program and benefit from it. *A program manager in suburban Minneapolis comments that the best way to educate neighbors is by quietly and non-obtrusively being a good neighbor.*

Share resources with neighbors: *A clubhouse and drop-in center in Minneapolis shares its snowblower and snowblowing duties with its neighbors; clients snowblow the neighbor's walks on weekdays and the neighbors reciprocate on the weekend.*

What Residents Can Do

Get comfortable with being a part of the community, by attending some neighborhood activities and using community resources.

Give others a chance to get to know you personally.

Take pride in your residence by assisting with program maintenance and yardwork, and by following rules for property maintenance.

What Community Officials Can Do

Make explicit to the general public, through the media and relevant organizations, how policies of deinstitutionalization are being developed and implemented. In educational efforts, provide information using objective facts about the merits of deinstitutionalization. Allow residents themselves to demonstrate the benefits of programs, based on their subjective experiences.

Establish task forces of residents, neighbors, realtors and developers, and program operators, to critically examine and solve housing issues. Explore distribution of programs throughout cities, maintaining a register of vacant and suitable housing, and assessing and enhancing relations between programs and their neighbors.

When making decisions about community-based treatment for persons with mental illness in a new community, recognize that preventing the opportunity for failure also prevents the opportunity for success.

Examine the implications of and the inconsistencies between the Minnesota Statutes requiring special use permits for community-based group home programs, and the 1988 Fair Housing Amendments Act ending the unnecessary exclusion of persons with handicaps from the mainstream.

Specific examples of community cooperation were provided by program providers and neighbors across the state. Ideas for community officials came from the University of Minnesota Center of Urban and Regional Affairs.

Educational Resources for Mental Illness and Community-based Residential Treatment

Understanding Mental Illness

Depression...What you should know about it
A pamphlet explaining depression, its causes, treatments, sources of help, and suggestions for dealing with a depressed person (1)

Finding Help for Depression and Manic-Depression
From the D/ART program, information about types of treatment for depression and where to find help (1)

About Manic Depressive Illness
A pamphlet about the illness and its symptoms, causes, and treatments (1)

Schizophrenia
A pamphlet providing information on definitions, symptoms, and treatment (1)

How to deal with Mental Problems
A pamphlet discussing the differences between normal difficulties and emotional illnesses,with suggestions on how to offer understanding (1)

Give Mental Health a Chance
A brochure, produced by the Hennepin County Mental Health Association, describing mental illness and its incidence, and the problems of stigma (1)

The 14 Worst Myths about Recovered Mental Patients
A brochure which dispels 14 common myths about mental illness and people who suffer from it (1)

Stigma: a lack of awareness and understanding
A pamphlet discussing common misconceptions about mental illness (1)

Mental Health Advocate
A newsletter published six times per year, providing resources and information on mental illness and mental health issues (2)

Understanding Mental Illness and Community-based Residential Treatment

Bridge to Understanding *(included in kit)*
A videotape produced by the Hennepin County Mental Health Association, featuring residents, program directors, and neighbors of community-based residential treatment programs talking about their community living experiences (1)

With Open Arms
Video about community programs that assist mentally ill people (2)

Dr. Paul Carling on Housing

A 74 minute video by a nationally recognized expert on housing talks about the housing needs of persons with mental illness and strategies for meeting those needs (2)

Halfway Houses for Mentally Ill Persons

A videotape discussion on residential treatment for mentally ill persons, featuring program directors, social workers, and family members (1)

Neighborhood Approach to Mental Health

A videotape discussion on community mental health (1)

The Neighborhood Advisory Committee: Prompting Interactions between Residence and Community

A 51 page handbook, for facility operators who want to develop neighborhood advisory committees, with practical information on role, functions, committee guidelines, membership, recruitment, selection, training, and problem resolution (3)

There Goes the Neighborhood

A 74-page summary of studies addressing common fears about the effects of group homes on neighborhoods, of interest to elected officials, municipal staff, community groups, and group home providers (3)

A variety of additional materials about mental illness and community-based residential treatment are available from the Minnesota Department of Human Services-Mental Health Division. For more information, call 612-296-2307.

1....Available from the Mental Health Association of Minnesota (612-331-6840) at nominal charge
2....Available from the Alliance for the Mentally Ill/Minnesota (612-645-2948) at nominal charge
3....Available from Community Residences Information Services Program (CRISP), (914-328-7802)

Mental Illness and Employment

This section provides information about, and support for, mainstream employment for persons with mental illness, as well as strategies for successful job placement. The target audiences for materials in this section include employers, business and professional organizations, chambers of commerce, rehabilitation counselors, and consumers. Materials in this section include:

Facts about Mental Illness and Employment
The effect of mental illness on business and the available programs for workers with mental illness

Alleviating Employers' Concerns
Common questions, raised by employers, about workers with mental illness

Mental Illness and Employment: A Research Review
A literature review examining employer attitudes about mental illness

Strategies for Successful Job Placement
Suggestions of ways that employers, counselors and community support staff, and employees with mental illness can effectively work together toward a successful job experience

Real Life Examples of Successful Working Relationships
Examples of realistic working relationships benefiting Minnesota employers

Returning to Work-Employers Helping Employees
Tips for employers for successful employee transitions back to work after an absence due to mental illness or a mental health need

Returning to Work-Making the Transition Back to Work
Tips for employees for successful employee transitions back to work after an absence due to mental illness or a mental health need

How to Create a Healthy Workplace
Some examples of ways that employers can take a pro-active approach to mental health in the workplace

What to Do if You are a Victim of Employment Discrimination
Steps to take if you or a family member are denied employment due to a disability

Mental Health Educational Materials for Worksites
Educational materials on employment, including pamphlets, booklets, and tapes

Seeking Employment Services
Information about the services available from the Division of Rehabilitation Services

Facts about Mental Illness and Employment

Mental Illness in Minnesota and the United States

One out of four families is affected by mental illness.

Approximately one percent of the adult population has serious and persistent mental illness, or approximately 29,000 people in Minnesota (1)

Contrary to long-standing assumptions, there is potential for improvement and recovery among many people with serious disabilities. Some symptoms go into remission, while other people learn effective ways of coping. (2)

Nationally, only 20-25 percent of persons who were hospitalized for psychiatric illnesses are employed full-time at competitive employment. Only 15% of the persons with more serious and persistent mental illness are employed. (3)

Nationally, only 37% of all health insurance policies and HMOs offer inpatient coverage for mental illness, compared with 100% which cover physical illness. (4)

Much of the success of treatment for persons with mental illness depends on helping them learn to become more comfortable and less isolated in handling the stresses of daily living. Employment, in independent or supported employment settings, assists persons with mental illness in developing skills for independence.

Mental Illness and Effects on Business

Each year ten million Americans suffer from clinical depression. Many are in their most productive work years. (5)

It has been calculated that the economy loses $10 million annually because of an estimated 156 million days missed from work due to clinical depression. An added $4.2 billion in potential earning power is lost each year because 15% of people with severe depression eventually commit suicide. (5)

No one has estimated the productive time workers lose while on the job, but undiagnosed depression saps energy, affects concentration, memory, and decision-making, and contributes to alcohol and drug abuse. In addition, the depression of a family member can affect a worker's productivity.(5)

Types of workers with mental illness

There are at least three distinct groups of workers among persons with mental illness:1) people who *develop emotional problems while working and are at risk for leaving* their current employment, 2) people who have *had emotional problems, and dropped out of the labor force, but who may be able to renew employment*, and 3) those who have a mental illness and either have *never worked or are unable to renew past employment* and who therefore require new employment support and options. (6)

Understand mental illness

EVERY MIND MATTERS

Employment Options and Needs

There are a variety of types of programs to help persons achieve their potential through various types of vocational rehabilitation services. (7)

Job placement services assist persons in identifying, obtaining, maintaining, and/or advancing in employment, including preparation of the person for employment, job development, placement, and follow-up.

Pre-placement services include assessment of the appropriateness of the referral for job placement, analysis of pertinent findings from medical, psychological, or prior vocational services, counseling and/or training persons regarding job seeking and job maintenance, and assisting persons to become knowledgeable about the job, prior to job acceptance. In addition, pre-vocational programs, community support programs, employment programs,and volunteer work, help develop work skills and provide work experience.

Job development and placement services should include contacting employers to identify job opportunities for persons with disabilities, providing job analysis and consultation for modifications, educating employers about various disabilities and vocational implications, and maintaining communication with internal and external resources.

Post-employment services include follow-up with employers, supportive services on or off the job-site, and ongoing personal contact to ensure adequate adjustment. Services also include support and technical assistance to the employer regarding the employee's job performance.

Supported employment means employment of a person with a disability so severe that the person needs ongoing training and support to get and keep a job. Employees in supported employment benefit from pay and the opportunity to have social interaction with people without disabilities. The employer gains from reduced turnover, increased production, as well as the reputation for employing people with disabilities. Society benefits from having people less dependent on government financial assistance.

Transitional employment is a type of supported employment for persons with severe and persistent mental illness. Its purpose is not to provide skill training or specific jobs, but to strengthen basic work habits and attitudes, provide current job references, and enhance personal confidence. Transitional employment is time limited, part-time, and in a variety of settings. Employers are not expected to modify work standards.

Competitive employment exists when an individual is engaged in the competitive job market, is paid prevailing wages for all work performed, and is supervised by personnel within the company. Additional case management or support services may be provided outside of the work setting.

1 *from the Minnesota Department of Human Services, Mental Health Division*
2 *from the Minnesota Department of Human Services, Mental Health Division*
3 *from the League of Women Voters Study on "Mental Illness in Minnesota", 1988-89*
4 *from "Scheidemandel, "The Coverage Catalog", Washington DC, American Psychiatric Association, 1989*
5 *from DIART and the Mental Health Association of Minnesota*
6 *from U.S. Department of Health and Human Services*
7 *from RISE and from Minnesota Department of Jobs and Training, Division of Rehabilitation Services*

Mental Illness and Employment: Alleviating Employers' Concerns

There has been increasing interest and effort in the availability of employment opportunities for persons with mental illness. Although many of Minnesota's employers are providing employment opportunities, many persons with mental illness face unemployment due to a reluctance by employers to hire them. This reluctance typically is the result of misperceptions about mental illness. Concerns expressed by employers frequently include the stigma associated with mental illness and the resulting concerns of workers and clients, reliability and attendance of workers with mental illness, and fear of saying or doing the wrong thing with a employee with mental illness.

One of the ways to counteract stigma is to provide accurate information and educational materials that increase employers' awareness and understanding of mental illness. Another way is through effective job placement, matching job candidates with the right job and employer.

The following addresses some of the common questions and concerns raised by employers, in regard to hiring persons with mental illness:

Can I rely on persons who have been treated for mental illness to be good and reliable workers?

When placed in appropriate job situations, persons with mental illness are as effective in their work as other workers. When there is additional support provided, either through a supported employment program, community support programs, or other kinds of vocational rehabilitation, employer/worker relationships are even more successful.

Employers' experiences show that workers with a mental disability are equal to other workers in terms of job performance. In some cases, these workers have demonstrated superior motivation, attendance, and punctuality. This may be because these workers show a great loyalty to persons and companies that assist them in leading a normal life.

However, it is important that employers have realistic expectations. All situations are not successful. In some cases, as with all employees, the employee will demonstrate an ability to meet performance expectations or even to perform at above average levels. In other cases, again as with all employees, individuals with mental illness may not be ready or able to handle the job demands. In other words, people with a history of mental illness present the same risks as any other employee. Like other employees, they must be able to show qualifications for a particular job in order to be hired, and must be able to meet the expectations of the job in order to be retained The important thing is that persons who have a mental illness deserve, like all persons, the chance to succeed and the chance to fail in a job. When additional support is needed to maintain employment, it is essential that employers work with the employee and available support programs to enhance the possibility of successful employment.

What kind of jobs are people with mental illness suited for?

Like all job-seekers, an individual's potential depends on personal talents, experiences, and motivation. Many people who have recovered from mental illness have held positions of high regard and responsibility, such as Abraham Lincoln, Vincent Van Gogh, and Virginia Wolff. An employer who hires persons with mental illness provides them with the opportunity to achieve

independence and full potential, and provides a benefit to society through the enhancement of individual creativity and productivity.

Will people with mental illness negatively affect my productivity, turnover and health and disability insurance rates?

As discussed above, the key to successful job placement and stability is a good match between the worker's talents and abilities and the job itself. A person with mental illness presents the same opportunity and risk for productive work as any other employee.

But expectations should be realistic. Loss of time from the job by any worker can pose a problem. A person with mental illness may possibly relapse and require short-term treatment. Flexibility in scheduling and work hours will help all workers, including workers with occasional personal needs. Flexibility at work helps improve morale for all workers, as they continue to meet the performance and productivity expectations of their jobs.

As far as increased insurance rates, insurance companies do not track disabled employees. It is the business of the employer to make employment decisions, not the business of the insurance company. Employers interested in containing their health care costs and insurance premiums in general can do so by having employee assistance programs, safety programs and policies, and health promotion activities to enhance the health of all employees.

How will other workers feel about having persons with mental illness at the workplace? Will they be safe working with a person with mental illness?

Lack of accurate information fuels fears about persons with mental illness and their ability to adapt into situations. Most employers and workers are surprised to learn that they cannot distinguish persons with mental illness from other workers. Mental illness is quite prevalent in our society. One in four families is affected.

Unfortunately, movies and television often portray persons with mental illness as violent and unpredictable. This promotes a negative and inaccurate stereotype of mental illness.

In reality, persons with mental illness are no more likely to commit criminal acts than persons without mental illness. In a study of people who had been treated for mental illness, only one tenth of one percent were arrested for violent crimes. In each of those few cases, all had a criminal record before their treatment for mental illness. In other words, a person who has been treated for mental illness and does not have a previous criminal record is considered to be less likely to be arrested than the average citizen. In addition, because mental illness often makes people more passive, persons with mental illness are more likely to be victims, not perpetrators, of aggressive acts.

Unpredictability is another myth of mental illness. Experts state that most relapses into acute episodes of mental illness develop gradually, not instantly or even unpredictably. Physicians, family and friends, supervisors, and individuals themselves can help recognize some early warning signs and assist in seeking care before symptoms progress.

Mental Illness and Employment:
A Research Review

Employers often express concerns regarding hiring persons with histories of mental illness: concerns regarding reliability, unpredictability, and the impact on co-workers and business clients are common.

Numerous studies have explored mental illness and employment. *The following is a review of some of those studies:*

Performance of employees with mental illness

Two studies of a majority of organizations that hired workers with mental disabilities found that few of them had a formal policy of hiring such workers, but that in most cases those *employers rated the worker's performance as favorable.* (Burden, 1975)

Research of the 2,745 employees with physical and mental disabilities at DuPont indicates that their *job performance is equivalent to that of their non-impaired co-workers in safety, job duties, and attendance.* (DuPont Company, 1982)

A comparative study of employees with mental illness showed that such employees are *indistinguishable from randomly selected employees in job performance, human relations, and overall rating.* (Howard, 1975)

A survey of 48 employers of persons with a history of mental illness revealed that most employers rated the employees as *comparable to their other workers.* Those who rated them as inferior workers cited difficulties with working alone, remembering job responsibilities, and problem solving. *Those who rated them as superior workers noted eagerness, cooperativeness, thoroughness, reliability, conscientiousness, dependability, and openness to advice.* (Margolin, 1961)

Attitudes of employers about employees with mental illness

When a group of *52 employers was asked to consider the possibility of hiring persons with a current or past mental illness, more than 75 percent responded positively.* Their attitudes were further tested when a vocational counselor attempted placements of 33 prospective employees with these employers. Out of 59 attempts with this pool of workers, nineteen employees were placed. Nine others landed jobs on their own. (Landy and Griffith, 1958)

Employer's attitudes, toward status of workers with a history of mental illness or psychiatric hospitalization, were examined. Analysis of the data showed that *job tenure is shorter among workers of employers with unfavorable attitudes, while job tenure is not affected when employers are unaware* of having persons with mental illness in their employ. (Whatley, 1963)

In an overview of employer reluctance to hire persons with histories of psychiatric problems, the most prominent reasons were fear arising from lack of knowledge and the unusual nature of psychiatric problems. (Hall, 1966)

Strategies for Successful Job Placement: How Employers, Counselors, and Employees Can Work Together

What employers can do to enhance work experiences for employees with mental illness

Work closely with a vocational counselor, or community support program, to provide details about job expectations. This will help match an employee to the employer's needs.

Be confident about working with disabled persons. Studies show that mentally disabled workers are typically indistinguishable from other employees, and in many cases demonstrate strengths over their co-workers in the areas of conscientiousness and dependability.

Note that you cannot exclude categories of people from consideration for a job. For example, specifying a desire to recruit a physically disabled person is unethical. Instead, identify a desire to access the job applicant pool from a vocational rehabilitation firm or community support program, and they will provide you with information regarding all qualified candidates.

Upon interviewing a prospective employee, remember that information regarding mental health history is confidential information and should be respected as such.

Once an acceptable match is made, work with the program counselor to determine an appropriate training schedule and transition to the job. If possible, assign an understanding supervisor or sensitive co-workers to work with the employee, to aid in the success of the work experience.

What vocational rehabilitation counselors, community support programs, and case managers can do to enhance their client's work experiences *

Know your clients and your employers well, including your client's skills and tolerances, your employer's needs and values, the skills and tolerances of each particular job, and the consequences of poor placement in relation to the client, the employer, and the job.

Prepare presentations regarding particular job candidates. Be clear and concise with employers. Avoid psychological jargon.

Obtain detailed work histories on all clients. Gather as much detailed information as possible, including positive aspects of the work experience for both the employer and the employee, as well as overall work assessment.

Take the time to complete an asset and skill review for clients who have been out of work for a long time, in order to identify the qualifications that the client can bring to a job. This information will enable both counselor and client to best "sell" the client's skills to a prospective employer, rather than relying on descriptive psychiatric symptoms.

Build up the client's confidence, in order to improve their motivation and momentum in job seeking. This can be accomplished through job skills groups, peer support groups, or regular contacts and pep talks.

Examine your own attitudes regarding the client's skills and abilities. Fears of client failure will sabotage counselor's ability to convince an employer to hire a client. A belief that people can and do progress, and that everyone has some job skills, is critical to the counseling role.

Be open-minded and do not simply screen out people for certain jobs before they have a chance to compete for that job. If someone has skills reasonably similar to the expectations of a job, refer him/her for an interview. The interview is a forum for the client to get information and feedback.

Recognize that "stressful jobs" are in the "eye of the beholder." While an employer might indicate that a job is stressful, do not assume that it is not appropriate for someone with a mental illness.

When sharing information about a client's disability with a prospective employer, stress the positive aspects of the person's past, with primary emphasis on current functioning. Describe clients in terms of their qualifications for the job, not in terms of their disabilities.

Maintain communication with clients once they have been placed in a job. Recognize the reality of the client's losses (agency support, financial support, etc.) in addition to the more obvious gains (status, income, and independence). Therefore, it is important to plan for ongoing follow-up with the client, including brief meetings (off the client's work-time) or phone calls.

What employees can do to enhance their job search and work experiences

Provide your vocational counselor or case manager with any information regarding your skills and your work history. Regardless if you have been out of the job market for a long time or have never had a job, you have skills and abilities that can contribute to many jobs.

If you do not know your skills, actively participate in an asset and skill review provided by your counselor or case manager. This provides important information about your abilities. Focus on these abilities, rather than on fears and limitations, as you proceed with vocational planning.

Job seeking can be frustrating for anyone. You put yourself on the line each time you go out to a job interview, so take care of yourself and accept support. Look upon each job interview as a opportunity to improve your interpersonal skills and to get information and feedback. Focus on positive aspects of your performance in the interview, even if you were not accepted for a job.

Don't rule out a job just because you do not fulfill all the expectations listed for a job. Focus on the qualifications that you do have for the job. Be open-minded and confident about your abilities.

Participate in job skills groups, peer support groups, or other pep talks from counselors and peers. Your confidence in yourself will fuel your motivation and give you momentum in job seeking.

Accept the fact that it may take you some time to prove to yourself that you are able to work. Take pride in your determination along the way.

Be honest in interviews and on job applications, when asked if you have ever been treated for a mental illness. You need not provide other information concerning your mental illness history.

Once on the job, assume that your employer is interested in making your work experience a smooth and successful one. Set goals with your employer, and work to achieve those goals.

Recognize that all your fellow workers may not be supportive. Many will become more understanding over time, especially when they see you taking pride in your yourself and your work.

Maintain communication with your counselor or case manager after you have been placed in a job. This is an important time for acknowledgement of your progress.

Recognize that the excitement and challenge of a job is both a gain and a loss. While you benefit from improved status, income, and support, it is common to feel anxious as you give up agency support, financial support, and vocational support. Accept the normality of these feelings, but emphasize the gains of your new found job status.

**adapted with permission, from "Job Placement Techniques for Counselors Working with Persons with Psychiatric Disabilities", by Joseph Marrone*

Working Together:
Examples of Successful Relationships between Employers and their Employees with Disabilities

Despite the reluctance of some employers to hire people with mental illness, more and more employers are establishing successful working relationships with employees with mental disabilities. These employers are confirming what many enlightened employers have already known: that many workers with a history of mental illness have demonstrated superior motivation, attendance, and punctuality, often because of their loyalty to those who have offered them an opportunity to lead a normal life. *The following are actual examples of some of the realistic and successful working relationships benefiting Minnesota employers today:*

A vocational program in the Twin Cities has received praise for their program for providing "consistently good workers" to area employers. Program representatives credit the *openness of employers and the mutual preparation and communication between employer and employee*, as well as the close follow-up and problem identification offered by the program.

A suburban manufacturing company insists that all employees are called by their first name and not by a label that reflects their disability. This philosophy is just one of the ways that they support all workers and have *positively affected the self-confidence and abilities* of workers with special needs.

A young women with a history of depression was balancing the stress of two, fairly low-paying, jobs. One job partially-paid for her ongoing counseling visits, but she needed a second job to supplement her income in order to help pay for the remaining portion of the fees. She was caught in a vicious cycle of needing the jobs to pay for her counseling and needing the counseling to help her manage the stress of her jobs. *Through assistance from a job placement specialist, she was able to land a full-time position which included a greater portion of benefits for counseling, and flexibility about time-off for the counseling appointments.* Even better, her employer is extremely pleased with a new loyal and devoted worker.

Positive attitudes from a retail company has meant a growing number of clerical and janitorial positions for a number of workers with mental illness. *With strong job coaching from a job placement program and support from the employer, employees have proven to be particularly valuable* to the company.

A young woman with a bi-polar mental illness involving extreme mood swings holds a clerical position for a popular retail chain. Working for six different people created added stress, as she was overly concerned that people were displeased with her work. *Through support of the supervisor, the woman was accompanied on breaks to help her make connections with others. In addition, she was encouraged to regularly meet with her supervisor to help allay her concerns regarding her work performance.* The employer notes that her work has been of outstanding quality.

A older man works full-time for a janitorial service that contracts with a large department store. In the past, he has become agitated and stressed when his work area becomes overcrowded or cluttered. His supervisor has arranged a system

whereby *if the work area is too crowded with customers or merchandise to be cleaned, he is permitted to take a break or to change to a different, less cluttered area.* After nearly three years with the company, the man *boasts a nearly flawless attendance record.* Although he is scheduled to retire soon, the company has asked him to stay on part-time because of the high quality of his work.

A young woman with a mental illness has demonstrated some difficulties in working with males. Prior to her new position as a maid for a janitorial service, she is coached on the realities of working with men. However, she is assigned to a female supervisor and *linked up with a female "buddy" to take breaks with, which gives her the opportunity to develop social relationships at work. Also, in an instance involving her getting lost in the building because of the similarity between floors, her supervisor personally orients her to the building and some of the visual cues* for recognizing differences on each floor.

Instead of calling in a temporary service to assist with an important mass mailing, an advertising agency in the Twin Cities contacts a nearby day program for adults with mental illness. (The program offers art classes as a method for encouraging expression of feelings through art, crafts, and poetry.) Although it had been some time since one woman had worked, she accepted and handled the temporary assignment well. The ad *agency received quality work and got their mailing out by deadline, while the individual was especially pleased with the opportunity to work and earn a little extra money.*

A women's clothing chain enjoys a very successful relationship with an enclave of 12 workers from a Twin Cities transitional employment program. The enclave is responsible for ticketing nearly 95% of the store's inventory. According to the distribution center manager, *the employees are "conscientious, hard working, and concerned about the quality of their work.* With their supervisors, the group is as productive as our other employees."

A suburban manufacturing firm relies on a metro area transitional employment program for supplying needed workers with little advance notice. According to the plant manager, *"the workers have proven to be reliable and steady group."*

Vail Place also shares the following examples of successful working relationships they have learned about, from across the country:

From a fast food restaurant manager: "Absenteeism is much less of a problem. And motivation seems stronger. As an employer, I have the right to expect and demand performance, and in general, their performance is outstanding.

From a nursing home administrator: "There is definitely not rapid turnover among mentally ill workers, if anything, they stay longer than other workers and are more reliable. Our departments tend to compete for them because they're so productive."

From another employer, "These guys stand toe to toe with anybody. In the beginning, they seem shy, just like anyone else who is new. But after a few days, they seem to join in the crowd. They are dependable, and they show a degree of loyalty. They are the kind of people we want working here."

Thanks to RISE Inc., Vail Place, and the 26th Street Project, for the success stories described above.

Returning To Work:
Ideas for Employers Helping Employees Make the Transition Back to Work

As an employer, you know that every employee sometimes experiences stress, anxiety, or even depression. Some employees are able to cope more easily than others. Some can manage stress on their own, with support from family, friends, or people at work. Others may benefit from a formal support services, such as a referral to the employee assistance program or other counseling in the community.

But some employees may experience feelings so severe that traditional methods of coping are not adequate. Some may become incapacitated to the point that they are temporarily unable to work, possibly requiring hospitalization before they can return to work.

You can play an important role in helping to make the transition back to work a smooth one for both the worker and the workplace. *The following are some tips for employers interested in helping their employees who, because of a mental health problem or mental illness, have been temporarily absent from work.*

Be sensitive
Recognize that treatment of a mental illness is a process, just as treatment from a physical health problem or illness takes some time.

Be patient
Provide the employee with an opportunity to "walk before running" on the job. This allows the employee a chance to acclimate to the work environment, and helps ensure a more complete recovery. Soon the employee will return to previous, even improved, levels of functioning over pre-illness work performance.

Be positive, but realistic, in setting return to work goals
Assume that the returning employee can return to his/her former position, but if the employee indicates that he/she is not yet ready to return to that position, work with the employee to find a somewhat less demanding task or modify the job to accommodate the employee. Then, establish some step-by-step goals for returning to the former position. This will help ensure a smoother transition.

Be supportive
If possible, assign an understanding supervisor to the employee. Encourage co-workers to take a role in welcoming the employee back to work. Such support at work can help eliminate feelings of isolation on the part of the employee.

Be respectful of privacy
As the employer, you may be aware of the details regarding the employee's absence. This is confidential information and should be respected as such. If the employee elects to share an explanation for his absence, that may foster added support from a co-worker who experienced a similar situation in his/her own life or in the family. But it is up to the employee how much or how little information, if any, he/she wishes to make public.

Special thanks to consumer John Wills for generating the ideas used in this information sheet

Returning to Work:
Ideas for Employees Making the Transition Back to Work

Every employee sometimes experiences stress, anxiety, or even depression. Some employees are able to cope more easily than others. Some can manage stress on their own, with support from family, friends, or people at work. Others may benefit from a formal support services, such as counseling through the employee assistance program or other program in the community.

But some employees may experience feelings so severe that traditional methods of coping are not adequate. Some may become incapacitated to the point that they are temporarily unable to work, possibly requiring hospitalization before they can return to work.

If you have experienced a temporary leave of absence due to a mental health problem or mental illness and are now looking at returning to work, you play an important role in helping to make the transition back to work a smooth one for both you and your employer. *The following tips are for employees who, because of a mental health problem or mental illness, have been temporarily absent from work, and are now making the transition back to the workplace.*

Be patient
Accept the fact that it may take you some time to prove to yourself, as well as your co-workers and your employer, that you can manage your job.

Be realistic
Upon returning to work, you may find that you cannot return immediately to your old position. Instead, you may need to take a different, less stressful, position for a short time period. This may occur for a variety of reasons:

- You may decide that you are not ready to return to your old position.
- Your employer may want to see how you handle the work situation in general, before you return to your former position.
- Your position may have been filled in your absence.

Be flexible and willing to accept a change in your position, even your job status, when you first return. Work with your employer to set realistic goals for a smooth transition back to your former position. Trust that your employer wants you to succeed, but you must learn to "walk before you run" on the job again.

Be positive
Believe that your employer and your co-workers want to help. They are interested in making your transition back to work a smooth and successful one.

Be aware
Not all your fellow workers may be supportive. Some may be insensitive or unsympathetic. Give them time. Many will become more understanding over time, especially when they see you respecting yourself and taking pride in your ability to return to work. And remember that one in four families have experienced mental illness, so chances are that most people already know or will know someone close to them who has a mental illness.

Be yourself
There is no need to explain your illness in great detail to anyone. When necessary, explain, in general terms, that you were ill and simply indicate that you received help and now you are much better and able to work again.

Your fellow employees will react to you, based on how you react to them. Be yourself; not apologetic, not defensive, just yourself.

Be proud
Each day, you are taking another step in the process of overcoming a major illness. Take pride in your determination. Though you may feel frustrated that your illness may mean a temporary set back in your work career, your eventual success on the job, and proving to yourself and your employer that you are fully recovered is worth it!

And if you are looking for a new job, be determined
Looking for a new job, may be more difficult because of your mental illness. Be determined, however, because with effort you will find the right job and the right employer for you.

Be honest in interviews and on job applications when asked if you have ever been treated for a mental illness. However, you do not need to provide other details or information concerning your mental illness history.

When you are on a job interview, you are selling yourself. Therefore, emphasize your skills, qualifications, and achievements. Prospective employers are interested in the benefits to them and to their company if they hire you.

Special thanks to consumer John Wills for generating the ideas used in this information sheet

How to Maintain an Healthy Workplace

Employers can play an important role in improving or maintaining workers' health. Employee health is not simply the concern of the employee. Worksites are greatly affected, both in productivity and bottom line terms, by unhealthy employees.

Mental health costs are among the fastest rising in health care: it is estimated that mental health care costs the nation more than $200 billion in direct and indirect costs, and that American businesses are paying for an ever increasing portion of those costs. It is imperative that employers examine some solutions for managing mental health care costs. The following are examples of ways employers can take a pro-active approach:

Provide employee assistance programs that enable employees to receive early intervention and referral in managing mental health problems.

Train supervisors how to recognize problem behavior in work performance, and how to refer employees to employee assistance programs.

Orient employees on how to use the employee assistance program and other employee support services.

Use a variety of communication channels, such as newsletters, posters, and pamphlets to educate employees about maintaining mental health.

Offer educational programs and events, for employees and their families, on mental health topics.

Examine and alter stress-producing policies and styles in the workplace, particularly ones that perpetuate negative communication patterns and unrealistic performance expectations.

Allow for flexible work schedule policies, child care support programs, participative decision-making, and other programs and policies that help employees manage stress and increase work satisfaction.

Educate employees about disabilities, including mental illness, to increase employee awareness and sensitivity to individual differences in the workplace.

Sponsor community projects that assist people with special needs in your area.

Sponsor workers in transitional or supported employment programs, and hire qualified persons with disabilities, including persons with mental illness, for available jobs in your workplace. Work with the employee, setting clear and realistic job expectations.

Help employees make a smooth transition back to work after a health-related leave.

Offer insurance benefits that include coverage for mental health care. Enhance those benefits with good managed care programs that help ensure quality and appropriate care for mental health.

Understand mental illness

EVERY MIND MATTERS

What To Do If You Are A Victim of Employment Discrimination

What is Employment Discrimination?

Employment Discrimination or unfair employment practice, occurs when an employer, employment agency, or labor organization denies employment to (whether not hiring, firing, or discriminating against) an individual on the basis of *race, color, creed, religion, national origin, sex, marital status, and status with regard to age, public assistance, or disability.*

Disability refers to any condition or characteristic that makes a person disabled. A disabled person refers to anyone who has a *physical or medical impairment which materially limits one or more major life activities*, who has a record of such impairment, or who is regarded as having such an impairment.

What is within the rights of the employer?

An employer can look for information which will determine whether a person can *safely and efficiently perform* the duties of the position for which he or she applies. This may include requiring a physical examination, provided (1) that an offer of employment has been made on the condition that the person meets the physical or mental requirements of the job, (2) that the physical examination only tests for essential job-related abilities, and (3) that the examination is required of all persons conditionally offered employment for the same position.

An employer can also *administer pre-employment tests*, provided (1) that the tests measure only essential job-related abilities, (2) that the tests are required of all applicants for the same position, and (3) that the tests accurately measure the applicant's aptitude, achievement level, or whatever factors they purport to measure.

An employer may also, with the employee's consent, *obtain additional medical information* for the purpose of establishing an employee health record.

What can you do if you believe you are victim of employment discrimination?

The Department of Human Rights advises that any person who experiences discrimination as defined by the Human Rights Act may file a discrimination charge, by calling:

Minnesota Department of Human Rights
500 Bremer Tower
7th Place and Minnesota Street
St. Paul, MN 55101
612-296-5663 / Toll Free 1-800-652-9747 / TTY 612-296-1283

Understand mental illness

EVERY MIND MATTERS

The Department conducts an investigation into the charge to uncover evidence to support the allegation.

If the findings support the charge, the department issues a determination of probable cause, and becomes an advocate for the charging party. Action is then taken to stop the discriminatory act and to provide relief for the person who has suffered the discrimination.

In an employment discrimination case, relief may include (1) the hiring, reinstatement or upgrading of a person, (2) the admission or restoration to membership in a labor organization, and (3) the admission to or participation in an apprenticeship training program, on-the-job training program, or other retraining program. Relief could also include (1) compensatory damages, (2) punitive damages, and (3) damages for mental pain and suffering. Violators of the law will be assessed a civil penalty payable to the State of Minnesota.

Any person who files a charge of discrimination, testifies, assists, or participates in any way in an investigation, hearing, or any other proceeding conducted by the Minnesota Department of Human Rights, is protected by law against any reprisal by person, employer, labor organization, or employment agency.

from the Minnesota Department of Human Rights

Mental Health Education Materials for Worksites

Understanding Mental Illness

Depression...What you should know about it
A pamphlet explaining depression, its causes, treatments, sources of help, and suggestions for dealing with a depressed person (1)

Finding Help for Depression and Manic-Depression
From the D/ART program, information about types of treatment for depression and where to find help (1)

About Manic Depressive Illness
A pamphlet about the illness and its symptoms, causes, and treatments (1)

Schizophrenia
A pamphlet providing information on definitions, symptoms, and treatment (1)

How to deal with Mental Problems
A pamphlet discussing the differences between normal difficulties and emotional illnesses,with suggestions on how to offer understanding (1)

Give Mental Health a Chance
A brochure, produced by the Hennepin County Mental Health Association, describing mental illness and its incidence, and the problems of stigma (1)

Mental Health Advocate
A newsletter published six times per year, providing resources and information on mental illness and mental health issues (2)

Mental Health Issues in the Workplace

Job Rights of Persons who have Disabilities
A reprint about job rights and what to do when dealing with employers (1)

Stress in the Workplace
A three-part series, on videotape, examining organizational stress (1)

Working Parents
A videotape featuring psychologists and parents (1)

Mental Health Issues of the Working Woman
An audiotape examining the stresses on working women in traditional and non-traditional roles, with special focus on prevention in the workplace (1)

Mental Health Materials for use in worksite wellness and employee assistance programs

Developing Self-Esteem in your child
Developing Self-Esteem in yourself
Tips on improving your self-esteem and the self-esteem of your child (1)

Mental Health is 1, 2, 3
A pamphlet outlining the characteristics of people with good mental health (1)

When Things Go Wrong
Anyone can have emotional problems and what to do about them (1)

Anger - the mystery feeling
Information about anger and ten suggestions on ways to deal with it (1)

How to deal with your tensions
A brochure on ways to recognize tension that is turning into a crisis and how to deal with and seek guidance for those tensions (1)

Managing Stress / Occupational Stress / Recognizing Stress
These pamphlets provide information on stress management, particularly in relation to work (1)

A variety of additional materials about mental illness and employment are available from the Minnesota Department of Human Services-Mental Health Division. For more information, call 612-296-2307.

1.....Available from the Mental Health Association of Minnesota (612-331-6840)
2.....Available from the Alliance for the Mentally Ill/Minnesota (612-645-2948)

Seeking Employment Services:
About the Division of Rehabilitation Services

The Division of Rehabilitation Services (DRS) provides vocational rehabilitation services aimed at increasing employment opportunities and promoting greater independence for people with physical or mental disabilities. DRS provides counseling, evaluation, training, and placement services to eligible individuals, as well as direct service programs involving worker's compensation and independent living.

DRS uses three basic criteria to determine if a person is eligible to receive vocational rehabilitation services:

1) The individual must have a documented mental or physical disability
2) The disability must create or result in a substantial handicap to employment
3) Vocational rehabilitation services could help the individual become employed

Vocational rehabilitation services are provided by rehabilitation counselors located in 48 offices throughout the state. DRS has designated a number of staff with mental health experience as members of mental health teams. *Contact your local DRS office (check phone book under blue government listing pages, under Jobs and Training) or call the closest administrative area office (listed below) for more information regarding eligibility and services in your area.*

Area Administrative Offices

Metro Area:

East Metro
Yankee Square Office Building
Suite #3
Eagan, MN 55122
612-296-9362 (Voice/TDD)

West Metro
Suite 20, Century Plaza
1111 3rd Ave. South
Minneapolis, MN 55404
612-341-7100 (Voice/TDD)

Southern Minnesota Area:

Colonial Square Business Center
1650 Madison Ave.
Mankato, MN 56001
507-389-6511 (Voice/TDD)

Central Minnesota Area:

54 - 28th Ave. North
St. Cloud, MN 56301
612-255-2224 (Voice/TDD)

Northern Minnesota Area:

401-11th Street SE
Grand Rapids, MN 55744
218-327-4485

State Administrative Office

390 Robert Street
5th Floor
St. Paul, MN 55101
612-296-5616 (Voice/TDD)
General Information

Information obtained from Minnesota Department of Jobs and Training, Division of Rehabilitation Services

Mental Illness and Community Responsiveness

This section provides information regarding mental illness and ways to understand mental illness as a community issue, including tips for increased community responsiveness. The target audiences for this section include businesses, churches leaders and members, teachers, principals, librarians, police, social and public health services, physicians, health care organizations, community officials, families, consumers, and other groups and organizations. Materials in this section include:

Understanding Mental Illness: A Community Approach
The key issues, important to understanding mental illness

Facts about Child and Adolescent Mental Health
Child and adolescent emotional disturbances and the services available for their care

Understanding Mental Illness: Signs and Symptoms
A summary of the different types of mental illness

Understanding Child and Adolescent Emotional Disturbance
A summary of the different types of child and adolescent emotional disturbances

What Health Care Organizations Can Do
Ways that health care organizations can promote health and respond to mental health needs

What Business Organizations Can Do
Ways that businesses can promote employee health and encourage greater employee understanding and responsiveness to people with mental illness

What Churches, Synagogues, and Service Groups Can Do
Ways that churches can respond most effectively to people with mental illness.

What Schools, Colleges, and Education Programs Can Do
Ways that schools can promote information about mental health and can respond more effectively to students' mental health needs

What Community Organizations Can Do
Ways that other community organizations, like law enforcement, social and public health services, libraries, etc. can contribute to and benefit from public education on mental illness

What Families Can Do
Ways that families can promote mental health and address family mental health needs

Ways to Get Legislators and Community Officials Involved
Tips for educating community officials and addressing legislative issues

Tips for Consumers Helping Consumers
Tips for consumers living in the community

Seeking Help: Where to Go and What to Do
General guidelines and first steps to take in seeking mental health assistance

Mental Health Education Materials for Community Education
General mental health materials, including pamphlets, videos, and curricula

Understanding Mental Illness:
A Community Approach

Mental illness is prevalent.

One in five persons are affected in some way by mental illness. They may be directly affected through a personal experience with a mental illness. They may be indirectly but significantly affected, helping a family member or close friend cope with a mental illness. There are people throughout our communities, whose lives are challenged by mental illness.

Mental illness is diverse.

There are a variety of kinds, and a variety of degrees, of mental illness. The most common types of mental illness include depression, manic depression, schizophrenia, and anxiety disorders.

Mental illness can affect anyone.

Mental illness can affect children, adolescents, adults, and elderly people.

Mental illness can be devastating to individuals and families.

The effects of mental illness can be worse than the effects of other illnesses. A Rand Corporation Study showed that depressed persons had significantly more social difficulties than all other chronic disease groups. And untreated mental illness is a powerful risk factor for suicide.

Persons with mental illness are people first.

People with mental illness are *people* with capabilities and talents. It is important to focus attention and compassion on *people*, not on their symptoms.

Mental illness *is* an illness. Mental illness *is not* a choice.

Mental illness is not a personal weakness. It is an illness, just as diabetes is an illness, with different degrees of chronicity, symptoms, and effectiveness of treatment. People with mental illness are experiencing something over which they have no control; in most instances an illness caused by a biochemical disturbance in the brain or another physiological basis. And just as with other illnesses, people with mental illness deserve understanding and compassion.

With proper treatment, many people manage their mental illness.

Help is available for successfully treating people with mental illnesses. However, not all people with mental illness do recover, as is true with all types of illness. It is unfortunate that many people do not receive the treatment they need, due to lack of affordable services, lack of understanding, or the stigma associated with mental illness.

Mental illness is a community issue.

Mental illness indirectly impacts nearly every part of the community. Mental illness is an issue in our neighborhoods, where housing and community-based treatment are greatly needed. It is an issue in our workplaces, where co-workers are coping with the mental illness of a loved one or making a transition back to work after their own challenges with mental illness. It is an issue in our schools and churches, where persons with special needs are in need of help and compassion.

In 1987, the Minnesota Legislature passed the Minnesota Comprehensive Mental Health Act, outlining mental health services that must be available to all adults with *severe and persistent* mental illness, and all children with emotional disturbances, in every Minnesota county.

We must work together for greater understanding of mental illness.

In order to deal with mental illness as a community, we must educate ourselves about mental illness and accept persons with it as community members. As a community, we cannot close our doors, our minds, or our hearts, to those whose lives are affected by mental illness.

"Understand Mental Illness. Every Mind Matters."

Understand mental illness

EVERY MIND MATTERS

Facts about Child and Adolescent Mental Health

Children and Adolescents in Need

The exact number of American children with an emotional disability is not known.

A 1981 conservative estimate, developed by Gould et al based on reviews of many studies, reveals that *1 child in 8 (11.8%) has an emotional problem* limiting capacity to function, *1 child in 20 (5%) has a "severe emotional disturbance,"* and an additional *15-20% of all children are from groups which are at higher risk of developing a mental health problem.* (1)

A more recent 1989 study by Brandenberg et al suggests that the number of children with an emotional disability is likely to be higher, and that possibly *14-20% of all children have an emotional disturbance.* (1)

In addition, the National Institute of Medicine reported that *20% of children from low income, inner-city areas may be experiencing an emotional disturbance.* (1)

Estimates of children's mental health in Minnesota reveal the following:

According to the Wilder Foundation, *9% of middle-high income preschool children and 14% of low-income preschoolers have received professional help* for a emotional, behavioral, or mental problem. In school age children, *32% of low-income parents and 19% of middle-high income parents felt that their children needed mental health services*, though *only 18% and 10% respectively actually sought professional help* for their children. The study also found relatively low rates of help-seeking behavior among racial/ethnic minorities, with *only 2% of low income minority children receiving professional help* in the prior year. (1)

The Minnesota Department of Education's survey of 90,000 children in grades 6, 9, and 12, revealed that *1 student in every nine surveyed reported a suicide attempt*, and *14% had had professional treatment for an emotional or behavioral problem.* The survey also noted that high levels of stress can be a risk factor for the development of mental health problems and that *large numbers of students identified that they were exposed to high levels of stress* in recent months. (1)

Approximately 40% of youth in chemical dependency programs have been found to have symptoms of depression. (2)

Suicide is the second leading cause of death among Minnesota teens. Nationwide, suicide is the third leading cause of death among teens. (4)

In a University of Minnesota Adolescent Health Survey study of 2,200 young people in southwestern Minnesota, 58 percent indicated that they know someone in their school who has thought of suicide. Minnesota teenagers between 15-19 years old continue to commit suicide in a dramatically increasing numbers. (4)

Five percent of all teens in the Adolescent Health Survey said that they worry about "losing their mind" very much, and 7 percent felt they have little or no control over their behaviors, thoughts, and feelings. (4)

Understanding Child and Adolescent Mental Health Problems

An emotional, behavioral, or mental disorder involves a psychological pattern that significantly impairs daily functioning. To be clinically diagnosed as having a particular mental disorder, a person must exhibit symptoms that occur over time; in children, usually six months or more. (2)

Mental disorders are not the same as mental retardation. People with mental retardation have a diminished intellectual capacity usually present since birth. Children with mental disorders are usually of normal intelligence, although they have difficulty performing at a normal age-level, due to their illness. (5)

A wide range of therapeutic, educational, and social services are essential to address the needs of most of these children and their families. Unfortunately, in most communities, comprehensive services are not available. (6)

Availability of and Access to Child and Adolescent Mental Health Services

Throughout the state, waiting lists for mental health services for children are uniformly longer than for adults. (3)

Few mental health professionals are specifically trained in the developmental differences and needs of children and adolescents. (3)

It is often difficult to secure intensive treatment in residential or inpatient settings for children because neither county nor private insurers want to pay. (3)

The division of responsibility between the schools, medical system, counties, and corrections often lead to fragmentation of services and denial of responsibility. There is typically a lack of case management or community support services for emotionally disturbed children, especially for those not in the welfare system. (3)

Children with untreated mental health problems will achieve less than they could school, will be less employable, and will have serious problems as parents. (2)

Common barriers to parents seeking or obtaining help for their children include lack of knowledge about where to get services, the high cost of services, lack of understanding about their child's problems, difficulty in admitting that their child needs help, and concern that they or their children will be stigmatized. (2)

1 *from "Children and Youth at Risk of Emotional Disturbance," Minnesota Department of Human Services-Mental Health Division, 1989*
2 *from the Children's Mental Health Initiative Fact Sheets, 1988*
3 *from the League of Women Voters Fact Sheets, 1988*
4 *from the Adolescent Health Survey, University of Minnesota, 1987*
5 *from information from Anoka County Mental Health Consortium and National Alliance for the Mentally Ill*
6 *from The Federation of Families for Children's Mental Health*

Understanding Mental Illness in Adults: Signs and Symptoms

Adults in Need

Mental illness can affect persons of any age, race, or nationality. Millions of people are affected.

One in seven adults suffers from a diagnosable mental disorder in need of help from a mental health professional. One in fourteen adults suffers from a serious mental illness.

One in four families is affected by mental illness, making it more widespread than cancer, lung disease, and heart disease combined.

Nearly 25 percent of older Americans have significant mental health problems.

Understanding Mental Illness

Mental Illness is a term used to describe a variety of disorders causing disturbances in thinking, feeling, and relating. These disorders may result in a diminished capacity for coping with life.

Mental illness is not the same as mental retardation. People with mental retardation have a diminished intellectual capacity usually present since birth. People with mental illness are usually of normal intelligence, although they may have difficulty performing some tasks at a normal level, due to disabilities created by their illness.

Signs and Symptoms of Mental Illness

Just as there are different types of physical illness, there are many different types of mental illness.

In our lifetimes, we all experience changes in well-being, both physically and mentally, due to personal crises, life changes, and biochemical changes.

Mental illnesses are each described by a particular set of symptoms, assessed and identified by psychiatrists and psychologists. People may have different diagnoses over time. It is important that people not be labeled by their diagnosis or symptoms. Understanding some of the symptoms of mental illness should prompt us to care for (not label) the *person* with mental illness.

Major symptoms of mental illness may include:

- drastic changes in behavior and emotions
- withdrawal, confusion, or isolative behavior
- inability to function or communicate
- loss of interest in self-care, surroundings, activities
- self-destructive behavior, including alcohol or drug abuse or self-abuse
- socially disruptive behavior

Signs and Symptoms of Specific Mental Illnesses

Each mental illness has its own set of symptoms. Not all persons with a particular mental illness will exhibit the same symptoms or behaviors.

Schizophrenia
Schizophrenia is one of the most serious and disabling of the mental illnesses. It affects approximately one percent of the adult population. Its onset is typically in the teens or twenties. Schizophrenia is caused by a biochemical disturbance in the brain.

Symptoms of Schizophrenia may include:

- disconnected and confusing language
- poor reasoning, memory, and judgement
- disturbances in eating and sleeping
- hallucinations: hearing or seeing things that do not exist in reality
- delusions: persistent false beliefs about something
- tendency to withdraw or isolate
- high levels of anxiety

Affective Disorders and Depression

Affective disorders are one of the most common of mental illness. Approximately six percent of the population suffer from affective disorders.

The primary disturbance in these disorders is that of mood. These mood disorders may include *manic depression*, in which the person swings between extreme euphoric to extreme depressed moods, or *depression*, where the person experiences severe and persistent depressed mood.

Symptoms of Manic Depression may include:

- boundless energy and hyperactivity
- grandiose ideas and poor judgement
- rapid, loud, and disorganized speech
- argumentativeness and impulsive behavior
- decreased need for sleep
- rapid switch to severe depression

Symptoms of Depression may include:

- loss of interest in daily activities
- loss of appetite and difficulty in sleeping
- feelings of worthlessness, hopelessness, and guilt
- inability to concentrate
- suicidal thoughts and even actions

Anxiety Disorders

Anxiety disorders are quite common and affect almost 10% of the adult population.

Normal anxiety is adaptive: it helps people to survive and be productive. Too much anxiety, however, can become disabling. In an effort to control the anxiety, people with anxiety disorders will try to avoid the situations that cause them to be anxious. Examples of anxiety disorders include *panic disorders* and *phobias*.

Symptoms of Panic Disorders may include:

- panic attacks of a few minutes or a few hours duration
- shortness of breath, faster heart beat, and/or dizziness
- trembling, shaking, and/or sweating
- feeling flushed or chilled
- avoidance of specific or all situations that the individual associates with anxiety

Symptoms of Phobias may include:

- Simple Phobias involve fear of a specific situation or thing. Usually people with simple phobias know that their fears are excessive but are unable to overcome them.
- Social Phobias involve fear of being closely observed or of acting in a way that will be humiliating. Usually people deal with the phobic situation by avoiding it or enduring it, but with much anxiety.
- Agoraphobia is a severely disabling condition that may prevent people from leaving their homes. It may begin with a panic attack following a seriously stressful situation and develop into a continual state of anxiety where the individual avoids all situations.

adapted from information prepared by the Anoka County Mental Health Consortium, the National Alliance of the Mentally Ill, and the Dakota County Mental Health Resources manual

Understanding Child and Adolescent Emotional Disturbances: Signs and Symptoms

Risk Factors Emotional Disturbance in Children and Adolescents

Emotional, behavioral, and mental disorders cut across all income, educational, ethnic, and religious groups, and across all types of family structures.

The causes of these problems not entirely understood. Current research suggests that biological, social, psychological, and environmental factors all play a part. (3)

There are a number of organic and environmental factors which research suggests have a strong relationship to the development of serious emotional and behavioral disturbance in children. These are NOT causal factors. (1)

- Risk factors associated with the child include major physical illness, low birth weight, premature birth, difficult temperament, and children who have experienced physical or sexual abuse or neglect.
- Risk factors associated with the family include insecure attachment, teenage parenthood, and parental mental illness.
- Risk factors associated with the environment include homelessness, lack of social support and isolation, poverty and foster care placement.

Types of Emotional Disturbance in Children and Adolescents

Some of the most common childhood psychiatric disorders are: (2)

- *Depression*, which affects between 5-10% of youth
- *Disruptive behavior disorders*, which occur in 2% of girls and 9% of boys
- *Autism*, which occurs in 4-5 of every 10,000 children, mostly in boys
- *Attention-deficit/Hyperactivity*, which affects 3-5% of school age children and occurs more frequently in boys
- *Eating Disorders*, including anorexia which affects 1% of high school girls and bulemia which affects 5-10% of that age group

These problems may take on many forms. Some children may be self-abusive or aggressive toward others. Others may be withdrawn, fearful, or depressed. Those with the most serious disorders may be out of touch with reality. (3)

Seeking Mental Health Care for Children and Adolescents

If a child exhibits any of the following problems, it is likely that that child should be referred for mental health treatment: (1)

- Problem limits child from doing things like other children of the same age
- Problem occurs more frequently and seriously than in others of same age
- Problem is ongoing
- Problem occurs in multiple settings
- Problem has not improved, despite efforts by parents or teachers
- Problem causes child high degree of personal suffering

The following list provides more specific descriptions of behavior, by age level, that may indicate need for professional evaluation or treatment: (1)

Infants:
- Does not respond to external sensory stimuli
- Over-responds to external sensory stimuli
- Does not show pleasure when approached or cuddled
- Does not begin using simple sounds to get needs met
- Failure to thrive, shown by weight loss or inadequate gain
- Failure to acquire other normal developmental milestones

Toddlers:
- Developmental delays in language, motor, or cognitive areas
- Self-stimulating or self-harming behaviors
- Does not show appropriate pleasure, sadness, fear, anger
- Indifferent to caregivers
- Frequently hit, kick, or bite others with intent to harm
- Overly active without restraint, and very short attention span

Preschoolers:
- Poor attention span for age level
- Self-stimulation
- Depression, sadness, boredom, or lack of interest
- Low self-esteem and low confidence
- Unusually anxious or fearful
- Frequently plays out negative experiences
- Excessive dependency on parents
- No interest in parents or other children
- Does not get involved in group activities
- Extreme aggressiveness
- Removed from child care setting because of their behavior

Primary School Children:
- Disinterested in activities
- Bizarre behavior, such as hearing voices or other delusions
- School refusal or frequent physical complaints
- Have experienced trauma and either repeat the event in play or are detached, avoiding talking about the trauma
- Delays or changes in school performance
- Difficulty completing tasks in school
- Dominate, manipulate, or control others
- Unusually fearful of new situations
- Excessively immature behavior
- Unpredictable, unaware of consequences of their actions
- Poor peer relationships

Junior High and High School Adolescents:
- Loss of interest in activities
- Bizarre behavior, such as hearing voices or other delusions
- Difficulty concentrating
- Talk of suicide
- Unusually fearful
- Obsessive concern with body shape or weight
- Extreme elation, with excessive talking, laughing, spending
- Have experienced trauma and either repeat the event in play or are detached, avoidant of talking about the trauma
- Aggressive, destructive
- Break rules, such as truancy, chemical use, or running away

1 *from "Children and Youth at Risk of Emotional Disturbance," Minnesota DHS-Mental Health Division*
2 *from the Children's Mental Health Initiative Fact Sheets, 1988*
3 *from The Federation of Families for Children's Mental Health*

Community Responsiveness to Mental Illness: What Physicians and Health Care Organizations Can Do

The physician is a recognized community leader in the area of health care and therefore often the first professional sought for assistance in dealing with mental health concerns or crises. Therefore, internal medicine, family practice, pediatric or other primary care doctors play an important role in the prevention, identification, early intervention, and referral of persons with mental health problems.

In addition, hospitals, clinics, and other health care organizations are important sites for the promotion of mental health and the provision of information about mental illness. *The following are some of the ways that primary care physicians and health care organizations can open the door to health and to help for persons and families experiencing mental health crises or mental illness:*

Ways to promote mental health and mental illness awareness in your practice or institution

Utilize your waiting area with information on maintaining good health and on accessing support services. Offer magazines, books, and articles health and mental health topics, as well as pamphlets, posters, and other available materials. Display your local emergency services phone number for mental health crisis in your waiting area

Provide or post information about mental illness for Mental Health Month in May or Mental Illness Awareness Week in October. Include information about mental illness or about support groups in a hospital or clinic newsletter.

Include questions regarding emotional and behavioral functioning in initial health assessments and health histories.

Promote information regarding stress management classes, parenting support groups, and other kinds of self-help groups and programs to meet mental health needs.

When treating any medical problem, recognize the linkages between the patient's body and mind, including the psychological impact of many physical illnesses or diseases.

Encourage medical schools in your state to expand training and educational activities in psychiatric disorders, with the goal of increasing knowledge and skills of medical students and residents in mental health-oriented areas.

Explore your own attitudes regarding mental health and mental illness and how those attitudes are reflected in your practice.

Provide information about careers in the mental health field for high school and college career programs.

Become aware of how different cultures, such as Southeast Asian or Native American cultures, view and are affected by mental illness.

Identification, early intervention, and referral of patients with mental health needs

Respond to patient's and parent's mental health concerns, by being an empathetic and non-judgmental listener.

Through patient health assessments, further explore patient or family concerns related to emotional, behavioral, psychological, or social functioning. If warranted, refer patients for further assessments or services by appropriate mental health professionals or to specialists for ongoing care.

Follow-up with the referred patient to determine assessment results and patient follow-through for further services. As a health professional, you are in an important educational and advocacy role in helping to assure that the individual or family obtains the services they need.

Become aware of community support services or refer patients to social service agencies who can help them identify needed services.

Provide hospital- or clinic-based crisis and needs assessment services to help in the identification, early intervention, and referral of persons in need.

Read Minnesota's Comprehensive Mental Health Act. Work with your local county social service agency to refer and coordinate the care of persons with mental illness. Learn about Minnesota's mandated mental health services and work with case managers and other mental health providers in client care.

Community Responsiveness to Mental Illness: What Employers and Business Organizations Can Do

Worksites are greatly impacted, both in productivity and bottom line terms, by unhealthy employees. Mental health costs are among the fastest rising in health care and American businesses are paying for an ever-increasing portion of those costs. One of the ways that employers can recognize the wide-spread impact of mental health problems and mental illness in the community, and manage health care costs, is through health awareness and educational activities at the worksite.

Employers can play an important role in improving or maintaining worker's health, and in educating employees about health-related issues. Employers can promote information about personal mental health, be responsive to employees' mental health needs, and encourage awareness and understanding of mental illness at the worksite and in the community.

The following are some examples of ways that employers and their business organizations can be responsive to mental illness in the community:

Promoting information about personal mental health

Use a variety of communication channels, such as newsletters, posters, and pamphlets to educate employees about maintaining mental health.

Offer educational programs and events for employees and their families on mental health topics.

Examine and alter stress-producing policies and styles in the workplace, particularly ones that perpetuate negative communication patterns and unrealistic performance expectations.

Allow for flexible work schedule policies, child care support programs, participative decision-making, and other programs and policies that help employees manage stress and increase work satisfaction.

Becoming responsive to employees' mental health needs

Provide employee assistance programs that enable employees to receive early intervention and referral in managing mental health problems.

Train supervisors how to recognize problem behavior in work performance, and how to refer employees to employee assistance programs.

Orient employees on how to use the employee assistance program and other employee support services.

Help employees make a smooth transition back to work after a health-related leave.

Offer insurance benefits that include coverage for mental health care. Enhance those benefits with good managed care programs, that help ensure quality and appropriate care for mental health.

Encouraging understanding of mental illness at the worksite and in the community

Educate employees about disabilities, including mental illness, to increase employee awareness and sensitivity to individual differences in the workplace.

Sponsor community projects that assist people with special needs in your area.

Sponsor workers in transitional or supported employment programs, and hire qualified disabled persons, including persons with mental illness, for available jobs in the workplace.

Sponsor school curriculum that promotes mental health for children, and community programs that provide mental health services for young people.

Provide information about careers in the mental health field for high school and college career programs and other business/education partnerships.

Incorporate mental health information into professional development programs for professional organizations. Hold discussions on movies or books that deal with mental illness in sensitive or in stigmatizing ways. Or invite a speaker from a mental health center to discuss depression, stress management, or other mental health topics.

Provide presentations on employee mental health and employee assistance issues, at breakfast meetings and seminars sponsored through chambers of commerce and professional organizations. Include information on mental health and mental illness as a topic in conferences for human resource professionals or employee health benefits workers.

Community Responsiveness to Mental Illness: What Churches and Service Organizations Can Do

In every community, every neighborhood, every church in that neighborhood and every service organization in the community, you can find people whose lives have been touched by mental illness. Some may have a colleague who has experienced a personal crisis resulting in the need for mental health counseling. Others may have a friend who suffers from bouts of anxiety. And some may cope daily with the serious and persistent mental illness of a family member.

Regardless of the type or severity, mental illness is prevalent. And people whose lives are touched personally, directly or indirectly, by mental illness need support and understanding, as they are particularly prone to isolation and the effects of misperceptions.

Churches, synagogues, and other places of gathering are a natural place for education, outreach, caring, and non-judgmental support. *The following is a list of ideas for churches, synagogues, and other service organizations in the community, to help improve community awareness and understanding for people and families affected by mental illness.*

Ideas for members and parishioners

Reach out to families who are coping with the serious and persistent mental illness of a family member or an emotionally disturbed child. Offer your support and understanding.

Respond to mental illness in the same ways you respond to physical illness of a parishioner. This may include hospital visits, cards, prayers, and well-wishes.

Recognize instances of stigma in your church or community. Report any abuses you see of people with mental illness, and speak out when you see persons forgotten or underserved, when you see parents being blamed for their child's emotional disturbance, or when you hear the media misinform the public.

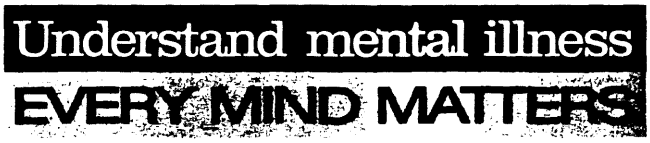
Do more than be nice. Be a friend to a parishioner who is isolated by a mental illness. Invite him or her to church functions or lunch after church services.

Examine your own attitudes about mental illness. Mental illness is not a personal weakness or the result of sinful behavior, but a biochemical condition affecting the brain. Avoid labeling people by their illness. Recognize them as people first.

Volunteer to assist people with mental illness. Provide driving, friendly visiting, needed clothing and personal items, or just a helping and supportive hand.

Include in your personal thoughts, hope for the future for people with mental illness and their families, and for greater understanding for members of the community.

Read Minnesota's Comprehensive Adult and Children's Mental Health Acts. Learn about mental health services that each county is mandated to provide.



Ideas for pastors, ministers, rabbis, and other religious leaders

Reach out, through pastoral care, to families who are coping with the serious and persistent mental illness of a family member.

Learn more about how the mental health system works in your community or state. Identify community resources in the area for more information and referral.

Respond to mental illness in the same ways you respond to physical illness of a parishioner. This may include hospital visits, cards, prayers, and well-wishes.

In sermons, speak about the reality of differences between the various church or temple members. Acknowledge that the church is there for all different types of families, educational and income levels, and disability groups.

Participate in special community programs, such as "Mental Illness Awareness Sundays", programs for pastors held by local hospitals and mental health centers.

Examine your own feelings and attitudes regarding mental illness.

Ideas for church groups and service organizations

Offer factual information about mental illness, denouncing the many myths and misperceptions of mental illness. Encourage members to educate themselves on what mental illness is and what it is not.

Reach out, through support groups and programs, to families who are coping with the serious and persistent mental illness of a family member.

Donate building space for a community mental health program or activity.

Sponsor a program to benefit people with mental illness or those who are homeless.

Sponsor a program about a community mental health topic. Invite a speaker from the Mental Health Association, Alliance for the Mentally Ill, the County Mental Health Advisory Council, or the local community mental health center to speak. Invite parishioners or the general public to attend.

Provide or post information about mental illness. Include information about mental illness or about support groups in a newsletter.

Examine policies and programs that encourage participation by church members who are disabled, including people disabled by mental illness.

Hold cooperative mental illness awareness programs with other churches and synagogues in your community. Focus on the topic of mental illness in sermons, presentations by affected families or recovering persons, educational or support programs, fundraisers, or commemorations for people who had a mental illness.

Support efforts at the community or government level to raise awareness, provide research funding, or promote legislation concerning people with mental illness.

Some of the ideas listed came from the National Alliance for the Mentally Ill, the Alliance for the Mentally Ill-Minnesota, and Reverend Arthur Dale of the St. Louis County Mental Health Advisory Council.

Community Responsiveness to Mental Illness: What Schools, Colleges, and Community Education Can Do

Schools are institutions of learning. Whether addressing young children, college students, or adult learners, schools provide opportunities for increasing knowledge and expanding experience.

One of the opportunities and responsibilities that rests with schools is the promotion of accurate information about mental health, as well as specialized services for people who are affected by mental health problems. These problems exist in every community and in every school.

Students young and old have something to learn and experience regarding the value of their own mental well-being and the prevalence of mental illness in their community. Schools can make information about mental health and mental illness available through educational curriculum, self-improvement classes, or information/referral or counseling services. *The list below includes just a few of the ways that school, colleges, and community education programs can be responsive to mental illness in their communities:*

Pro-active approaches for promoting mental health and mental illness information

Begin promoting information, in early grades, about mental health and well-being, in the same way that information is provided regarding physical health.

Include self-esteem and relationship enhancement activities as a part of other units in elementary and secondary curriculum. Emphasize the importance of acceptance of self, expression of feelings, and connections with others, as these critical elements of mental health and well-being are major skills needed throughout life.

Provide mental illness information in high school or college psychology or sociology classes, including information about stigma and exploration of attitudes about persons with mental illness.

Provide or post information about mental illness for Mental Health Month in May or Mental Illness Awareness Week in October. Include information about mental illness or about support groups in a school newsletter.

Offer self-improvement classes, such as stress management and communication, through community education or extension to promote mental wellness and awareness of personal and community mental health issues.

As part of curriculum on mental illness, give high school or college students an assignment to identify examples of negative stereotypes of mental illness. Discuss common attitudes about mental illness by the public, how people with mental illness are not fully accepted in the community, or how the news and entertainment media often promote misinformation about mental illness. Encourage students to speak out when they see examples of stigma, misinformation, or discrimination.

Publish the emergency services number for mental health crises in school directories.

School-based methods for problem identification and mental health intervention

Stay informed about normal child development so you can recognize symptoms that are out of the norm. Be aware of mental health disorders and mental illnesses that may affect child or adult students. Learn about community resources that serve children, adults, and families affecting by mental illness.

Determine the extent and type of students at risk for mental health-related problems, such as family crises, low self-esteem, poor performance, and behavioral problems in the classroom. Involve teachers, administrators, school nurses, counselors, and health educators, and parents and students in using this data to determine the prevention and intervention programs needed.

Provide student assistance programs, using school nurses, counselors, and community resources, to respond to students in crisis or need.

Offer support groups and peer and adult "mentors" for at-risk students.

Educate families about the range of prevention and intervention services being provided by the school.

Intervene early to ensure that the student can receive the needed evaluation, educational, social, and health care services, as soon as possible. Work with your local county social service agency to refer and coordinate services.

Involve parents, teachers, counselors, and administrators, as well as medical and community resources, in working together toward establishing plans for accommodating the special needs of students who have emotional disturbances. A partnership, which focuses on the needs of the student, will ensure the most appropriate plan.

Involve community workers from ethnic communities, such as Southeast Asian, Native American , or Hispanic communities, in the planning of mental health education programs and particularly in the identification and intervention of all children with mental health needs.

If the student must leave school for health care or treatment, provide a designated counselor or teacher to follow-up in order to prepare for working with the health care team as soon as the student is ready to return to school.

Upon return to school, provide supplemental school and community support services to help the student make the best transition possible back to the school environment.

Recognize that healthy children, who have a parent or guardian with a mental illness, may also have need for individual support and community support services.

Read Minnesota's Comprehensive Mental Health Act. Learn about Minnesota's mandated mental health services.

Community Responsiveness to Mental Illness: What Community Organizations Can Do

Mental illness is a community issue. Mental illness impacts the lives of so many. It affects the lives of one in five persons and one in four families. It affects our co-workers, our friends, our neighbors, and even our own families. Children, adolescents, adults, and elderly people in our communities are affected by mental illness. So are people at every income and educational level.

In order to deal with mental illness as a community, law enforcement, social service agencies, media, health, school, business, and church and other community organizations, must all work together for greater understanding of mental illness, and acceptance of mentally ill persons. We must accept differences and diversity throughout the community and reach out to others in need. As a community, we cannot close our doors, our minds, or our hearts, to people whose lives are impacted by mental illness.

The following are some additional ways that people can work together to recognize and respond to mental illness as a community. (Specific information for physicians and health organizations, for schools, for businesses, and for churches, is also available for more ideas for community responsiveness.)

Ways that law enforcement agencies, courts, and corrections agencies can be responsive

Provide education for the police, including information to aid in understanding mental illness and specific ways to respond to incidents involving a person with mental illness.

Educate police, courts, and corrections agencies about resources for social and health care services. Educate them about the Minnesota Mental Health Act and each county's mandated mental health services. Work with local mental health providers to coordinate services.

Educate the public about the insanity defense, and when and how it is used. Irresponsible information promotes the misperception of a link between mental illness and violence. (In actuality, persons with mental illness are less likely to commit acts of violence than the general public, and are more likely to be victims of violence.)

Involve police and courts in supporting youth diversion activities and community education programs that help children and adolescents make healthy choices.

Ways that social service and public health agencies can be responsive

Sponsor educational programs for service, civic, educational, or church groups regarding mental health. Utilize educational resources and help answer questions about mental illness and the stigma and misperceptions around it.

Speak out as an organization when you hear negative or inaccurate stereotypes about mental illness being promoted by individuals, groups, or the media.

Encourage volunteerism or internships in your agency. Involve volunteers or interns in a project to enhance community awareness of mental illness. Involve consumers of mental health services as volunteers as well.

Provide support and advocacy programs for parents of children with mental health problems, in addition to your other social service programs.

Act as a resource to the schools to provide accurate information regarding mental health and mental illness, mental health and social services, or careers in the human service field.

Advocate for more integration and coordination of services between social service, public health, and mental health programs.

Recognize mental illness in any disability awareness programs your agency sponsors or supports.

Promote general information regarding mental health through a variety of communication channels at your office, including pamphlets, posters, or newsletters.

Ways that libraries can be responsive

Display books and materials on mental health and mental illness for Mental Health Month in May or Mental Illness Awareness Week in October.

List the emergency services numbers for mental health crises on bulletin boards.

Write book reviews of fiction and other works dealing with the topic of mental illness and include them in your newsletters and other communications. Address the accuracy of the information on mental illness and whether it takes a sensitive or stigmatizing view of mental illness.

Sponsor workshops at the library about mental illness and the needs of people with mental illness.

Encourage and welcome use of the library by residents from community -based treatment programs.

Do an in-service for library staff on mental illness and Minnesota's Adult and Children's Comprehensive Mental Health Act.

Community Responsiveness to Mental Illness: What Families Can Do

Mental, emotional, and behavioral disorders cut across all income, educational, and ethnic groups. They can be found in two-parent families, single parent families, and birth, adoptive, or foster families. Yet despite the diversity of families affected by mental illness, they have much in common. These families share the problems of isolation, inconsistency and lack of coordinated services, and staggering health care costs. They share the need for accurate information, therapeutic, educational, social, and recreational resources, and support and advocacy services, to help them and their affected family member cope with the impact of mental illness.

Despite these challenges and needs, families have strengths. And it is with these strengths that they can help their family member, support each other, and attempt to improve the system of mental health services. *The following list shows ways that families can work together with others in the community toward an improved awareness of the needs of, and the services for, their loved ones with mental illness:*

Ways that families can promote mental health and well-being at home

Listen to your children's concerns. Family communication is an important part of family health. When parents take an active interest in their children's behavior, they can provide the guidance and support children need to maintain a healthy lifestyle.

Encourage children and family members to express feelings at home. Expression of feelings are an important part of mental health and well-being.

Give children and other family members the message that you value them for who they are, as well as for their contributions to the family. Remind them that they are capable and lovable.

Help promote family member's self-confidence and uniqueness. Praise and encourage them. Acknowledge that mistakes are simply a learning experience. And most importantly, model your appreciation of your own self-worth.

Recognize times of change and crisis as a source of stress in the family. Talk about the situation and identify ways that family members can support one another.

Recognize the important role that you, as a parent or family member, play in the healthy development of children in the family.

Ways that families can address mental health needs within the family

Assess changes in the mood, affect, or behavior of a family member. If the changes become more serious or persist, seek help by contacting a mental health professional.

Recognize the common phases that a family goes through when one family member becomes ill to increase your own self-awareness and awareness of your family. Typically, the family may become more isolated, both from extended family and

friends and from the community-at-large. They may also begin to seek support and self-help from individual, groups, and books, and gather information to educate themselves about the illness. Finally, the family may look for individual and group advocacy to help themselves and the affected family member cope. These stages may repeat themselves, not necessarily sequentially. As a result of dealing with these various stages, a family may also experience times of effective coping.

Learn about Minnesota's Comprehensive Adult and Children's Mental Health Acts and the mental health services mandated in each county in the state.

Do not be afraid to ask for help. Many families keep family problems within the home for fear of being stigmatized, but it is nearly impossible for families to become empowered without outside support and advocacy.

If you are a parent of a child or adult, assist your child but set limits.

If your family member is hospitalized or placed in a community-based treatment program, stay in touch with their case manager or primary treatment professional. Ask questions if you don't understand the treatment plan.

Accept and acknowledge that your family member has an illness. Learn all you can about ways to help.

Take care of yourself. Utilize a variety of support systems and techniques: attend support groups, exercise, participate in community, religious, or social activities that help you in coping.

Recognize the important role that you, as a parent or family member, play in recognizing the onset of problems and supporting the affected individual through the treatment and ongoing care process.

Ways that families can promote mental illness awareness outside their homes

Involve extended family members in helping to support and understand the family member with mental illness. Let them know that with proper treatment, people can recover from mental illness.

Speak out against misperceptions and discrimination against people with mental illness. Dispel myths and educate the uninformed with facts.

Get involved with advocacy and support organizations. They can provide needed information, reassurance, and the opportunity to channel frustrations about public misunderstanding into productive efforts at raising public awareness. The collective wisdom and experience of family members of people with mental illness can provide a powerful force for advocacy and support.

Recognize the important role you, as a parent or family member, play in helping the attitude change process in the community. Share information and resources with others to improve public awareness and attitudes about mental illness. Serve as a resource to other families who share your intimate understanding of mental illness.

Some of the suggestions came from the Dakota County Mental Health Resources for Individuals and Families, The Federation of Families for Children's Mental Health, and the Education and Partnership Project of the Children's Mental Health Initiative.

Community Responsiveness to Mental Illness: How to Involve Community Officials and Legislators

One of the most important ways to promote awareness of mental illness and issues that affect people with mental illness is by capturing the attention and interest of public officials.

While it may appear challenging to gain the attention of these groups, given their busy agendas and competing influences, establishing a connection with state legislators and county officials involves many of the same elements as the connections made with other community leaders and groups: via personal contact and a mix of communications techniques. *The following is a list of tips for educating community officials and addressing legislative issues:*

Get to know more about your legislators or community officials: Identify what causes they support, their voting records, on what committees they serve, etc.

Establish personal contact. Visit your legislator's office. Make phone calls. Personalize all communications and letters.

Learn about Minnesota's Adult and Children's Comprehensive Mental Health Acts, and the service provision requirements of local social service agencies.

Prepare facts sheets and other brief informational materials. Capture attention with interesting graphics or bold messages. Hand deliver information.

Establish contact appropriate legislative aides to share information and encourage them to bring information to legislators.

Be visible at public hearings, council meetings, and other community forums. Involve authoritative experts to testify at hearings, with concise but compelling information to make a point. Be specific with what is needed and how legislators or other officials can help make that happen.

Invite officials to your group's meetings or special events. Ask them to educate you about related issues that impact persons with disabilities.

Demonstrate impact of action or inaction, using two groups as an illustration.

Involve a legislator in spearheading your cause. Involve key committee chairs, in addition to your own legislator, county commissioner, etc.

Mobilize members throughout your group for action, commitment, and advocacy.

Establish relationships with related organizations to build numbers and influence.

Gather information about the issues before your state legislator and the bills he or she may be authoring. With this information, you can present your views, concerns, and issues to the legislator in the more concise manner. *(See the numbers on the back of this page to learn how to contact your state legislators and about the bills they are involved in.)*

Tracking state legislation can be easy once you have the information you need.*

Generally, ideas of proposals are drafted into *bills*, introduced by a House and Senate author, and assigned a *file number*. Knowing a file number is important because, with the volume of bills legislators must handle each year, the file number quickly becomes the code word for specific legislative proposals.

You can track a specific proposal, a particular bill, or can check to see what bills your state Senator or Representative is authoring. You can also request information on how the bill is progressing through the legislative process.

To find out who your state Senator or Representative is, call:

Senate:	612-296-0504
Representative	612-296-2146

To find out what bills a Senator or Representative is authoring, call:

Senate:	612-296-2887
Representative:	612-296-6646

To receive a copy of a bill at no charge, call:

Senate:	612-296-2344
Representative:	612-296-2343

To find out about Committee schedules and agendas, call:

Senate:	612-296-8088
Representative:	612-296-9283

(Note: the messages on these recordings change daily, and sometimes more frequently as the session nears adjournment.)

* Information obtained from the Minnesota Department of Human Services, Mental Health Division

Tips for Consumers by Consumers

Believe in yourself.
You have the same abilities and talents as you did before your illness. They haven't left because you have an illness, even if you think they have. It's easy to get caught up in your illness and believe you can't make it on your own.

Set-up and use a support network.
Talk to people you feel you can trust and who accept you. Although you may feel alone, you're not! There are people who care, understand and are willing to listen. Include people who are not in the mental health system as well as those who are.

Let people close to you know what your cues are.
If you're having a hard time, sometimes it's easy to cover that up. For example: when I have a hard time I try to make sure I look and dress perfectly. It helps me to feel better about myself but can give the opposite message to my friends. So let people know what some of the things are that you do when you're having a hard time. By doing this, even if you can't always ask for the support you need, others have a better chance to offer it.

Recognize that it is not easy.
It's hard to live in a community so don't let frustration get the best of you. Often, people believe we can't do anything <u>but we can</u>! Find something, such as a volunteer job or a talent like painting, writing, sewing, etc., and schedule time to let your self expression work for you. There are lots of places that will appreciate your efforts.

If you are on medications take them.
Sometimes the side effects can be really uncomfortable--talk to your doctor if you're having trouble.

Get to know your community.
It helps when living in a high-rise or apartment setting to try and be helpful and let neighbors know you. Respect your own confidentiality--having a mental illness is not something to be ashamed of, but tell only those people you want to know. Once people know you as their neighbor, they'll be more receptive to hearing about your illness.

Remember that it is not a failure to occasionally need to be hospitalized.
Problems don't go away just because you're ready to live independently and sometimes the hospital can be a safe, supportive environment when things get tough and you can't make it on your own--keep the faith, it will get better again.

Give yourself positive strokes
Though it's not always easy to see them, you deserve positives! Acknowledge all the positive things you do and have accomplished, and keep going.

Thanks to Nadine Phillips for these helpful tips for consumers living in the community

Seeking Help:
What to Do and Where to Turn
When You or A Family Member Need Mental Health Services

How do you know if you or a member of your family need mental health care? In the case of a serious crisis, the need may be clearly apparent, but in many instances, it may not.

Despite the need for professional help, many individuals and families resist help, fearing that seeking help is a sign of weakness, or that it will create a stigma, or that family problems must stay a secret and remain known only to the family. In actuality, asking for help is a sign of strength, resourcefulness, and determination.

The following information provides very general guidelines and first steps to take when seeking mental health services. (NOTE: It is not meant to take the place of the sound advice you get from your mental health professional. Only qualified, trained people should ever make a diagnosis or prescribe treatment for you.)

When to ask for help for yourself or your family member

- Dramatic and persistent change in mood
- Constant fatigue or persistent insomnia
- Drastic and persistent change in eating habits, or extreme weight gain or loss
- Persistent feelings of guilt, depression, hopelessness, worthlessness, despair
- Irrational feelings of panic, worry, confusion, or forgetfulness
- Lack of interest in family, friends, school, work, or previously enjoyed activities
- Constant physical ailments, such as headaches or backaches
- Problems in family relationships
- Alcohol or drug abuse
- Behavior that is a danger to self or others

Where to turn

Your county is legally responsible to provide, or to designate who will provide, mental health services in each community. Contact your local *county social service agency*, the local *mental health center*, or the *emergency services* number for mental health crises in your county.

Other information resources include the *Mental Health Association of Minnesota (612-331-6840) or Alliance for the Mentally Ill-Minnesota (612-645-2948) for information.* For information concerning child mental health, you can also call the *PACER Center (612-827-2966 or 1-800-53-PACER).* In addition, local *hospitals, clergymen*, or your employer's *employee assistance program* may be able to provide you with general information.

What type of help is available

Once you have taken the first step to ask for help, you will be referred to the most appropriate type of services available. There are a variety of types of mental health professionals and mental health services:

Mental Health Professionals

Psychiatrists typically are involved if medication is needed, or if the individual requires hospitalization. *Psychologist, social worker, therapist, or nurse* may work alone or in conjunction with a psychiatrist, to provide services. Psychologists may also provide psychological testing and other assessment services, helpful in diagnosis and determination of treatment. Social workers may also assist with referral to other related services to meet family needs. Psychiatric nurses also assist with medication management.

According to the Minnesota Adult and Children's Comprehensive Mental Health Acts, each of these mental health professionals must have specific education and experiences beyond their basic education in their fields.

Mental Health Services (mandated by the Adult Comprehensive Mental Health Act)

Education and Prevention
Emergency Services
Outpatient medical, diagnostic, and assessment services
Case Management Services
Day Treatment Services
Community Support Programs
Residential Treatment Facilities
Acute inpatient facilities
Regional Treatment Facilities

Sources of Mental Health Services

Social Service Agencies may provide short-term crisis intervention services, and information and referral for needed mental health care. Social workers may also help family members with coping and identification of services.

Mental Health Centers offer a variety of mental health services, employing many of the mental health professionals listed above. Services may range from individual and group counseling services, to comprehensive programs and medication management, to community mental health education.

Some *hospitals* have crisis centers and outpatient clinics providing mental health services. Some also provide short-term inpatient treatment programs for children, adolescents, and adults, if acute care services are warranted.

Many churches and synagogues provide *pastoral counseling*, offered by a priest, minister, pastor, or rabbi trained in counseling people experiencing personal, marital, or family problems.

Some employers offer *employee assistance programs* for their employees. These programs typically provide free, confidential, short-term counseling, and information and referral for employees and their families.

Many community agencies and organizations offer *support and self-help groups* for individuals and families with a specific need. Some are run by a trained group leader or professional experienced in a particular area. Others are open, welcoming people who share common concerns. Typically, information, support, and experiences are shared.

from "Your Child and Adolescent's Mental Health", Mental Health Association and from information from the Anoka County Mental Health Consortium

Mental Health Education Materials for Community Education Activities

Understanding Mental Illness

Depression...What you should know about it
A pamphlet explaining depression, its causes, treatments, sources of help, and suggestions for dealing with a depressed person (1)

Schizophrenia
A pamphlet with information on definitions, symptoms, and treatment (1)

Your Child and Adolescent's Mental Health
A booklet for parents, with information on child and adolescent mental health needs resources

Roads to Recovery / With Open Arms
Videos about persons with mental illness (2)

Lionel Aldridge
Former football star talks about coping with schizophrenia (2)

Mental Health Advocate
A newsletter published six times per year, providing resources and information on mental illness and mental health issues (2)

Mental Health Materials for use in Schools

Why Talk to your Students about Depression
A guide for junior and senior high teachers, including symptoms, intervention, and treatments, as well as awareness building activities (1)

What to do When a Friend is Depressed
Answers teens questions about depression, including what signs to look for and how to help a friend in need (1)

Very Important Kid
A curriculum for promoting mental health and self-esteem for children (1)

The ME in Mental Health
A self-esteem program for junior high students (1)

Defeat of the Dragon
A puppet show that helps preschool and young children understand depression (1)

After the Tears: Teens Talk about Mental Illness in their Families
Video by United Mental Health focusing on mental illness and families (1)

Mental Health Materials for use in Churches, Hospitals, and Community Education

What's With You, My Friend?
A multi-media presentation on depression (1)

How to Deal with Mental Problems
A pamphlet discussing the differences between normal difficulties and emotional illnesses,with suggestions on how to offer understanding (1)

Give Mental Health a Chance
A brochure, produced by the Hennepin County Mental Health Association, describing mental illness and its incidence, and the problems of stigma (1)

Parents Voices: A Few Speak for Many
Parents describe problems they have encountered in seeking mental health services for their children (3)

When Things Go Wrong
Anyone can have emotional problems and what to do about them (1)

Mental Health Materials for use by Families

Your Child and Adolescent's Mental Health
A resource guide for parents and families

My Child's Mental Health: When Do I Get Concerned
Audiotape helping parents discriminate between normal child development and the symptoms of emotional and behavioral disturbance

Developing Self-Esteem in your child / in yourself
Tips on improving your self-esteem and the self-esteem of your child (1)

Children in Distress
Brochure discussing mental illness in children

Families in Stress
Brochure discussing hints for seeking help as a parent

Coping: Getting Help When You Need it
A series of nine brochures detailing common problems people face (1)

Why Won't my Child Pay Attention?
Videotape about children who have difficulties with hyperactivity (3)

Silent No More: Families Speak Out on Mental Illness
A new video in which family members discuss their experiences, feelings, and ways of coping (2) *(included in kit)*

A variety of additional materials about mental illness and community-based residential treatment are available from the Minnesota Department of Human Services-Mental Health Division. For more information, call 612-296-2307.

1.....Available from the Mental Health Association of Minnesota (612-331-6840)
2.....Available from the Alliance for the Mentally Ill/Minnesota (612-645-2948)
3.....Available from the PACER Center (612-827-2966 / 1-800-53-PACER)

Mental Illness in the Public Eye and Tools for Public Awareness

This section addresses ways to bring accurate information regarding mental illness to the public, particularly via the media. The target audiences for these materials include the media, general public, and all mental health consumer and provider organizations. Materials in this section include:

Understanding Mental Illness: Signs and Symptoms
A summary of the different types of mental illness

Understanding Child and Adolescent Mental Health
Child and adolescent emotional disturbances

Sorting the Myths from the Facts about Mental Illness
Common myths about mental illness and the real story

Avoiding Stigmatizing Language: Tips for Writers and Speakers
Suggestions for people who write or speak about mental illness

How to Do a Media Watch
Steps for organizing a media watch and ways to respond to an ad or program that inaccurately portrays mental illness

Making your Pitch to the News Media
Tips for effectively working with news, radio, and TV reporters

Story Ideas on Mental Health Issues
Suggestions for positive stories on mental health and mental illness

How to Write a Press Release
Tips for getting mental illness information in the news

Samples Scripts for Presentations and Interviews
Suggested areas to cover and questions you may be asked in presentations or interviews on mental illness topics

Tips for Interviews or Presentations
Tips for effectively presenting information to the public

Attitude Exploration Exercises
Thought provoking questions to raise awareness about stigma

Creative Expression: Life with Mental Illness, by Consumers
Thoughts about mental illness and the ways that stigma impacts lives

This section also provides tools for bringing accurate information regarding mental illness to the public, particularly via the media. The target audiences for materials in this section include the media and the general public. Tools in this section include:

Radio PSA Script
Sample scripts for radio announcers to read on the air

TV PSA
Television PSA available for sharing with your local stations

Newspaper/Magazine Print Ad
Public service ads for inclusion in local papers or magazines

Posters
Mental illness awareness posters to post in any community location

Logo
Project logo to use when printing additional communication tools

Videotapes for use in presentations
"Bridge to Understanding" from the Mental Health Association of Minnesota, and "Silent No More" from the Alliance for the Mentally Ill in Minnesota

Understanding Mental Illness in Adults: Signs and Symptoms

Adults in Need

Mental illness can affect persons of any age, race, or nationality. Millions of people are affected.

One in seven adults suffers from a diagnosable mental disorder in need of help from a mental health professional. One in fourteen adults suffers from a serious mental illness.

One in four families is affected by mental illness, making it more widespread than cancer, lung disease, and heart disease combined.

Nearly 25 percent of older Americans have significant mental health problems.

Understanding Mental Illness

Mental Illness is a term used to describe a variety of disorders causing disturbances in thinking, feeling, and relating. These disorders may result in a diminished capacity for coping with life.

Mental illness is not the same as mental retardation. People with mental retardation have a diminished intellectual capacity usually present since birth. People with mental illness are usually of normal intelligence, although they may have difficulty performing some tasks at a normal level, due to disabilities created by their illness.

Signs and Symptoms of Mental Illness

Just as there are different types of physical illness, there are many different types of mental illness.

In our lifetimes, we all experience changes in well-being, both physically and mentally, due to personal crises, life changes, and biochemical changes.

Mental illnesses are each described by a particular set of symptoms, assessed and identified by psychiatrists and psychologists. People may have different diagnoses over time. It is important that people not be labeled by their diagnosis or symptoms. Understanding some of the symptoms of mental illness should prompt us to care for (not label) the *person* with mental illness.

Major symptoms of mental illness may include:

- drastic changes in behavior and emotions
- withdrawal, confusion, or isolative behavior
- inability to function or communicate
- loss of interest in self-care, surroundings, activities
- self-destructive behavior, including alcohol or drug abuse or self-abuse
- socially disruptive behavior

Signs and Symptoms of Specific Mental Illnesses

Each mental illness has its own set of symptoms. Not all persons with a particular mental illness will exhibit the same symptoms or behaviors.

Schizophrenia

Schizophrenia is one of the most serious and disabling of the mental illnesses. It affects approximately one percent of the adult population. Its onset is typically in the teens or twenties. Schizophrenia

Symptoms of Schizophrenia may include:

- disconnected and confusing language
- poor reasoning, memory, and judgement
- disturbances in eating and sleeping
- hallucinations: hearing or seeing things that do not exist in reality
- delusions: persistent false beliefs about something
- tendency to withdraw or isolate
- high levels of anxiety

Affective Disorders and Depression

Affective disorders are one of the most common of mental illness. Approximately six percent of the population suffer from affective disorders.

The primary disturbance in these disorders is that of mood. These mood disorders may include *manic depression*, in which the person swings between extreme euphoric to extreme depressed moods, or *depression*, where the person experiences severe and persistent depressed mood.

Symptoms of Manic Depression may include:

- boundless energy and hyperactivity
- grandiose ideas and poor judgement
- rapid, loud, and disorganized speech
- argumentativeness and impulsive behavior
- decreased need for sleep
- rapid switch to severe depression

Symptoms of Depression may include:

- loss of interest in daily activities
- loss of appetite and difficulty in sleeping
- feelings of worthlessness, hopelessness, and guilt
- inability to concentrate
- suicidal thoughts and even actions

Anxiety Disorders

Anxiety disorders are quite common and affect almost 10% of the adult population.

Normal anxiety is adaptive: it helps people to survive and be productive. Too much anxiety, however, can become disabling. In an effort to control the anxiety, people with anxiety disorders will try to avoid the situations that cause them to be anxious. Examples of anxiety disorders include *panic disorders* and *phobias*.

Symptoms of Panic Disorders may include:

- panic attacks of a few minutes or a few hours duration
- shortness of breath, faster heart beat, and/or dizziness
- trembling, shaking, and/or sweating
- feeling flushed or chilled
- avoidance of specific or all situations that the individual associates with anxiety

Symptoms of Phobias may include:

- Simple Phobias involve fear of a specific situation or thing. Usually people with simple phobias know that their fears are excessive but are unable to overcome them.
- Social Phobias involve fear of being closely observed or of acting in a way that will be humiliating. Usually people deal with the phobic situation by avoiding it or enduring it, but with much anxiety.
- Agoraphobia is a severely disabling condition that may prevent people from leaving their homes. It may begin with a panic attack following a seriously stressful situation and develop into a continual state of anxiety where the individual avoids all situations.

adapted from information prepared by the Anoka County Mental Health Consortium, the National Alliance of the Mentally Ill, and the Dakota County Mental Health Resources manual

Understanding Child and Adolescent Emotional Disturbances: Signs and Symptoms

Risk Factors Emotional Disturbance in Children and Adolescents

Emotional, behavioral, and mental disorders cut across all income, educational, ethnic, and religious groups, and across all types of family structures.

The causes of these problems not entirely understood. Current research suggests that biological, social, psychological, and environmental factors all play a part. (3)

There are a number of organic and environmental factors which research suggests have a strong relationship to the development of serious emotional and behavioral disturbance in children. These are NOT causal factors. (1)

- Risk factors associated with the child include major physical illness, low birth weight, premature birth, difficult temperament, and children who have experienced physical or sexual abuse or neglect.
- Risk factors associated with the family include insecure attachment, teenage parenthood, and parental mental illness.
- Risk factors associated with the environment include homelessness, lack of social support and isolation, poverty and foster care placement.

Types of Emotional Disturbance in Children and Adolescents

Some of the most common childhood psychiatric disorders are: (2)

- *Depression*, which affects between 5-10% of youth
- *Disruptive behavior disorders*, which occur in 2% of girls and 9% of boys
- *Autism*, which occurs in 4-5 of every 10,000 children, mostly in boys
- *Attention-deficit/Hyperactivity*, which affects 3-5% of school age children and occurs more frequently in boys
- *Eating Disorders*, including anorexia which affects 1% of high school girls and bulemia which affects 5-10% of that age group

These problems may take on many forms. Some children may be self-abusive or aggressive toward others. Others may be withdrawn, fearful, or depressed. Those with the most serious disorders may be out of touch with reality. (3)

Seeking Mental Health Care for Children and Adolescents

If a child exhibits any of the following problems, it is likely that that child should be referred for mental health treatment: (1)

- Problem limits child from doing things like other children of the same age
- Problem occurs more frequently and seriously than in others of same age
- Problem is ongoing
- Problem occurs in multiple settings
- Problem has not improved, despite efforts by parents or teachers
- Problem causes child high degree of personal suffering

Understand mental illness

EVERY MIND MATTERS

The following list provides more specific descriptions of behavior, by age level, that may indicate need for professional evaluation or treatment: (1)

Infants:
- Does not respond to external sensory stimuli
- Over-responds to external sensory stimuli
- Does not show pleasure when approached or cuddled
- Does not begin using simple sounds to get needs met
- Failure to thrive, shown by weight loss or inadequate gain
- Failure to acquire other normal developmental milestones

Toddlers:
- Developmental delays in language, motor, or cognitive areas
- Self-stimulating or self-harming behaviors
- Does not show appropriate pleasure, sadness, fear, anger
- Indifferent to caregivers
- Frequently hit, kick, or bite others with intent to harm
- Overly active without restraint, and very short attention span

Preschoolers:
- Poor attention span for age level
- Self-stimulation
- Depression, sadness, boredom, or lack of interest
- Low self-esteem and low confidence
- Unusually anxious or fearful
- Frequently plays out negative experiences
- Excessive dependency on parents
- No interest in parents or other children
- Does not get involved in group activities
- Extreme aggressiveness
- Removed from child care setting because of their behavior

Primary School Children:
- Disinterested in activities
- Bizarre behavior, such as hearing voices or other delusions
- School refusal or frequent physical complaints
- Have experienced trauma and either repeat the event in play or are detached, avoiding talking about the trauma
- Delays or changes in school performance
- Difficulty completing tasks in school
- Dominate, manipulate, or control others
- Unusually fearful of new situations
- Excessively immature behavior
- Unpredictable, unaware of consequences of their actions
- Poor peer relationships

Junior High and High School Adolescents:
- Loss of interest in activities
- Bizarre behavior, such as hearing voices or other delusions
- Difficulty concentrating
- Talk of suicide
- Unusually fearful
- Obsessive concern with body shape or weight
- Extreme elation, with excessive talking, laughing, spending
- Have experienced trauma and either repeat the event in play or are detached, avoidant of talking about the trauma
- Aggressive, destructive
- Break rules, such as truancy, chemical use, or running away

1 *from "Children and Youth at Risk of Emotional Disturbance," Minnesota DHS-Mental Health Division*
2 *from the Children's Mental Health Initiative Fact Sheets, 1988*
3 *from The Federation of Families for Children's Mental Health*

Sorting Out the Myths from the Facts about Mental Illness

Myth: Mental illness doesn't affect the average person.
Fact: *No one is immune from mental illness. According to the National Institute of Mental Health, one in five Americans has some form of mental illness in any given six months. One in four families is affected.*

Myth: People with mental illness will never recover.
Fact: *Mental illness is treatable and some people can recover. Like with other physical illnesses, with proper treatment can lead to improvement and/or recovery, allowing individuals to lead normal lives. Unfortunately, too often stigma prevents some people with mental illness from re-entering the vocational and social mainstream and blocks their efforts to lead normal lives.*

Myth: People with mental illness are unpredictable.
Fact: *While some people with acute symptoms may be impulsive, once they have been treated, most people are consistent in their behavior and affect.*

Myth: People with mental illness are violent and dangerous to society.
Fact: *People with mental illness pose no more of a crime threat than the general population. In fact, given that individuals recovering from a mental illness are apt to be anxious and passive, they are more likely to be victims of violent crimes. (In a study of 20,000 people treated for mental illness, only thirty-three were arrested for violent crimes. All of those had a criminal record prior to their hospitalization, suggesting that a person with mental illness but without a criminal record, is considered even less likely to be a perpetrator of a violent crime.)*

Myth: Children don't get mental illness.
Fact: *More than seven million of the nation's 63 million children have emotional or behavioral problems that warrant mental health treatment.*

Myth: There isn't much that can be done for people with mental illness.
Fact: *A combination of prescription medication, psychotherapy, behavior therapy, education, and skill training help people with mental illness lead normal lives.*

Myth: There isn't much that I can do to help people with mental illness.
Fact: *You can make a difference in the lives of people with mental illness. You can learn more about people with mental illness and support their efforts to obtain housing and jobs in your community. You can avoid using stigmatizing statements about people with mental illness, and speak out when you hear others making such statements. You can personally reach out to an individual with mental illness through support, encouragement, advocacy, or friendship.*

Information obtained from National Mental Health Association, National Institute of Mental Health, U.S. Department of Health and Human Services, and the Anoka County Mental Health Consortium.

Understand mental illness

EVERY MIND MATTERS

How to Avoid the Use of Stigmatizing Language: Tips for writers and speakers

Serious mental illnesses are often in the news and are subjects of films and television programs. *The following information, by the National Alliance of the Mentally Ill, will be helpful to writers in the film, television, radio, and print media industry. It may also be useful to public speakers, and nearly everyone who speaks about mental illness.*

Mental illnesses are not the same as mental retardation. Mental retardation involves deficits in learning ability and intellectual processes, while mental illness involves interference with people's thought processes and ability to live and work.

Mental illnesses are not the result of weak character. The serious mental illnesses, like depression, manic-depression, and schizophrenia, are brain diseases that are genetically-based, and are no one's fault.

Schizophrenia is not multiple or "split personality." It is a brain disease that often strikes young people between the ages of 16 and 25, and interferes with their thought processes, focus of attention, and grasp of reality. Over 2 million Americans over 18 will have schizophrenia during their adult lifetime.

Depressive Illness is not just a case of the blues. It is a severe and persistent biological disease. The two most common types of depressive illness are uni-polar depression, characterized by cycles of deep, prolonged depression, and bi-polar manic-depression, characterized by cycles of deep depression and inappropriate highs. Nearly 10 million Americans over 18 suffer from depression during their adult lifetime, though sadly only one-third will receive treatment.

Horror movies featuring stereotypical "psychotic killers" are not a realistic depiction of persons with mental illness. Actually, violence among people with mentally illness is less common than the incidence of violent behavior in the general public. People with mental illness are more frequently victims of crimes, than perpetrators.

People with mental illness and their families are understandably sensitive about the misuse of certain words to label mental illnesses, because use of these words poses a stigma about mental illness and creates barriers for people with this disability.

Words like "psychotic" or "insane" are inappropriate, except when used in a medical and legal context.

Words like "crazy", "nuts", "wacko", "sicko", "psycho", "lunatic", "demented", and "loony" are offensive.

Phrases like "the mentally ill" or "he's a schizophrenic" de-personalize people and focus on their illness. Therefore, referring to someone as a person with mental illness is preferable.

Terms like "schizophrenic" and "manic-depressive illness" have very specific meanings and apply only to people with diagnosed symptoms. They should not be used in ways not related to the illnesses themselves.

How to Do a Media Watch and How to Respond to a Offensive News Story, Ad, or Program

The following information on media watch was developed by the National Alliance for the Mentally Ill.

Organizing a Media Watch

Elect or appoint a "media watch" committee in your organization or community. Assign different people to monitor different media, including radio, TV, newspaper, magazines, etc. The committee should also develop procedures for reporting on both positive and negative coverage.

Involve the entire group or organization in the media watch process. Inform them how to document the story and the media watch representative to call.

Constructive Responses to an Offensive News Story, Ad, or Program

Responding by letter

Send a letter on the group's letterhead, signed by the group leader, whether the Advisory Council Chair or the advocacy group president or other representative.

Also send individual letters to illustrate that a number of people are concerned. If handwritten, make sure they are legible.

Make reference to the story or item about which you are writing. Give author, date, etc.

Be concise. Stay focused and current. Check your accuracy. Include supplemental brochures, fact sheets, etc. if it will help make your point.

Be positive and constructive. Avoid being rude, threatening, or self-righteous. Remember, if your letter should be published or read, you are really representing your organization and cause to the whole community. Thus, it is important to make a positive impression.

Use your own words and personalize your letter. Don't apologize for writing, which tends to undermine your argument. Instead, focus specifically on the issue.

Time your letter so that it arrives promptly while the issue is still current.

Responding with a meeting

Schedule a meeting between you and other members of your group, and the reporter or manager. Meetings can be either informal lunches or formal meetings at the reporter's office.

Prepare for the meeting by determining the desired outcomes, the key people to influence, the strengths and weaknesses of the situation, the anticipated responses by the media, and some strategies for dealing with some of those likely responses. Rehearse key points and practice ways to effectively respond when they avoid or are defensive of your feedback.

Attend meeting, keeping your desired outcomes focuses and your key points prepared.

Remember to keep things in perspective. Approach the media with a level of action consistent with the significance of the issue. In other words, don't overreact.

Respect lines of authority. Contact the reporter directly and use this opportunity to build a relationship with the reporter. Then if the reporter is not responsive, contact his/her supervisor or editor.

Responding with increased public awareness

Distribute literature in public places, like church bulletins, shopping malls, local newsletters, etc.

Host a seminar with a reputable speaker. Develop publicity materials and encourage media coverage, via press releases and follow-up calls to editors and reporters.

Develop press releases or feature stories that take a more positive or accurate view of the issue.

Building Media Relationships

Gather information about all media in your area and the specific reporters that cover issues specific to your cause. Update the information annually.

Maintain information about reporters in a card file. Collect any vital information, as well as specifics of their type of coverage.

Send out press releases regarding your events and follow-up with reporters and editors to encourage coverage.

Remember to reward reporters or media that tell a positive story. Cultivate relationships by inviting them to speak at a meeting of your organization and present them with an award or certificate of appreciation. Or ask media representatives to serve on your advisory board.

Making Your Pitch To The News Media

Selling a local reporter on a story is easier than you might think. Newspapers gobble up material at an amazing rate. Editors and reporters who often lack time to beat the bushes for ideas nearly always welcome timely, meaty stories - especially if they have a strong "people" angle.

Mental health advocates can get their message out by tuning into the needs of the news media, critically analyzing their areas of expertise for story ideas, and pitching those ideas to the right reporter or editor. *Here are some tips for working with the news media:*

Working with newspaper reporters and editors:

Identify an individual in your community who is knowledgeable about mental health issues, such as the county social services' mental health contact person or other mental health professional. Call upon that resource person for media and public information activities in your area.

Call the newspaper and introduce yourself and organization to the reporter who covers mental health issues or the city editor who controls what stories are written.

When you meet, identify the individual who can be considered as a resource person on mental health issues. Ask what kind of stories their newspaper is interested in covering. Provide a brief overview of current local and national issues, and perhaps whet their appetites with story ideas.

Before suggesting an idea, ask yourself: Is it newsworthy? Does it provide timely information that a broad cross-section of readers will find useful and interesting? If something happened today, it's timely. If it's expected to happen tomorrow, it's even more timely. If it happened last week, it's probably not timely. Judgments about whether something is newsworthy can also vary with people, so if one reporter bypasses an idea, you might try another reporter or an editor.

If there's an issue you'd like to see written about, it has a better chance of making the paper if there's a "news hook." A news hook helps make the case for an otherwise timeless story to go in the paper now. For example, Mental Health Month could provide a news hook for many issues.

Don't give up if you get a cool response to one idea. News value is relative - it changes every day depending on what's going on in the world. What makes the front page one day might not get in the paper, yet the next day, might be news.

Watch for national and state-wide stories that have local angles. It's probably one of your best bets for getting coverage. If there's a national story on community services for people with mental illness for example, you could suggest a follow-up story on what is being done locally.

Reporters often try to quickly "localize" stories from news wire services such as the Associated Press by asking hometown experts for their opinions. Provide reporters with a list of names and numbers of mental health professionals and reliable, clear-thinking advocates who are willing to be quoted on particular topics.

Look for success stories among the programs you're involved with the people they serve. Stories probably will focus on an individual's personal accomplishments, but they'll likely also include information on the program itself, the broader issues involved, and what is needed in the future.

Keep an eye out for background stories. If the county board is considering a particular issue, suggest a preview story to the media. Provide background information and identify resources.

Watch the bylines - the names of reporters that appear at the top of stories. If no one regularly handles mental health issues as part of their beat, watch for reporters who do a particularly good job presenting complicated subjects. When you have a good story idea, pitch it to them.

Be reliable. Think through what you're trying to accomplish and why. Promote a half-baked idea once and you may find it difficult to sell a good idea the next time. You'll be valued, if reporters can depend on you to provide useful information.

Mental health issues are important, but be sure you have reliable data when dealing with the news media. Strong, unsupported opinions can ruin your reputation in the newsroom.

If there's a speech or other event you want covered, let the editor know one to two weeks in advance. Any longer warning, and it could get lost in the shuffle. Any less lead time and there may be no one available to cover the event.

If you convey information through a phone call, follow it up by sending the information in writing to the person you spoke with.

The more legwork you're willing to do, the better your chances of getting a story in the paper. Make it easy on the reporter or editor. Supply names of people and numbers of people they can contact. Provide background information on the subject. Offer to track down other information.

Don't forget the editorial writers. Often these people need ideas for opinions and you can be among their best sources of information. Find out who writes their newspaper's editorials, meet with that person, and be prepared with well-rounded arguments to support your case.

Most editorial pages provide space for reader commentaries, usually lengthier, more formal version of a letter to the editor. Ask the editorial writer for guidelines on what kind of material is accepted and how you go about getting something in.

If you want to pass on a story idea or some information to the newspaper but don't want to be quoted, be sure the reporter knows that at the start of the conversation.

Working with Radio and Television Reporters

The same basic rules for working with newspapers apply to radio and television journalists. There are additional opportunities, though, for getting coverage.

Local radio stations usually have talk shows that deal with current issues in the news or of general interest. Meet with the program director to find out how a spokesperson for your group can be included. Choose a mental health resource person who states your group's position articulately, who can answer questions on other related areas, and who has a good radio voice.

Radio stations that take editorial positions must provide time for opposing viewpoints. Call the news director to respond to an editorial, and watch for opportunities for guest commentaries.

Many local television stations also have public affairs programs, most often in a talk show format. Call the program director to find out more about how to get an issue on the air.

For news coverage of an event, call the stations' assignment desk the morning the event takes place. Recap the information they'll need; time, place, etc. When reporters aren't available, often on weekends, cameras may be sent to get pictures that are described from the press release.

Local public access stations provide a better chance for getting air time, although your audience will be smaller than with commercial stations. Contact the cable access station in your city for specific information on what they offer. Ask about electronic bulletin boards for announcements.

Story Ideas about Mental Health Issues to Pitch to the Media

"Day in the life" stories.

This is a good way to chronicle what it's like to be a person with mental illness who in a community-based program, as one example. It provides an excellent opportunity for good photographs. The concept can also be adapted to other individuals, including mental health professionals who have particularly interesting or challenging careers.

Parents of children with mental illness

What are the special challenges? What support services are available in our community and what is needed?

Mental illness and the homeless

This is a timely topic that has received a lot of national attention. Are there any efforts being made to reach out? How serious is the situation here?

Community-based treatment

This is one of the major trends in the treatment of mental illness. Explain what this community is doing, putting it in the broader context of what is being done nationwide.

The stigma of mental illness

This story could explain what it's like to live with stigma by talking to people who are mentally ill, as well as their family members and the professionals who treat them. A good candidate for an in-depth Sunday story.

Going back to the community after hospitalization

Finding a job, a place to live and adequate support services are all major challenges. Each is a key issue that could be a separate story but would also work well linked to one person's experience.

Finding treatment close to home

Are there people in your community having difficulty because they cannot find treatment nearby? What are the options?

Depression

Depression among the elderly is beginning to get more recognition from researchers. Suicide rates in that age group are also being noted. Also of interest may be depression among teens and children, or what people do to cope when faced with chronic depression.

Care-giver burnout

What are the challenges of caring for someone who is mentally ill? Are there support groups available that can help?

Minnesota's Adults and Children's Comprehensive Mental Health Act

Explain the acts and the services mandated by them

Housing

Identify the need for safe and affordable housing for persons with mental illness, and the financial and support services needed to ensure a successful living situation

Holiday depression, or the holiday "blues."

This is a sure-fire story at Christmas. It's a good way to get information out from local professionals on how to deal with the holidays and other every day stresses of life.

Treating people with more than one problem

If someone is mentally ill and is chemically dependent, for example, what are the challenges of treating that person? Are new approaches needed?

Crime and mental illness

Next time there's a crime committed by someone who is mentally ill, consider doing sidebars of follow-up stories on 1) how the mental health system responded, or 2) Data on how people with mental illness are no more dangerous than the general population.

Mental illness and child neglect

What role does mental illness play when a child is neglected, particularly in cases involving single, teen-age mothers and the death of their infants.

Features on mental health advocates

How did they become involved? Most have personal stories about mental illness to share. Features can also focus on the problems that support and advocacy groups are geared to and how they help members cope.

Families and mental illness

How does mental illness affect families? How do they handle feelings of guilt and shame? How does society in general treat them?

A newspaper column on mental health issues

A mental health advocacy group or professional may be willing to supply regular columns about current issues.

How to Write a Press Release

Press releases are one of the main ways to get information to reporters, editors and news directors. When you're writing your release, remember that newsrooms get flooded with paper every day. *Here are some ways to help make sure your news doesn't get overlooked.*

Follow an easy-to-use format. Leave about one third of the first page blank for editing marks. Allow generous margins.

Double space and use standard punctuation. DON'T USE ALL CAPS. It irritates typists and can lead to misspellings.

Provide a contact person. Put the name of that person on the top of the page, indicate what organization that person is with, and list a daytime phone number where they can be reached.

Keep it clean. The less editing that needs to be done, the more likely the information is to get in the paper or on the air.

Be conscious of style. Make it sound like other news stories you've read. Summarize the most important information in the first paragraph and list the details in the body of the story.

Don't write chronologically. Instead start with the most current information and list the background.

Be precise. Include times, dates and addresses of upcoming events and names and phone numbers of key people involved.

Stick to the facts. Avoid information or quotes that don't tell readers anything useful. Don't use quotes from your organization's president saying: "I'd like to thank everyone who worked to make this program a success." It's guaranteed to be cut, and if there are too many to clean up, the whole release may be tossed out.

Think like a reporter. Be sure to answer all of the basic reporting questions: who, what, when, where, why and how.

Do their homework. Include separate background information that may be helpful.

More information about writing press releases is featured on the back-side of this page, including tips on structuring the release. Note that it is written in standard press release format.

Information prepared by the Department of Human Services Communications Office

Understand mental illness

EVERY MIND MATTERS

Press Release Format

Contact: Jane Smith, Director
Any County Mental Health Advisory Board
(000) 123-4567

Terri Gunderson, Public Information Officer
Minnesota Department of Human Services
(612) 296-0000

HEADLINES SHOULD BE COMPLETE SENTENCES

The first paragraph should contain the most important, timely information: What is going to happen, when, where and what for or why.

"The second paragraph often includes a quote from the leader of the organization, an expert, or a well-known person," said John Doe, President of the AnyCounty Mental Health Association.

The third paragraph gives more detail on the issue discussed or on the event being publicized.

Also remember to include phone or address for more information about the issue or your organization.

Keep in mind that when editors are short of space or time, they use only the information that fits -- starting from the top of your press release. So leave least important information for last.

Double check spelling of all names and places. Be accurate. Use only one side of the paper. It is also helpful to double space the press release for easy reading.

End the press release with a little "30" with a dash on either side. That's an old-fashioned code still taught in journalism school signalling that what follows is not part of the press release.

- 30 -

Sample Scripts And Key Areas To Discuss in Interviews or Presentations on Mental Illness

The following are many of the basic questions that you may get when you are on an interview. These answers are to be used as guidelines and can help you in preparing for interviews or presentations.

General Information on Mental Health and Mental Illness

What is Mental Illness? What Is Mental Health?

This may be a time when you will be most challenged by your audience. Many people may have in their mind stereotypes about mental illness, perpetuated by the news media and the entertainment world. Tread carefully when trying to describe either of these definitions. The following comments may be used or may just be something to ponder!

Mental illness is a term that we are not really able to describe. Almost daily new discoveries are being made about mental illness and treatments. In diagnosing a mental illness, professionals often refer to the Diagnostic and Statistical Manual of Mental Disorders Third Edition (DSM-III). Many mental illnesses are caused by a chemical imbalance in the brain. There are medications that alleviate some of the symptoms of mental illness. Some people use talk therapy to deal with their mental illness; and some use a combination of both.

Mental illness is not a result of personal failure or moral weakness. People with a mental illness often suffer because they are made to feel they are somehow to blame for their illness. However, we do not blame a person who has diabetes, heart disease or the flu. It is important to emphasize that the person is not to blame.

Mental health often refers to adherence to acceptable norms of a society. This may challenge some people's beliefs in the accepted American culture. In our multi-cultural society we must learn to be tolerant of those who are different from ourselves or our neighbors. However, if an individual displays behavior that is dangerous to self or others or is disruptive to family relations, job performance, physical well-being or everyday functioning such as sleep patterns or eating patterns, it is time to seek help from a mental health professional.

Mental health is something all of us want for ourselves, whether we know it by name or not. When we speak of happiness, peace of mind, enjoyment or satisfaction we are usually talking about mental health. Mental health has to do with everybody's everyday life. It means the overall way that people get along - in their families, at school, on the job, at play, with their associates and in their community. There is no line that neatly divides the mentally healthy from the unhealthy. There are many different degrees of mental health. No one characteristic by itself can be taken as evidence of good mental health nor can the lack of any one as evidence of mental illness. And nobody has all of the traits of good mental health all of the time.

Who Is Affected By Mental Illness?

All Americans are affected in some way. Mental illness knows no boundaries. Mental illness does not discriminate on basis of age, race, gender, or socio-economic conditions. Children as young as four years old have been diagnosed as having depression. Individuals with mental illness and families and friends of someone with a mental illness suffer greatly because of lack of understanding or because of the stigma of mental illness. Job discrimination, insurance discrimination, housing discrimination, or lost educational opportunities impact on the daily lives of those in our society who suffer the most are understood the least.

According to the National Institute of Mental Health, twenty percent of Americans will have a mental illness at some point in their lives.

Today, 10 million Americans have some form of depression.
12 million have a phobia.
1.5 million have schizophrenia.
Nearly 2.5 million have an obsessive compulsive disorder.
1.5 million have a panic disorder.

General Information on Treatment of Mental Illness

There are "traditional" types of mental health services:

One treatment is medication therapy. Specific drugs are prescribed to alleviate symptoms of the mental illness.

The second treatment is talk therapy. This relies upon a mental health professional working with the client to understand the reasons for the feelings or actions of the mental illness and how to control these.

Mental health professionals often depend upon a combination of both types of therapies to address a person's mental illness.

There are also many alternative mental health treatments. These include mega-vitamin therapy, dietary restrictions, bio-energetics and several others.

It is important to not say one type is the only way to treat a mental illness. One specific type of treatment may have worked in your personal experience, but it may not work for another person.

Sample Scripts And Key Areas (continued)

Stigma and Misunderstanding

What Is A Stigma?

Stigma is the unfair generalization of a group of people based upon false or exaggerated circumstances.

Stigma does not allow people to see others as individuals. People with a mental illness often become identified only by their mental illness, and it is often assumed that their every action is dictated by their mental illness. The majority of people with a mental illness are living and working and struggling to carry on normal lives. Their mental illness interferes with everyday life, but it does not run their lives.

Stigma closes doors on opportunities for people with a mental illness in the work place, on where to live, with educational opportunities, on having a "normal" life.

Why Are These People Let Out On The Streets?

People with a mental illness have a right to the least restrictive and most appropriate treatment available. Individuals have a right to choose to live where they want. State law mandates that each county provide a full range of community based services for people with a mental illness. This law should provide for increased community based treatment. In mental health treatment it is important to allow people to live in the most normalized setting as possible. This encourages learning social skills and independent living skills. It is in the best interest of the person with mental illness, his/her families and the community as a whole to live in the community.

However, there are some people with a mental illness who either do not have access to the appropriate services, or cannot pay for the services, or refuse the services that are offered. These issues demonstrate a lack of adequate and/or appropriate funding for appropriate services.

Are People With A Mental Illness Dangerous?

Research has shown that people with a mental illness are no more likely to commit crimes than the general population. People with a mental illness are very often victims of crimes. The entertainment media and the news media often distort perceptions of people with a mental illness.

A person with a mental illness may, at times, portray unusual behavior. This may make people around him/her uncomfortable. It is human nature to not trust a situation that you are not familiar with. Do not misjudge action for more than it is.

What About Homeless People?

There seems to be no agreement on the number of people who are homeless and who have a mental illness. Estimated vary from as few as one third to over two thirds of the homeless people have a mental illness.

Getting and Giving Help

Where Can A Person Go For Help?

There are many alternatives that a person can turn to for referrals.

Your county's Social Services Department or Community Mental Health Center
Each county in Minnesota has an identified number for mental health crisis.
Your own physician or health clinic
Check the yellow pages under:
- Mental Health Services
- Psychiatrists
- Psychologists
- Social Service Agencies

For general information on mental health

Mental Health Association of Minnesota	612-331-6840
Toll Free	1-800-862-1799
TDD	612-331-1630
Greater Duluth area (	218 726-0793
Alliance for the Mentally Ill	612-645-2498
Schizophrenia Association of Minnesota	612-922-6916
MN Depressive & Manic Depressive Association	612-333-0219

What Can I Do To Help?

Gain a better understanding of mental illnesses and people with mental illness.

Volunteer at a local mental health program.

Avoid terms which are derogatory to people with a mental illness.

Speak out when you hear others use negative, inaccurate comments about mental illness.

Challenge the media when they report one-sided stories.

Complain to advertisers who sponsor gimmicks that laugh at a person's illness.

Encourage your service, civic, social, educational, or church group to become better educated.

Be open; be available. If someone you know has a mental illness, acknowledge it. Send flowers or a card or visit. Remember a mental illness is an illness. You would not think twice about sending something to someone you know who has pneumonia. Treat a person with mental illness with the same respect.

Information prepared by the Mental Health Association of Minnesota.

Tips for Interviews or Presentations on Mental Illness

Tips for interviews or presentations

Look upon all interviews with the media or presentations to community groups as excellent opportunities to reach large groups of people that we may not be able to otherwise reach.

Be prepared to tell your own story. As a mental health consumer, family member or professional, tell what you know about mental illness.

Do your research. Know the message you want to leave with your audience.

If you have resources to refer to, have the correct address and phone numbers. Write them down!

If you have read a particularly helpful book, tell your audience. People want to learn; they just don't know where to start.

If you don't know an answer, say so. Offer suggestions of where to find answers.

Speak slowly and clearly.

Be prepared for some leading questions. Many people have strong misconceptions about people with a mental illness. Do not respond with anger. Rehearse your responses.

Avoid using stereotyping terms - refer to "people with a mental illness" not "the mentally ill!"

Don't let one person dominate the conversation. Validate concerns, then move on.

Wear appropriate clothing. Checks and stripes or flashy jewelry will detract from your message. Dress simply, attractively, and comfortably.

Use your most positive self-talk before the event or interviews. The right frame of mind will enable you to respond effectively to the questions.

Information prepared by the Mental Health Association of Minnesota

Attitude Exploration Exercise:
Examining your Attitudes about Mental Illness

The following questions were designed to provoke thought and to raise awareness about the stigma surrounding mental illness and the people who have a mental illness.

Understanding mental illness

Do people with a mental illness have a right to refuse mental health treatment?

Do you know the difference between mental illness and mental retardation?

Do most people who are homeless also have a mental illness?

Understanding the rights of persons with mental illness

Do you believe that a person who has had a mental health problem should avoid overly stressful situations?

Do you believe that people with a mental illness should be allowed to raise children?

Do you believe the statement "Once a person has a mental illness, he or she will always have a mental illness?"

Should people who have a mental illness be given responsibility?

Are people with a mental illness accountable for their actions?

If an acquaintance had been hospitalized for depression, would you send a card or call? How about if that person had a heart attack?

Understanding mental illness in the community

Should our government increase spending for mental health research?

Should our government increase spending for mental health programs?

Would you object to a person with mental illness living next door to you?

Would you object to a community-based treatment program moving into your neighborhood?

Do you think a Regional Treatment Center is an appropriate option for most people with a mental illness?

Does mental illness strike people with lower socio-economic status more often?

Would you hire someone who has a mental illness?

Understand mental illness

EVERY MIND MATTERS

Would you work with someone who has a mental illness? Or do you know that you may in fact already work with someone with a mental illness, but because of the stigma, he or she does not talk about it?

If the news media reported that an elected official suffers from a mental illness, do you think it is correct for the media to question that official about his/her illness?

Have you ever written a letter of complaint to a store that advertises "Crazy Days" or "Moonlight Madness" or to a television network that incorrectly portrays a person with a mental illness?

Are you comfortable when a newscaster explains that the person who went on a shooting spree had a history of mental health problems, or does it anger you?

Understanding the stigma of mental illness

Did you know that approximately 20% of Americans have mental health problems?

When you hear a friend make a comment about a "crazy person," do you speak up?

Do you correct misinformation about assumptions of people with a mental illness or mental illnesses in general?

If you have a mental illness would (are) you able to tell others?

Do you recognize the fact that many people who have had (or currently have) a mental illness are productive citizens working as doctors, lawyers, teachers, truck drivers, and every other walk of life?

Did you know that Patty Duke, Winston Churchill, Virginia Woolf and Abraham Lincoln have (had) lived with mental illness?

Do you ever comment "he is driving me crazy" or "that is nuts?"

Do you see people with a mental illness as having a personal weakness?

Would you conceal the fact that you or a friend had experienced a mental illness at some point in your or his/her life?

Learning to respond to someone with a mental illness

Do you have a clear understanding about what mental illness is?

Do you know some of the warning signs or symptoms of mental illness?

Would you know what to do if a friend came to you needing help because he or she had a mental illness?

Do you know what to do in a mental health emergency (suicide attempt, psychotic behavior, danger to self or others)?

Information prepared by the Mental Health Association of Minnesota.

Thoughts on the Stigma of Mental Illness

Stigma-A Journey
By Susan Talbott Carey

I always thought of life as a journey with some moments of light and some of darkness. Some persons who have mental illness have substantially more times of darkness.

Stigma is a source of that darkness and contributes to the perpetuating of ideas in the community which contribute to discrimination and feelings of shame. Can anyone ever escape it?

For me, the patterns that stigma made in my life changed and lessened when I became involved in an advocacy organization about eight years ago, after I had struggled with mental illness for 17 years. I learned that some very sensitive people, both consumers and non-consumers, were working to reform the mental health system, a system that I thought would destroy my life. I was elected president of that organization's chapter in my county. The years have passed and I have become more and more involved as the opportunities have come to speak out.

I consider that involvement to have been crucial to my recovery and to being free of institutionalization for seven years.

The work to be done creates its own light and erases darkness. We have made a beginning in creating a new system. Some important remnants of the old system are still with us. Parts of the cruelty that stigma breeds is still here. But services are being created and are innovative. More people are speaking out.

There is much to be done. Speeches to be given, lobbying to do, people to talk to, and organizations to form. Fear will bind stigma to us if we let it thrive. The stigma must be fought as fiercely as the mental illness. They can hold power over us and our loved ones. To paraphrase the poet Tennyson, it is not too late to seek "a newer world."

Thoughts on the Stigma of Mental Illness

On My Own
by Nadine Phillips

Finding a place in the world where you feel accepted and you fit in, can be difficult for anyone. Finding that place in the world when you have a mental illness often feels impossible.

I'm learning to cope with my mental illness, however I run into a lot of obstacles. People in the community believe in myths and fears about persons with mental illnesses. They fear for safety of themselves and their children. They fear if a treatment center is located near them, property values will decrease and that residents there will be dangerous. Even some of my friends are not accepting me anymore. It is as though they think I am a different person than I once was. A few friends cross the street to avoid talking with me, pretending they don't see me.

To me, my mental illness is just like any other kind of illness. I didn't choose to have it. I struggle with it sometimes having bad days and a lot of good days. I'm recovering and I need all the support I can get, but I often feel branded as "crazy." It feels like I've become a "label" that doesn't feel, think and care. I know I'm still the same person I was. My mental illness has affected me, by slowing me down in the things I want to accomplish, but I'm still doing them. I have many talents and abilities. They haven't disappeared because of my illness. I get frustrated that I can't always accomplish what I want to, at a faster pace, but I have to accept that, being a part of my illness and then go on. That's just what I am doing and with success. After getting my G.E.D, I continued on in college and maintained a 3.8 grade point average, while becoming well known as a public speaker on mental health issues and finding success in fashion design. I'm in therapy and working hard in my recovery.

I guess when it comes right down to the bottom line, people are afraid because they don't understand and haven't had the education available to help them know what a mental illness means. It's easy to believe in the myths and fears when even the media portrays persons with mental illnesses in a negative light. There are a lot of people like me, who have a mental illness and are living and working the community. Maybe it's time we all learn to cope, recover and grow together. The stigmas of mental illness exist because of the lack of knowledge and understanding--not because they are true.

Radio Public Service Announcement for Mental Illness Awareness

ANNOUNCER: Quick! Name any five friends. Now, try to guess which one of them will be affected in some way by mental illness.

That's exactly how wide-spread mental illness is. In fact, one in four families and one in five individuals will be affected by mental illness each year.

But mental illness isn't hopeless. With help and understanding, people lead productive lives.

Now when you think about mental illness, remember, it isn't nameless or faceless. Mental illness touches people close to you, people close to all of us.

So be a friend. And learn more about mental illness through your local and state mental health organizations.

Understand mental illness. Because every mind matters.

(60 Second Copy)

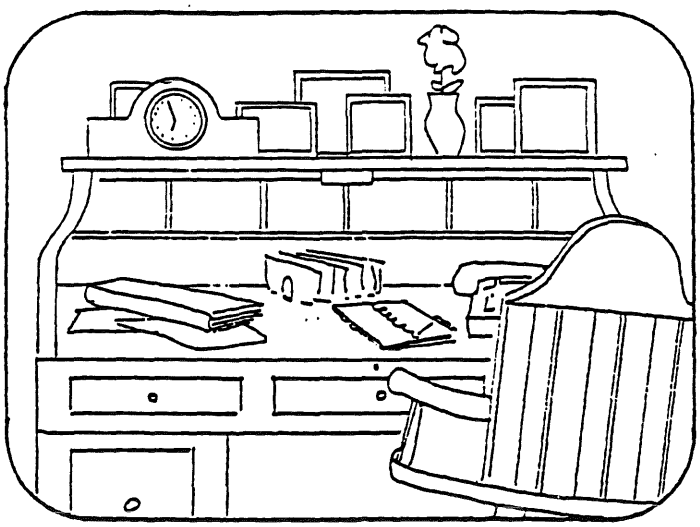
Understand mental illness

EVERY MIND MATTERS

Television Public Service Announcement for Mental Illness Awareness

To obtain a copy of this ten second PSA to share with television stations in your area, please contact the Department of Human Services, Mental Health Division at 612-296-7908, or the Communications Office at 612-296-4416.

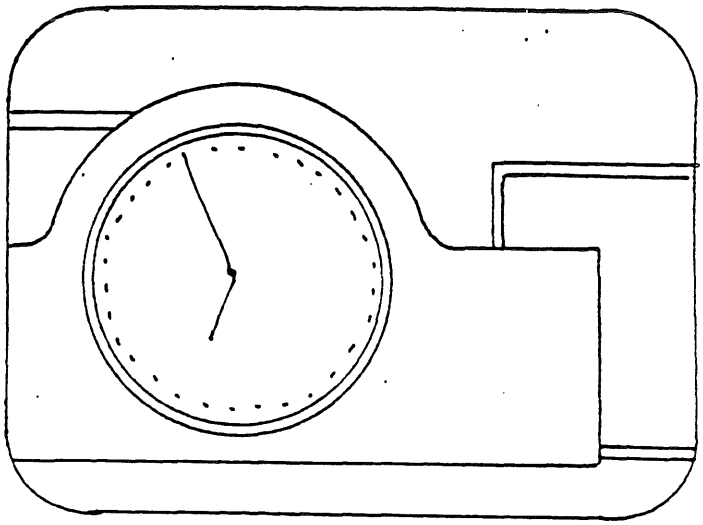
(1)



Audio: Tick, tick of background clock.
(VO) "Mental illness affects...

Video: Slow move-in and pan on roll-top desk showing personal items and photos.

(2)



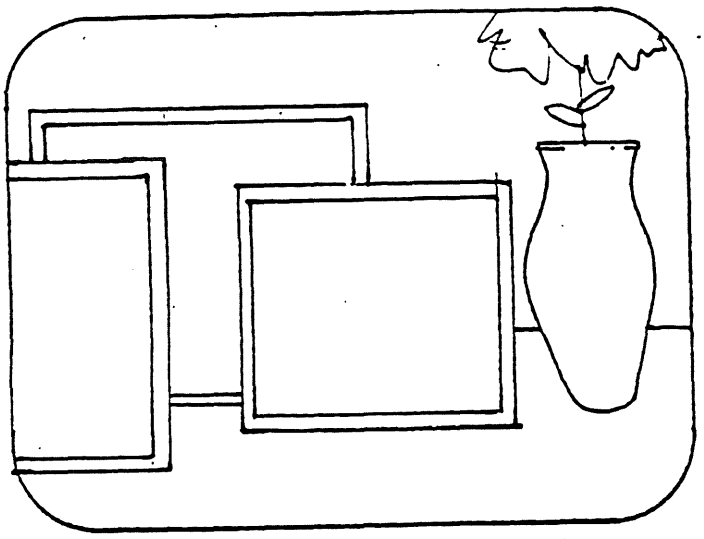
Audio: ...one in five, including people...

Video: Camera continues close-up pan.

Understand mental illness

EVERY MIND MATTERS

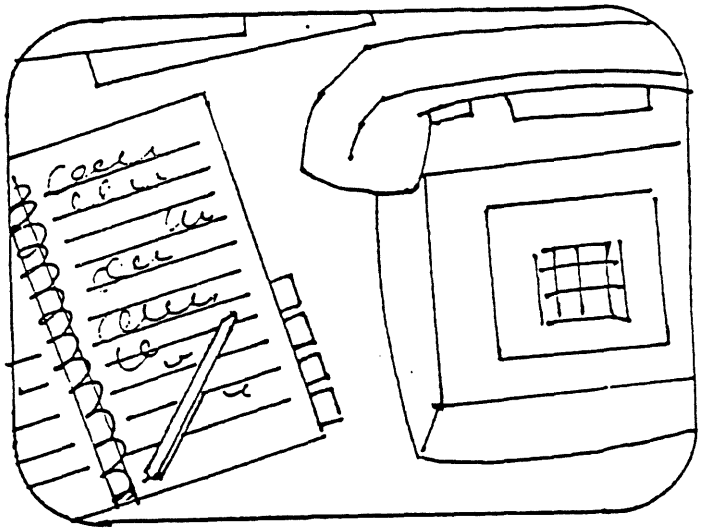
(3)



Audio: (Ticking of clock continues) ...close to you...

Video: Pan continues.

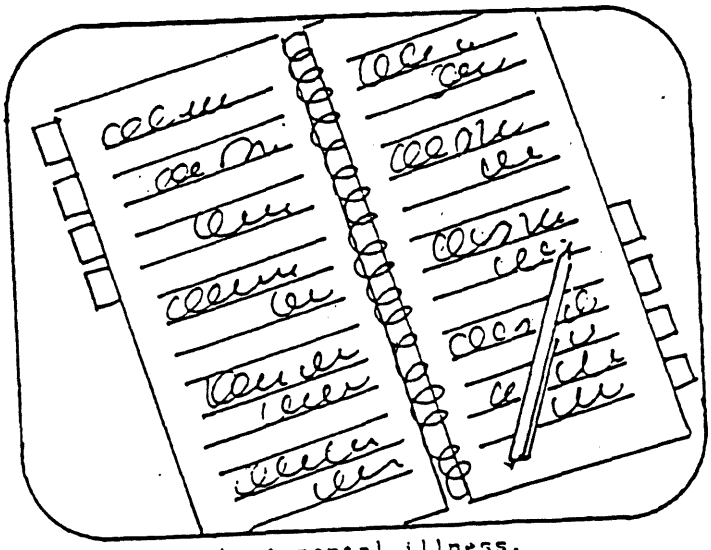
(4)



Audio: ...So learn more...

Video: Pan across phone to address/phone book.

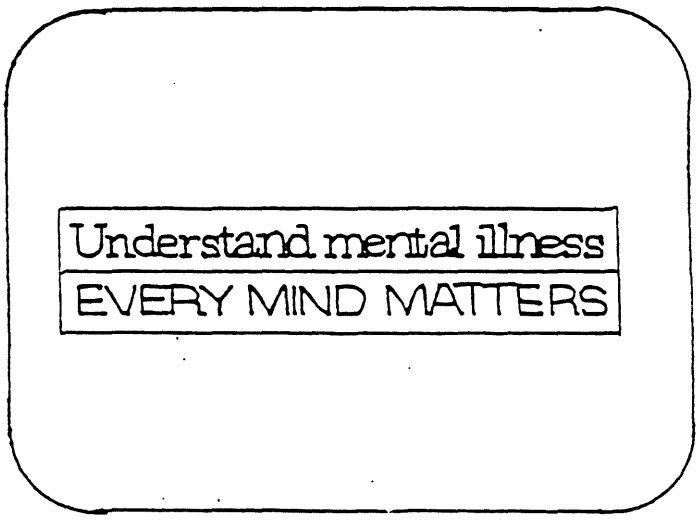
(5)



Audio: ...about mental illness.

Video: Stop on address/phone book, zone in.

(6)



Audio: Because every mind matters.

Video: Fade to black. Bring up logo.

Resources

This section provides resources for mental health education and mental health services. The target audiences for the materials in this section include all audiences discussed in this kit, the general public, and all mental health consumer and provider organizations. Materials in this section include:

Mental Health Education Materials for Community Education
General mental health materials, including pamphlets, videos, and curricula

Seeking Help: Where to Go and What to Do
General guidelines and first steps to take in seeking mental health assistance

Seeking Help in the Metropolitan Area
General mental health services in the Twin Cities

Seeking Help in Greater Minnesota
General mental health services around the state

Seeking Help: Support Groups and Advocacy Organizations
General state-wide resources for support, education, and advocacy

Mental Health Education Materials for Community Education Activities

Understanding Mental Illness

Depression...What you should know about it
A pamphlet explaining depression, its causes, treatments, sources of help, and suggestions for dealing with a depressed person (1)

Schizophrenia
A pamphlet with information on definitions, symptoms, and treatment (1)

Your Child and Adolescent's Mental Health
A booklet for parents, with information on child and adolescent mental health needs resources

Roads to Recovery / With Open Arms
Videos about persons with mental illness (2)

Lionel Aldridge
Former football star talks about coping with schizophrenia (2)

Mental Health Advocate
A newsletter published six times per year, providing resources and information on mental illness and mental health issues (2)

Mental Health Materials for use in Schools

Why Talk to your Students about Depression
A guide for junior and senior high teachers, including symptoms, intervention, and treatments, as well as awareness building activities (1)

What to do When a Friend is Depressed
Answers teens questions about depression, including what signs to look for and how to help a friend in need (1)

Very Important Kid
A curriculum for promoting mental health and self-esteem for children (1)

The ME in Mental Health
A self-esteem program for junior high students (1)

Defeat of the Dragon
A puppet show that helps preschool and young children understand depression (1)

After the Tears: Teens Talk about Mental Illness in their Families
Video by United Mental Health focusing on mental illness and families (1)

Understand mental illness

EVERY MIND MATTERS

Mental Health Materials for use in Churches, Hospitals, and Community Education

What's With You, My Friend?
A multi-media presentation on depression (1)

How to Deal with Mental Problems
A pamphlet discussing the differences between normal difficulties and emotional illnesses,with suggestions on how to offer understanding (1)

Give Mental Health a Chance
A brochure, produced by the Hennepin County Mental Health Association, describing mental illness and its incidence, and the problems of stigma (1)

Parents Voices: A Few Speak for Many
Parents describe problems they have encountered in seeking mental health services for their children (3)

When Things Go Wrong
Anyone can have emotional problems and what to do about them (1)

Mental Health Materials for use by Families

Your Child and Adolescent's Mental Health
A resource guide for parents and families

My Child's Mental Health: When Do I Get Concerned
Audiotape helping parents discriminate between normal child development and the symptoms of emotional and behavioral disturbance

Developing Self-Esteem in your child / in yourself
Tips on improving your self-esteem and the self-esteem of your child (1)

Children in Distress
Brochure discussing mental illness in children

Families in Stress
Brochure discussing hints for seeking help as a parent

Coping: Getting Help When You Need it
A series of nine brochures detailing common problems people face (1)

Why Won't my Child Pay Attention?
Videotape about children who have difficulties with hyperactivity (3)

Silent No More: Families Speak Out on Mental Illness
A new video in which family members discuss their experiences, feelings, and ways of coping (2) *(included in kit)*

A variety of additional materials about mental illness and community-based residential treatment are available from the Minnesota Department of Human Services-Mental Health Division. For more information, call 612-296-2307.

1....Available from the Mental Health Association of Minnesota (612-331-6840)
2....Available from the Alliance for the Mentally Ill/Minnesota (612-645-2948)
3....Available from the PACER Center (612-827-2966 / 1-800-53-PACER)

Seeking Help in the Metropolitan Area: Information, Referral and Treatment Sources

(Note: Emergency services numbers are italicized.)

Anoka County	*Mercy Medical Center Crisis Center*	*612-422-2200*
	County Social Services	612-427-2200
Carver County	*YES Emergency Service*	*612-379-6363*
	County Mental Health Program	612-442-4437
	County Social Services Department	612-448-1215
		800-535-7530
Dakota County	*Crisis Intervention*	*612-437-5111*
	County Human Services Department	612-450-2660
	Dakota County Mental Health Center	612-455-9651
Hennepin County	*Crisis Center*	*612-347-3161*
	County Social Services: Adult Services	612-348-8587
	County Social Services: Family Services	612-348-2324
	Hennepin County Mental Health Center	612-347-5773
	Family and Children's Service	612-340-7444
Ramsey County	*St. Paul Ramsey Medical Center*	*612-221-2121*
	County Human Services Department	612-298-4016
	Family Services of St. Paul	612-222-0311
	Ramsey County Mental Health Center	612-297-4737
Scott County	*County Human Service Department*	*612-445-7751*
Washington County	Mental Health Center	612-777-5222
	County Social Services	612-779-5404
	Human Services, Inc.	612-430-2720

Information obtained from the Mental Health Association of Minnesota and the Minnesota Department of Human Services-Mental Health Division

Seeking Help in Greater Minnesota: Information, Referral and Treatment Sources

(Note: Emergency Services Numbers are italicized)

Aitkin County	*Northland Mental Health Center*	*218-927-3718*
	County Family Services	218-927-3744
Becker County	*Lakeland Mental Health Center*	*800-223-4512*
	County Welfare Department	218-847-5684
Beltrami County	*Evergreen House*	*218-751-4333*
	County Service Center	218-751-4310
	Upper Mississippi Mental Health Center	218-751-3280
Benton County	*Central Minnesota Mental Health Center*	*612-252-5210*
	Central Minnesota Mental Health Center	612-252-5010
	County Social Service Agency	612-968-6254
Big Stone County	*Life Center*	*800-642-2737*
	Family Service Center	612-839-2555
Blue Earth County	*County Human Services*	*507-625-9034*
Brown County	*Sioux Trails Mental Health Center*	*507-354-3181*
	Family Service Center	507-354-8246
Carlton County	*Human Development Center, Duluth*	*800-634-8775*
	County Human Services Center	218-879-4583
Cass County	*Sheriffs Office / switched to mental health center*	*911*
	County Social Services Department	218-547-1340
	Northern Pines Mental Health Center	218-587-2927/218-568-5342
	Upper Mississippi Mental Health Center	218-751-3280
Chippewa County	*West Central Community Services*	*800-992-1716*
	County Family Service and Welfare Department	612-269-6401
Chisago County	*Sheriffs Office / switched to social worker*	*911*
	County Family Service & Welfare Department	612-257-1300
	Five County Human Development	612-396-3333
Clay County	*Lakeland Mental Health Center*	*800-223-4512*
	County Social Service Center	218-299-5200
Clearwater County	*Sheriffs Office / switched to medical center*	*911*
	County Social Services Department	218-694-6164
	Upper Mississippi Mental Health Center	218-751-3280
Cook County	*Crisis Center*	*800-634-4775*
	County Social and Health Services Department	218-387-2282

Cottonwood County	*Unity House*	*800-642-1525*
	County Family Service Center	507-831-1891
	Southwestern Mental Health Center	507-283-9511
Crow Wing County	*Mental Health Center in Emergency*	*218-828-4357/800-462-5525*
	Northern Pines Mental Health Center	218-829-3235
	County Social Service Center	218-828-3966
Dodge County	*South Central Human Relations Center*	*507-451-1951*
	County Social Services	507-635-2361
Douglas County	*Douglas County Hospital*	*612-763-6638*
	Lakeland Mental Health Center	800-223-4512
	County Social Welfare Center	612-762-2302
Faribault County	*Sheriffs Office / switched to social worker*	*507-526-5148*
	County Human Service Center	507-238-4757
Fillmore County	*Sheriffs Office / switched to crisis center*	*911*
	County Welfare Department	507-765-3304
	Zumbro Valley Mental Health Center	507-288-1873
Freeborn County	*Crisis Center*	*507-373-2223*
	County Human Services Department	507-377-5230
	Upper Mississippi Mental Health Center	218-751-3280
Goodhue County	*County Welfare Department*	*612-388-8261*
	Zumbro Valley Mental Health Center	612-288-1873
Grant County	*Lakeland Mental Health Center*	*800-223-4512*
	County Social Service Department	218-685-4417
Houston County	*Broadway Center*	*507-454-1046*
	County Social Service Department	507-724-5211
Hubbard County	*Mental Health Center, Bemidji*	*800-422-7843*
	County Social Service Center	218-732-3339
Isanti County	*Mental Health Center, Braham*	*612-887-0464*
	County Family Service Department	612-689-1711
Itasca County	*Northland Mental Health Center*	*218-326-1274*
	County Social Service Department	218-327-2941
Jackson County	*Sheriffs Office*	*911*
	Southwestern Mental Health Center	507-283-9511
	County Welfare Department	507-847-4000
Kanabec County	*Sheriffs Office*	*911*
	County Family Service Department	612-679-4740
	Mental Health Center, Braham	612-887-0464
Kandiyohi County	*West Central Community Services*	*612-235-4613*
	County Family Service Department	612-235-8317
Kittson County	*Northwest Hospital*	*800-422-0863*
	County Welfare Department	218-483-2689

Information obtained from the Mental Health Association of Minnesota and the Minnesota Department of Human Services-Mental Health Division

Seeking Help in Greater Minnesota: Information, Referral and Treatment Sources (continued)

(Note: Emergency Services Numbers are italicized)

Koochiching County	*Northland Mental Health Center*	*218-283-3406*
	County Family Service Department	218-283-8405
Lac Qui Parle County	*Crisis Receiving Center*	*800-992-1716*
	County Family Service Center	612-598-7594
	West Central Community Services	612-235-4613
Lake County	*County / St. Lukes Hospital*	*800-642-1300*
	Human Development Center, Duluth	800-634-8775
	County Social Service Department	218-834-5681
Lake of the Woods County	*Sheriffs Office*	*911*
	County Social Service Department	218-634-2642
LeSueur County	*Sheriffs Office / switched to mental health center*	*911*
	County Welfare Department	612-357-2251
Lincoln County	*Western Human Development Center*	*507-532-3236*
	County Welfare Department	507-694-1452
Lyon County	*Western Human Development Center*	*507-532-3236*
	County Welfare Department	507-537-6747
McLeod County	*Hutchinson Hospital*	*612-587-5502*
	County Social Service Center	612-864-3144
	West Central Community Services	612-235-4613
Mahnomen County	*Northwest Medical Center*	*800-422-0863*
	Northwest Mental Health Center	800-282-5005
	County Welfare Department	218-935-2568
Marshall County	*Northwest Medical Center*	*800-422-0863*
	Northwest Mental Health Center	800-282-5005
	County Welfare Department	218-745-5124
Martin County	*Crisis Center*	*507-235-3456*
	County Human Services Center	507-238-4757
Meeker County	*West Central Community Services*	*800-992-1717*
	County Social Services Department	612-693-2418
Mille Lacs County	*Sheriffs Office*	*911*
	County Family Services	612-983-6161
Morrison County	*Sheriffs Office*	*911*
	County Human Services	612-632-2941
	Northern Pines Mental Health Center	612-632-6647

Mower County	*Distress Center at St. Olaf Hospital*	*507-433-8826*
	County Social Service Department	507-437-9483
Murray County	*Western Human Development Center*	*507-532-3236*
	County Welfare Department	507-836-6144
Nicollet County	*County Social Services*	*800-247-5044*
	Sioux Trails Mental Health Center	800-247-2890
Nobles County	*Unity House*	*507-372-7671*
	County Social Services	507-372-2157
Norman County	*Northwest Mental Health Center*	*800-282-5005*
	County Social Services	218-784-7136
Olmsted County	*Crisis Receiving Center*	*507-288-8750*
	County Social Services	507-285-8891
	Zumbro Valley Mental Health Center	507-288-1873
Otter Tail County	*Lakeland Mental Health Center*	*218-736-6987*
	County Social Services	218-739-4491
Pennington County	*Northwest Medical Center*	*218-681-4240*
	County Social Services	218-681-2880
Pine County	*Sheriffs Office*	*911*
	Five County Mental Health Center	612-396-3333
	County Social Services	800-629-3930
Pipestone County	*Unity House*	*800-642-1525*
	Southwest Mental Health Center	507-825-5888
	County Social Services	507-825-3357
Polk County	*Riverview Hospital*	*800-282-5005*
	Northwest Mental Health Center	218-281-3940
	County Social Services	218-281-3127
Pope County	*Lakeland Mental Health Center*	*800-223-4512*
	Family Services	612-634-5301
Red Lake County	*Northwest Medical Center*	*800-422-0863*
	County Social Services	218-253-4131
Redwood County	*Mental Health Center*	*800-622-5226*
	County Social Services	507-637-5741
Renville County	*West Central Community Services*	*800-992-1716*
	County Social Services	612-523-2202
Rice County	*In Hospital - District #1*	*800-422-1286*
	County Social Services	507-334-0031
Rock County	*Southwestern Mental Health Center*	*800-642-1525*
	County Social Services	507-283-9507

Information obtained from the Mental Health Association of Minnesota and the Minnesota Department of Human Services-Mental Health Division

Seeking Help in Greater Minnesota: Information, Referral and Treatment Sources (continued)

(Note: Emergency Services Numbers are italicized)

Roseau County	*Northwest Hospital*	*800-422-0863*
	County Social Services	218-463-2411
Sherburne County	*Sheriffs Office / switched to social services*	*612-441-2522*
	Central MN Mental Health Center	*800-635-8008*
	County Social Services	612-441-1711
Sibley County	*Sioux Trails Mental Health Center*	*800-247-2890*
	County Social Services	612-237-2978
St. Louis County	*Crisis Line - St. Lukes Hospital*	*800-634-8775*
	Range Mental Health Center, Virginia	800-972-4567
Stearns County	*Central MN Mental Health Center crisis number*	*800-635-8008*
	Central MN Mental Health Center	*612-253-5555*
	County Social Services	612-255-6000
Steele County	*South Central Human Relations*	*507-451-1951*
	County Social Services	507-451-0414
Stevens County	*Rule 36 House, Hancock*	*612-392-5111*
	County Social Services	612-589-1481
Swift County	*West Central Community Services*	*800-992-1716*
	County Social Services	612-843-3160
Todd County	*Sheriffs Office*	*911*
	Northern Pines Mental Health Center	612-732-6602/218-894-1002
	County Social Services	612-732-6181
Traverse County	*Stevens Community Memorial Hospital*	*800-642-2737*
	County Social Services	612-563-8255
Wabasha County	*Hiawatha Valley Mental Health Center*	*507-454-4341*
	Broadway Center	*507-454-1046*
	County Social Services	612-565-3351
Wadena County	*Sheriffs Office*	*911*
	Northern Pines Mental Health Center	218-631-2426
	County Social Services	218-631-4225
Waseca County	*South Central Human Relations*	*507-451-1951*
	County Social Services	507-835-0560
Watonwan County	*Sheriffs Office / switched to social worker*	*507-375-3341*
	County Social Services	507-238-4757

Wilkin County	*St. Francis Medical Center*	*218-643-3000*
	County Social Services	218-643-8561
Winona County	*Winona Police*	*507-454-6100*
	Broadway Center	*507-454-1046*
	County Social Services	507-457-6200
Wright County	*Central MN Mental Health Center in Buffalo*	*612-252-5010* *612-682-4400*
	Wright County Human Services	612-682-3900
Yellow Medicine County	*Western Human Development*	*800-622-5226*
	County Social Services	612-564-2211

Information obtained from the Mental Health Association of Minnesota and the Minnesota Department of Human Services-Mental Health Division

Seeking Help:
Support Groups and Advocacy/Education Organizations

Mental Health Association of Minnesota	Non-profit, voluntary organization with goal of improving care for persons with mental illness, promoting mental health, and providing advocacy, family support, and educational programs and resources. Local chapter activities state-wide.	612-331-6840/ 800-862-1799
Alliance for the Mentally Ill of Minnesota	Non-profit organization, serving persons with mental illness and their families. Local affiliate activities state wide.	612-645-2948
REACH	Mutual support groups for families and friends of individuals with mental illness and neurological disabilities. Groups held in communities across Minnesota.	612-331-6840 800-862-1799
Schizophrenia Association of Minnesota	Non-profit organization providing informal support and informational meetings. Groups meet every Monday, at 7:00 pm, in Minneapolis.	612-922-6916
Minnesota Depressive and Manic Depressive Association	Non-profit organization, of individuals with affective disorders and their families. Support groups held at sites in the metropolitan area.	612-333-0219
PACER Center	Information and training center for parents of children with disabilities, with special programs for parents of children with emotional and behavioral disabilities	612-827-2966 800-53PACER
Mental Health Law Project	Organization serving persons who have legal issues arising from mental illness or emotional disturbance	612-332-1441 800-252-4150

Understand mental illness

EVERY MIND MATTERS

Seeking Help:
What to Do and Where to Turn
When You or A Family Member Need Mental Health Services

How do you know if you or a member of your family need mental health care? In the case of a serious crisis, the need may be clearly apparent, but in many instances, it may not.

Despite the need for professional help, many individuals and families resist help, fearing that seeking help is a sign of weakness, or that it will create a stigma, or that family problems must stay a secret and remain known only to the family. In actuality, asking for help is a sign of strength, resourcefulness, and determination.

The following information provides very general guidelines and first steps to take when seeking mental health services. (NOTE: It is not meant to take the place of the sound advice you get from your mental health professional. Only qualified, trained people should ever make a diagnosis or prescribe treatment for you.)

When to ask for help for yourself or your family member

- Dramatic and persistent change in mood
- Constant fatigue or persistent insomnia
- Drastic and persistent change in eating habits, or extreme weight gain or loss
- Persistent feelings of guilt, depression, hopelessness, worthlessness, despair
- Irrational feelings of panic, worry, confusion, or forgetfulness
- Lack of interest in family, friends, school, work, or previously enjoyed activities
- Constant physical ailments, such as headaches or backaches
- Problems in family relationships
- Alcohol or drug abuse
- Behavior that is a danger to self or others

Where to turn

Your county is legally responsible to provide, or to designate who will provide, mental health services in each community. Contact your local *county social service agency*, the local *mental health center*, or the *emergency services* number for mental health crises in your county.

Other information resources include the *Mental Health Association of Minnesota (612-331-6840) or Alliance for the Mentally Ill-Minnesota (612-645-2948) for information.* For information concerning child mental health, you can also call the *PACER Center (612-827-2966 or 1-800-53-PACER).* In addition, local *hospitals*, *clergymen*, or your employer's *employee assistance program* may be able to provide you with general information.

What type of help is available

Once you have taken the first step to ask for help, you will be referred to the most appropriate type of services available. There are a variety of types of mental health professionals and mental health services:

Mental Health Professionals

Psychiatrists typically are involved if medication is needed, or if the individual requires hospitalization. *Psychologist, social worker, therapist, or nurse* may work alone or in conjunction with a psychiatrist, to provide services. Psychologists may also provide psychological testing and other assessment services, helpful in diagnosis and determination of treatment. Social workers may also assist with referral to other related services to meet family needs. Psychiatric nurses also assist with medication management.

According to the Minnesota Adult and Children's Comprehensive Mental Health Acts, each of these mental health professionals must have specific education and experiences beyond their basic education in their fields.

Mental Health Services (mandated by the Adult Comprehensive Mental Health Act)

Education and Prevention
Emergency Services
Outpatient medical, diagnostic, and assessment services
Case Management Services
Day Treatment Services
Community Support Programs
Residential Treatment Facilities
Acute inpatient facilities
Regional Treatment Facilities

Sources of Mental Health Services

Social Service Agencies may provide short-term crisis intervention services, and information and referral for needed mental health care. Social workers may also help family members with coping and identification of services.

Mental Health Centers offer a variety of mental health services, employing many of the mental health professionals listed above. Services may range from individual and group counseling services, to comprehensive programs and medication management, to community mental health education.

Some *hospitals* have crisis centers and outpatient clinics providing mental health services. Some also provide short-term inpatient treatment programs for children, adolescents, and adults, if acute care services are warranted.

Many churches and synagogues provide *pastoral counseling*, offered by a priest, minister, pastor, or rabbi trained in counseling people experiencing personal, marital, or family problems.

Some employers offer *employee assistance programs* for their employees. These programs typically provide free, confidential, short-term counseling, and information and referral for employees and their families.

Many community agencies and organizations offer *support and self-help groups* for individuals and families with a specific need. Some are run by a trained group leader or professional experienced in a particular area. Others are open, welcoming people who share common concerns. Typically, information, support, and experiences are shared.

from "Your Child and Adolescent's Mental Health", Mental Health Association and from information from the Anoka County Mental Health Consortium

This kit was assembled by members of the Creative Living Center (CLC),
a day treatment and vocational program of MRC Mental Health Services.
CLC encourages people with psychiatric disabilities
to develop skills for living in the community.

Understand mental illness

EVERY MIND MATTERS

MH CASE MANAGEMENT SERVICES FOR CHILDREN AS REPORTED BY COUNTIES

COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED Est. Actual 1988***	CLIENTS SERVED Planned 1990	CLIENTS SERVED Planned 1991
* AITKIN	$1,322	$12,000	$20,000	2	9	10
ANOKA	$0	$70,000	$300,000	0	40	160
BECKER	$4,000	$5,000	$10,000	8	30	50
BELTRAMI	$6,607	$9,642	$11,202	15	30	40
BENTON	$0	$8,000	$12,800	0	20	32
BIG STONE	$1,159	$4,000	$4,000	1	5	5
BLUE EARTH	$732	$37,140	$39,529	1	60	62
BROWN	$15,000	$15,500	$28,000	15	18	27
CARLTON	$18,407	$15,000	$20,000	9	20	32
CARVER	$59,826	$74,783	$83,757	20	25	28
* CASS	$756	$6,900	$10,400	4	16	26
CHIPPEWA	$4,974	$10,978	$20,907	3	8	10
CHISAGO	$30,000	$40,000	$50,000	10	30	34
CLAY	$0	$8,108	$8,513	0	15	17
CLEARWATER	$4,726	$4,888	$5,323	5	7	9
COOK	$10,784	$7,200	$28,275	16	12	15
COTTONWOOD	$4,586	$8,905	$11,132	7	10	12
* CROW WING	$0	$4,320	$200,000	0	2	105
DAKOTA	$55,994	$60,560	$63,588	52	58	61
DODGE	$7,859	$13,441	$28,420	4	19	24
DOUGLAS	$2,000	$12,000	$15,000	6	23	36
FILLMORE	$6,475	$13,626	$15,526	7	25	27
FMW	$0	$0	$12,500	0	0	27
FREEBORN	$12,250	$16,000	$19,600	12	16	25
* GOODHUE	$11,352	$13,743	$13,743	50	50	50
* GRANT	$6,689	$10,700	$15,500	5	8	10
* HENNEPIN	$0	$2,172,805	$2,172,805	0	4,493	4,493
HOUSTON	$345	$345	$10,000	2	2	20
HUBBARD	$14,435	$15,000	$16,000	12	12	12
* ISANTI	$62,440	$57,130	$58,844	40	50	50
* ITASCA	$0	$25,000	$25,000	0	10	10
JACKSON	$0	$4,027	$5,248	0	10	13
KANABEC	$2,456	$6,000	$8,240	8	15	20
KANDIYOHI	$17,000	$18,000	$18,720	120	150	150
KITTSON	$7,352	$4,550	$5,550	2	5	6
KOOCHICHING	$9,837	$9,985	$40,000	5	11	15
LAC QUI PARLE	$700	$2,800	$5,400	2	7	11
LAKE	$1,460	$11,200	$17,600	2	28	44
LAKE OF WOODS	$2,185	$1,698	$4,320	1	4	6
LE SUEUR	$10,000	$25,000	$27,000	35	46	50
MCLEOD	$0	$5,000	$6,500	0	10	15
MAHNOMEN	$2,800	$3,500	$4,000	3	5	7
MARSHALL	$2,100	$3,500	$4,500	3	9	10
MEEKER	$8,000	$7,200	$15,000	3	5	10
MILLE LACS	$10,000	$15,000	$20,000	5	30	20
MORRISON	$1,750	$14,400	$21,600	4	20	30
MOWER	$26,276	$30,000	$35,400	38	40	40
* NICOLLET	$60,000	$65,000	$70,000	15	30	40
NOBLES	$0	$11,240	$17,430	0	15	25
NORMAN	$5,000	$8,000	$10,000	7	12	12

MH CASE MANAGEMENT SERVICES FOR CHILDREN AS REPORTED BY COUNTIES

	COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED Est. Actual 1988***	CLIENTS SERVED Planned 1990	CLIENTS SERVED Planned 1991
	OLMSTED	$0	$100,000	$85,631	0	35	45
	OTTER TAIL	$6,000	$10,000	$16,000	15	25	40
	PENNINGTON	$5,500	$5,500	$5,500	5	10	15
	PINE	$7,000	$12,500	$13,050	6	16	25
	PIPESTONE	$3,095	$3,100	$3,200	3	9	9
	POLK	$5,000	$5,500	$6,000	20	21	22
	POPE	$7,500	$7,500	$8,500	10	10	16
*	RAMSEY	$0	$100,000	$390,000	0	120	225
	RED LAKE	$1,062	$2,000	$2,575	3	4	6
	REDWOOD	$2,700	$10,000	$15,000	7	20	25
	REGION VIII	$35,000	$45,000	$55,000	21	25	35
	RENVILLE	$0	$15,700	$22,300	0	18	23
	RICE	$5,039	$20,000	$45,000	9	20	40
	ROCK	$0	$750	$750	0	1	5
	ROSEAU	$1,160	$2,000	$3,000	2	10	15
*	SAINT LOUIS	$0	$209,000	$229,000	0	220	220
	SCOTT	$15,366	$24,766	$44,333	15	30	45
	SHERBURNE	$45,643	$57,054	$79,767	24	40	45
*	SIBLEY	$5,950	$5,000	$5,000	6	6	5
	STEARNS	$35,480	$37,609	$38,737	44	47	48
*	STEELE	$0	$0	$0	0	0	
	STEVENS	$15,000	$12,000	$12,000	15	15	1
	SWIFT	$0	$3,000	$3,000	0	2	2
*	TODD	$156	$7,600	$12,960	1	19	30
	TRAVERSE	$7,000	$7,000	$7,000	5	5	8
	WABASHA	$0	$9,500	$7,000	0	8	10
*	WADENA	$1,000	$3,600	$6,300	1	8	16
*	WASECA	$2,000	$22,000	$22,000	4	24	24
	WASHINGTON	$40,917	$45,000	$71,660	54	85	130
	WILKIN	$2,350	$3,800	$4,500	6	10	12
	WINONA	$35,000	$37,693	$54,201	8	10	11
	WRIGHT	$53,130	$62,000	$128,000	45	100	200
	YELLOW MEDICINE	$7,000	$9,000	$9,500	8	10	10
16	TOTAL	$854,682	$3,893,986	$5,073,336	896	6,558	7,420

NOTE: THESE FIGURES ARE TAKEN FROM THE LATEST INFORMATION FROM COUNTY MENTAL HEALTH PLANS FOR THE PERIOD OF 1990 AND 1991. THE 1988 FIGURE IS THE ESTIMATE OF HOW MUCH WAS SPENT AND HOW MANY CLIENTS WERE SERVED FOR THAT YEAR. THE 1990 AND 1991 FIGURES ARE HOW MUCH IS PLANNED TO BE SPENT AND HOW MANY CLIENTS ARE PLANNED TO BE SERVED DURING THAT TIME.

* AN ASTERISK NEXT TO A COUNTY INDICATES THAT THE COUNTY'S CHILDREN'S MH PLAN HAS NOT BEEN APPROVED AS OF 9/20/90.

** THE EXPENDITURES INCLUDE ALL COUNTY EXPENDITURES, INCLUDING MEDICAID & GENERAL ASSISTANCE MEDICAL CARE REVENUE.

*** THE 1988 CLIENT FIGURE FOR ONE COUNTY WAS MODIFIED TO BE CONSISTENT WITH THE 1988 EXPENDITURES WHEN IT APPEARED THAT REVISIONS WERE SUBMITTED FOR THE 1990 AND 1991 CLIENT FIGURES, BUT NOT FOR THE 1988 CLIENT FIGURES.

MH CASE MANAGEMENT SERVICES FOR ADULTS AS REPORTED BY COUNTIES

COUNTY	EXPENDITURES** Est. Actual 1988	Planned 1990	Planned 1991	CLIENTS SERVED Est. Actual 1988***	Planned 1990	Planned 1991
AITKIN	$18,413	$20,254	$21,267	24	26	27
* ANOKA	$331,385	$489,400	$523,700	257	260	275
BECKER	$11,000	$30,000	$30,000	70	70	90
BELTRAMI	$37,442	$54,863	$54,965	36	50	55
BENTON	$0	$67,222	$70,583	0	60	63
BIG STONE	$28,891	$13,000	$13,000	24	12	12
BLUE EARTH	$55,220	$76,808	$81,110	106	124	133
BROWN	$70,000	$72,000	$74,000	95	95	95
* CARLTON	$42,995	$45,000	$50,000	55	60	60
CARVER	$70,231	$68,456	$71,194	57	46	53
CASS	$10,393	$18,389	$18,941	55	58	58
CHIPPEWA	$58,026	$61,388	$56,975	14	14	15
CHISAGO	$21,385	$30,000	$32,000	26	45	47
CLAY	$16,767	$24,323	$25,540	35	51	54
CLEARWATER	$13,129	$13,119	$14,287	50	51	51
COOK	$43,614	$24,126	$24,850	43	12	12
COTTONWOOD	$12,889	$25,026	$25,777	15	28	30
CROW WING	$100,000	$175,000	$190,000	43	72	75
DAKOTA	$308,513	$395,258	$415,020	546	575	590
DODGE	$28,000	$33,271	$42,221	9	11	12
DOUGLAS	$30,000	$30,000	$31,000	76	76	76
FILLMORE	$5,815	$16,364	$17,426	21	45	28
FMW	$46,658	$51,852	$51,852	70	95	105
FREEBORN	$40,600	$60,000	$65,000	67	84	88
* GOODHUE	$52,764	$52,329	$52,329	112	110	110
GRANT	$17,084	$10,207	$12,250	23	10	10
* HENNEPIN	$1,902,351	$2,656,833	$2,656,833	1,991	2,157	2,205
* HOUSTON	$31,345	$31,000	$40,000	35	35	40
HUBBARD	$37,600	$37,600	$37,600	60	60	60
ISANTI	$65,041	$57,130	$58,844	50	50	50
ITASCA	$50,000	$50,000	$50,000	50	50	50
JACKSON	$7,200	$13,680	$14,400	18	19	20
KANABEC	$5,840	$14,400	$17,304	19	36	42
KANDIYOHI	$44,000	$78,300	$81,432	100	110	115
KITTSON	$8,071	$9,200	$9,200	15	15	15
KOOCHICHING	$88,531	$89,866	$92,560	43	43	43
LAC QUI PARLE	$12,654	$17,593	$15,496	22	22	22
LAKE	$5,200	$5,720	$6,300	12	13	14
LAKE OF WOODS	$3,894	$2,123	$7,200	5	10	10
LE SUEUR	$15,500	$25,000	$28,000	35	45	48
MCLEOD	$30,000	$35,000	$37,500	63	70	73
MAHNOMEN	$6,500	$8,000	$8,500	13	25	30
MARSHALL	$29,400	$31,800	$32,100	13	13	15
MEEKER	$42,000	$36,720	$49,680	50	34	46
MILLE LACS	$40,000	$60,000	$65,000	20	30	35
MORRISON	$33,146	$16,080	$16,804	83	55	65
MOWER	$34,000	$42,300	$43,600	66	70	75
NICOLLET	$30,000	$33,000	$36,000	60	65	69
NOBLES	$39,023	$40,000	$40,000	30	34	37
NORMAN	$10,000	$13,000	$15,000	25	35	35

MH CASE MANAGEMENT SERVICES FOR ADULTS AS REPORTED BY COUNTIES

	COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED Est. Actual 1988***	CLIENTS SERVED Planned 1990	CLIENTS SERVED Planned 1991
*	OLMSTED	$93,600	$96,408	$99,300	263	289	317
	OTTER TAIL	$71,339	$80,000	$90,000	38	40	50
	PENNINGTON	$30,000	$30,000	$30,000	30	30	30
	PINE	$22,329	$91,397	$93,967	28	55	55
	PIPESTONE	$18,837	$15,000	$15,500	20	15	15
	POLK	$30,000	$32,000	$33,000	60	70	80
	POPE	$9,480	$17,500	$18,000	25	27	28
	RAMSEY	$1,318,095	$2,337,576	$2,431,079	1,125	1,550	1,550
	RED LAKE	$4,550	$4,900	$5,425	26	28	31
	REDWOOD	$5,000	$20,000	$25,000	13	40	50
	REGION VIII	$127,000	$145,000	$140,000	200	200	200
	RENVILLE	$53,000	$70,000	$70,000	50	50	50
	RICE	$25,052	$25,000	$28,800	46	45	48
	ROCK	$0	$14,250	$14,250	0	19	19
	ROSEAU	$29,120	$18,055	$18,055	30	30	30
	SAINT LOUIS	$670,000	$725,000	$761,000	190	350	350
	SCOTT	$56,562	$75,000	$78,750	95	95	95
	SHERBURNE	$120,000	$122,000	$133,600	70	100	110
	SIBLEY	$15,376	$17,000	$20,000	26	30	32
	STEARNS	$139,929	$148,325	$152,774	272	288	297
*	STEELE	$102,086	$79,962	$82,362	25	28	[illegible]
	STEVENS	$25,000	$25,000	$25,000	25	25	[illegible]
	SWIFT	$28,000	$35,000	$37,000	35	35	35
	TODD	$11,786	$29,160	$40,582	25	32	32
	TRAVERSE	$13,000	$13,000	$13,000	8	10	10
	WABASHA	$26,395	$36,144	$44,000	24	30	35
	WADENA	$8,000	$8,000	$8,500	8	8	9
	WASECA	$18,879	$21,214	$21,850	15	20	23
	WASHINGTON	$107,734	$263,736	$309,590	300	325	350
	WILKIN	$3,101	$13,121	$14,500	8	25	30
	WINONA	$113,983	$126,189	$137,337	70	90	112
	WRIGHT	$53,130	$59,892	$61,824	145	145	195
	YELLOW MEDICINE	$15,000	$13,888	$14,433	26	30	30
7	TOTAL	$7,407,873	$10,170,717	$10,593,118	8,127	9,390	9,796

NOTE: THESE FIGURES ARE TAKEN FROM THE LATEST INFORMATION FROM COUNTY MENTAL HEALTH PLANS FOR THE PERIOD OF 1990 AND 1991. THE 1988 FIGURE IS THE ESTIMATE OF HOW MUCH WAS SPENT AND HOW MANY CLIENTS WERE SERVED FOR THAT YEAR. THE 1990 AND 1991 FIGURES ARE HOW MUCH IS PLANNED TO BE SPENT AND HOW MANY CLIENTS ARE PLANNED TO BE SERVED DURING THAT TIME.

* AN ASTERISK NEXT TO A COUNTY INDICATES THAT THE COUNTY'S ADULT MH PLAN HAS NOT BEEN APPROVED AS OF 9/20/90.

** THE EXPENDITURES INCLUDE ALL COUNTY EXPENDITURES, INCLUDING MEDICAID & GENERAL ASSISTANCE MEDICAL CARE REVENUE.

*** THE 1988 CLIENT FIGURE FOR SIX COUNTIES WERE MODIFIED TO BE CONSISTENT WITH THE 1988 EXPENDITURES WHEN IT APPEARED THAT REVISIONS WERE SUBMITTED FOR THE 1990 AND 1991 CLIENT FIGURES, BUT NOT FOR THE 1988 CLIENT FIGURES.

CSP AND DAY TREATMENT FOR CHILDREN AS REPORTED BY COUNTIES

COUNTY	EXPENDITURES** Est. Actual 1988	Planned 1990	Planned 1991	CLIENTS SERVED*** Est. Actual 1988	Planned 1990	Planned 1991
* AITKIN	$2,000	$1,000	$1,000	1	1	1
ANOKA	$2,666	$20,000	$150,000	3	30	100
BECKER	$0	$2,000	$8,500	0	10	10
BELTRAMI	$25,000	$27,000	$38,012	30	30	30
BENTON	$13,306	$21,306	$22,724	6	4	4
BIG STONE	$0	$0	$0	0	0	4
BLUE EARTH	$0	$0	$39,829	0	0	15
BROWN	$6,930	$7,000	$7,000	9	9	9
CARLTON	$14,805	$15,000	$35,000	5	5	10
CARVER	$0	$75,108	$77,848	0	20	20
* CASS	$378	$1,726	$1,800	2	2	5
CHIPPEWA	$0	$2,500	$10,000	0	2	4
CHISAGO	$0	$0	$38,000	0	0	6
CLAY	$0	$0	$50,000	0	0	24
CLEARWATER	$0	$0	$0	0	1	3
COOK	$0	$0	$10,000	0	0	15
COTTONWOOD	$0	$400	$1,200	0	2	6
* CROW WING	$1,000	$0	$76,000	0	0	48
DAKOTA	$216,115	$216,837	$227,679	49	52	55
DODGE	$0	$1,500	$5,500	0	4	6
DOUGLAS	$0	$3,000	$21,000	0	2	6
FILLMORE	$0	$14,250	$25,400	0	10	13
FMW	$0	$19,375	$29,375	0	15	50
FREEBORN	$0	$0	$0	0	0	0
* GOODHUE	$0	$10,000	$20,000	0	50	50
* GRANT	$0	$0	$15,000	0	0	3
* HENNEPIN	$2,730,313	$3,547,313	$3,545,028	830	2,125	2,125
HOUSTON	$1,360	$11,494	$26,759	3	5	10
HUBBARD	$0	$0	$15,000	0	0	6
* ISANTI	$0	$89,000	$92,500	6	16	20
* ITASCA	$19,248	$28,138	$16,461	30	30	30
JACKSON	$0	$4,985	$15,000	0	1	4
KANABEC	$0	$0	$0	0	0	12
KANDIYOHI	$8,000	$13,100	$15,823	20	25	35
KITTSON	$0	$0	$970	0	0	2
KOOCHICHING	$0	$0	$0	0	0	0
LAC QUI PARLE	$0	$200	$4,000	0	1	4
LAKE	$0	$2,650	$13,000	0	2	10
LAKE OF WOODS	$0	$213	$198	0	1	1
LE SUEUR	$0	$5,800	$11,800	0	8	15
MCLEOD	$0	$5,000	$7,500	0	10	15
MAHNOMEN	$0	$0	$8,000	0	0	3
MARSHALL	$0	$1,000	$2,200	0	2	2
MEEKER	$4,160	$8,000	$15,000	1	2	5
MILLE LACS	$0	$0	$20,000	0	0	5
MORRISON	$10,881	$20,088	$20,992	2	25	130
MOWER	$6,415	$89,200	$100,825	5	100	100
* NICOLLET	$10,000	$12,000	$30,000	6	12	15
NOBLES	$0	$0	$15,000	0	0	5
NORMAN	$0	$0	$11,000	0	0	5

CSP AND DAY TREATMENT FOR CHILDREN AS REPORTED BY COUNTIES

	COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED*** Est. Actual 1988	CLIENTS SERVED*** Planned 1990	CLIENTS SERVED*** Planned 1991
	OLMSTED	$0	$160,000	$170,000	0	15	45
	OTTER TAIL	$0	$4,000	$15,600	0	15	73
	PENNINGTON	$0	$1,000	$1,000	0	2	2
	PINE	$0	$0	$4,000	0	0	9
	PIPESTONE	$2,661	$6,593	$6,593	1	5	5
	POLK	$0	$1,000	$7,000	0	1	15
	POPE	$4,000	$9,750	$11,000	3	6	9
*	RAMSEY	$379,200	$405,744	$456,974	205	217	223
	RED LAKE	$933	$0	$6,060	3	0	3
	REDWOOD	$0	$4,000	$8,500	0	2	5
	REGION VIII	$2,000	$2,000	$6,000	2	2	5
	RENVILLE	$0	$2,300	$3,000	0	4	6
	RICE	$0	$15,000	$29,300	0	8	20
	ROCK	$0	$0	$10,000	0	0	5
	ROSEAU	$0	$500	$4,600	0	2	5
*	SAINT LOUIS	$15,000	$17,000	$18,000	12	12	12
	SCOTT	$0	$21,525	$31,525	0	48	48
	SHERBURNE	$36,486	$68,500	$76,500	22	35	50
*	SIBLEY	$0	$1,000	$2,000	0	2	2
	STEARNS	$82,373	$87,315	$89,935	107	113	117
*	STEELE	$0	$0	$3,750	0	0	
	STEVENS	$0	$1,000	$1,000	0	1	16
	SWIFT	$0	$425	$4,500	0	1	2
*	TODD	$0	$20,802	$28,000	0	3	6
	TRAVERSE	$0	$0	$1,390	0	0	2
	WABASHA	$0	$1,500	$4,500	0	1	6
*	WADENA	$0	$0	$0	0	0	0
*	WASECA	$0	$0	$17,000	0	0	10
	WASHINGTON	$50,718	$98,191	$290,931	57	65	150
	WILKIN	$0	$0	$13,952	0	0	6
	WINONA	$13,400	$14,910	$19,506	5	6	20
	WRIGHT	$0	$28,600	$71,870	0	8	41
	YELLOW MEDICINE	$0	$200	$200	0	1	1
16	TOTAL	$3,659,348	$5,249,038	$6,312,109	1,425	3,189	3,982

NOTE: THESE FIGURES ARE TAKEN FROM THE LATEST INFORMATION FROM COUNTY MENTAL PLANS FOR THE PERIOD OF 1990 AND 1991. THE 1988 FIGURE IS THE ESTIMATE OF HOW MUCH WAS SPENT AND HOW MANY CLIENTS WERE SERVED FOR THAT YEAR. THE 1990 AND 1991 FIGURES ARE HOW MUCH IS PLANNED TO BE SPENT AND HOW MANY CLIENTS ARE PLANNED TO BE SERVED DURING THAT TIME.

* AN ASTERISK NEXT TO A COUNTY INDICATES THAT THE COUNTY'S CHILDREN'S MH PLAN HAS NOT BEEN APPROVED AS OF 9/20/90.

** THE EXPENDITURES INCLUDE ALL COUNTY EXPENDITURES, EXCLUDING MEDICAID & GENERAL ASSISTANCE MEDICAL CARE REVENUE.

***THE CLIENT TOTALS ARE THE HIGHER OF THE CSP CLIENT TOTAL AND DAY TREATMENT CLIENT TOTAL.

CSP AND DAY TREATMENT FOR ADULTS AS REPORTED BY COUNTIES

	COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED*** Est. Actual 1988	CLIENTS SERVED*** Planned 1990	CLIENTS SERVED*** Planned 1991
	AITKIN	$31,979	$48,132	$49,708	17	19	20
*	ANOKA	$550,497	$639,300	$683,400	297	300	300
	BECKER	$51,100	$51,100	$53,655	40	120	120
	BELTRAMI	$163,348	$181,497	$192,387	135	143	152
	BENTON	$24,648	$66,497	$75,876	12	70	74
	BIG STONE	$25,508	$32,939	$40,000	2	11	15
	BLUE EARTH	$138,873	$325,329	$335,089	230	423	450
	BROWN	$40,380	$50,095	$51,134	25	28	28
*	CARLTON	$55,002	$63,408	$64,333	33	40	40
	CARVER	$85,345	$98,597	$102,941	43	50	50
	CASS	$5,946	$10,128	$92,315	24	25	25
	CHIPPEWA	$10,989	$46,500	$46,500	16	26	30
	CHISAGO	$39,825	$69,943	$73,123	6	15	20
	CLAY	$32,851	$104,312	$107,071	21	120	120
	CLEARWATER	$23,821	$46,556	$50,000	12	14	14
	COOK	$2,317	$20,591	$21,210	10	32	32
	COTTONWOOD	$35,058	$37,460	$38,584	26	36	36
	CROW WING	$144,070	$137,238	$138,933	66	80	100
	DAKOTA	$527,505	$475,169	$498,928	822	859	898
	DODGE	$22,800	$43,596	$39,600	45	53	54
	DOUGLAS	$42,000	$55,000	$69,000	35	35	38
	FILLMORE	$27,892	$39,178	$40,000	15	35	35
	FMW	$56,918	$412,365	$402,375	70	70	70
	FREEBORN	$56,139	$65,800	$66,550	45	85	85
*	GOODHUE	$142,949	$168,010	$168,010	69	70	70
	GRANT	$564	$40,600	$43,000	4	10	14
*	HENNEPIN	$2,700,593	$4,082,936	$4,082,936	1,006	1,374	1,374
*	HOUSTON	$66,260	$36,706	$40,000	37	50	60
	HUBBARD	$52,150	$66,500	$69,000	15	20	23
	ISANTI	$46,010	$38,013	$50,000	45	20	30
	ITASCA	$124,889	$139,852	$143,352	300	381	400
	JACKSON	$5,036	$33,249	$50,000	4	18	18
	KANABEC	$28,714	$55,747	$60,500	2	15	20
	KANDIYOHI	$323,501	$275,815	$280,334	270	280	285
	KITTSON	$17,246	$46,288	$46,288	6	12	12
	KOOCHICHING	$65,044	$66,586	$73,100	47	47	47
	LAC QUI PARLE	$16,000	$38,993	$40,000	2	14	14
	LAKE	$29,800	$32,295	$76,065	12	13	14
	LAKE OF WOODS	$0	$1,175	$1,168	0	1	4
	LE SUEUR	$10,000	$33,000	$33,500	10	40	40
	MCLEOD	$28,000	$70,000	$95,000	15	40	45
	MAHNOMEN	$16,748	$36,663	$33,663	5	10	13
	MARSHALL	$31,600	$37,000	$43,500	17	27	28
	MEEKER	$76,948	$79,716	$80,365	58	60	60
	MILLE LACS	$39,928	$63,200	$66,000	15	30	30
	MORRISON	$103,334	$102,903	$132,632	135	125	135
	MOWER	$132,000	$185,500	$220,000	100	125	150
	NICOLLET	$32,000	$71,000	$82,000	30	35	40
	NOBLES	$41,224	$45,531	$47,678	21	22	26
	NORMAN	$28,069	$36,711	$33,711	6	10	15

CSP AND DAY TREATMENT FOR ADULTS AS REPORTED BY COUNTIES

	COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED*** Est. Actual 1988	CLIENTS SERVED*** Planned 1990	CLIENTS SERVED*** Planned 1991
*	OLMSTED	$259,010	$266,779	$174,781	290	319	350
	OTTER TAIL	$118,859	$134,300	$148,000	40	50	60
	PENNINGTON	$40,022	$46,122	$38,822	20	20	20
	PINE	$18,437	$39,095	$41,050	15	35	40
	PIPESTONE	$15,964	$36,614	$37,436	6	14	14
	POLK	$89,752	$130,153	$146,487	70	70	70
	POPE	$11,200	$16,000	$20,500	6	8	12
	RAMSEY	$2,855,533	$2,931,623	$3,133,066	4,245	4,561	4,600
	RED LAKE	$17,946	$38,946	$38,440	8	10	11
	REDWOOD	$27,000	$58,773	$66,000	5	15	25
	REGION VIII	$56,839	$240,572	$270,340	60	60	90
	RENVILLE	$69,451	$85,000	$85,000	30	35	35
	RICE	$75,861	$93,500	$91,300	39	40	40
	ROCK	$17,529	$22,107	$26,244	15	15	15
	ROSEAU	$14,105	$52,590	$56,550	6	20	25
	SAINT LOUIS	$604,000	$667,000	$700,000	585	626	626
	SCOTT	$15,000	$72,352	$73,221	81	90	95
	SHERBURNE	$36,700	$62,400	$66,625	50	90	100
	SIBLEY	$59,025	$59,000	$60,000	15	21	23
	STEARNS	$270,038	$286,240	$294,818	208	220	227
*	STEELE	$33,030	$57,086	$58,799	20	42	4
	STEVENS	$28,000	$33,023	$40,000	5	15	15
	SWIFT	$51,244	$68,000	$71,000	35	35	35
	TODD	$38,747	$59,000	$73,000	11	15	19
	TRAVERSE	$25,000	$32,644	$40,000	7	7	7
	WABASHA	$45,835	$61,081	$69,960	24	30	35
	WADENA	$32,000	$53,102	$56,561	50	60	60
	WASECA	$13,000	$36,122	$37,206	5	22	27
	WASHINGTON	$545,334	$723,898	$767,332	162	170	180
	WILKIN	$15,505	$46,318	$34,548	13	16	18
	WINONA	$239,141	$256,006	$266,247	80	96	100
	WRIGHT	$82,827	$96,253	$115,134	40	77	90
	YELLOW MEDICINE	$31,000	$59,049	$64,000	4	8	9
7	TOTAL	$12,206,352	$15,925,467	$16,691,981	10,528	12,450	12,891

NOTE: THESE FIGURES ARE TAKEN FROM THE LATEST INFORMATION FROM COUNTY MENTAL HEALTH PLANS FOR THE PERIOD OF 1990 AND 1991. THE 1988 FIGURE IS THE ESTIMATE OF HOW MUCH WAS SPENT AND HOW MANY CLIENTS WERE SERVED FOR THAT YEAR. THE 1990 AND 1991 FIGURES ARE HOW MUCH IS PLANNED TO BE SPENT AND HOW MANY CLIENTS ARE PLANNED TO BE SERVED DURING THAT TIME.

* AN ASTERISK NEXT TO A COUNTY INDICATES THAT THE COUNTY'S ADULT MH PLAN HAS NOT BEEN APPROVED AS OF 9/20/90.

** THE EXPENDITURES INCLUDE ALL COUNTY EXPENDITURES, EXCLUDING MEDICAID & GENERAL ASSISTANCE MEDICAL CARE REVENUE.

***THE CLIENT TOTALS ARE THE HIGHER OF THE CSP CLIENT TOTAL AND DAY TREATMENT CLIENT TOTAL.

RTC (STATE HOSPITAL) SERVICES FOR CHILDREN AS REPORTED BY COUNTIES

COUNTY	EXPENDITURES** Est. Actual 1988	Planned 1990	Planned 1991	CLIENTS SERVED*** Est. Actual 1988	Planned 1990	Planned 1991
* AITKIN	$0	$0	$0	0	1	2
ANOKA	$1,516	$0	$0	8	12	14
BECKER	$5,500	$3,192	$3,496	7	7	7
BELTRAMI	$1,160	$1,260	$4,101	1	2	3
BENTON	$24,890	$27,682	$24,868	1	1	1
BIG STONE	$0	$0	$0	0	0	0
BLUE EARTH	$1,390	$1,470	$1,638	6	5	5
BROWN	$0	$0	$0	0	0	0
CARLTON	$0	$0	$0	1	0	0
CARVER	$0	$0	$0	0	0	0
* CASS	$4,234	$6,064	$6,064	3	3	3
CHIPPEWA	$0	$0	$0	2	2	2
CHISAGO	$0	$0	$0	0	0	0
CLAY	$3,179	$6,222	$6,222	4	5	5
CLEARWATER	$660	$521	$564	1	1	2
COOK	$0	$0	$0	0	1	1
COTTONWOOD	$1,080	$1,077	$1,123	1	3	3
* CROW WING	$0	$0	$0	39	39	39
DAKOTA	$4,350	$4,271	$4,508	3	3	3
DODGE	$0	$1,066	$1,172	0	6	2
DOUGLAS	$0	$0	$0	0	1	0
FILLMORE	$0	$1,600	$2,000	0	2	1
FMW	$1,145	$1,297	$1,426	2	2	2
FREEBORN	$0	$0	$0	0	0	0
* GOODHUE	$0	$0	$0	0	0	0
* GRANT	$0	$0	$0	0	0	0
* HENNEPIN	$6,423	$6,534	$6,897	4	4	4
HOUSTON	$10,712	$1,000	$1,000	2	1	1
HUBBARD	$2,557	$4,909	$5,143	1	2	2
* ISANTI	$1,459	$2	$3	2	0	0
* ITASCA	$0	$0	$0	0	0	0
JACKSON	$0	$0	$0	0	0	0
KANABEC	$0	$0	$0	0	1	1
KANDIYOHI	$1,350	$1,000	$1,000	4	6	6
KITTSON	$0	$0	$0	0	0	0
KOOCHICHING	$0	$0	$0	0	0	0
LAC QUI PARLE	$3,772	$0	$0	4	0	0
LAKE	$0	$0	$0	0	0	0
LAKE OF WOODS	$0	$0	$0	0	0	0
LE SUEUR	$4,000	$4,000	$5,000	2	2	3
MCLEOD	$18,000	$19,000	$20,700	5	5	4
MAHNOMEN	$0	$0	$0	0	0	0
MARSHALL	$0	$4,134	$9,096	0	1	2
MEEKER	$350	$380	$420	3	3	3
MILLE LACS	$0	$0	$0	0	0	0
MORRISON	$0	$3,724	$3,892	0	4	4
MOWER	$3,871	$0	$1,900	4	0	1
* NICOLLET	$0	$0	$0	0	0	0
NOBLES	$0	$0	$0	0	0	0
NORMAN	$0	$0	$0	0	0	0

RTC (STATE HOSPITAL) SERVICES FOR CHILDREN AS REPORTED BY COUNTIES

	COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED*** Est. Actual 1988	CLIENTS SERVED*** Planned 1990	CLIENTS SERVED*** Planned 1991
	OLMSTED	$250	$0	$0	1	0	0
	OTTER TAIL	$0	$0	$0	0	0	0
	PENNINGTON	$0	$0	$0	0	0	0
	PINE	$0	$0	$0	1	2	3
	PIPESTONE	$0	$0	$0	0	0	0
	POLK	$3,084	$0	$0	1	0	0
	POPE	$1,364	$1,400	$400	1	1	1
*	RAMSEY	$0	$5,931	$6,000	12	12	12
	RED LAKE	$0	$0	$0	0	0	0
	REDWOOD	$0	$0	$0	0	0	0
	REGION VIII	$0	$0	$0	0	0	0
	RENVILLE	$3,000	$2,000	$3,000	3	2	3
	RICE	$1,400	$0	$0	1	0	0
	ROCK	$0	$1,828	$2,011	0	1	1
	ROSEAU	$0	$1,000	$0	0	2	0
*	SAINT LOUIS	$9,000	$10,400	$11,000	8	8	8
	SCOTT	$0	$8,000	$8,000	0	3	3
	SHERBURNE	$17,140	$36,900	$40,500	7	8	9
*	SIBLEY	$50	$0	$0	1	0	0
	STEARNS	$22,586	$23,940	$24,656	13	20	20
*	STEELE	$0	$0	$0	0	0	
	STEVENS	$0	$1,000	$1,000	0	1	1
	SWIFT	$4,285	$3,285	$3,500	4	1	1
*	TODD	$463	$588	$644	2	2	2
	TRAVERSE	$0	$0	$0	0	0	0
	WABASHA	$904	$1,600	$2,000	1	2	1
*	WADENA	$3,000	$4,000	$4,000	2	3	3
*	WASECA	$0	$0	$0	0	0	0
	WASHINGTON	$2,803	$0	$0	2	0	0
	WILKIN	$0	$0	$0	0	0	0
	WINONA	$164	$0	$0	1	1	1
	WRIGHT	$2,727	$3,636	$3,731	3	4	4
	YELLOW MEDICINE	$0	$0	$0	0	0	0
16	TOTAL	$173,818	$205,913	$222,675	174	198	199

NOTE: THESE FIGURES ARE TAKEN FROM THE LATEST INFORMATION FROM COUNTY MENTAL HEALTH PLANS FOR THE PERIOD OF 1990 AND 1991. THE 1988 FIGURE IS THE ESTIMATE OF HOW MUCH WAS SPENT AND HOW MANY CLIENTS WERE SERVED FOR THAT YEAR. THE 1990 AND 1991 FIGURES ARE HOW MUCH IS PLANNED TO BE SPENT AND HOW MANY CLIENTS ARE PLANNED TO BE SERVED DURING THAT TIME.

* AN ASTERISK NEXT TO A COUNTY INDICATES THAT THE COUNTY'S CHILDREN'S MH PLAN HAS NOT BEEN APPROVED AS OF 9/20/90.

** THE EXPENDITURES INCLUDE ONLY COUNTY EXPENDITURES, WHICH ARE USUALLY 10% OF RTC PER DIEM. A FEW ADMISSIONS ARE HOLD ORDERS WHICH ARE 100% COUNTY COST.

***THE NUMBER OF CLIENTS INCLUDES ALL CHILDREN REGARDLESS OF TYPE OF REIMBURSEMENT.

RTC (STATE HOSPITAL) SERVICES FOR ADULTS AS REPORTED BY COUNTIES

COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED Est. Actual 1988	CLIENTS SERVED Planned 1990	CLIENTS SERVED Planned 1991
AITKIN	$12,980	$27,159	$29,874	11	15	15
* ANOKA	$197,365	$356,400	$381,300	68	70	70
BECKER	$40,100	$61,492	$65,434	45	45	46
BELTRAMI	$56,838	$63,216	$64,244	41	44	47
BENTON	$51,783	$56,566	$63,894	39	25	26
BIG STONE	$28,406	$20,713	$22,780	5	6	6
BLUE EARTH	$181,597	$181,565	$190,853	72	65	59
BROWN	$42,000	$51,955	$51,247	26	28	27
* CARLTON	$39,039	$43,491	$48,070	41	42	43
CARVER	$15,389	$20,000	$20,800	11	9	11
CASS	$74,790	$82,882	$85,368	65	70	75
CHIPPEWA	$31,144	$24,771	$26,220	18	11	11
CHISAGO	$6,900	$36,499	$36,499	16	16	16
CLAY	$60,403	$118,222	$132,958	71	89	49
CLEARWATER	$2,595	$3,125	$3,382	5	6	6
COOK	$4,085	$9,810	$10,355	3	3	3
COTTONWOOD	$28,334	$30,839	$31,749	20	19	22
CROW WING	$160,923	$246,750	$272,550	160	160	160
DAKOTA	$79,754	$119,240	$125,864	55	55	55
DODGE	$7,089	$3,552	$3,906	4	4	4
DOUGLAS	$59,000	$60,000	$61,000	29	30	30
FILLMORE	$14,108	$14,307	$14,884	8	10	10
FMW	$77,093	$87,622	$96,362	63	63	63
FREEBORN	$44,900	$45,960	$54,600	24	26	26
* GOODHUE	$16,170	$40,500	$42,750	17	17	17
GRANT	$4,335	$5,200	$5,491	5	5	5
* HENNEPIN	$1,813,146	$2,030,332	$2,143,200	781	781	781
* HOUSTON	$14,182	$16,220	$16,220	10	10	10
HUBBARD	$20,709	$26,910	$28,500	16	16	16
ISANTI	$55,388	$27,306	$35,340	46	30	34
ITASCA	$51,000	$69,552	$66,500	24	24	20
JACKSON	$11,130	$9,425	$10,365	10	3	5
KANABEC	$34,075	$26,550	$18,442	14	17	15
KANDIYOHI	$188,677	$201,406	$221,521	73	80	84
KITTSON	$410	$4,860	$5,030	1	6	6
KOOCHICHING	$18,875	$25,100	$25,850	17	17	17
LAC QUI PARLE	$30,096	$24,466	$24,910	15	10	10
LAKE	$600	$660	$730	1	1	1
LAKE OF WOODS	$1,764	$3,602	$3,816	2	5	4
LE SUEUR	$43,000	$47,865	$51,950	25	25	25
MCLEOD	$50,700	$59,578	$62,100	21	21	22
MAHNOMEN	$10,212	$16,802	$17,889	4	4	4
MARSHALL	$9,900	$16,398	$18,040	7	8	8
MEEKER	$73,140	$73,849	$64,369	35	35	31
MILLE LACS	$23,000	$28,000	$30,000	27	25	25
MORRISON	$58,891	$116,615	$113,050	48	60	60
MOWER	$30,000	$61,851	$64,000	34	51	35
NICOLLET	$32,736	$39,568	$43,000	12	14	18
NOBLES	$30,000	$30,000	$30,000	20	20	20
NORMAN	$25,398	$31,537	$33,921	13	11	11

RTC (STATE HOSPITAL) SERVICES FOR ADULTS AS REPORTED BY COUNTIES

	COUNTY	EXPENDITURES** Est. Actual 1988	EXPENDITURES** Planned 1990	EXPENDITURES** Planned 1991	CLIENTS SERVED Est. Actual 1988	CLIENTS SERVED Planned 1990	CLIENTS SERVED Planned 1991
*	OLMSTED	$159,933	$194,996	$169,671	105	96	110
	OTTER TAIL	$204,867	$268,719	$309,261	95	80	85
	PENNINGTON	$26,623	$26,623	$26,623	11	11	11
	PINE	$14,238	$33,022	$36,136	33	35	35
	PIPESTONE	$12,358	$11,000	$12,000	8	5	6
	POLK	$90,626	$128,155	$125,828	45	38	34
	POPE	$2,520	$2,520	$3,990	15	20	20
	RAMSEY	$535,136	$899,217	$988,989	287	287	287
	RED LAKE	$876	$4,961	$5,457	2	3	3
	REDWOOD	$48,192	$45,994	$46,435	18	22	19
	REGION VIII	$95,976	$116,115	$129,357	49	63	63
	RENVILLE	$45,000	$36,000	$36,000	26	26	26
	RICE	$99,260	$97,200	$103,740	35	32	30
	ROCK	$11,593	$9,142	$10,054	7	5	5
	ROSEAU	$5,740	$4,000	$4,000	8	8	8
	SAINT LOUIS	$302,000	$369,600	$388,000	200	112	112
	SCOTT	$34,506	$40,000	$42,000	20	21	21
	SHERBURNE	$61,400	$49,501	$49,501	14	14	14
	SIBLEY	$13,060	$21,300	$23,425	12	12	13
	STEARNS	$331,079	$350,928	$361,456	163	173	17?
*	STEELE	$25,918	$12,464	$12,838	13	10	1
	STEVENS	$10,350	$10,350	$6,373	15	15	15
	SWIFT	$18,800	$28,080	$29,640	11	8	8
	TODD	$23,111	$29,600	$32,559	23	23	23
	TRAVERSE	$5,000	$5,000	$5,000	7	7	7
	WABASHA	$14,535	$15,000	$17,000	15	16	16
	WADENA	$9,000	$10,000	$11,000	12	12	12
	WASECA	$10,436	$11,500	$12,120	11	10	10
	WASHINGTON	$71,232	$100,530	$108,680	26	24	25
	WILKIN	$26,516	$49,336	$51,754	7	10	9
	WINONA	$44,029	$115,200	$121,600	23	38	30
	WRIGHT	$48,971	$94,464	$116,088	54	64	70
	YELLOW MEDICINE	$27,000	$31,112	$32,567	16	19	19
7	TOTAL	$6,394,030	$8,021,917	$8,500,319	3,564	3,526	3,499

NOTE: THESE FIGURES ARE TAKEN FROM THE LATEST INFORMATION FROM COUNTY MENTAL HEALTH PLANS FOR THE PERIOD OF 1990 AND 1991. THE 1988 FIGURE IS THE ESTIMATE OF HOW MUCH WAS SPENT AND HOW MANY CLIENTS WERE SERVED FOR THAT YEAR. THE 1990 AND 1991 FIGURES ARE HOW MUCH IS PLANNED TO BE SPENT AND HOW MANY CLIENTS ARE PLANNED TO BE SERVED DURING THAT TIME.

* AN ASTERISK NEXT TO A COUNTY INDICATES THAT THE COUNTY'S ADULT MH PLAN HAS NOT BEEN APPROVED AS OF 9/20/90.

** THE EXPENDITURES INCLUDE ONLY COUNTY EXPENDITURES, WHICH ARE USUALLY 10% OF RTC PER DIEM. A FEW ADMISSIONS ARE HOLD ORDERS WHICH ARE 100% COUNTY COST.

MENTAL HEALTH DIVISION WORKPLAN

July 1, 1990 - June 30, 1991

Goal #1

To plan for and promote development of high quality mental health services for children and adults. (E.g., planning, new initiatives, State Mental Health Advisory Council administrative functions.)

Objectives:

A. To redesign and implement the mental health planning process.

B. To promote new models of service delivery which enhance consumer involvement and independence.

C. To collaborate with other DHS divisions in the development of MI SOCS as required by law.

D. To expand housing options for persons with serious and persistent mental illness through development of a housing initiative.

E. To enhance leadership capacity of state and local advisory councils.

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

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

H. To participate in opportunities to promote mental health research.

I. To enhance opportunities for positive consumer outcomes through employment opportunities.

Goal #2:

To assure that publicly funded mental health service quality meets the standards of the Comprehensive Mental Health Acts and best contemporary practice.

Objectives:

A. To initiate development of appropriate standards for new children's mental health services.

B. To complete rule revision of Rule 14/15, Rule 29 and Rule 36.

C. To determine the best methods for assuring that out-of-home treatment settings of adults and children are appropriate and necessary.

Goal #3:

To assist counties in the provision of high quality services. (Consultation, technical assistance, training.)

Objectives:

A. To facilitate provision of information about best contemporary knowledge regarding service models to counties.

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

C. 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.

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

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

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

G. To implement a process for the discharge of Anoka-Metro Regional Treatment Center patients who no longer require RTC levels of care.

H. To reorganize division so that opportunities for professional consultation with counties are optimized.

Goal #4:

To develop and manage resources for the provision of mental health services for children and adults. (E.g., budget requests, grants, consolidated funding planning, HRD, leadership training.)

Objectives:

A. To prepare a long term plan for mental health funding consolidation.

B. To develop and support budget requests for the funding and/or expansion of existing services.

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

D. To provide effective management of mental health service grants.

Goal #5:

To monitor and evaluate the state's mental health service system for compliance with standards in law and rule.

Objectives:

A. To improve operation of the Comprehensive Mental Health Reporting System.

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

C. To continue operation and improvement methods of extracting mental health data from other DHS data systems.

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

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

F. To improve Division's capacity to evaluate service provision.

G. To implement state and federal statutory requirements as they relate to planning and reporting.

H. To implement Mental Health Statistics Improvement Project prototype in 2-3 community mental health centers and 3-5 community support programs.

I. To identify Mental Health Statistics Improvement Project elements which can be incorporated with MMIS, RTC and Licensing data systems.

J. To review and analyze of Community Survey Data.

K. Housing and Homeless Reporting/Analysis/Evaluation

L. To analyze case management survey results.

M. To revise Rule 14/Rule 12 supplemental reporting.