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State of Minnesota

910762

Department of Human Services

Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

September 23, 1991

Mr. Maury Lieberman, Acting Chief
System Development and Planning Section
System Development and Community Support Branch
Division of Applied and Services Research
National Institute of Mental Health
5600 Fishers Lane, Room 11C-25
Rockville, Maryland 20857

Dear Mr. Lieberman:

This document, along with the attached report from the State Mental Health Advisory Council, is Minnesota's submission under Public Law 99-660, "The State Comprehensive Mental Health Services Plan Act of 1986", and Public Law 101-639, "The Mental Heatlh Plan Amendments of 1990", to indicate substantial compliance with the State's goals for implementing community-based services under its Mental Health Plan.

A copy of this document and the report and review by the State Mental Health Advisory Council have been submitted to the Governor, the Honorable Arne H. Carlson, as required by Public Law 101-639.

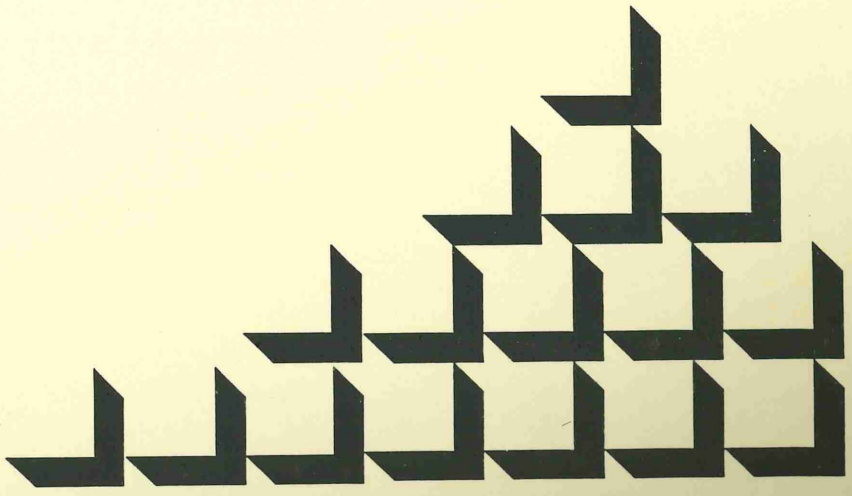
Sincerely,

James B. Stoebner

JAMES B. STOEBNER
Assistant Commissioner for Community Mental
Health and Residential Treatment Center
Administration

P.L. 99-660 & P.L. 101-639 Plan

September 30, 1991



Minnesota Department of Human Services

Mental Health Division

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P.L. 99-660 & P.L. 101-639 Plan

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MENTAL HEALTH DIVISION GOALS

The 1987 and 1989 Comprehensive Mental Health Acts were based on the mission statements established by the 1986 and 1988 Minnesota Legislatures. The following goals are the focus for efforts by the Mental Health Division to achieve those missions, as well as for emerging issues and initiatives undertaken by the Division.

Goal #1:

To plan for and promote development of high quality mental health services for children and adults.

Goal #2:

To assure that the quality of publicly funded mental health services meets the standards of the Comprehensive Mental Health Acts and best contemporary practices.

Goal #3:

To assist counties in the provision of high quality mental health services.

Goal #4:

To develop and manage resources for the provision of mental health services for children and adults.

Goal #5:

To monitor and evaluate the state's mental health service system for compliance with standards in law and rule.

PART A
IMPLEMENTATION REPORT

PART A: IMPLEMENTATION REPORT

1. Overall Profile of Mental Health Services Prior to 1987 (prior to the initiation of P.L. 99-660 planning)

a. Overview of Policy, Mission and Rights Issues: On June 14, 1985, Minnesota's 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 action in addressing the mental health needs of the state. The formation and subsequent activities of this commission were a highly significant step in the development of a comprehensive, community-based mental health system in Minnesota.

The Commission concluded that the State's 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 was no mission statement in State statutes for 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 these 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 with mental illness 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 DHS had 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 followup and aftercare, crisis care/emergency services, transportation, day treatment programs, social and recreational activities, prevention and education services, and services for special populations.

In 1984, The Mental Health Advocates Coalition of Minnesota, Inc., surveyed 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, 42% reported having no access and 10% were unaware of services accessible to them. Approximately one in five individuals felt 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. In 1986, 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 adequately available to meet the projected need.

b. Geographic Distribution of Services: Major changes have occurred in the statewide distribution of service availability since 1987, as seen in Table 1, below:

TABLE 1

GEOGRAPHIC AVAILABILITY
Percent of Counties Offering Key Mental Health Services

	1987	1991
Emergency 24-Hour "Hot-line" for Adults and Children	66%	100%
Case Management for Adults and Children	0%	100%
Community Support Programs for Adults with Serious and Persistent Mental Illness	52%	100%
Family Community Support Services for Children with Severe Emotional Disturbance	0%	61%

Although all 87 counties provided some form of case management in 1987, availability was very limited within each county and the services provided did not meet mental health quality standards promulgated in 1989.

A few counties provided limited family community support services, but no organized state program and no dedicated funding for these services existed in 1987.

Funding for community support programs (Rule 14) was provided to 36 of 87 counties, serving 2,750 clients in FY 84. However, lack of long-term funding and fiscal disincentives to counties resulted in less than statewide distribution of community support programs. By 1987, 52% of counties offered community support programs for adults with serious and persistent mental illness. Table 1, in Appendix I, illustrates county by county estimates of the number of persons served and expenditures for CSP/day treatment services in 1987 and 1990. A total of 4,475 persons were served in 1990, for total expenditures of approximately $8,470,000. Table 2, in Appendix I, provides information on the number of persons receiving case management services in 1987 and 1990.

Emergency 24-hour "Hot-line" services for adults and children were available in 66% of Minnesota counties in 1987, versus 100% in 1991.

c. Distribution of Funding Resources: In 1987, there were no statewide mandates for Rule 14 community support services. Outpatient services and some Rule 36 community residential facilities were operating, with limited availability.

In 1987, funding for adult mental health services supervised or administered by the Department of Human Services totaled approximately $150,277,000. Community non-residential services comprised 27%, community residential expenditures 18%, and community inpatient services 18% of total adult mental health expenditures. All community-operated services comprised 62% of total expenditures for adult services, with State-operated inpatient expenditures comprising 37% of total adult service expenditures (see Table 2). Figures 1 and 2 illustrate changes in funding patterns for regional treatment centers (RTCs), community residential facilities (Rule 12/36) and community services (Rule 14) from FY 87 to the present.

Table 2

DISTRIBUTION OF FUNDING

Mental Health Services Supervised or Administered by the MN Dept. of Human Services

	FY 1987		FY 1991		Change from FY87 to FY91	
	Dollars	Percent of Total	Dollars	Percent of Total	Dollars	Percent Increase
ADULTS						
Community Non-Residential	$41,054,811	27.3%	$72,066,268	31.7%	$31,011,457	75.5%
Community Residential	$26,271,599	17.5%	$30,002,102	13.2%	$3,730,503	14.2%
Community Inpatient	$26,640,736	17.7%	$36,450,503	16.0%	$9,809,767	36.8%
Sub-total Community-Operated	$93,967,146	62.5%	$138,518,873	60.9%	$44,551,727	47.4%
State-Operated Inpatient	$55,669,854	37.0%	$87,651,564	38.5%	$31,981,710	57.4%
State Prev.,Trng. & Admin.	$639,769	0.4%	$1,353,620	0.6%	$713,851	111.6%
Total MH Services for Adults	$150,276,769	100.0%	$227,524,057	100.0%	$77,247,288	51.4%
CHILDREN						
Community Non-Residential	$12,214,362	30.5%	$25,743,834	40.8%	$13,529,472	110.8%
Community Residential	$17,000,000	42.5%	$22,135,827	35.1%	$5,135,827	30.2%
Community Inpatient	$8,388,510	21.0%	$10,117,434	16.0%	$1,728,923	20.6%
Sub-total Community-Operated	$37,602,873	94.0%	$57,997,095	91.9%	$20,394,223	54.2%
State-Operated Inpatient *	$2,319,577	5.8%	$4,945,264	7.8%	$2,625,687	113.2%
State Prev.,Trng. & Admin.	$71,085	0.2%	$144,291	0.2%	$73,206	103.0%
Total MH Services for Children	$39,993,535	100.0%	$63,086,650	100.0%	$23,093,115	57.7%

Table 2

DISTRIBUTION OF FUNDING

Mental Health Services Supervised or Administered by the MN Dept. of Human Services

	FY 1987		FY 1991		Change from FY87 to FY91	
	Dollars	Percent of Total	Dollars	Percent of Total	Dollars	Percent Increase
* FY 1987 data are based on a different rate-setting system which did not reflect the full costs of state-operated children's inpatient.						
CHILDREN AND ADULTS						
Community Non-Residential	$53,269,173	28.0%	$97,810,102	33.7%	$44,540,929	83.6%
Community Residential	$43,271,599	22.7%	$52,137,929	17.9%	$8,866,330	20.5%
Community Inpatient	$35,029,247	18.4%	$46,567,937	16.0%	$11,538,691	32.9%
Sub-total Community-Operated	$131,570,019	69.1%	$196,515,969	67.6%	$64,945,950	49.4%
State-Operated Inpatient	$57,989,431	30.5%	$92,596,827	31.9%	$34,607,396	59.7%
State Prev.,Trng. & Admin.	$710,854	0.4%	$1,497,911	0.5%	$787,057	110.7%
Total MH Services	$190,270,304	100.0%	$290,610,707	100.0%	$100,340,403	52.7%

Adult Mental Health Expenditures

Administered or Supervised by MN Dept. of Human Services

Figure 1

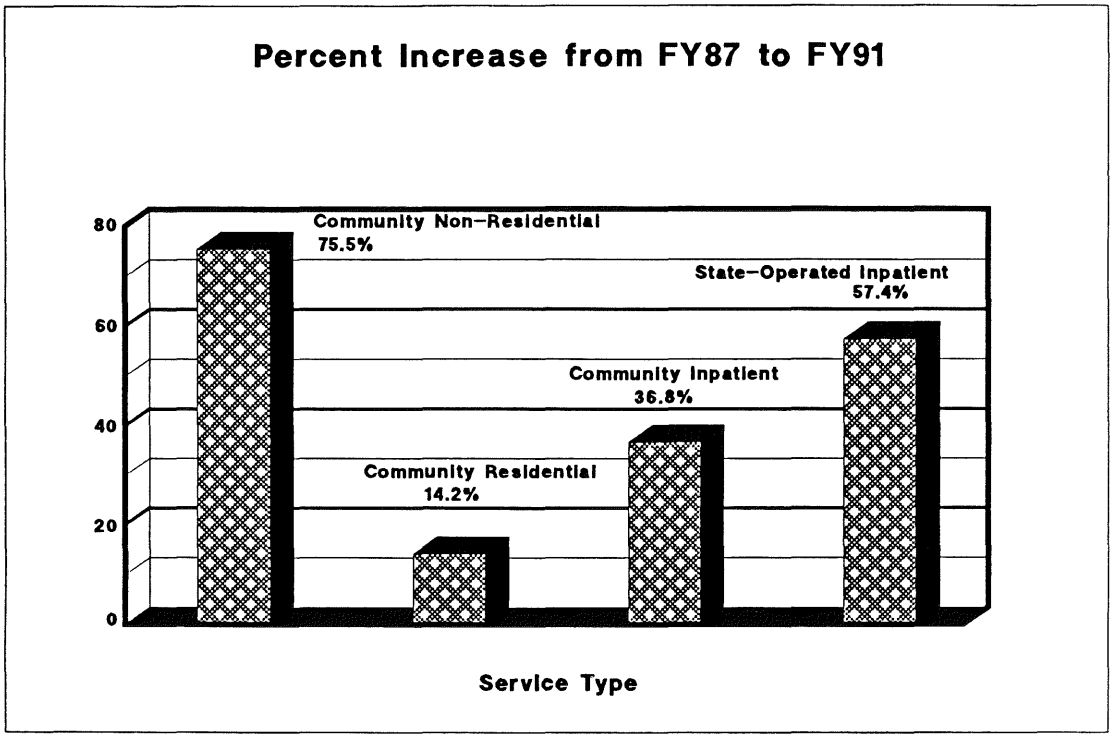
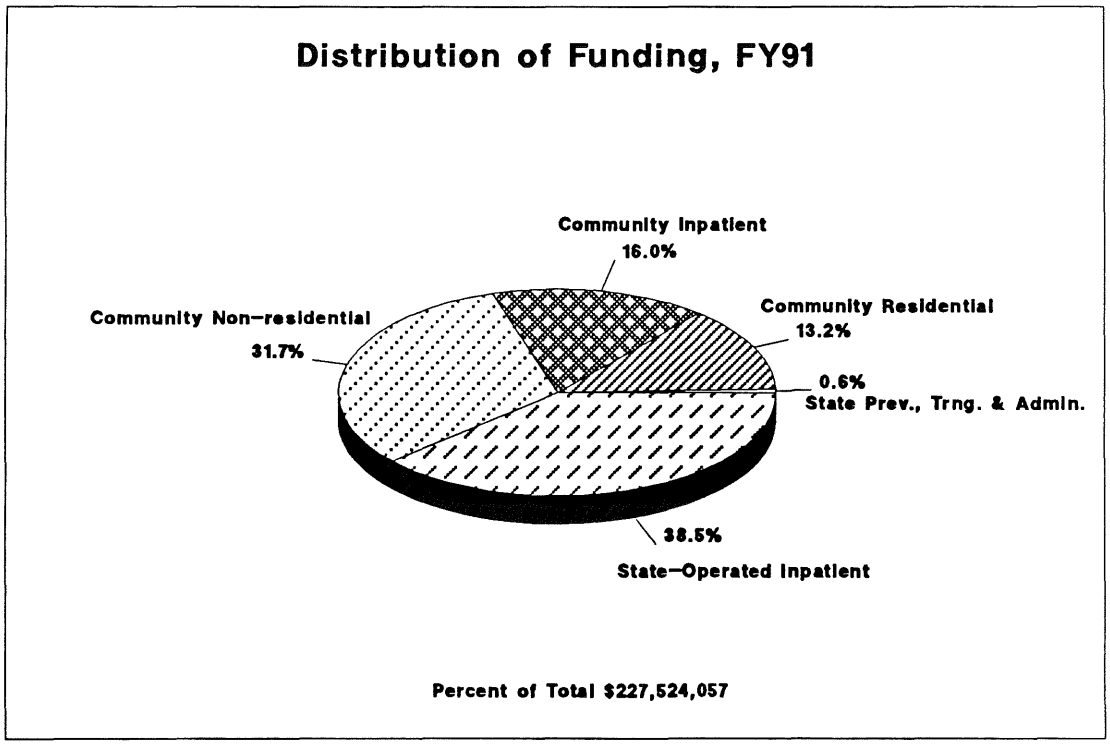


Figure 2



Sept. 1991

Funding for children's mental health services was considerably more limited than for adult services in 1987. Total funding for mental health services for children was approximately $39,994,000, with 30% assigned to community non-residential, 42% to community residential, and 21% to community inpatient services. Community-operated children's mental health services comprised 94% of mental health expenditures for children, with State-operated inpatient services comprising 6% (expenditures are estimated to be higher than this for State-operated inpatient services at this time, since the rate system in existence in 1987 did not reflect the true cost of these services.) (See Table 2, above, for a comparison of expenditures by service by year. Figures 3 and 4 illustrate changes in funding patterns from 1987 to 1990.)

Children's Mental Health Expenditures
Administered or Supervised by MN Dept. of Human Services

Figure 3

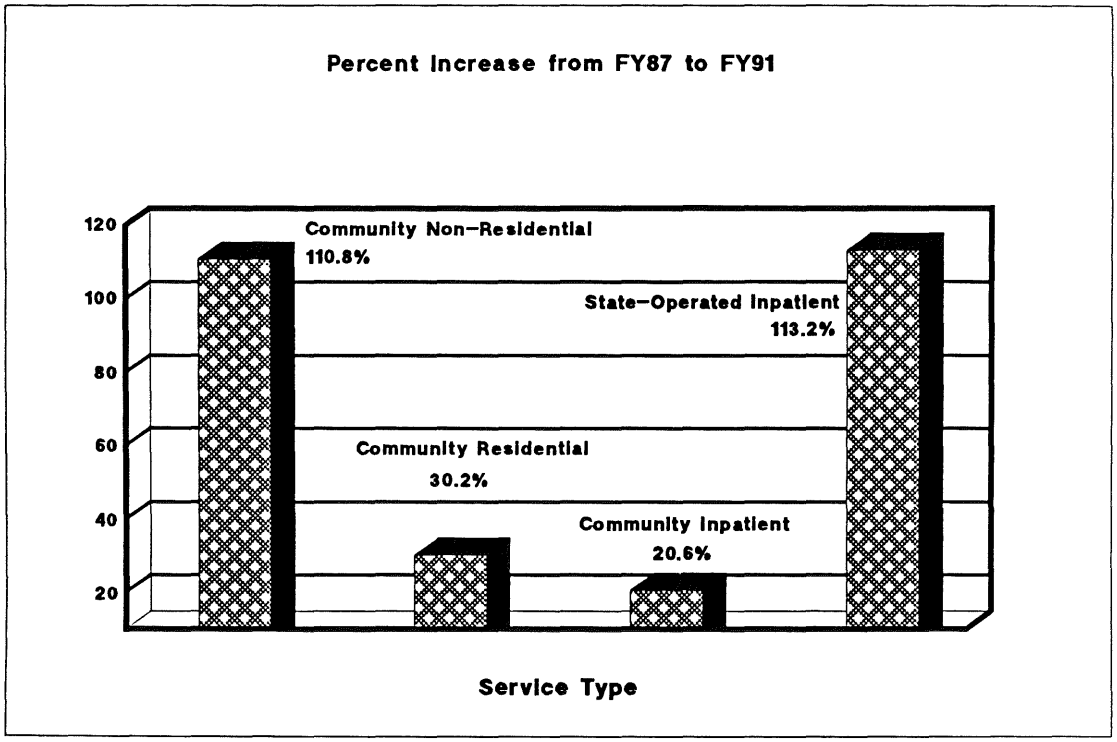
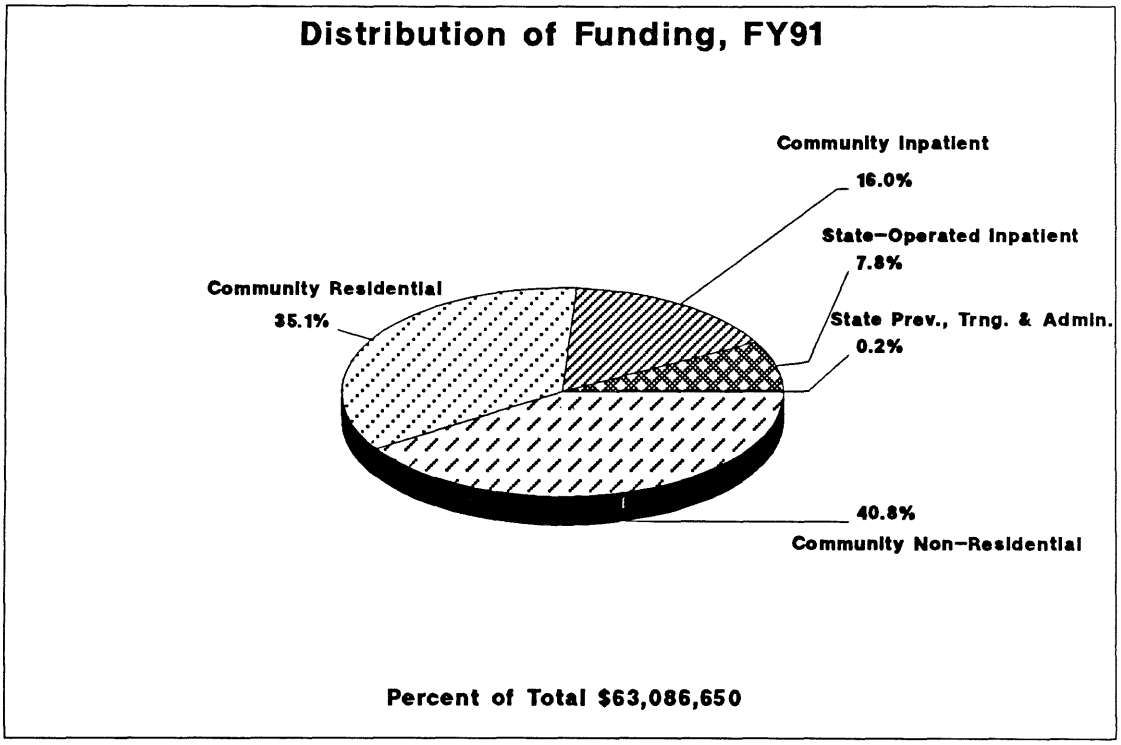


Figure 4



Sept. 1991

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 service planning. Rule 36, the licensing rule for community residential treatment programs for adults with mental illness, also required the establishment of Resident Councils, through which residents have opportunities to express feelings about the program and to affect policies and procedures of the program.

2. Plan Objectives Achievement

REQUIREMENT I. Establishing and implementing an organized community-based system of care for individuals with serious emotional and mental disorders

The Mental Health Division (MHD) is responsible for statewide implementation of the Comprehensive Adult and Children's Mental Health Acts, assuring high quality, cost-effective, and appropriate services to persons with mental illness in Minnesota, with particular concern for the approximately 32,000 adults with serious and persistent mental illness and 58,000 children with severe emotional disturbance. The Division's responsibilities include five primary functions: standard setting, resource allocation and development, monitoring for compliance and evaluation, technical assistance/consultation, and statewide planning. The Acts lay out both definitions of required services and scope of service development to be achieved. Material describing these Acts can be found in the 1990 State plan.

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

a. The original milestone:

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:

Production of State reports: Legislation passed in 1990 required the Mental Health Division (MHD) to prepare reports for the Minnesota Legislature regarding various mental health issues as part of the "February 1991 Mental Health Report to the Legislature". These included: annual reports on the implementation of the Comprehensive Adult and Children's Mental Health Acts; adult and children's screening for residential and inpatient treatment; funding and statistical review of adult and children's mental health services; state-level coordination of children's mental health services; mental health planning simplification and special initiatives. Copies of these reports are made available on request to consumers, county staff, providers, and advocates, as well as to members of the State Mental Health Advisory Council.

The Division produces several types of periodic reports from its databases, including: (a) a set of thirteen service utilization tables that is sent to counties to assist them in preparing their biennial mental health plans, and (b) semi-annual reports summarizing the types of services, number of clients, and units

of service provided by each county and its contracted provider organizations. MHD staff now also have available to them extract databases containing records specific to their areas of responsibility, along with menu-driven PC programs that enable them to quickly and easily produce reports for specific counties, providers, and client groups. The Division's databases are also used to supply management with statistics, tables, and graphs for inclusion in annual and ad hoc reports to the Legislature and to other external organizations, and in the State mental health plan.

State Networking: The Division has networked with other states to expand the knowledge base and share information about programs and policies. Information was shared with professionals, providers, consumers, families, and others through numerous public speaking forums, through consultation with other states, and through participation in national surveys, meetings, conferences and other information gathering efforts around mental health issues. Bulletins, presentations, training sessions, as well as meetings on specific topics have been utilized as methods by which this networking has occurred with counties, providers, and service consumers.

Work Groups and Task Forces: The Department utilized work groups, task forces and other advisory groups in reviewing rules, in studying specific needs for services, in the grant review process, and in other capacities to assist the Division in building an appropriate and responsive mental health system for both adults and children. See Appendix II for a listing of these groups.

Technical Assistance to Counties: In 1990-91, the MHD's program consultants provided technical assistance to counties to develop or enhance 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.

The Mental Health Division co-sponsors semi-annual one-day Area Informational Meetings in four regions of Greater Minnesota (outside the St. Paul/Minneapolis metropolitan area); they are typically attended by 40 to 65 county and provider representatives and five representatives of the Division. These meetings have the following objectives: to promote cooperation, coordination and communication between the counties, mental health service providers and the Division; to provide mental health updates on national information, statewide issues and trends, legislation, funding, services rules, and other announcements; to provide consultation and opportunity for discussion on service delivery topics; to provide training on areas of general interest; and to share county and provider updates. The metropolitan counties have established monthly

meetings of counties and providers to which the Mental Health Division is regularly asked to present information.

The Division sponsors an annual statewide Community Support Program (CSP) Conference, contracting with a county to plan and organize the event. This three-day conference involves the primary stakeholders in CSPs: consumers, families, county mental health advisory councils, advocacy groups, and representatives of minority groups, county staff, providers, regional treatment centers (state hospitals), and the MHD. The 1991 conference was attended by more than 550 people and included over 50 presentations on topics related to CSP services.

In August, 1990, the Division reorganized to focus more on development of specialist expertise and less on site visits to individual counties and providers in order to improve the effectiveness of the Division's technical assistance efforts. The Division developed model contracts to provide a format for counties that include all applicable requirements of rule and statute for community services to persons with mental illness, in response to county questions and results from the Policy Coordination and County Monitoring Division's review of county contracts. The models provide a suggested format that ensures minimum quality service standards and fulfills the State's mandates for contracting.

The Model Grant Contract and the Model Purchase of Service Contract include statutory and rule requirements from Rule 160 (governing administration of community social services) and the Comprehensive Mental Health Acts that are applicable when purchasing services. The intent was that the model contracts would be revised locally to reflect the specific contractual requirements of the two negotiating parties.

The Division also collaborated with the Division for Persons with Developmental Disabilities in holding half-day workshops at seven locations throughout the State on developing contracts for community services to persons with disabilities during 1990. The workshops were designed to assist county agencies to develop contracts that will assure service delivery and comply with State and Federal requirements. Topics included legal perspectives, Rule 160 (the rule governing administration of state Community Social Service Act funds) requirements, and review of the Model Grant Contract and the Purchase of Service Contract for mental health services. An average of 40 county agency staff and providers attended each of the workshops. An Informational Bulletin, providing additional information on questions raised at the training sessions, was distributed to county commissioners and agency directors.

The 1987 Comprehensive Mental Health Act and 1989 Comprehensive Children's Mental Health Act mandated local mental health

advisory councils (LACs) for each county (counties may combine councils). Representation on the councils is to include consumers, family members of consumers, parents of children with emotional disturbance and persons who received mental health services as a child or adolescent, in addition to mental health professionals. A major goal of the councils is to increase consumer/family and provider collaboration. The Division provides one full time staff person for the support and training of LACs. The staff person works with the State Mental Health Advisory Council to provide additional State/local coordination. Training of LACs focuses primarily on: (1) information and training regarding the mental health system to empower LACs; and (2) training in group dynamics and effective meeting management techniques.

In Minnesota, administration of the mental health portion of the Preadmission Screening/Annual Resident Review (PASARR) process required by P.L. 100-203 (OBRA-87) is the responsibility of designated mental health authorities in each county. The Division provides ongoing technical assistance, oversight and monitoring of compliance with the law. Seventy regional and statewide training sessions have been provided from January 1, 1990 through May, 1991 to a total of 1875 county staff, mental health, long term care and acute care providers and other interested parties. During FY 91-92, another series of regional meetings for county staff who are charged with the PASARR implementation are planned. Formal and informal technical assistance is provided on an ongoing basis at the request of counties and other interested parties.

As one means of assisting communities to meet their responsibilities to provide appropriate mental health treatment services for compulsive gamblers, the MHD offers 60 hours of special skills training for provider agency personnel.

Children: The MHD has provided ongoing technical assistance and support to eight demonstration counties as they develop and implement services to children and their families. Through their experiences, these counties share information and provide assistance to other communities throughout the State in designing and implementing services which meet the mandates of the Comprehensive Children's Mental Health Act.
Technical assistance efforts of the children's demonstration project efforts have included:

- Responding to numerous requests for technical assistance and consultation;
- The development of a quarterly newsletter regarding the projects' efforts in implementing the Comprehensive Children's Mental Health Act.;

- A series of trainings developed and presented by project staff in four regions of the State on local level coordination issues;
- Participation in an evaluation to collect data on service development, barriers to collaboration and service coordination across systems, strategies for overcoming service and system barriers, and information regarding child and family satisfaction with mental health services to be incorporated into a training curriculum for use across the State; and
- Participation in a wide variety of conferences and trainings throughout the State and nationally which focus on children's mental health issues and service development for children with emotional disturbance and their families.

As of June 1991, 77 of Minnesota's 87 counties received direct technical assistance or consultation from the demonstration projects.

Preservice and inservice training activities are among the collaborative activities planned between the Department of Education and the Division.

1991 Activity Statistics on Adult and Children's Mental Health:

Number of technical assistance workshops	95
Number of site visits to individual counties and providers	200
Responses to letters from legislators and public	130
Number of persons provided technical assistance and training	3,200
Number of bulletins produced for counties and providers (Jan.-July, 1991)	17

State Level Coordination of Children's Mental Health Services: Minnesota Statutes direct the coordination of the development and delivery of children's mental health services on the State and local levels. The Departments of Human Services, Health, Education, State Planning, Corrections and Commerce, along with a representative of the Minnesota District Judges' Association Juvenile Committee, are directed to meet at least quarterly to: educate each agency about the policies, procedures, funding, and services in agencies serving children with emotional disturbance; develop mechanisms for interagency coordination on behalf of children with emotional disturbance; identify programmatic, policy or procedural barriers that interfere with delivery of

mental health services for children across 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; identify mechanisms for better use of federal and State funding in the delivery of mental health services for children; and report on policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.

The Committee has been meeting approximately monthly since 1989. undertaking a project to obtain data on the provision of services to children with emotional disturbance. Phase I involved identification of the various funding sources currently available for mental health services, funding amounts, and the number of children being served. Committee recommendations contained in the 1990 Report to the Legislature, and actions taken to meet these recommendations, are summarized under Requirement X.

Multistate Collaborative Technical Assistance/Training:
Minnesota is a member of the Midwest Consortium for Leadership Development (MCLD), a multistate Human Resource Development effort coordinated by the Ohio Department of Mental Health funded by the National Institute for Mental Health. Its stated mission is to develop and enhance the leadership capacity of public sector mental health administrators to engage in dynamic systems change.

Leadership Corps classes, comprised of approximately 20 members representing a variety of administrators from the mental health service field, are a project of the MCLD. Members benefit from training events, technical assistance and on-site visits over an eighteen-month period. The MCLD combines lessons from the latest leadership training materials and the experiences of individual administrators. Eight of Minnesota's local level mental health service administrators have had the benefit of this training opportunity.

Following the 1989 inclusion of Minnesota as an affiliate state in the Western Interstate Commission for Higher Education (WICHE), the Department has participated in the activities of the WICHE Mental Health Program. Staff from the Department and the University of Minnesota-Duluth attended and made a presentation at a WICHE sponsored conference on the use of telecommunications in mental health services. In addition, the Department was able to exercise its links with the State's Technical Colleges to make a WICHE sponsored teleconference, "Forensic Evaluation", available at several sites in Minnesota.

Diffusion Network Project. Minnesota is participating in the Diffusion Network Project of the Research and Training Center at the Stout Vocational Rehabilitation Institute at

the University of Wisconsin-Stout in Menomonie, Wisconsin. This project, funded by the Rehabilitation Services Administration, is intended to help rehabilitation facilities and consumers to establish new programs or expand existing programs to serve persons with serious and persistent mental illness and/or traumatic brain injury. The goal is to help establish community-based programs that lead to community employment and living and social integration. The project provides three years of technical assistance and consultation to help facility staff and consumers to develop and evaluate the new programs funded by this project.

c. Description of problems encountered:

Minnesota's mental health service system is changing so rapidly that it is sometimes difficult to convey information and technical assistance to providers and counties as quickly as would be desired. With the exception of LAC publications, the MHD does not communicate directly with consumers, relying instead on counties and providers to communicate information.

State level coordination efforts on behalf of children have not yet resulted in accomplishments of major policy recommendations due to lack of comparable data between systems and the difficulties inherent in developing true collaboration between major departments.

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

Reports to the Legislature assisted in the passage of amended legislation in 1990-91 and laid the groundwork for subsequent adult and children's mental health service funding and development.

Model contracts were developed and training was provided to county staff to assist counties in complying with mandates for community services.

Training in both adult and children's mental health services was provided during the year to 3,200 persons in 95 sessions.

Counties are developing increased expertise in provision of services to children and their families, as well as in certain specialized services (e.g., compulsive gambling).

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

a. The original milestone:

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:

Departmental Restructuring: The Department of Human Services was restructured during FY 91 so that residential management and community based services are under the same Department of Human Services Assistant Commissioner, a critical step to planning for a comprehensive system of mental health care. This action is viewed by the Advisory Task Force on PL 99-660 as a "major step in fulfilling the first requirement of establishing and implementing an organized system of care". This should permit more informed and coordinated consideration of such issues as the relative impact of the costs associated with institutionally-based care upon the development of community-based services and service coordination between the two systems.

By the end of 1991, the following will be in place:

- uniform planning, budgeting and implementation of legislation; and
- a mental health team composed of the Assistant Commissioner for Mental Health, DHS Medical Director, Mental Health Division Director, and Residential Division Director.

The stated goal of the Department is to more completely implement federal and state legislation. This reorganization is designed to facilitate the achievement of that goal.

Mental Health Acts: Legislation to revise substantially the nature and extent of adult services to persons with mental illness was introduced in the 1987 Legislature. The Comprehensive Adult Mental Health Act mandated a set of services based on best practice indicators so that service delivery to this population would be considerably more comprehensive, flexible and community-and consumer-based than in the past. In 1989, the Comprehensive Children's Mental Health Act was enacted by the Legislature, but only minimal funding was provided. The Act mandated a comprehensive set of state-wide services to children and their families, established mechanisms for coordination among agencies, and development of state and local advisory councils to provide input from consumers and providers.

The 1987 and 1989 Mental Health Acts required counties to produce two separate biennial plans for mental health services, one for adults and one for children. Statutory and regulatory guidelines were highly detailed and prescriptive. Prior to 1987, each county had been asked to provide one biennial social service plan, covering all social services, including mental health.

In 1990, at the invitation of three Assistant Commissioners from the Department of Human Services, a group of county directors from the Minnesota Association of Social Service Administrators began to discuss with State staff how planning efforts could be simplified and streamlined. The problem was framed as one for joint deliberation and decision between State and local staff. Minnesota is a county-administered State-supervised system. The State agency cannot effectively mandate planning processes if counties view such processes as excessively burdensome and unnecessary. The group defined three goals:

1. To reduce unnecessary paperwork from county plan requirements;·

2. To move from a focus on compliance through county plans to a focus on the planning process;

3. To enlist the county social service directors themselves in the effort to make planning effective for clients and to achieve county support for solutions.

After a series of meetings, the State agency and county directors agreed that:

1. Previously separate biennial plans for Community Social Services, federal Title XX funds, Child Care, Adult Mental Health, Children's Mental Health, and Mental Illness Community Support Programs would be merged into a single biennial plan for services.

2. Timetables for submission and approval would be the same for all sections of the plan.

3. The State agency would continue to evaluate the plan for approval-disapproval decisions using as criteria:

· the adequacy of local planning processes, including the involvement of stakeholders;
· the appropriateness of local objectives, based on State goals;
· the appropriate allocation of funds within program areas and for specific identified services;
· county certification that identified legal mandates had been and would be met.

4. Information requested of counties would be only that which could not be obtained through other means, such as the Community Mental Health Reporting System or the licensing or county monitoring divisions.

5. Accomplishment of objectives and compliance with rules would be determined through the department's reporting and monitoring systems.

6. The taxonomy of program areas and individual services would be identical with the Budgeting Reporting and Accounting for Social Services [BRASS] system currently used for fiscal reports.

7. The State agency would supply counties with current information on incidence and prevalence rates where obtainable.

8. The State agency's authority to approve or disapprove plans or to apply sanctions for non-compliance would not be changed.

Guidelines for an integrated social services plan were distributed to counties in January, 1991. Training for counties about changes in planning requirements was handled jointly by State staff and county directors in the first months of 1991. Statutory changes to implement these changes were approved by the State Legislature in May 1991, removing some of the detailed prescriptive language from statute while retaining for future planning cycles the following basic requirements:

- A description of the planning process, including methods used to assess needs and obtain citizen input;
- County outcome goals and specific objectives for each program area;
- A description of resources allocated within the county to support each program and service;
- A description of the services to be provided;
- An analysis of the adequacy of resources available to support the plan including estimates of unmet need; and
- A description of methods of service system coordination within each program area.

In addition, the role of local mental health advisory councils in the planning process was strengthened by new statutory language. Previous legislation had required "sign-off" by the chair of the LAC on the county plan, a process which, in many instances, was considered pro forma. The amendments provide for formalized input into both needs assessment and plan development. Counties continue to struggle with the relatively new process of inclusion of LAC advice into their biennial planning.

The annual report mandated by the 1991 Legislature from the Local Coordinating Councils is to be used to assist counties in identifying areas of strength and needs for community-based services, using a standard protocol and procedures for reporting community needs. Identified needs are to be developed and

incorporated into county mental health planning requirements, including the planning of local budgets for service delivery. By focusing on the individual needs of consumers, rather than the number of services and programs available within the community, planning is expected to better reflect attention to current service needs instead of maintenance of present service arrangements.

Case Management: Statewide implementation of case management services began January 1, 1989. The Division established a Case Management Implementation Group in 1990, comprised of practitioners and administrators, to examine and resolve issues encountered in the statewide implementation process. Early in its development, the group met quarterly but more recently has met about every six months, last meeting on April 1, 1991. The group has accomplished the following to date:

- Recommendation of a case management survey. This survey was designed by the MHD and administered to counties and their contracted providers in September, 1990 in an effort to obtain information about administration of the case management program as well as information about the time spent by case managers in various activities. The Division presented a brief summary of initial conclusions at the April meeting, with supporting statistical data.

- Review of a draft of the Individual Community Support Plan. The plan was developed by a subcommittee, comprised of six case managers, for statewide use.

- Collaborative work with the MHD on methods of monitoring case management providers. Upon completion of data collection and analysis, the MHD is sharing that information with the implementation group in order to assess local compliance with statute and rule, and to establish technical assistance and training materials and methods for local providers.

- Involvement with the revision of the case management rule (Rule 74). Revision is required by statute by July 1, 1992, and must include consideration of the following:

  - The clinical basis for the proposed changes;
  - Local responsiveness to revised case management rule provisions; and
  - The fiscal impact of revisions on county budgets.

A more complete discussion of the case management system and proposed Rule 74 revisions is presented under Requirements VII and VIII.

Community Support Services: Since 1987, the Legislature has provided increased State funding in excess of $19 million for expanded community support services for adults with serious and persistent mental illness. In addition, the 1991 Legislature approved community support funding for FY 92-93 which is $28 million more than the FY 87 level. In order to utilize these funds as effectively as possible, the Division's consultants provided technical assistance to counties to develop or enhance 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. Few states do this statewide without federal dollars, underscoring Minnesota's commitment to the CSP program. CSP services are available to clients residing in all counties. About 8,000 persons were served during 1990, an increase of approximately 75% over 1987 (see Requirement II for a discussion of increases in service use).

Adult Screening for Inpatient and Residential Treatment: Minnesota Statutes had required that, beginning January 1, 1992, county boards "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". Adults were to be screened within ten days before or within five days after admission to ensure that admission was necessary, the length of stay was as short as possible, and that the case manager was developing an individual community support plan.

The same statute required the establishment of a task force, set up in August, 1989, on residential and inpatient treatment services for adults. During the current fiscal year, task force members modified their previous recommendations, concluding that screening as a distinct service should not be mandated by the State due to the costs of service implementation, duplication with other processes, such as hospital admission precertification, and the clinical complexity of the process. Instead, the task force recommended that the functions of screening be included in several ongoing activities, and that screening functions should be responsive to both emergency and non-emergency situations (see Requirement VI for a discussion of task force recommendations).

The Department subsequently obtained statutory changes to eliminate screening as a separate service within the adult mental health system and to add requirements for contractual agreements to assure compliance with admission, continued stay, and discharge criteria for publicly funded services. (Inpatient

services funded under General Assistance Medical Care and Medical Assistance are not subject to these contractual requirements because these services are not directly funded through the county.)

The Division worked with the Residential Program Management Division in studying the feasibility of a new process for independent screening of voluntary admissions to RTCs. In addition, recent changes in RTC policies, developed with the assistance of the Mental Health Division, more strictly control such informal admission to these facilities (See Requirement VI for a more complete discussion of these policies).

Housing Initiative: The Division's development of a housing initiative to meet the needs of persons with mental illness consists of:

- an expansion of housing support pilot projects to include additional counties;
- the development and implementation of a pilot housing subsidy program; and
- the downsizing of Institutions for Mental Diseases (IMDs) to permit receipt of federal funding along with the development of alternative services for persons moving because of downsizing.

The 1991 Legislature approved and funded the Governor's Mental Health Housing Initiative, which encompasses the services indicated above. In addition, the Minnesota Housing Finance Agency received one-time funds of $250,000 from the 1989 Legislature to develop housing for persons with serious and persistent mental illness. The agency is utilizing these dollars for a two-year housing subsidy program, which was announced in early December, 1990. Division staff worked very closely with this agency's staff to develop the guidelines for the housing subsidy program. Division staff will continue to collaborate and to provide technical assistance during the implementation and evaluation stages of this project.

Compulsive Gambling Initiative: The MHD 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. DHS also works closely with a number of other State agencies to plan and coordinate development of the statewide programs for compulsive gamblers and family members. State law also requires a rule governing the screening for compulsive gambling of persons convicted of specified felonies.

Underserved populations: Indian mental health projects, designed to provide mental health services in coordination with county community support services, utilize the services of traditional healers as well as services available through county community mental health centers. Indian mental health project staff are involved in county mental health advisory committees for adults and children and work with counties to offer the array of mandated mental health services in a culturally competent manner. Each of the ten existing Indian mental health projects received continuation funding in 1991.

Although the refugee mental health project was completed in 1989, the Division continues to provide technical assistance and consultation to members of the refugee consumer and provider communities sharing information on State and federal opportunities for funding, service development and service expansion.

Anoka Alternatives Project: To address overcrowding at the Anoka-Metro Regional Treatment Center (AMRTC), the 1990 Legislature authorized that $500,000 be used for alternative services for difficult-to-serve persons being discharged from the facility. This FY 1991 funding was awarded to the six metro counties served by the AMRTC.

Uses of these funds included: housing subsidies and support services to enable these individuals to live in their own homes; expanded staffing at existing programs to enhance service to more difficult clients; and other services needed by these individuals to remain and function in their home communities. Counties had projected that they would be able to assist between 35 and 50 persons to move out of the RTC with services created by these dollars. In the first year, 85 persons were discharged and discharge planning was occurring with an additional 63 persons. Sixty additional persons had received project services such as transitional services or relocation from a Rule 36 facility to an apartment.

Homelessness: In FY 1990, Stewart B. McKinney federal ($485,000) and state ($237,000) funds served 2,351 homeless individuals with mental health problems in seven counties. In 1991, Minnesota contributed $346,000, a match of $2.87 for every $3.00 of federal funding for the homeless program, and served 3,152 persons. In addition to assessment, meeting basic needs and attempting to connect the person with needed mental health services, the MHD asked counties to focus on persons with mental illness at risk of homelessness as well as on homeless migrant workers with mental illness, and on encouraging have more of their clients accept county mental health case management on an on-going basis. Each county's program is unique to that county.

Children's Services

Significant new legislation to meet the needs of children with emotional disturbance was passed by in the 1989 Legislature. This legislation was designed to accomplish three primary goals:

- 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;

- establish mechanisms at the State, local and individual case levels for coordination among agencies serving children with mental health needs and their families; and

- establish advisory councils at the State and county levels, assuring input from parents, providers, advocates, and others in planning and developing a system of care.

Although the 1991 Legislature approved most elements of the Governor's proposed Children's Mental Health Initiative (including $4.8 million in new funding to expand grants to counties for non-MA eligible family community support services and case management), the amount of funding necessary to meet the estimated need has not yet been made available. (For example, for case management, total estimated costs are approximately $2.4 million, instead of the $1.5 million available from State and federal funds). The $4.8 million appropriation will allow continuation of the previous allocation for family community support, plus an increase based on the number of children in the county's population. The Department will issue an RFP this fall for these grants, with increased funding available April 1, 1992. The legislation requires that family community support services be the first priority for these funds; case management is the second priority. In addition, new Medicaid (State and federal) funding totaling over $2,000,000 for FY 92-93 was approved for children's case management and children's home-based mental health services.

Children's Mental Health Demonstration projects: The Children's Mental Health Demonstration projects were created in 1988 to support local communities in implementing the Comprehensive Children's Mental Health Act. Recognizing the uniqueness of communities throughout Minnesota, the Division, through a Request for Proposal process, funded eight demonstration projects in both urban and rural areas to pioneer Minnesota's efforts in developing comprehensive, coordinated mental health services for children and families. These counties share information and provide assistance to other communities throughout the State in designing and implementing services which meet the mandates of the Comprehensive Children's Mental Health Act.

In the second year, the demonstration projects expanded from serving 59 children in pilot counties, averaging 3 child-serving agencies each (March, 1989), to 176 children and an average of 12.6 agencies (September, 1990). The services most frequently provided in the pilot project counties over the period of the grants were case management, day treatment, prevention and education, professional family based treatment and outpatient services. (For a further description of these demonstration projects, refer to Requirement X.)

Task Force on Children's Specialized Residential Treatment Services. The 1991 Minnesota Legislature established a joint legislative committee to study the need for specialized residential treatment programs for children with emotional disturbance who exhibit violent or destructive behavior and for whom local treatment programs are not feasible due to the small number of children who need the services and the specialized nature of the services required. The joint committee must report its findings to the Legislature by December 1, 1991. The report must include an estimate of the number of children who need specialized services, the extent to which these children are now being served in other states, recommendations for actions needed to develop resources within Minnesota and mechanisms by which the commissioner shall approve out-of-state placements of children for whom the commissioner is responsible for partial payment of specialized treatment costs. This report should assist in targeting planning efforts to reduce unnecessary out-of-State placements.

Children's Screening for Inpatient and Residential Treatment: State Statutes require county boards to screen all children 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. The same statute required the establishment of a task force to examine and evaluate existing and available mechanisms that have as their purpose determination and review of appropriate admission and need for continued care for all children with emotional disturbance who are admitted to residential treatment facilities or acute care hospital inpatient treatment.

The task force submitted its initial conclusions and recommendations as part of the Division's 1990 Report to the Legislature, but continued meeting to examine further mechanisms to address inconsistencies and to identify successful models from which to build an effective and coordinated screening system for children. (See Requirement VI for a more extensive discussion of final screening recommendations.)

The Department obtained statutory amendments to address the issues raised by the task force. Counties are required to

assure, in contracts for residential and acute inpatient care, that providers adhere to admission, discharge, and continued stay criteria. Coordination in planning and continuity of care between service providers, and appeal mechanisms are also required in contracts under this legislative amendment.

Screening is now required before children are admitted, except for emergency admissions to acute care inpatient hospitals, when a three working day delay is permitted. For care provided under General Assistance Medical Care and Medical Assistance in an acute care inpatient hospital, no additional screening beyond that already required under DHS Rule 48 is necessary. Screening of children requires both diagnostic and functional assessments by mental health professionals and must address needs for community services. Counties are required to collect summary data on screening recommendations and the degree to which these are followed in placement decisions, as well as reasons for not following the screening recommendations.

A subgroup of the task force worked with staff from the Mental Health and Audits Divisions to revise DHS Rule 48, which governs admission of children to acute care hospital services under Medical Assistance. Staff from the Hospital Reimbursements Unit of the Audits Division will utilize this material in revisions of Rule 48, undertaken in the summer of 1991. Finally, a process has been established to assure independent evaluation of all children admitted to RTCs for whom Medical Assistance is expected to provide reimbursement.

c. description of problems encountered:

By mid-1989, the biennial planning burdens on both county and State staff had become enormous. The size and detail required in the two mental health plans were a major source of conflict between the State agency and the counties,with the guidelines alone totaling almost two hundred pages. At least half of the time of virtually all Division staff was required for plan review, technical assistance, and approvals. County staff felt their time was being spent in paperwork and not with clients. In the meantime, the demands of the more generic Community Social Service Plan had also become far more demanding in time and paperwork.

Although Minnesota's Medicaid program received over $3 million in new funding for case management since 1987, local providers of Rule 74 case management services have expressed concern that the amount of federal and State financial participation that local agencies are realizing from this program is still inadequate.

Lack of staff precluded the MHD from fully addressing issues related to employability and consumer-run business development for adults with mental illness.

Children's service development was impeded by lack of staff and service funding.

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

Adults: Planning requirements for counties were revised jointly with county staff. The process was more collaborative than previously, and local mental health advisory councils played a greater role in plan development for the 1992-93 biennium; requirements were streamlined to reduce unnecessary duplication and burdensome efforts on the part of both State and county staff, and information was more focused on assessment of needs and resources available to meet the needs.

Statutory changes have eliminated screening for adults as a separate service and added requirements for contractual agreements to assure compliance with admission, continued stay, and discharge criteria for publicly funded services.

Indian mental health project staff worked with counties to offer the array of mandated mental health services in a culturally competent manner. The ten existing Indian mental health projects received continuation funding in 1991.

Anoka Alternatives and homelessness projects were continued and extended to address new concerns. Anoka Alternatives assisted in the discharge of more than the anticipated 35 to 50 difficult-to-serve persons from AMRTC.

The compulsive gambling program was implemented, with new State requirements to strengthen the program.

A new housing initiative was approved and funded by the Legislature. It includes expanded housing support pilot projects, development and implementation of a pilot housing subsidy program, and downsizing of IMD's. The MHD worked with the Minnesota Housing Finance Agency to assist in the development of a two-year housing subsidy program for persons with serious and persistent mental illness.

Children: The Department obtained statutory amendments to address issues raised by the task force on Children's Screening. Screening is now required before children are admitted to out-of-home placements, with the exception of emergency admissions, and must include both diagnostic and functional assessments and identification of needed community services.

Eight Children's Mental Health Service Demonstration Projects were continued, and a second year evaluation was completed.

Funding was expanded for children's mental health services by the Legislature to include development of expanded family community services and case management services for non-Medical Assistance eligible children.

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

a. The original milestone:

To reassess rule development and revision plans and develop or 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 completion of rule revisions of Rule 14/15, Rule 29 and Rule 36, described below, as well as promulgation of emergency and permanent rules governing adult and children's case management, children's professional home-based treatment services, children's community-based services grants, and standards for licensure of children's community residential treatment programs.

Adult Services

Rule 14/15. Rule 14 is the fiscal management procedure rule for State community support program funding for persons with serious and persistent mental illness. Rule 15 will contain the program standards rule for community support services. Rules 14/15 have been in the process of rule revision for the past three years. It is expected that these rules will be promulgated by January 1, 1992.

The new Rule 15 will provide consistent definitions of mandated CSP services to be provided in each county. Additionally it requires orientation and annual training of CSP staff and individual service plans for CSP clients. The proposed Rule 14 revision simplifies the financial information required in the grant application, in line with both increased data collection capabilities of the Department and agreements reached in the mandates reduction bill passed by the 1991 Legislature.

Rule 29 (approval for third party reimbursement of services provided by community mental health centers and clinics). Standards for approval are being revised to reflect contemporary standards. Promulgation is anticipated in early spring, 1992.

Rule 36. Minnesota funds 76 adult residential treatment programs located throughout the State through Rule 12 grant awards. The Department of Human Services is currently revising the administrative rule (Rule 36) which governs the operation of residential treatment programs. The central purpose of this revision is to achieve a greater degree of consistency between the rule and the Minnesota Comprehensive Mental Health Act, as well as other statutes and rules which have become effective since the promulgation of the current residential treatment rule. The revision will update the rule to reflect contemporary practice philosophy regarding community-based mental health services. In addition, the proposed rule enhances staffing requirements in residential programs in order to prepare facilities to accept more challenging clients.

Revision of Rule 36 has involved a broad range of interested parties, including consumers, family members, providers of residential and other mental health services, mental health advocates, county social service agencies, and other State agencies. Over the past three years, numerous meetings have taken place and a considerable amount of information gathered in an effort to establish a collaborative interchange between the Department of Human Services and the various stakeholders. Some of the issues which emerged in the rule revision process included: the general applicability or scope of the rule; staff qualifications; staff training; client empowerment and rights; the use of restrictive practices; facility size; admission and discharge criteria; and utilization review. The rule is scheduled for final promulgation in late 1991.

Rule 74 (Case Management Program and Medicaid Reimbursement Standards). The Department is revising the case management rule (commonly called Rule 74) to respond to feedback from consumers and providers as well as to meet the requirements of a new mandate. New State legislation calls for the revision to:

- Make improvements in rule flexibility;
- Establish a comprehensive coordination of services;
- Require county case managers to arrange for standardized assessments of side effects of psychotropic medications;
- Establish a reasonable caseload limit for case managers;
- Provide reimbursement for transportation costs for case managers; and
- Review the eligibility criteria for case management services covered by Medical Assistance.

The required revision of Rule 74 must be completed by July 1, 1992. The Health Care Management Division continues to work with the MHD on a set of specific rule proposals that would allow for greater Title XIX reimbursement by local agencies while increasing flexibility in service provision (see Requirements VII and VIII for a more complete discussion of case management).

Compulsive Gambling Initiative. Minnesota statutes require that DHS develop a rule by 1993 to provide the guidelines needed to implement the provision that probation officers include a compulsive gambling screen as part of the pre-sentence investigation for specified felon convictions. By February 1992, the Division must also submit a report to the Legislature on progress toward meeting the rule requirement. The Mental Health Division will involve the Minnesota Department of Corrections in development of this new rule.

Children

Rule 78. Work on an emergency rule to govern grant applications, approvals, and allocations for community-based services to children with severe emotional disturbance and their families is underway, with promulgation by January 1, 1992. The rule will be used in awarding Children's Community-Based Mental Health grants in April, 1992. (The 1991 Legislature mandated the commissioner to award grants to counties to establish, operate, or contract with private providers for services, utilizing State funds, in order to assist counties in providing such services.)

Rule 77. The 1991 Legislature mandated the promulgation of emergency rules for case management services for children with severe emotional disturbance and their families by January 1, 1992. Staff time has been reallocated to meet this statutory mandate. In addition, Emergency Rule 77 is being drafted to cover case management service standards for children with severe emotional disturbance. These standards are based on the CASSP model and will facilitate a team approach to case management, using representatives of the system of care. Implementation of the statewide service mandate is required by statute by April 1, 1992. The emergency Rule 74 amendment cited above also includes provision for reimbursement of these services for children with severe emotional disturbance under Medical Assistance.

Rule 5. Rule 5 is the licensing rule governing mandated residential facilities providing services to more than 10 children and adolescents with "emotional handicaps". Originally written in 1971, MHD staff began rule revision in January, 1991. The 1991 Legislature mandated that a revised rule be in effect by July 1, 1992.

The Rule 5 Advisory Committee has met monthly during the summer of 1991 to seek public input and recommendations. Public hearings will begin in January, 1992 in order to meet the July 1, 1992 deadline. Although the public comment period is somewhat limited due to the expedited timeline for rule revision, Division staff have been meeting informally with providers, family members, county staff, and other State agencies since January for the purpose of soliciting input for the revision.

The revised Rule 5 will reflect the statutory requirements of the Children's Comprehensive Mental Health Act. By July 1, 1991, all children referred for residential treatment must be screened prior to admission by a mental health professional who is not financially affiliated with any residential treatment facility, inpatient hospital, or regional treatment center. The screening must establish that the child has severe emotional disturbance and is in need of residential treatment services. The Act also requires admission, continued stay, and discharge criteria; clinical supervision of program services and individual treatment plans must be provided by a qualified mental health professional. Special mental health consultants must be used as necessary in assessing and providing appropriate treatment to children of cultural or racial minority heritage. The revised rule will also have clear treatment standards which meet the intent of the Comprehensive Children's Mental Health Act and will include significant involvement of the family as partners in the child's treatment.

Rule 5 revision will also include standards for restrictive procedures, cultural competence, physical plant requirements, health care procedures, staff qualifications, and staff training to assure the protection and safety of the children served and compliance with the intent of the Comprehensive Children's Mental Health Act.

Rule 47. Rule 47 (Medical Assistance Reimbursement Rule) is being revised to provide standards for reimbursement of professional home-based family treatment for MA-eligible children. The State will utilize the Medicaid Rehabilitation Option, using the EPSDT program as the gatekeeping mechanism. Emergency rule promulgation is mandated by January, 1992, with a permanent rule required to be in place by January, 1993.

c. description of problems encountered:

Under the Minnesota Administrative Procedures Act, permanent rule revision normally takes a minimum of 18 months. If the rule is complex or if the Division is overloaded with other responsibilities, this period is longer. Faced with such a heavy load of rules to be written or revised in a very brief time period, both the MHD and the Rules Division anticipate delays in other planned activities. Administrative and staff changes have delayed revision of Rules 14 and 15 for four years.

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

Four major rules have undergone revision and will be promulgated in 1991 or early 1992 (Rules 14, 15, 29 and 36). Input has been extensive and the revised rules reflect current standards. Work on other rules, including emergency and permanent service

standards and reimbursement standards for adult and children's case management, professional home-based family treatment, children's community based treatment funding and children's residential treatment standards (Rules 74, 77, 78, 47 and 5), is continuing.

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

a. The original milestone:

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, included in the 1990 Plan submitted to NIMH.

Oversight of the Funding Process: Each year, the MHD awards approximately $25,000,000 in state and federal funding to counties and providers for development and delivery of specific mental health services. To assure that this funding meets the direction set in the Comprehensive Mental Health Acts, the Mental Health Division routinely establishes short-term grant review committees to provide advice in the award process. (Such committees are also used in the review and approval process for biennial county mental health plans.) Composition of the committees includes advocates and consumers, representatives of the State Mental Health Advisory Committee (and/or, the Children's Subcommittee) and county or provider representatives as appropriate. When appropriate to the specific grant, staff from other DHS divisions, representatives of professional groups, and representatives of target populations are included in the grant review process. This review process has been found exceedingly helpful in assuring that the goals of the grant process are met.

Adult Services: With the passage of the Comprehensive Adult Mental Health Act in 1987, Minnesota laid out an array of mental health services to be provided in all areas of the State. Counties, responsible for direct or contracted provision of nine mandated mental health services, submit biennial plans to the Department for review and approval prior to allocation of funds. Services must be provided according to priorities stated in law.

The Division, which administers State and federal funding for community services as well as four federal grants supporting a variety of service-related activities, provides administrative

services related to statewide mental health planning, resource development, standard setting, consultation and quality assurance.

Case Management: Case management services, by which individuals with serious and persistent mental illness are assisted toward community living, are currently provided to approximately 10,700 adults per year statewide. Services to about 3,800 of these individuals are reimbursed by Medical Assistance or General Assistance Medical Care. Division staff have worked with a range of groups involved in the provision of case management to maximize funding for the services, and to determine the modifications necessary to the rule governing their reimbursement under Medical Assistance (Rule 74).

Community Support Services: The use of community support services (CSP) and/or day treatment has increased to 8,500 persons during FY 1990. Services are available to clients residing in each county as originally targeted. With new programs and service enhancements occurring around the State, some counties are experiencing such rapid growth in demand for these services that they are unable to meet the identified need. One CSP component, Housing Support Services, has benefitted from a State allocation permitting development of 11 pilot projects. The projects have assisted persons with mental illness to obtain safe, affordable housing of their choice and to maintain these living arrangements through receipt of a variety of supportive services. Unfortunately, these projects have also shown that basic housing for persons with mental illness is not available statewide. Joint efforts between the Division and the Department of Jobs and Training's Division of Rehabilitation Services have also shown the need for expanded employability services for persons with mental illness.

OBRA-87: The Division developed the OBRA-87 project in response to federal P.L. 100-203, which requires that nursing facilities serve only those individuals whose needs require the level of care provided by the facilities. The State's Alternative Disposition Plan, approved by the Health Care Financing Agency (HCFA), projected that a total of 143 persons with mental illness who do not require nursing facility care would be relocated with appropriate mental health services by June, 1992. In addition to a very complex federal statute, draft HCFA requirements for screening these persons have changed repeatedly, making the State task of assuring compliance with the OBRA process very difficult. State funds have been awarded to 11 counties with financial responsibility for the first groups of persons requiring relocation. Despite the difficulty in setting up processes for compliance with federal law, it is anticipated that most of these individuals will make a transition to the community with intensive services provided through State funds.

Anoka Alternatives: The Anoka Alternatives Project has demonstrated the effectiveness of a coordinated discharge planning process with funding for intensive services. This project, designed help eliminate overcrowding of the Anoka Metro Regional Treatment Center, made $500,000 available to counties responsible for persons whose mental illness made them difficult to serve in the community. By the end of SFY 1991, 85 persons had been discharged and were utilizing funding for intensive services, 63 were in the discharge planning process, and another 60 were discharged as a result of the process, without need for additional funding. (See Requirement VI for a fuller discussion of this project.)

Housing: The MHD works very closely with the Minnesota Housing Finance Agency (MHFA) to implement state and federal housing and homeless legislation for persons with mental illness. This work includes joint membership on the CHAS (Comprehensive Housing Affordability Strategies) task force, collaborative work on MHFA's rental assistance demonstration projects, interagency task force on homelessness and the new housing initiative legislation. (A formal interagency agreement has not been reached at this time).

In May, 1990 a fulltime mental health program consultant position was established in the MHD to oversee the housing support pilot projects and Stewart B. McKinney Mental Health Services for Homeless Persons (MHSHP) program. Additionally, this staff person is responsible for providing technical assistance regarding implementation of the housing mission statement and coordination with housing and housing support agencies. With input from the MHD, the Minnesota Housing Agency developed a $250,000 pilot rental assistance project for persons with serious and persistent mental illness in three counties.

The 1991 Legislature approved the Governor's Mental Health Housing Initiative, which includes $1 million for a new housing subsidy program to serve 400 people, $500,000 in new funds for additional housing support services pilot projects, increased flexibility to use existing Rule 12 funds for housing support services, $750,000 for alternative services to downsize 18 IMDs, and $882,000 to develop alternative services for 100 people in seven other IMDs certified as nursing facilities. Additional funding was made available to convert larger IMD nursing facilities to non-IMDs.

Adult Screening for Inpatient and Residential Treatment: A task force representing a wide array of adult interest groups has completed recommendations about provision of currently mandated screening services by counties. The group recommended eliminating screening as a distinct service, substituting statutory requirements that counties assure placement decisions based on the clinical needs of the adult. In addition, the group

recommended that contracts for the provision of services be required to have admission, continued stay and discharge criteria, as well as linkages between counties and other providers of services. These amendments were adopted by the 1991 Legislature.

Children's Services

Significant new legislation to meet the needs of children with emotional disturbance was introduced in the 1989 Legislature. The passage of that legislation substantially increased the MHD's responsibilities. Since January, 1988, 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 for services to be provided in FY 90-91. It mandated a comprehensive set of services throughout the State, to be phased in by January, 1993, so that all children and their families would receive services based upon their individual need. The DHS also funded eight demonstration projects which are modeled after the CASSP (Child and Adolescent Service System Program) principles of interagency coordination and service delivery with ADM Block Grant set-aside funds. The first new funding for children's mental health services was awarded to counties in March, 1991 for establishing Family Community Support Services.

Efforts to develop coordinated early identification and intervention services are underway following multi-agency planning. These included regional meetings during 1991 on Child Mental Health Awareness for professionals serving children and families. Promulgation of rules governing children's case management professional home-based family treatment, and children's community-based mental health grants is also underway (see the discussion of rulemaking, above).

Case Management: Children's case management is viewed as the primary mechanism for coordination between service providers from multiple systems and children and their families. An informal children's case management advisory group examined local and national models of case management for children, and developed potential funding strategies for this service. Rules governing service standards will be developed by January, 1992 (see Requirement I for a discussion of the rulemaking process for children's case management).

Rule 5: In order to bring the licensing rule governing children's residential treatment facilities (Rule 5) into compliance with contemporary standards of practice, revisions of this rule are underway. In addition, the Division is attempting to address both the high cost to counties of Rule 5 services and to assure that funding options do not establish incentives for out of home placement. The revised Rule 5 will reflect the statutory requirements of the Children's Comprehensive Mental Health Act, including: requirements for independent screening; determination that the child has severe emotional disturbance and is in need of residential treatment services; admission, continued stay, and discharge criteria; clinical supervision by a qualified mental health professional; culturally sensitive assessments for minorities; and clear treatment standards which meet the intent of the Comprehensive Children's Mental Health Act and which include significant involvement of the family as partners in the child's treatment (see Requirement I).

c. description of problems encountered:

The OBRA-87 project has been very slow in starting because of confusion over federal requirements, the attendant difficulty in conveying these requirements to counties and providers, and the service development necessary for full implementation.

Lack of staff resources and very stringent timelines for emergency children's and adult rule promulgation will continue to create problems over the next several months.

Full implementation of the Children's Comprehensive Mental Health Act has been delayed due to the lack of funding to counties for service provision and to the Division for developing service standards, consultation, and technical assistance. However, significant new funding was appropriated in 1991, with the establishment of the first step toward an integrated Children's Mental Health Services Fund.

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

Adults: Case management services were expanded to over 9,000 persons with serious and persistent mental illness. Service standards are being revised. CSP services standards are also being revised and 8,500 persons are being served statewide.

Services were developed to permit 85 difficult-to-serve persons to be discharged from Anoka Metro RTC, with continuation funding received from the Legislature based on initial success of the project..

State funding is available to develop new services for persons required to be relocated under OBRA-87, resulting in service system expansion.

Children: Priorities for children's services were developed and approved; services were more clearly defined; and most of the funding requested by the Governor was approved by the 1991 Legislature to implement the Comprehensive Children's Mental Health Act.

Children's demonstration projects were continued, with these eight counties developing locally appropriate service delivery systems and provision of technical assistance on collaborative development of children's mental health services.

The first new funding for children's mental health services was awarded to counties wishing to establish Family Community Support Services. Grants were awarded to 39 counties to provide services to families and children in 53 of Minnesota's 87 counties.

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

a. The original milestone:

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:

Adult Services

The MHD has participated in numerous efforts to ensure State-level coordination in service development. As part of this coordination, a large variety of task forces, advisory groups and/or committees provide input to the MHD. These involve multiple State level inter- and intra-departmental coordination for the development, implementation and funding of mental health services. In most cases, other agencies and organizations, consumers, providers and advocates are also involved. A complete listing is found in Appendix II.

Specific examples of State level coordination for the development, implementation and funding of mental health services are described below.

Employment: The employability component of community support services is closely coordinated with services available through the Department of Jobs and Training's Division of Rehabilitation Services (DRS). The MHD continues to work cooperatively with DRS

to implement the joint Interagency Cooperative Agreement to discuss program and budget issues and legislative concerns.

In December 1990, the Agreement for Supported Employment between DRS, DHS and the Department of Education was negotiated and signed. A policy committee and advisory committee have been established to plan, fund and regulate programs that deliver supported employment services in Minnesota. The MHD continues to be involved with DRS in the Supported Employment Policy and Advisory committee meetings and work groups on Quality Assurance, Training and Technical Assistance, and Local Resource Development for Supported Employment. The three agencies agreed to seek additional appropriations to convert a portion of existing resources to supported employment, to apply for federal funding for joint projects as those opportunities become available, and to create systems change to achieve the goals of the agreement.

As agreed in the Interagency Agreement, the Division and DRS are collaborating on the funding for and development of a request for proposals for demonstration projects to provide supported employment services for persons with mental illness. Both agencies have committed funding for the development of these projects, which are expected to be implemented in the fall of 1991.

Housing: The MHD works very closely with the Minnesota Housing Finance Agency (MHFA) to implement State and federal housing and homeless legislation for persons with mental illness. This work includes joint membership on the CHAS (Comprehensive Housing Affordability Strategies) task force, collaborative work on MHFA's rental assistance demonstration projects, interagency task force on homelessness and the new housing initiative legislation. (A formal interagency agreement has not been reached at this time). In May, 1990 a fulltime mental health program consultant position was established in the MHD to oversee the housing support pilot projects and Stewart B. McKinney Mental Health Services for Homeless Persons (MHSHP) program. Additionally, this staff person is responsible for providing technical assistance regarding implementation of the housing mission statement and coordination with housing and housing support agencies.

Public/Academic Liaison: The MHD used he technical assistance provided by the Pew/APA State/University Collaboration Project to build substantial linkages between the Department of Psychiatry at the University of Minnesota Medical School and the Department of Human Services. Representatives from relevant groups participated in both the State/University Collaboration Project's (S/UCP) Midwest Workshop and in an in-depth consultation held this past January. During the consultation process, the following agreements were reached:

- to endeavor to negotiate a contract using existing State funds to hire a new University faculty person to serve on the staff of a State regional treatment center;

- to review and streamline existing procedures for the review/approval of research projects in State institutions;

- to work with University faculty and community mental health service representatives to provide outreach/continuing medical education for community-based providers; and

- to review loan forgiveness as an incentive for practice in rural areas to discuss the feasibility of legislation supporting such a program with key legislators.

Several follow-up meetings have been held, as well as a workshop to involve the State's larger psychiatric community in planning and supporting these efforts. The Department of Psychiatry at the Mayo Medical School has also become involved and is interested in pursuing collaborative activities with both State facilities and community programs.

Human Resource Development: An NIMH funded Human Resource Development Capacity Building Project engages in a variety of inter- and intra-agency activities in order to improve the Department's ability to deal with mental health human resource issues. The project has taken the lead in facilitating the collaboration with academic Departments of Psychiatry. It has initiated collaboration with other relevant academic disciplines through a survey of academic faculty and programs and inclusion of faculty persons on the Project's advisory group. The HRD Project has also developed intra-agency linkages with the Personnel, Residential Programs Management and Licensing Divisions as well as interagency relationships with the Departments of Health and Jobs and Training as part of its objective to create an administrative focal point for mental health human resource development.

Midwest Consortium for Leadership Development (MCLD): The MCLD, an NIMH-funded multi-state human resource development effort coordinated by the Ohio Department of Mental Health, is charged with developing and enhancing the leadership capacity of public sector mental health administrators to engage in dynamic systems change. MCLD Leadership Corps classes, which are held for administrators from the mental health service field, provide training events, technical assistance and on-site visits over an eighteen-month period for participants. The MCLD combines lessons from the latest leadership training materials and the experiences of individual administrators. Eight of Minnesota's local level mental health service administrators have had the benefit of this training opportunity, including administrators from the Washburn Child Guidance Center, YES/NEON, Inc., Adult

Services, Olmsted County Community Services, Crisis Intervention Center, Hennepin County Medical Center, Community Support Program, Human Development Center, MH/Ed. Programs, Amherst Wilder Foundation, Residential Services, HECLA, Inc., Northern Pines Mental Health Center. These represent a variety of mental health service administrators in both urban and rural areas, working with residential programs, crisis services, aging populations, community mental health centers, and others.

Mental Illness/Chemical Dependency (MI/CD): The Mental Health and Chemical Dependency Divisions are currently working to identify MI/CD training needs throughout the State of Minnesota. Statewide MI/CD cross-training of health professionals has been identified as a need. A training plan is being formulated. Although funding for development of such training is currently unavailable, the Mental Health Division is encouraging community-based providers to cross-train their staff. In addition, the Mental Health and Chemical Dependency Divisions are assessing the possibility of applying for training money from NIMH. These monies would be utilized to develop and implement a statewide MI/CD training program. The two Divisions collaborated on providing technical assistance to a pilot program for persons with MI/CD at the Willmar RTC. Technical assistance to this program is ongoing as the program evolves into an integrated model for MI/CD services.

Compulsive Gambling: The MHD works closely with a number of other State agencies to plan and coordinate development of the State-wide program for compulsive gamblers and family members. The basis for collaboration is stipulated by Minnesota Law, which requires all gaming and gambling establishments under the supervision of the Department of Gaming to post the Minnesota Compulsive Gambling toll-free Hotline number and that DHS approve the posted signs. It also requires DHS to develop a rule governing the screening for compulsive gambling of persons convicted of specified felonies. This provision will require close collaboration with the Department of Corrections because screening is the responsibility of the probation officer who does the pre-sentence investigation. This effort will be coordinated through the representative of the Department of Corrections who is already a member of the DHS State Advisory Group for the compulsive gambling treatment program.

Children's Services

The 1989 Comprehensive Children's Mental Health Act 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 parents, providers,

advocates, and others. State level coordination is provided by the interagency coordinating group required by statute.

Training: As communities attempt to implement the Comprehensive Children's Mental Health Act, the complexities of interagency coordination and collaboration have become clear. There has been a tremendous need throughout the State for additional information and training to assist counties in designing and implementing coordinated mental health services, in collaboration with parents and service providers from multiple systems serving children and families. Consequently, the MHD has provided assistance at the local level in the form of consultation, technical assistance, and training. This activitiy is the major focus of the CASSP grant.

State-Level Coordination: 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 at least quarterly since the end of the 1989 legislative session in order to design a system which would identify children at risk or in need of 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; examination of pooled funding to enhance access to resources and eliminate duplicative service and eligibility requirements; and State development of model interagency agreements to promote the provision of early identification and intervention services at the local level.

The Committee met approximately monthly, and undertook a project to obtain data on the provision of services to children with emotional disturbance. Phase I of the project involved identification of the various funding sources currently available for mental health services, funding amounts, and the number of children being served. Phase I data is provided in Tables 3 and 4 under Requirement V. In general, this analysis provided the first evidence that most children's funding for mental health services is not duplicative across State agencies, but rather is used for different types of services. For example, the Department of Human Services tends to fund clinical services, whereas the Department of Education funds instructional and related services.

Family Community Support Services Grants: In November, 1990, the Division solicited proposals from county agencies for pilot projects to demonstrate innovative ways to provide family community support services to children with severe emotional disturbance and their families. Counties were encouraged to make use of community resources as much as possible to meet the individualized mental health needs of children and their

families. Proposed providers of these services included, but were not limited to, schools, community mental health centers, county welfare agencies, and public health agencies. Applicants were required to demonstrate the methods used to secure the involvement of local agencies and community service providers such as: mental health; social services; education; health; vocational services; corrections; and recreational services. Counties described how each of these agencies (particularly schools) would ensure ongoing contact and coordination in the implementation of family community support plans.

Counties were required to provide evidence that the specified agencies were interested in collaborative efforts to develop individual family community support plans, to utilize existing funding resources, and to make changes in agency policies and procedures as necessary to facilitate needed systems change. Specific examples of these local collaborative efforts are provided below under Requirement I.

Early Identification and Intervention: Early Identification and Intervention (EI/I), one of the 12 required services of the Comprehensive Children's Mental Health Act, is intended to provide a framework in every community across multiple service systems to identify children in need of, or at risk of needing, mental health services and to intervene as early as possible to prevent or reduce the severity of emotional disturbance.

An EI/I task force, chaired by the MHD, was established to assist in designing and implementing these services statewide. Division staff worked collaboratively with staff from the Departments of Education and Health in designing and delivering a series of five regional trainings for 175 people throughout the State focused on the identification of mental health issues in children. Participants included representatives from education, health, public health, mental health, and social services agencies. Staff also developed a brochure on mental health issues of children and youth at various developmental stages which provided information on significant signs and symptoms that may indicate emotional disturbance. Brochures are being widely disseminated through the Departments of Human Services, Education, Health, and Corrections to counties, service providers, advocacy groups and families (250,000 brochures have been prepared for distribution). The Division also assisted in the development of a screening tool for use by early childhood screeners.

Children with Emotional/Behavioral Disorders (E/BD): A number of items relating to children with emotional/behavioral disorders appear on the Special Education State Plan 1991-93 Discretionary Priorities. Services to children and youth with E/BD are one of seven project areas funded with P.L. 94-142 discretionary monies. The identification, assessment and service needs of all children

and youth with E/BD are provided under this priority area. Estimated funds for 1991, 1992 and 1993 are $100,000 per year. An intergovernmental agreement will be used during the 1990-91 year to provide for a fulltime person to more specifically identify statewide needs of these children and youth. Task forces will be utilized to identify these needs and make recommendations to the Department. Examples of activities include: studies, development and provision of preservice, inservice and interagency collaboration with the Mental Health Division.

The Department of Education, in cooperation with the Department of Human Services is nearing completion of a resource manual entitled "Developing Quality Services for Children and Youth Experiencing an Emotional/Behavioral Disorder". Representatives from the Departments of Education, Health, Human Services and Corrections participated in a planning and networking committee convened by the Department of Education to identify the needs of children and youth experiencing emotional/behavioral disorders. The manual will provide a basis for future curriculum development and collaborative training between the Departments of Education, Health, Human Services, and Corrections.

Sharing of human and fiscal resources between the Departments of Human Services and Education has occurred as a result of the development of the resource manual. Personnel time from each department has been allocated for collaborative work in developing the manual to be used in training activities with representatives from multiple service systems. Each has agreed to share publication, printing, and dissemination costs. The Department of Education has received $150,000 in carry-over funding which will be pooled with the Division's CASSP grant to conduct joint regional trainings on interagency coordination and strategies for collaborative service development and funding during 1992.

The collaborative interagency relationship that exists between the Departments of Human Services and Education is expected to enhance training activities and ultimately local service delivery through the modeling of partnerships and shared human and fiscal resources that can be replicated at the local level. For example, the manual mentioned above will be used in training local coordinating councils as well as educators.

State Transition Interagency Committee: For the last year, the MHD has participated in the State Transition Interagency Committee (STIC). This group, hosted by the Minnesota Department of Education, is comprised of representatives of State and local agencies, institutions of post-secondary education, and family members in order to assure development of appropriate services for students with disabilities to help them make the transition to community life after secondary education. Although the STIC

has been in existence since 1984, and the DHS has participated for a number of years, this marks the first regular participation by MHD staff. As a result, the transition process is more available to those working on behalf of children with emotional disturbance than would otherwise be the case.

State Early Childhood/Early Intervention Council: Division staff meet periodically with members of the P.L. 97-142, Part H, Advisory Council to encourage interagency efforts on behalf of children, age 0 to 3, with emotional disturbance.

c. Description of problems encountered:

Administrative changes forced postponement of an interagency agreement with the State Housing Finance Agency. Linkages with some groups (Health and Corrections, for example) have not yet been developed to the desired extent.

Implementing the coordination required by the Comprehensive Children's Mental Health Act has required considerably more time investment from the small children's staff than anticipated in order to assure commitment by other State and local agency representatives.

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

Service development, including legislation, rule revision, specification of lines of responsibility, areas of service, target populations, and service delivery methodologies 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 are developing across systems for the provision of children's mental health services. On the State level, several jointly funded and staffed efforts for both children and adults are underway between the MHD and the Department of Education and the MHD and DRS.

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

a. The original milestone:

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:

County Planning Process: The 1987 and 1989 Mental Health Acts required counties to produce two separate biennial plans for mental health services, one for adults and one for children.

Statutory and regulatory guidelines were highly detailed and prescriptive. Prior to 1987, each county had been asked to provide one biennial social service plan covering all social services, including mental health.

Efforts initiated by the Department in 1990 have resulted in a more focused, less time-consuming process for local planning. That process is currently underway, with Division review of county adult and children's mental health plans. It is anticipated that the streamlined process will permit state and local staff time to be utilized more effectively on appropriate service planning and implementation than had previously been possible.

State Mental Health Advisory Council: In addition to consumers, providers, and advocates, membership on the State Advisory Council includes two county commissioners and two county social service directors, from a wide geographic distribution. It is the intent of the Council to be aware of the differences and similarities between urban and rural communities relative to mental health needs.

Council and Subcommittee members are particularly aware of the opportunities for collaboration between the private and public service sectors due to the varied composition in their membership. Because the counties are primarily responsible for the implementation of the Comprehensive Mental Health Acts for Adults and Children, the Council is sensitive to the unique characteristics of the regions of the State. Some counties are proceeding with children and adult service development at a faster pace than others. The Council attempts to be aware and advise the State on the progress of implementation.

Local Mental Health Advisory Councils (LACs): The 1987 Comprehensive Adult Mental Health Act and 1989 Comprehensive Children's Mental Health Act mandated local mental health advisory councils (LACs) for each county (counties may combine councils). Representation on the councils is to include consumers, family members of consumers, parents of children with emotional disturbance and persons who received mental health services as a child or adolescent, as well as mental health professionals. A major goal of the councils is to increase consumer/family and provider collaboration. LACs are often involved in the decision-making process of local resource allocation. LACs have provided valuable input on the prioritizing of mental health services, which is crucial to the allocation of resources, in the selection of service provider contracts, and to some extent in determining the terms of contracts.

County Commissioners' Advisory Committee: The Department of Human Services' County Commissioners' Advisory Committee (CCAC)

was formed in 1989. The goal of the CCAC is to establish a dialogue between State and local government officials for the purpose of broadening the participant's understanding of human services issues and fostering a partnership between the two levels of government. The CCAC meets quarterly to discuss issues, including the development of the Department's budget and legislative package. The committee is also responsible for planning the annual Human Services Institute, a conference on human services issues which is open to all county commissioners. Workshops on mental health issues have been included in each of the conferences held since the formation of the committee.

Four subcommittees of the CCAC have been established: the Interagency Community Health and Social Services Subcommittee; the Budget and Legislation Subcommittee, the Children's Services Subcommittee; and the Community Social Services Act Subcommittee. Mental health issues have been discussed at various times in each of the subcommittees, as well as in the committee as a whole. Committee members have given input on the mental health planning process and have commented on legislation on both children's mental health services and services for adults. The committee members have also met with one of the State's leading mental health advocates to discuss expectations.

The CCAC is strongly supported by the current administration and the Association of Minnesota Counties. It is anticipated that the committee will continue to provide valuable input to the Department and the MHD throughout the 1990s. In addition, committee participants become knowledgeable in strategies to be used at the local level.

Homeless Persons and Law Enforcement: In Hennepin County, the Mental Health Unit project serving homeless persons with mental illness began a monthly roundtable discussion with law enforcement officials to make sure that persons with mental illness are served properly. The ACCESS project in Ramsey County, with McKinney Act funds, works with all the homeless services providers and also with the McKinney Service Task Force, a forum for sharing work experiences and needs as well as planning. They also learned from the Hennepin County experience and have begun a roundtable with law enforcement officials. On the Iron Range in northeastern Minnesota, the homeless project is responsible for working closely with 14 different law enforcement agencies. A law enforcement group has requested development of a training package for new law officers who may come in contact with homeless persons with mental illness.

Children's Services

Children's Services Demonstration Projects: Eight counties were funded through a Request for Proposal process with ADM Block Grant Funds in late 1988 to demonstrate the implementation of the

Comprehensive Children's Mental Health Act. The eight sites are located throughout the State, in both urban and rural areas. These projects have accumulated vast amounts of knowledge as they have developed services which are community-based and collaboratively-developed across multiple service systems.

These projects have now assumed an expanded role in assisting the Division in disseminating information to other counties for their use in designing and implementing high quality, collaborative mental health services. With second year CASSP grant funding, the Division has utilized the expertise of staff from the demonstration projects to serve as mentors to other representatives of the systems of care as they attempt to implement the Comprehensive Children's Mental Health Act in their local communities throughout the State.

Training on Coordination: Due to the need for training and assistance in implementing the Comprehensive Children's Mental Health Act at the local level and the limited number of Division staff to serve the entire State, the MHD has been involved in three primary efforts during the past year designed to assist counties and providers in meeting the needs of children with severe emotional disturbance and their families. Two of these have involved regional or local efforts.

The Division designed and conducted a series of regionally-based trainings on interagency coordination targeting members of county Local Coordinating Councils throughout the State. The purpose of these trainings was to assist Local Coordinating Councils in developing strategies for identifying barriers to collaborative service development and mechanisms to promote coordinated services across service systems. One hundred-fifty persons attended the four training sessions.

The Mental Health Division received a National Institute of Mental Health Child and Adolescent Service System (CASSP) grant to design and implement a series of trainings throughout the State during 1992 and 1993. A training curriculum is being designed utilizing evaluation information from the eight child mental health demonstration projects that are currently providing coordinated, collaborative services to children with severe emotional disturbance and their families. It is hoped that these trainings will create "experts" at the local level to serve as ongoing resources in the development and implementation of collaborative services within their communities.

Children's Local Coordination. Family Community Support Services grants are funding many excellent examples of collaborative efforts with local agencies, including: school-based family community support services; family community support service cooperatively provided by the county agency and community corrections; school and community-based, collaboratively funded

and staffed day treatment programs; school-based crisis intervention services; school-based recreational and leisure time activities; recreational and leisure time activities designed and provided by community education; and the certification of day care providers as "special needs" day care providers by contracting with a vocational school to include specialized training designed to meet the needs of children with severe emotional disturbance in their curriculum, and the use of mentors and volunteers through contracts with local colleges.

Outreach and Information Dissemination. A collaborative effort with the Departments of Education and Health resulted in a series of five trainings for 175 people throughout the State which focused on the identification of mental health issues in children; 250,000 copies of a brochure regarding mental health issues in children at various developmental stages is being disseminated through the Departments of Human Services, Education, Health, and Corrections to counties, service providers, advocacy groups, and families.

Children's Demonstration Projects Newsletter. The Division assists with the publication of a quarterly newsletter by the eight child mental health demonstration projects. This newsletter provides information regarding the service efforts of these projects. It has been an excellent vehicle for distributing this information to a wide audience of over 400 individuals and agencies across the State.

E/BD Handbook. Thirty-two focus group interviews were held around the State with people from multiple systems concerned about children and youth with emotional or behavioral disorders (E/BD). The results of the focus group interviews were used as a guideline for the development of a resource manual based on a shared mission and vision of children's mental health services in Minnesota. The collaborative interagency relationship that exists between the Departments of Human Services and Education is expected to enhance training activities and ultimately local service delivery through the modeling of partnerships and shared human and fiscal resources that can be replicated at the local level. The handbook will be used in the training of local coordinating councils as well as educators. The handbook will include: the legislative impetus, a State study, data from the MN Department of Education and the Department of Human Services, the mission for CASSP and the Planning and Networking Committee, a model for improving and evaluating collaboration, evaluation of quality services, case studies exemplifying prevention, early intervention, services and treatment options, maintenance of wellness-transitioning, and a collection of resources by topic.

Collaborative Training. The Department of Education has agreed to provide $150,000 in carry-over funding for use with the Division's CASSP grant dollars to develop regional trainings on interagency collaboration and funding strategies.

State Transition Interagency Committee (STIC): In addition to obtaining data on the needs of students with disabilities, training educators and community agency staff, assisting with local issue resolution, and providing information to students and parents, members of STIC work with local groups (Community Transition Interagency Committees) to bring about more effective transition services throughout the State.

c. Description of problems encountered:

By mid-1989, it had become evident that the planning burdens on both county and State staff had become enormous. The size and detail required in the two mental health plans were a major source of conflict between the State agency and the counties. The guidelines alone for the two mental health plans totaled almost two hundred pages. At least half of the time of Division staff was required for plan review, technical assistance, and approvals. County staff felt their time was being spent in paperwork and not with clients. In the meantime, the demands of the more generic Community Social Service Plan had also become far more demanding in time and paperwork.

Counties complain that multiple laws, each with slightly different emphasis, require local coordination mechanisms (e.g., Early Childhood, Mental Health, Transition, Abuse and Neglect Prevention). In some small counties, the requirements have reduced available time for work with families and children or have forced delegation of coordination to staff with little decision-making authority.

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

Planning requirements for counties were revised jointly with county staff for the State 1992-93 planning period. The process is expected to be more collaborative than previously, with local mental health advisory councils playing a greater role in plan development. Requirements were streamlined to reduce unnecessary duplication and burdensome efforts on the part of both State and county staff, and information requested is more focused on assessment of needs and resources available to meet the needs. Legislation passed in 1991 will continue this process.

A collaboratively-developed handbook about children with emotional/behavioral disorders is nearly complete. Brochures are being distributed. Department of Education funding is being used

jointly with MHD dollars to publish the handbook and provide regional trainings. Training has also been provided to 150 Local Coordinating Council members.

The role of the LACs has been strengthened. Collaboration in all phases of the planning and implementation process, as well as within various projects, is the rule rather than the exception, with all stakeholders involved. Although this is more time-consuming, it assures a more rational process with all perspectives represented.

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

a. The original milestone:

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.

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:

Adult Services

OBRA-87: In Minnesota, administration of the mental health portion of the Preadmission Screening/Annual Resident Review (PASARR) process required by OBRA is the responsibility of designated mental health authorities in each county. The Division provides ongoing technical assistance, oversight and monitoring of compliance with the law. Since the passage of PL 100-203 (OBRA-87), five drafts of complex regulations have been issued by the Health Care Financing Administration to govern implementation of nursing home reform. Compliance with these regulations is required in order to assure appropriate care for persons with mental illness and to maintain Medicaid financing of services.

Seventy regional and statewide training sessions have been provided from January 1, 1990 through May, 1991 to county staff and mental health, long term care and acute care providers and other interested parties, for a total of 1,875 persons. Formal and informal technical assistance is provided on an ongoing basis at the request of counties and other interested parties. During FY 1992-93, another series of regional meetings for county staff who are charged with the PASARR implementation are planned after the final PASARR regulations have been promulgated.

PASARR requires states to relocate residents of MA-certified nursing facilities who have a mental illness and who have been determined to be inappropriately residing in the facility. States were permitted to submit Alternative Disposition Plans (ADPs) that identified the numbers of persons and the timelines states would follow to relocate these persons. Minnesota submitted a plan in 1989. An estimated 143 residents will require relocation, which is to be completed by June, 1992.

A total of $1,495,399 in State funds to support activities of the ADP were awarded to counties to assist with relocation efforts during the FY 90-91 biennium. Eleven counties with financial responsibility for residents currently found to need relocation applied for these State dollars. For the FY 91-92 biennium, $2.8 million dollars has been allocated to continue this effort. Thirteen counties have applied for these funds to continue the relocation effort and/or maintain persons already relocated to the community. It is projected that the cost of individual ADPs will average about $1,200 per person per month, including room and board.

These funds are to be used to develop new community-based services and/or to enhance and expand existing services to meet the specific needs of this population. Funding is flexible and is geared to meet the specific needs of each individual. For example, dollars can be used for rental subsidies and the enhancement of an array of wrap-around mental health and social services to assist the individual in transition to the community. This funding is expected to provide not only services for affected individuals, but also expansion of the capacity of the States' mental health system in general.

Homeless Persons: McKinney Act funding for Mental Health Services for Homeless People and the State match associated with this program have been successful in meeting the following stated objectives:

- To provide services to homeless persons with mental illness so that they can receive basic supports;

- To support the efforts by homeless service providers to assist homeless persons with mental illness; and

- To engage the entire mental health provider system in providing services to the persons who are the most difficult to find and maintain contact.

In FY 1991, 3,152 homeless individuals with mental health problems received services from mental health providers in eight Minnesota areas where homeless people congregate. In 1987, prior to the availability of McKinney funding, the Minnesota State Legislature appropriated $350,000 for Minnesota's three largest

cities to provide mental health services for homeless persons with serious and persistent mental illness. With FY 1987 and FY 1988 McKinney funds, the ability to assist homeless persons with mental illness was expanded to five more communities, resulting in a small mental health service network which is accessed by both homeless service providers and homeless persons.

The essential services provided by the projects include: outreach (41%), mental health services (25%), medical services (5%), training (4%), case management (13%), and housing support (12%). Minnesota contributed $346,000 in 1991, a match of $2.87 for every $3.00 of federal funding for the homeless program. Each grantee is encouraged to develop a project which is responsive to local community needs and conditions. Hence, the homeless projects vary considerably. For example, northern St. Louis county, a sparsely populated and geographically large northern area of Minnesota, is comprised of several small towns of over 10,000 people surrounded by heavily wooded areas. Housing is readily available, but unemployment is very high due to the demise of the taconite industry, so that many have lost their houses. The Moorhead area is a rich farming area (the Red River Valley, noted for potatoes and sugar beets) just across the border from North Dakota. From spring to fall, it has many migrant workers, defined as homeless in Minnesota's 1988 CHAP. Some North Dakotans cross the border to receive services, since, unlike Minnesota, North Dakota does not have a General Assistance program. Many of the rural sites are relatively isolated from other services specifically for homeless persons, and hence are making a major contribution toward developing a network of service providers and services for homeless people in these areas. In contrast, Hennepin County, which contains Minneapolis, the State's largest city, shelters an estimated 46% of the State's homeless population, and has done so since 1987. Ramsey County, which contains St. Paul, the capital and second largest city, has done an excellent job of training homeless service providers to do an initial assessment for mental illness. Staff in the urban area of Minneapolis-St. Paul function as trainers, coordinators and support staff for shelter staff.

The variety of activities conducted by the homeless projects includes on-call support and assistance 24 hours a day to shelter workers, leasing a transitional house where homeless individuals with mental illness can live until more permanent arrangements can be made, searching local and State parks and abandoned and wooded areas to find homeless people, traveling 16,000 miles in one year to provide outreach and face-to-face training to 14 local law enforcement agencies, maintaining rental contracts with local landlords and screening and matching individuals' needs with available openings, purchasing a $1.00 HUD house for a transitional home, and developing program contracts with the client and their representative, identifying and then providing individual services necessary to maintain

independent living, among many others (see Appendix II for more detailed descriptions of each homeless project). The Polk County Homeless Project in the Red River valley has been a catalyst for bringing stability to a community with cultural diversity issues. A project staff person became the community coordinator for a celebration that was designed to diffuse the racial tensions between the predominantly Hispanic migrant worker homeless population and the white home/farm owners in the community.

Indian Mental Health: Indian mental health project staff work with counties to offer the array of mandated mental health services in a culturally-competent manner. Indian representatives participate in local advisory councils, assisting counties in developing culturally relevant services for Indian children and adults. Indian mental health projects utilize the services of traditional healers as well as services available through county community mental health centers.

During 1990, the Division continued its support of ten Indian Mental Health projects, utilizing 25 percent of the Federal Alcohol, Drug Abuse, and Mental Health Block Grant funds. From January through September of 1990, the projects served a total of 2,721 Indian men, women and children. A total of $379,689 was awarded in 1990 to these projects. (See Appendix II for a description of the individual projects.)

The Indian Mental Health Advisory Council, comprised of representatives from the reservations and urban communities of Minneapolis and Duluth, advises the Department regarding needed Indian mental health policy and service development. This Council meets quarterly.

The Advisory Council identified a high level of unmet mental health service need in Indian communities and an absence of State funding for Indian mental health service development and implementation. A majority of the Minnesota Chippewa Tribes, Sioux Communities, Minnesota Indian Affairs Council and urban Indian Organizations passed resolutions supporting the Indian Mental Health Advisory Council's efforts to seek additional mental health funding. However, no State funding was appropriated to meet these needs during the 1991 legislative session.

Refugee Mental Health: Following the completion of the Refugee Assistance project in July of 1989, the Refugee Mental Health Advisory Council continued to meet during 1990. After a year of struggling with the increasingly complex and challenging mental health issues facing the refugee communities in Minnesota, the Council decided to disband officially as of January, 1991. Despite this decision, the Division continues to provide technical assistance and consultation to members of the refugee consumer and provider communities to share information on State

and federal opportunities for funding, service development, and service expansion. The MHD is currently evaluating the potential use of ADM Block Grant or special project funds to assist this population, and will make a decision about how to best fund mental health services to the refugee population within the next six months.

Children's Services

The 1989 Comprehensive Children's Mental Health Act requires that mental health services for children with severe emotional disturbance be based on individual clinical, cultural, and ethnic needs. Services must be designed and delivered in a culturally-sensitive and age-appropriate manner. In order to assure appropriate services to children with severe emotional disturbance from cultural or racial minority groups, the Comprehensive Children's Mental Health Act was amended to assure that special mental health consultants are used as necessary to assist counties in assessing and providing appropriate treatment for children of cultural or racial minority heritage. Special mental health consultants are mental health practitioners or professionals with special expertise in treating children from a particular cultural or racial minority group.

Applicants for State positions in the children's mental health unit must demonstrate an understanding and ability to work with children and families of differing cultural and ethnic backgrounds. All Division children's services staff have participated in training on cultural competencies and communicate information learned through technical assistance to counties and providers.

Family Community Support Service (FCSS) projects funded by the State were required to demonstrate the provider's understanding of, and ability to plan, develop and implement services that meet the needs of minority children with severe emotional disturbance and their families. These services must be sensitive to cultural and age differences. FCSS outreach services to minority families and communities must take into account local minority cultural norms and values to assure that these services are culturally relevant and accepted by community members.

Case management training includes information about the characteristics of racial and ethnic minority groups and appropriate and culturally-relevant models of services for children and families from minority populations.

c. Description of problems encountered:

The amount of the federal Mental Health Block Grant for FY 1989 was $200,000 less than for FY 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.

It is anticipated that some counties will have difficulty in obtaining required special mental health consultants with expertise in treating children from a particular cultural or racial minority group.

The reduction in federal McKinney Act funds will result in curtailment of the number of grants and persons served soon if funding is not restored to the initial level.

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

A total of $1,495,399 in State funds to support activities of the OBRA-87 ADP were awarded to counties to assist with relocation efforts during the FY 90-91 biennium. Eleven counties applied for these State dollars. For the FY 91-92 biennium, $2.8 million dollars has been allocated to continue their efforts. Thirteen counties have applied for these funds to continue the relocation effort and/or maintain persons already relocated to the community.

In FY 1991, 3,152 homeless individuals with mental health problems received services from mental health providers in eight Minnesota areas with concentrations of homeless people. Minnesota contributed $346,000, a match of $2.87 for every $3.00 of federal funding for the homeless program.

The Department receive legislative approval to expand the housing support pilot projects. The projects served 448 persons in FY 90 utilizing $535,000 for housing support services, with 490 persons served in FY 91 with $549,445 in allocations.

During 1990, the Division continued its support of ten Indian Mental Health projects, utilizing 25 percent of the Federal Alcohol, Drug Abuse, and Mental Health Block Grant funds. From January through September of 1990, the projects served a total of 2,721 Indian men, women and children, with $379,689 awarded to these projects in 1990.

The 1989 Comprehensive Children's Mental Health Act requires that mental health services must be designed and delivered in a culturally-sensitive manner. MHD children's staff have been trained provide technical assistance to counties on cultural competencies. FCSS projects were required to demonstrate the provider's cultural sensitivity to minority children; FCSS outreach services to minority families must take into account local minority cultural norms and values. Case management

training includes information about racial and ethnic minority groups and culturally-relevant models of services for children and their families.

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

a. The original milestone:

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

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

Most of the activities described below relate to systems development rather than directly to the treatment process. However, the former type of involvement on the part of families and consumers is a necessary structure to assure that consumers will have the opportunity to participate in the treatment process, including the larger decisions about the types of programs and services that are to be funded, the ways in which they are designed and delivered, their geographic distribution, and other system issues, as well as the individual's decisions about their own treatment.

State Mental Health Advisory Council: In an effort to assure opportunities for consumer input into all facets of mental health services planning, the State Mental Health Advisory Council and the Subcommittee on Children's Mental Health have a designated task force to participate in the planning process and the development of the State plan. The Advisory Council and its Children's Subcommittee are composed of family members, consumers, providers, elected officials, county commissioners and others. The task force is fairly representative of the larger body.

The Council and Subcommittee have been involved with the Mental Health Division in the implementation of the Comprehensive Mental Health Act in an on-going advisory capacity. The members have monitored the planning process through monthly meetings and as participants of groups to review rule modifications and grant eligibility criteria. About one-half of the Advisory Council is comprised of newly appointed members who assumed responsibilities in August, 1991.

Adult and Children's Mental Health Acts: The Adult and Children's Mental Health Acts require input from consumers and their families, if appropriate, in the provision of mental health treatment services. For example, consumers and families are to be involved in service development. The housing mission statement in the Adult Mental Health Act, the appropriation for

community-based children's mental health services, and task force recommendations on treatment services are consistent with the emphasis throughout the system on consumer involvement and self-determination.

Service Development/Rule Revision: Consumers and families are involved in State planning for service development. This includes involvement in rule revisions advisory committees, using their experiences with this system to guide the revisions. Consumers are also involved with a variety of other activities which can influence service system development. For example, consumers are on each county mental health advisory council and are involved in determining the mental health needs of each county as they prepare their county plans. They are also expected to participate in the development of individual community support, individual service, and individual treatment plans.

Local Advisory Councils (LACs): LACs are often involved in decision-making about local resource allocation. LACs have provided valuable input, usually focusing on prioritizing mental health services, which is crucial to the allocation of resources. LACs also have been decisive in the selection of service provider contracts, and have sometimes played a role in determining the terms of contracts. Counties in which LACs have taken a lead role in this area include Ramsey, Hennepin, Wabasha and Hubbard.

Minnesota statutes require that the State Mental Health Advisory Council and each local advisory council have the representation of consumers, family members, parents of children with emotional disturbance and persons who received child or adolescent mental health services. Methods to facilitate and maintain consumer involvement include the distribution of materials to familiarize LAC members with mental health system issues, frequent updates about information obtained from national conferences regarding trends in the nationwide consumer movement, and others described under "problems" in this section. Staff also encourage LACs to obtain additional input from consumers and family members (only one consumer or family member is mandated) and to avoid an imbalance of provider or county agency representatives, so that true collaboration may be achieved.

Federal Grant to Train Consumers: In 1991, Minnesota was awarded systems improvement grant by NIMH which will be used to train consumer and family members of LACs. Training will be conducted by the Minnesota League of Women Voters, which has been involved in mental health advocacy in Minnesota for several years. The training will provide a more concentrated approach to consumer and family members on LACs than currently provided by MHD staff, with emphasis on recruitment of new members, systems knowledge, advocacy and leadership skills. It is anticipated that one of the staff members hired by the League will be a consumer.

Grants: Since 1989, all State mental health funding Requests for Proposals have encouraged grantees to hire consumers to fill positions under the grant. As a result, the numbers of consumers working in CSP programs in Minnesota has been on the increase, particularly in the metropolitan area, according to anecdotal evidence (privacy requirements preclude systematic collection of data to verify this information).

Fiscal support and program content for consumers to attend the CSP conference: The Division sponsors an annual statewide Community Support Program (CSP) Conference. This three-day conference involves the primary stakeholders in CSP, including consumers, families, county mental health advisory councils, advocacy groups, representatives of minority groups, county staff, providers, regional treatment centers (State hospitals), and the Division. The Division gives a grant to a county to plan and organize the conference. The grant also funds stipends which enable consumers and members of county mental health advisory boards to attend the conference. These stipends enable at least one consumer from each of 87 counties and minority group consumers to attend. The conference contract mandates that consumers be involved in all steps of the planning process.

For the 1991 conference, consumers were involved in the grant award process and the planning committee. Over 25% of all conference presentations were by consumers or family members. The conference program content included presentations on: a new three year training project to empower consumers and family members on participation on county mental health advisory councils; advocates' perspectives on the mental health system; the experience of consumers with case management services; cultural issues of consumers with hearing impairment; issues facing consumers who work in the mental health field; strategies for development of consumer leadership; combating stigma; decent and affordable housing issues; professional/consumer codependency; consumers as parents; the importance of humor in recovery by a consumer theater group; and recovery and rights protection, in a keynote speech by a consumer.

Compulsive Gambling: The MHD makes extensive on-going use of consumers and community-based providers in its management of the Compulsive Gambling Treatment program. This includes a broadly representative 19 member State Advisory Group that advises Division staff on development of the overall compulsive gambling program as well as small task groups to work on specific projects. Advisory Group members are typically involved in more than 20 compulsive gambling program-related meetings a year. Consumers involved with Gamblers Anonymous Groups (G.A.) or Gam-Anon are intentionally represented on the State Advisory Groups for the compulsive gambling treatment program. The DHS contract for a statewide toll-free hotline also stipulates a

responsibility to meet with the G.A. Inter-Group to assist with statewide development of new G.A. and Gam-Anon groups.

Self-Help Projects: In the 1991 legislative session, money was appropriated from the mental health special projects fund for grants to two nonprofit mental health self-help groups. One grant will be used to provide support services to people with major depression. The other grant will provide employability support services to people with mental illness, delivered by people who have or have had a mental illness.

Anoka Alternative Treatment Plans: The Anoka Alternatives Project, initially a one-year pilot project aimed at developing alternatives for clients who would otherwise continue to reside in the Anoka Metro Regional Treatment Center (RTC), used $500,000 for service development and implementation for SFY 1991. In this project, consumers must be involved with developing, and agree to, their alternative treatment plans. 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 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 (see Requirement IV for more detailed information on this project.).

OBRA-87: Persons with mental illness determined to be inappropriately residing in MA-certified nursing facilities are required to be relocated. State funds for relocation are intended to be used to develop new community-based services and/or to enhance and expand upon preexisting services to meet the specific needs of people qualifying for relocation. Funding is flexible and is geared to meet the specific needs of each individual. The individual must be involved in the choice process, including decisions about the residence and about supportive services. Dollars can be used for rental subsidies and the enhancement of an array of wrap-around mental health and social services to assist persons in making the transition into the community.

Housing Support: Ten counties are in their third year of State-funded 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.

Anti-Stigma Campaign: Consumers and their families were involved in the development of anti-stigma materials which were used as the cornerstone of Anti-Stigma Week activities in 1991.

Children's Inpatient and Residential Treatment Services: Consumers participated in task force activities resulting in recommendations for changes in children's screening requirements. Among the changes now required by statute were that the child and the child's family (when appropriate) are to be involved in screening decisions, and appeal mechanisms must be clear to them.

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. (These services are now part of the State's new Children's Community-Based Services grants program.)

c. Description of problems encountered:

Counties express frustration with their efforts to recruit and maintain members on LACs. Several steps have been, or are being, taken by the MHD to ensure consumer/family involvement. These include the development of the systems improvement grant for concentrated training and recruitment of consumer and family LAC members. The MHD staff member assigned to LACs is a consumer, and he emphasizes the importance of consumer input on LACs and occasionally shares personal experiences in an effort to increase the comfort level of consumers present at LAC meetings.

Although there are several local and regional consumer organizations, Minnesota does not yet have a statewide consumer organization to advocate and lobby for consumer concerns.

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

At least one consumer for each of 87 counties attended the CSP conference funded by MHD stipends; consumers were involved in the grant award process, the planning committee, and consumers or their families gave over 25% of all presentations.

LACs have been involved in local resource allocation through participation in prioritizing mental health services, selecting service provider contracts, and sometimes determining the terms of contracts. A systems improvement grant has been obtained which funds training and recruitment of consumer and family LAC members.

The Anoka Alternatives Project required consumer input to develop individually tailored, flexible alternative treatment plans for persons who would otherwise have resided in the Anoka Metro RTC. Relocations from nursing facilities under OBRA-87 are also based on consumer choice with respect to services provided and housing options.

The third year of housing support pilot projects is in process; the project assists people with mental illness to live in housing of their choice, with self-determined support services.

Initial funding for Children's Family Community Support Services encouraged family involvement in service planning, an emphasis which will be continued in the new Children's Community-Based Services grant program.

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

a. The original milestone:

To promote the employment of consumers.

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

Employability services are increasingly viewed as a top priority in the development of a community based system for persons with mental illness. Employability and housing were considered the most important priorities in a 1989 survey of consumer members of local mental health advisory councils. The 1989 Plan submission includes the objective of promoting the employment of consumers.

Historically, the mission of the Division of Rehabilitation Services (DRS), Minnesota Department of Jobs and Training, has been to serve persons with physical and developmental disabilities; only recently was there a recognition of the job-related needs of persons with mental illness. Many counties created their own programs by using money allocated for community support services and other funds. With the passage of the Comprehensive Adult Mental Health Act, all counties were required to provide employability services as part of a full array of CSP services.

While DRS provides services such as job training, job placement and work evaluation, CSPs assist persons with mental illness to improve their employability through activities such as medication management and assistance in developing social interaction skills in the context of employment or volunteer work. 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.

DRS/MHD Interagency Agreement:

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
- on-going 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 MHD will continue to be involved with DRS in the Supported Employment Policy and Advisory Committee meetings and work groups on Quality Assurance, Training and Technical Assistance, and

Local Resource Development for Supported Employment. Both agencies have committed to applying for federal funding for joint projects as those opportunities become available.

In accordance with their Interagency agreement, the Division and DRS are currently collaborating on funding and planning for supported employment demonstration projects for persons with mental illness. (These are the result of a legislative appropriation to DRS and a reallocation of unexpended CSP funds by MDH). These projects are expected to expand the availability of employability services, enhance coordination of services on the local level, and demonstrate the effectiveness of new models of service provision.

Self-Help Project: In 1991, money was appropriated from the mental health special projects fund for grants to two nonprofit charitable mental health self-help groups. One of these grants will be used to provide employability support services to people with mental illness delivered by people who have or have had a mental illness.

Diffusion Network Project: Minnesota is participating in the Diffusion Network Project of the Research and Training Center at the Stout Vocational Rehabilitation Institute at the University of Wisconsin-Stout in Menomonie, Wisconsin. This project, funded by the Rehabilitation Services Administration, is intended to help rehabilitation facilities and consumers establish new programs or expand existing programs to serve persons with serious and persistent mental illness and/or traumatic brain injury. The goal is to help establish community-based programs that lead to community living, employment and social integration. The project's goals are to:

- develop replicable community-based program models, and
- diffuse these program models to other facilities and consumer groups.

The project provides an initial one-time grant to two new programs each year for three years, as well as three years of technical assistance and consultation to help facility staff and consumers to develop and evaluate new programs.

Following an application and selection process, two programs have started. The Duluth-based program will serve adults with serious and persistent mental illness. Eventually, there will be six of these demonstration projects in operation, and they will provide important information on the establishment of quality supported employment program models.

Mental Health Division Grant Announcements: Since 1989, consumers are included in solicitations for hiring, and all Division grant announcements now indicate that applicants are

encouraged to hire consumers. Grant announcements include 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, and used as a cornerstone of the January, 1991 Anti-Stigma Week activities, includes a number of employment themes, including: information about the effects of mental illness on business and the available programs for workers with mental illness; 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 (see Minnesota's 1990 submission for the complete text of the Anti-Stigma campaign package.)

Other employment efforts: The MHD is exploring coordination with academic institutions and technical institutes to train additional vocational rehabilitation specialists, in coordination with the human resource development effort. Employment themes were also part of the annual statewide CSP conference.

c. Description of problems encountered:

While promoting employment of consumers has been a voiced priority of the MHD for several years, little money or staff time has been available to devote to this issue.

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

An employability support services self-help project has been funded.

The MHD and the Division of Rehabilitation Services (DRS) are jointly developing and funding a pilot employability project. The RFP is being distributed in September of 1991. The interagency agreement between MHD and DRS has resulted in better coordination of services to consumers and training for staff in both systems.

REQUIREMENT II. Specifying quantitative targets to be achieved in the implementation of such system, including numbers of individuals with serious mental illness residing in the areas to be served under such system.

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

a. The original milestone:

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

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

This objective was part of the broader State Plan (updated in September, 1989) goal of ensuring the statewide availability, accessibility and provision of services for children and adults as required by the Comprehensive Mental Health Act. The Plan update included two aspects which can be viewed as quantitative targets:

Projected 1990 client counts were provided for each service category, by county, for adults in the 1990 Plan submission. These projections were based on county plans submitted by counties August 1, 1989. Children's plans were not available at that date because of the later due date for county submission of biennial children's mental health plans. (In addition, given the developmental stage of the children's mental health system in Minnesota, projections by counties on numbers of children to be served varied considerably in their accuracy at that time.)

The larger goal referred to above refers to the Comprehensive Mental Health Act. This 1987 State legislation, with subsequent updates, incorporated federal P.L. 99-660 mandates, but the service objectives went far beyond P.L. 99-660. For example, the following is the key paragraph from the State legislation relating to case management:

> Subdivision 1. Availability of case management services. (a) By January 1, 1989, the county board shall provide case management services for all adults with serious and persistent mental illness 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.

State law includes similar mandates for community support programs for adults with serious and persistent mental illness,

case management for children with severe emotional disturbance and family community support services for children with severe emotional disturbance (with later implementation dates for children's services.)

Under Minnesota law, a county's responsibilities are not necessarily fulfilled by meeting the projection in its approved county plan. Case management for persons with serious and persistent mental illness is viewed as such a high priority that counties are expected to reallocate existing resources to serve everyone who needs and accepts the service. (State Medicaid funds are available on an open-ended entitlement basis to fund case management costs of all MA-eligible clients.)

Minnesota recognizes, however, that the definition of "everyone who needs and accepts the service" is influenced by many factors: extent of outreach efforts, location and times of service availability, manner in which service is offered and quality of service provided. One can expect an increase in requests for services as the quality and accessibility of services is improved.

Prevalence Estimates for Adults with Mental Illness: Minnesota has utilized federally funded studies in concluding that 1% of its adult population has serious and persistent mental illness. The National Institute of Mental Health (NIMH) conducted a series of 5 studies across the country in the early 1980s to estimate the prevalence of mental illness in the general population of persons 18 and older. From these studies, prevalence rates nationwide were estimated for the different types of mental illness.

Regier and other researchers estimated that during any one month period, 12.6% of the adult population has a mental illness disorder. Among the more severe disorders, they estimate that .7% of adults have a schizophrenic disorder and 5.1% have an affective disorder such as major depression or manic-depression. The estimated number of adults in Minnesota with these diagnoses is obtained by applying these percentages to the total adult population in 1988. Rates for these disorders appear to vary in prevalence depending on sex and age. Schizophrenia appears to occur equally among men and women, while women have a higher occurrence of affective disorders. Regier et al found that higher rates for most disorders were found among younger respondents, especially for those under 45. Affective disorders tended to have a higher rate up to age 65 before decreasing.

In examining the extent of serious mental disorders in the NIMH report Mental Health, United States, 1987, Goldman and Manderscheid discuss three components: diagnosis, disability and duration. Their review of studies indicates that, even among the more severe mental disorders such as schizophrenia, not all cases

will be chronic or long-term. They cite several national studies which estimate that approximately 800,000 individuals in the community have a severe mental disability and 700,000 more are moderately or partially disabled. This means that approximately .5-1.0 % of the adult population **living in the community** have a disabling mental illness. This estimate excludes adults who are in institutions such as nursing homes or State hospitals/regional treatment centers.

Applying the .5% estimate to Minnesota's adult population means that approximately 15,826 adults have a severe mental illness and 31,652 adults have at least a partially disabling mental illness. The 1% estimate (31,652 persons) would probably be most appropriate for estimating the number of adults with a serious and persistent mental illness living in the community.

However, there have been no reliable data which would indicate the portion of that 1% that "needs and would accept" publicly funded services. In working with individual counties in regard to the major State-funded expansion of community support services during 1988-1990, the Mental Health Division required counties to plan services for at least one-fourth of 1% of the adult population. Tables 1 and 2, found in Appendix I, indicate that, on the average, Minnesota counties provided case management and community support services to about one-fourth of 1% of the adult population in 1990. All indications are that increasing numbers are being served in 1991.

A county-by-county review indicates that, although one-fourth of 1% may have been a realistic objective for many counties, a higher level should and can be expected of other counties, and possibly a lower level may be appropriate for a few counties. It is still not clear, though, to what extent the current difference in numbers served per county is affected by a higher incidence of serious and persistent mental illness, and to what extent it may be affected by local attitudes, outreach efforts, and quality of services offered.

Prevalence Estimates for Children with Emotional Disturbance: Friedman (1987) presents one of the few existing models of targets for service capacity in what he considers to be a balanced system of services for seriously emotionally disturbed children. He notes that the empirical basis for these estimates is weak (nationally), and is likely to remain weak for some time. Given the absence of adequate State and national data bases, his estimates are one of the better sources upon which to initially base planning for services for children and adolescents. Friedman assumes that the prevalence of serious and persistent emotional problems in children and adolescents in between 2 and 5%. Among this group, some receive private mental health services, others receive non-mental health services, and still others receive services through the public sector. He estimates

that the public mental health sector should anticipate a need to provide services for 1% to 2% of children and adolescents, and that only .1% will need residential services because of emotional problems.

Minnesota has a population of approximately four million people, approximately 30% of whom are children and adolescents, for a total of 1,200,000 children and adolescents. Using Friedman's model, the State should anticipate a range of between 1,200 and 2,400 children and adolescents needing services. Minnesota's plan for children's services approximates his recommended capacity levels. For example, the fiscal note for Rule 74 assumed that counties would provide case management to about 1,000 children with serious and persistent mental illness, the category which is equivalent to Minnesota's definition of "severe mental illness" for adults. It assumed that approximately 500 of these children would be covered by Medical Assistance.

The 1989 Comprehensive Children's Mental Health Act legislation, effective July, 1991, included a statewide mandate for case management for children with severe emotional disturbance, which is estimated to include twice as many children as the earlier serious and persistent criteria. Unfortunately, little funding was appropriated for expansion of services until the 1991 legislative session (effective April 1, 1992), nor was MA coverage expanded to include the new population until that date. The low end of Friedman's range approximates the more severely disturbed population of children and adolescents with serious and persistent mental illness, and the high end the less severely disturbed population with severe emotional disturbance. Thus, current funding levels allow for services to the more severely disturbed population, or about 1% of the population of children and adolescents in Minnesota.

A major aspect of Minnesota's efforts has been to ensure that key services are available in each of the State's 87 counties. Since the inception of P.L. 99-660 planning, Minnesota has made major strides in increasing the geographic availability of key mental health services. In 1987, all counties provided some form of case management, but availability was very limited, and no counties had case management services which met State mental health quality standards promulgated in 1989. By 1991, all counties offered case management services meeting these standards. In 1987, a few counties provided limited family community support services, but there was no organized State program, and no dedicated funding for these services. By 1991, 61% of counties provided family community support services. In 1987, 52% of counties offered community support programs for adults with serious and persistent mental illness, compared with 100% of counties in 1991. Emergency 24-hour "hot-line" services were available for adults and children in 61% of counties in 1987; by 1991, all counties offered these services. Table 1 in

Part A, Section 1, of this report illustrates Minnesota's progress in geographic availability.

Figures 1 through 4, in Part A, Section 1, illustrate the changes in distribution of Minnesota's mental health funding resources and their overall growth between 1987 and 1991. Three themes are apparent: 1) The total amount of funding for both adult and children's mental health services has increased substantially; 2) the relative increase in funding for community-based non-residential services has increased dramatically relative to the increase for residential services; and 3) the amount of funding for children's services has increased even more dramatically than for adult services. Overall, they present a picture of a State which is increasingly devoting its resources to community support services and which making substantial headway in the development of a service system for children and adolescents capable of responding to the mental health needs of that population.

Minnesota has provided large increases for both State-operated and community-operated programs (see Figure 1 in Section 1). To a large degree, the increases for State-operated programs are due to substantially improved staffing ratios in Minnesota's State facilities. However, the State-operated increases are not due to increases in the number of persons served in State institutions. For both adults and children, most of the increase in community-operated funding has been directed toward non-residential programs, and has resulted in substantial increases in numbers served in the community.

Table 1 in Appendix I presents a county by county comparison of changes in numbers served and expenditures for CSP adult day treatment services from 1987 to 1990. The total number served increased from 4,475 to 8,014, an 80% increase, and total expenditures increased from about $8,469,516 to $15,985,284, an increase of 89% over the three year period. Table 3 in Appendix I presents county data for adults receiving case management and CSP services by a number of client characteristics (e.g., percent with serious and persistent mental illness), and by the hours spent and hours billed to Medical Assistance.

c. Description of problems encountered:

Minnesota does not have reliable incidence and prevalence data for children. It is hoped that national studies now underway will provide an improved methodology which could be applied to county-specific demographic, social and economic data from the 1990 Census.

The 1991 Legislature did not appropriate any funding related to the new mandate to expand case management services to include children and adolescents with severe emotional disturbance until

1991, nor did it amend MA coverage to include the expanded target population until that date (effective April 1, 1992.)

There is a lack of reliable and consistent data relating to unduplicated counts of people served, especially for 1988 and prior years. Staff have utilized a number of different sources to develop comparable data for 1987 and 1990. In part, this is due to changes in federal and State reporting categories over the past few years. There is still no federal definition of "serious mental illness". The State definition of "serious and persistent mental illness" was developed in 1987 (and implemented in reporting systems in 1989 and 1990), while the State definition of "children with severe emotional disturbance" was developed in 1989 (with reporting initiated in 1990). Therefore, construction of the tables has required some interpretation of data which may have been developed using different reporting categories.

The MHD and the counties have relied on projections of needs and persons served, or mental health plan data rather than individual client data to determine whether service needs are being met. Plan projections are not accurate. Changes in data reporting systems are enhancing the Division's capacity to monitor and evaluate service provision by client and by provider. Further changes are needed to eliminate duplicated counts and to provide accurate assessments of needs; in part, these depend upon decisions made by the Department of Human Services, which will affect the MHD and several other divisions within the Department.

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

Minnesota's funding allocations for services to children, adolescents and their families has improved dramatically since 1987. Currently, the numbers targeted for services approximate Friedman's estimates for a balanced system of services to this population.

Since 1987, Minnesota has provided large increases for both State-operated and community-operated programs. Increases for State-operated programs are largely due to improved staffing ratios, rather than increases in the numbers of persons served in State institutions. For both adults and children, most of the increase in community-operated funding has been directed toward non-residential programs and has resulted in substantial increases in numbers served in the community.

The geographic availability of key mental health services has improved substantially since 1987, with most key services available in all of Minnesota's counties.

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

a. The original milestone:

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

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

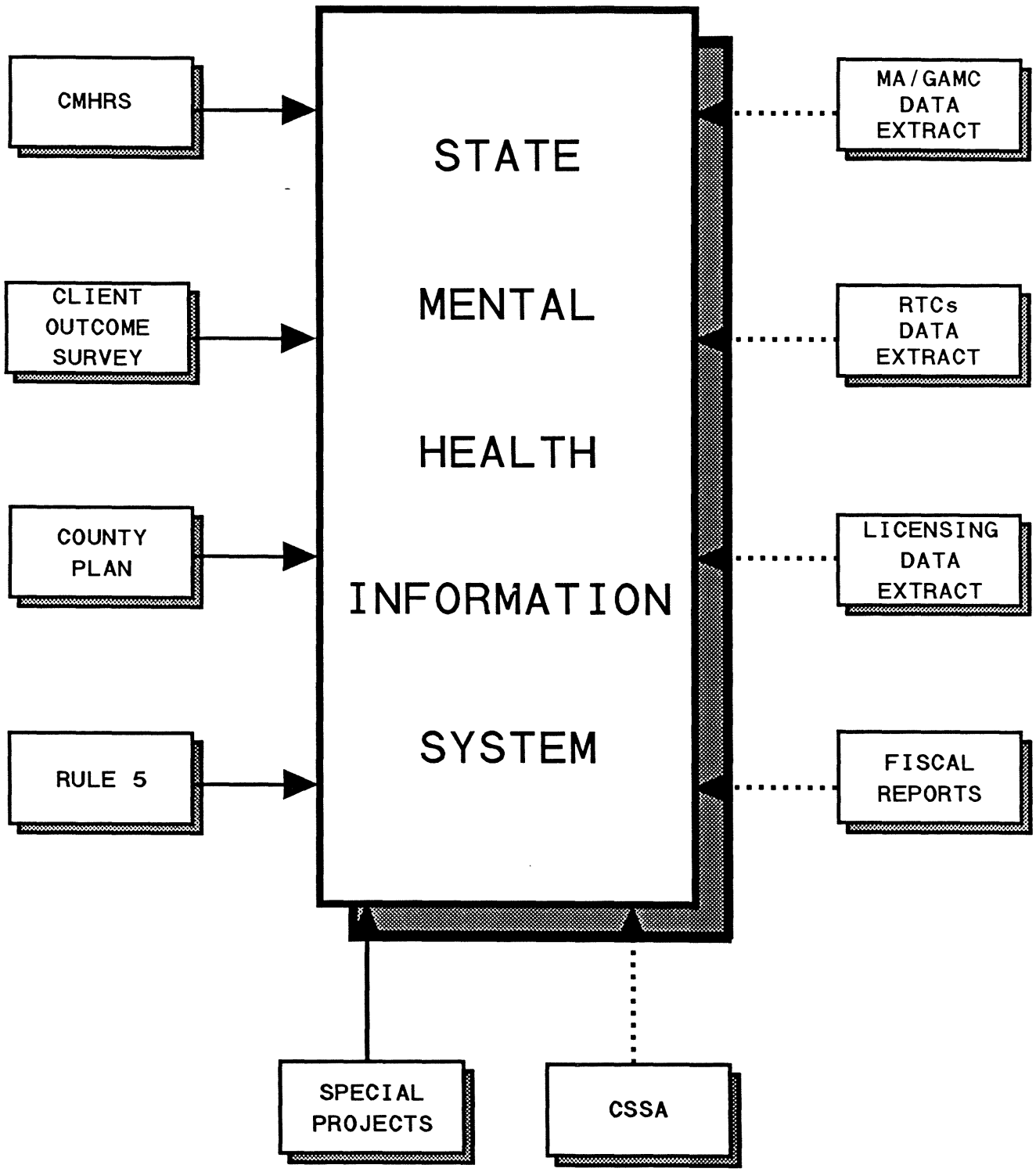
Overview: The MHD's ability to perform its role and meet its responsibilities depends to a large extent on the quality of its information system. The Division has worked with other DHS divisions in developing a new State mental health information system (SMHIS), a major component of which is a reporting system that collects data from community programs operating with public funds.

The State mental health information system is designed to use existing information systems, where feasible, to report on clients served and amount of mental health services received. The Community Mental Health Reporting System (CMHRS) is a component of SMHIS and is designed to produce information not available from other sources. The Division operates an information system composed of a variety of data collection methods, each of which supports a database (see Figure 5, below). The databases are linked to one another through shared data elements such as county, provider, and client identifiers; however, these linkages are only partial at this time (e.g., data about a client in one database cannot always be linked to data about the same client in another database). In the diagram, solid connecting lines indicate dataflows under control of the Division; hashed lines are dataflows under control of other divisions of the Department.

The CMHRS began collecting data as of January, 1989 (one year ahead of the legislative deadline) and produced its first annual reports by April, 1990. All counties have received copies of the system's reports in order to allow local utilization of the data and verification of accuracy. This system will enable more detailed data to flow more efficiently from provider to State, will assist counties in planning for service delivery, and will assist the MHD in evaluating compliance.

Figure 5

DATAFLOWS INTO THE MENTAL HEALTH DIVISION



Legislative Background: Minnesota statutes required the commissioner to report by February 15, 1990 recommended measures to improve the efficiency of mental health funding mechanisms, and to standardize and consolidate fiscal and program reporting. By January 1, 1990, a mental health management information system (CMHRS) was to be established. The development of the reporting system has resulted in significant progress towards the former objective.

During 1990 and 1991, the various components of the SMHIS, described below, were and will continue to be modified to allow greater integration of data from different programs and systems, and to streamline data collection procedures.

Specific Accomplishments: Clarification of State and local information requirements. From July, 1990 through November, 1990, the Division engaged in a structured process of clarifying its information requirements. These requirements were based on current mental health law and State rules, federal reporting requirements, the State mental health plan, the Division's workplan, prior requests for information from the Division, and assessment by staff. Seventeen categories of information requirements were identified, each containing a set of specific requirements. Priority of need was established through a scoring technique administered to staff, which defined "need" in terms of importance to the Division in performance of its role. Priority scores were highest in the following categories.

- program/service effectiveness in meeting the needs of clients.
- program/service provision that meets quality standards.
- county provision of mandated services to their residents.
- adequate levels of funding to programs/counties to support quality services.
- county effectiveness in meeting the level of need for programs/services
- program/service provision to client groups for whom they are intended.

Although each of the seventeen categories of information requirements were addressed by at least one method of data collection, many specific requirements could not be met by the existing information system. A particular area of "information deficit" was that of program effectiveness, which was assessed highest in importance.

In a series of meetings with county social services and mental health directors to discuss county planning, some of the information requirements of counties were clarified. Projections of the number of clients who would receive specific services were regarded as useless in the local planning process, while

projections of expenditures were viewed as important for budgeting and for establishing levels of county responsibility and accountability. Better estimates of need for services among county populations, especially estimates that could adjust for differences in population structures, was identified as a type of information needed on the local level.

Related to the effort to clarify information requirements was a restructuring of the State's mental health services taxonomy. Service definitions were revised or added, providing the Division with more extensive and detailed data on service utilization.

Emphasis on performance data. Review of information requirements (described above) and the experience of State and county staff in preparing and approving local mental health plans, raised questions about the usefulness of plan-based data. Collection and use of data about actual occurrence was viewed as preferable to the emphasis on projections. This represented a shift from use of local plans to use of performance-based data collection methods as the means to determine compliance with State law and rules. The Community Mental Health Reporting System (CMHRS), and other systems capable of providing client-specific data on service utilization, became the primary means of producing information by which to gauge the development of county service delivery systems and their level of compliance with law and rules.

Integration of data collection methods. A variety of data collection methods have been developed over the years to carry out particular functions of the Division and the Department. The emphasis on performance data in assessing mental health service delivery systems, along with an effort to reduce duplicative or unnecessary paper reports, coincided with a plan to integrate existing data collection methods as much as possible. A considerable amount of integration has been accomplished. The CMHRS serves as the core of a new State Mental Health Information System (SMHIS) in which client-specific data from community programs are reported directly to the Division and are enhanced by data extracted from the Department's Medical Assistance Billing System and the Regional Treatment Center Reimbursements System. To this client-specific database are added county- and provider-specific cost data, plan data, and grant performance (program goals) data. However, these linkages are still only partial. Development of a statewide client identifier code and other improvements to system integration are needed. (See Summary of Systems Planning section, below.)

Implementation of national data standards in provider systems. The Division received a three year NIMH grant, from October, 1989 through September, 1992, to help organizations that provide mental health services make improvements in their data systems (the Mental Health Statistics Improvement Project, or

MSHIP). Improvements include installation of national data standards and use of these standards to serve local management decision-making. County operated and county contracted community mental health centers and freestanding community support programs are involved in this project.

Fourteen community mental health centers have participated in the project. Five of these centers will have implemented the standards by the end of 1991; at least two more are expected to implement during 1992. In addition to implementing MHSIP standards at specific sites, the Division has presented the rationale for and the benefits of these standards at provider conferences, has developed management reports for use with the standards, and has published a document describing the status of data systems among Minnesota CMHCs and the ways in which these standards can be used to improve systems performance. Several CMHCs have implemented the standards independent of the grant-funded project.

Procedures for data quality control. In order to ensure that information produced from the SMHIS is reliable, the Division has implemented several procedures for quality control. Data reported by service providers are first screened by automated edit programs. Records not passing these edits are returned to the provider for correction. The Division provides a PC-based "pre-editing" computer program to reporting agencies that allows them to prescreen records prior to submission. The Division also produces county and provider summary reports after each reporting cycle, which allow local agencies to review reported data for errors and omissions. A new quality assurance database has been developed within the Division to track receipt and processing of reports from the over 300 programs that submit data through the CMHRS. Finally, linkages to the Medical Assistance system allow records from community programs to be cross-verified with MA claims, where appropriate, uncovering missing records and cases where data may not agree.

Summary of Data System Planning: State-operated data systems will be further enhanced, allowing a broader range of information requirements to be met. Specifically, the CMHRS will be expanded to allow better client tracking; human resources data collection will be added to the SMHIS system in coordination with the Licensing Division; a method for determining client outcomes in community support programs will be tested and implemented; the community programs data system will be further integrated with the Medical Assistance, regional treatment center, licensing, and financial reporting systems of the Department; national data standards will be implemented in more provider data systems; and special efforts will be made to further improve the completeness and accuracy of data that are collected.

Specific Plans:

Expansion of CMHRS dataset. The Community Mental Health Reporting System (CMHRS) is the method by which client-specific data are collected from community-based provider organizations. This system must be expanded to allow more accurate client tracking, removal of duplication from client counts in some reports, improvement to provider identification, and computation of length of stay statistics. The following data elements will be considered for inclusion: statewide client identifier code, license number for provider organizations, client admission and discharge dates, client residential and living arrangements, and Hispanic origin identifiers.

Development of a statewide client identifier code is expected to require the greatest effort, and will provide the greatest boost in capability to the CMHRS. Two approaches are under consideration: a) waiting for revival of the Department's design for a department-wide client identifier system that would allow linkage of data across mental health, social services, chemical dependency, and family support (income maintenance) programs; and b) use of all or part of the client's social security number. The latter approach offers an earlier, less costly, and less technologically burdensome solution; the former offers a greater range of linkage and may at some time become mandated by the Department.

Improved Integration of Systems. Integration of various databases now used by the Division will be improved. The most significant improvements will derive from development of a statewide client identifier code. This code will allow linkages among databases with client-specific records. Such linkages will prevent duplicative data collection and enable the State Mental Health Information System to produce a wider range of information.
Linkage of data at the provider level will be improved through the addition of a licensing number to the CMHRS and organizational and human resources data to the mental health licensing instrument. These linkages will establish the foundation for future provider-specific analyses.

At the county level, a new set of financial reports, implemented by the Financial Management Division, will provide the Division with financial data that can be linked to program data in the Division's other databases. This will add the critical cost dimension to the databases.

Finally, the Division will look at ways in which the current linkages with the Medical Assistance Billing System and the RTC Reimbursements System can be improved. This might include an expanded set of data elements transferred into the SMHIS, addition of the client MA ID number to the CMHRS, etc. The Division will also look at establishing a data transfer or linkage mechanism with the Department's SSI/SSDI database.

Expanded use of national data standards. The Division will continue to implement MHSIP national data standards in provider organizations through a NIMH grant. By the end of 1992, one-third to one-half of the State's community mental health centers will have implemented the standards. Several of these centers will participate in the CSP client outcomes pilot study, adding the dimension of "effects" to the MHSIP model in Minnesota.

Data Quality Assurance Procedures. The Division will expand and improve data quality assurance procedures in those data collection methods which it operates, primarily the CMHRS. Complete sets of records submitted by community mental health centers will be reported back to these centers to allow them to verify complete and accurate receipt of their records by the Division. (Provider reports are funneled through counties and occasionally fail to reach the Division.) An expanded set of provider summary reports will also be produced, allowing the providers another means of verifying reports.

Division staff will work with the County Monitoring Division to add data validation techniques to monitoring procedures, and with the other divisions in the Department that collect county data to develop more quality assurance procedures. Data quality in the primary system for reporting county data (CSIS) will be an area of focus, as will complete reporting of emergency services.

c. Description of problems encountered:

The lack of statewide individual client identifier codes has resulted in duplicated client counts. Uncertainty about Department plans for mandating client identifier codes across human service systems makes it somewhat difficult to plan for mental health client codes.

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

Since January of 1990, State-operated data systems have been improved through:

- Clearer identification of State and local information requirements;
- Shifting the emphasis of data collection away from local plans toward performance data;
- Integration of various methods of data collection into a single State mental health information system;
- Implementation of national data standards in systems of provider agencies;
- Implementation of procedures for data quality control;

- Production of State reports that summarize service utilization and the adequacy of service delivery at the county and provider levels; and
- Development of methods for the acquisition of information about program effectiveness.

These improvements have resulted in an increased capacity of the MHD to meet more of its own information requirements as well as those of other agencies. Counties and providers have recognized the importance of producing reliable and accurate information that can be shared statewide. They have further benefitted through the reduction of burdensome statistical reporting that the SMHIS has permitted.

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

a. The original milestone:

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:

Maintenance of effective computer resources is required in order for the Division to manage information about service provision and to free staff for consultation with counties and providers.

Computers and Databases Available to Division Staff: A network of 35 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. Support for this system is provided by the Information Policy and Service Division of the Department and by several knowledgeable MHD staff.

Staff now have available to them extract databases from the SMHIS containing records specific to their areas of responsibility. Menu-driven PC programs enable quick and easy access to these databases, in the form of statistics, tables, and graphs.

Mental Health Statistics Improvement Project: This project is funded by a three year NIMH grant to help organizations that provide mental health services make improvements in their data systems, and to assist the Division in requiring more data from providers. The grant has assisted the MHD in defining its information requirements and data improvements, and in determining the best methods of collecting data. It has also aided in development of an integrated SMHIS, including computer programs for quality control.

c. Description of problems encountered:

Problems encountered have been typical for development and maintenance of computerized systems.

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

MHD paperwork has been reduced through use of e-mail and wordprocessing software, productivity has increased, communications have improved, and turnaround time on reports has been reduced.

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

a. The original milestone:

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 State Mental Health Information System (SMHIS) 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 administers Rule 12 (for Rule 36 residential treatment programs), Rule 14 (community support programs), federal block grant, and special projects grants separately. Children's Community-Based Mental Health grants will be an additional program starting in April, 1992.

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 claims 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 the MHD with ongoing data on services and clients receiving treatment in the RTCs.

Financial Reports: A large number of funding sources can, under certain circumstances, be used to pay for mental health services.

Most of these sources are not specific to mental health. Collecting data from programs funded by these services, such as Medical Assistance, involves extracting the mental health datasets from the larger system.

Family support and medical programs within DHS are in the midst of major systems developments. These new automated systems will provide the reporting functions needed by the MHD, 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 the direction of the MHD.

RTC mental health units are administered by the Department of Human Services, 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. However, the recent Departmental reorganization, which places responsibility for both the RTCs and community mental health services under the same assistant commissioner, should facilitate sharing of data.

c. Description of problems encountered:

Possibilities for simplification and consolidation of fiscal reports are confined by the requirements of the various funding sources. Lack of statewide identifier codes for clients and providers have rendered linkages among systems incomplete, hindering client tracking and program evaluation efforts.

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

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.

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

a. The original milestone:

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

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

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

Human Resource Data Collection: The Division holds two NIMH funded grants that are active in establishing a human resource data system. These are the Mental Health Human Resource Development Capacity Building Project (HRD Project) and the Mental Health Statistics Improvement Program Project (MHSIP Project).

Human resource data is viewed as a vital part of a complete mental health data system. It serves as a link in the evaluation of service outcomes through client, service event, agency and human resource data. With these four pieces intact, Division staff can begin to support answers to basic questions such as, "Who was served in what way by whom?" "What kind of staff person produces the best client outcomes in a given service setting?" "Which services are suffering from high turnover or chronically vacant positions?"

During the past year, the HRD Project reviewed the current available sources of human resource data. Upon completing this review, it was clear that available data sources could not be combined into any kind of comprehensive data system that complied with NIMH promulgated standards for mental health service data systems.

The HRD and MHSIP Projects and the Division's Technical Support Unit teamed together to develop a mechanism for collecting human resource data. The projects plan to develop a machine readable human resource data collection instrument that providers could complete on an annual basis. The Department of Human Services has a scanner in its Licensing Division that is available to enter this data into a database. This human resource data will be linked to service event data through a staff ID number and to agency data through the Licensing Division's agency ID codes.

c. Description of problems encountered:

Currently available human resource data cannot be combined into a comprehensive data system meeting NIMH standards.

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

Plans are now being developed to incorporate some essential human resource data elements into the Community Mental Health Reporting System, the State's service event data collection system. This

means that these human resource data fields will be updated every six months and tied to service event data in a way that minimizes error. The machine readable form will be used along with stratified sampling methods to fill in other human resource data needs for service planning and other needs.

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

a. The original milestone:

To enhance Division's capacity to evaluate service provision.

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

Through a structured process, the Division clarified its information requirements and established priority of need, which was defined in terms of importance to the Division in performance of its role. The top priority was program effectiveness in meeting the needs of clients. In order to evaluate whether needs are being met, however, valid data about the prevalence of mental illness, as well as good estimates about the need for publicly funded services among those with mental illness, need to be available.

The Division estimated the adult prevalence rates of serious and persistent mental illness to be 1% of the adult population. Applying these estimates to Minnesota's adult population means that approximately 15,826 adults have a severe mental illness and 31,652 adults have at least a partially disabling mental illness. The latter figure would probably be most appropriate for estimating the number of adults with serious and persistent mental illness living in the community.

Although the prevalence of mental disorders can be estimated, public mental health service use does not necessarily follow its occurrence. For a variety of reasons, persons with the disorder do not seek mental health care, seek care from someone other than a mental health professional, or seek privately funded mental health services. The Division required counties to plan case management and CSP services for a minimum of .25 percent of the adult population, or slightly less than 8,000 adults with serious and persistent mental illness.

<u>Methods for Acquiring Effectiveness Data:</u> Planned changes which will enhance the Division's capacity to evaluate service provision include: expansion of the system for collecting client and services information from service providers to allow better client tracking; the addition of human resources data collection to the CMHRS system; further integration of the CMHRS community programs data system with the Medical Assistance, regional

treatment center, licensing, and financial reporting systems of the Department; and further implementation of national data standards in provider data systems; and testing and implementation of a method for determining client outcomes in community support programs.

The Division is working with counties to enhance their capacity to evaluate their own services. The MHD has required them to design their own evaluation plans, in addition to required participation in DHS' evaluations. Adult case management services and all grants funded through the Department, including Rule 12/36 and Rule 14 services, as well as all special project and other grants, are targeted for county-level evaluation.

With the help of a technical assistance grant from NIMH, Division staff have developed a client satisfaction and a quality of life questionnaire for measuring client outcomes in community support programs. Both instruments are to be completed by the consumer. The instruments will be refined through an initial assessment of validity and reliability, and then field-tested. The initial assessment of validity and reliability will be conducted at selected community mental health centers with their CSP clients. The instruments will be used among those CSPs that support clients on an ongoing basis (i.e., that do not have program "graduates"). Both instruments will be assessed for face validity by program staff and selected clients "key informants". The quality of life (QOL) instrument will be assessed for concurrent validity, using other instruments used at the centers and program staff evaluations of the client's QOL as criteria against which to assess the client's responses to this instrument. In addition, QOLs will be sent to case managers for confirmation of QOL results. Individual items on the instruments which do not correlate highly with criterion measures will be eliminated. Test-retest reliability will be computed on a reformatted version of both instruments with a time interval of one week between administrations. These technical studies are expected to be completed in about January of 1992.

Preliminary field-testing will be conducted this summer with a modified instrument in the Anoka Alternatives Program to identify questions which may be particularly confusing and to alert staff to problems in response rate and other issues. Actual field testing will follow the technical analysis and revision of questions from the validity and reliability phase, with approximately 400 clients. Field testing is expected to be completed by the end of 1992. Data analysis will be statewide, rather than provider-specific, and will attempt to determine whether 1) clients of CSPs regard these programs as effective, and 2) the information obtained can be combined with rehospitalization data to provide a good, rounded set of information on program effectiveness which can be used statewide.

c. Description of problems encountered:

Incomplete client tracking capability and inability to track organizational data across systems has hindered efforts to evaluate service provision.

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

Since January of 1990, State-operated data systems have been improved through clearer identification of State and local information requirements, shifting the emphasis of data collection away from local plans toward performance data, integration of various methods of data collection into a single State mental health information system, implementation of national data standards in systems of provider agencies, implementation of procedures for data quality control, production of State reports that summarize service utilization and the adequacy of service delivery at the county and provider levels, and development of methods for the acquisition of information about program effectiveness. These improvements have resulted in an increased capacity of the MHD to meet more of its own information requirements, including the ability to evaluate service provision.

An instrument for measuring client outcomes in community support programs has been developed. This is a basic step in the development of a statistical information system which will indicate program effectiveness. Plans are in place to test the instrument for statewide application.

The Community Mental Health Reporting System (CMHRS), and other systems capable of providing client-specific data on service utilization, are now the primary means of producing information by which to gauge the development of county service delivery systems and their level of compliance with law and rules, rather than reviews of county plans.

REQUIREMENT III. Describing services, available treatment options, and available resources (including federal, state, and local public services and resources, and to the extent practicable, private services and resources) to be provided for individuals with serious mental illness to enable them to gain access to services, including treatment, prevention, and rehabilitation services.

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

a. The original milestone:

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

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

Mandates to Counties to Ensure Access to Services: In a county-administered state-supervised system such as Minnesota, one of the traditional methods of ensuring that minimum services are available everywhere in the State is through legislative and administrative mandates to counties. The mandate to provide services, however, frequently lacks the funding needed to pay for that service. This obviously puts counties in a difficult position: the service is needed and wanted but the only resource available is county property tax dollars. In an effort to begin a more rational process of introducing mandates for services, the 1991 Minnesota Legislature enacted a bill that:

- requires the Department of Human Services to identify social service program requirements that are an administrative burden, social service program requirements lacking adequate State and local funding, and unmet local needs;
- permits the Department of Human Services to reduce unnecessary administrative rule costs and complexity;
- permits the Department of Human Services to establish demonstration projects to test alternatives to the current State administrative requirements; and
- provides a method through which counties in fiscal distress can justify a reduced level of services.

Arriving at a method for reducing services that was acceptable to both counties and advocates required a great deal of negotiation. It was acknowledged that many counties were on the brink of bankruptcy while others still enjoyed surpluses. It was also understood that counties experiencing fiscal distress needed a mechanism to reduce their level of effort in an equitable way, while still maintaining "essential services". Until 1991 State law had simply stated that counties had no obligation to provide

mental health services beyond the funds available. To address this problem, the Legislature established the following criteria:

- the county must demonstrate reasonable efforts to comply with all requirements, including maintenance of spending effort, applying for available State and federal funding, and being able to show that projected spending would exceed the monies available for social services;

- the county must agree to provide a minimum array of services required by federal or State statute, including child and adult protection, emergency and crisis services, individual needs assessments, case management services, family community support services for children with severe emotional disturbance, and licensure of family foster homes and family day care homes;

- the county must amend its biennial social services plan (including the mental health segments) to reflect the rule requirements with which the county will not comply and how the county intends to provide the minimum array of services;

- before denying, reducing or terminating services to any individual because of fiscal limitations, the county must both amend the individual's service plan and notify the individual of the proposed change, giving that individual the opportunity to meet with the county to discuss the problem and to appeal the county's decision; and

- the Department must consider the county's level of tax effort and the resources allocated for social services in determining the amount of any fine levied on a county for non-compliance with State requirements.

By establishing specific criteria for a county to meet before a reduction in services could be authorized, the Legislature was able to build in both minimal service requirements and client protection. In addition simplification of county planning requirements should permit counties to spend a greater percentage of time in service rather than administrative functions when the legislative changes are implemented in the 1994-95 State planning cycle.

Planning for Minorities and Persons with Dual Diagnoses. In developing county plans, the Division instructed counties having 100 or more adults or children in their population base qualifying as ethnic or racial minorities to indicate the steps that they would take to assure access to services by persons from these underserved groups (e.g., a county with 100 or more Native American adults would need to specify how they would assure access to traditionally underutilized mental health services by this population, including such means as special media and/or

outreach attempts, establishing linkages with tribal organizations or leaders, using Native American consultants or translators, etc.) All counties were required to address service provision to children and adults with dual diagnoses (chemical dependency, developmental disabilities, or hearing impaired diagnoses together with mental illness) in their plans. In addition, counties are now required to use special mental health consultants in addressing the mental health needs of minority children.

Needs Assessment, Identification and Service Evaluation: Access to services depends in part upon appropriate 1) local identification of community needs so as to plan for the array of services needed within each county, 2) assessment of individual needs so that services, treatments and placements will be appropriate, comprehensive and will maximize independence and local, community-based service options, and 3) evaluation of service effectiveness so as to determine whether the services available and/or selected met these criteria. The DHS has made progress in all of these areas.

LACs are now required to be involved in the identification of local needs as part of the local planning process. (Previously, "sign-off" on the entire county plan by the chair of the LAC was required. However, this process did not uniformly assure that the LACs were, in fact, actively involved in its development. Some advocates complain that the statutory change has not necessarily enhanced LAC participation. Clearly, this is an issue with which counties and LACs still struggle.) This additional perspective should assist in the identification of local needs, although it does not obviate the need for local prevalence data, which, as noted elsewhere in this document, has been extrapolated for adults from federal studies, but which is less known for children and adolescents. However, federal estimates from NIMH funded studies have been used to determine service targets (see Requirement II).

Second, it is expected the new screening mechanisms, together with requirements assuring compliance criteria for admission, continued stay and discharge will help reduce excessive costs and time involved due to duplicative processes while at the same time standardize care requirements.

Third, Division statistical information systems have been improved considerably, so that individual client by provider by service information can be collected, and fed back to the counties. This provides one form of evaluation of service effectiveness. In addition, a client outcome instrument has been developed and will soon be evaluated and field tested, which is expected to be useful in evaluating CSP effectiveness.

Community Support Services: Rule 15 is the program standards rule for community support services for persons with serious and persistent mental illness. Rule 15 will provide consistent definitions of mandated CSP services to be provided in each county, orientation and annual training of CSP staff, and individual service plans for CSP clients. It is expected that this rule will be promulgated by January 1, 1992.

Case Management: The Case Management Implementation Group has assisted the Division in efforts to increase the availability and accessibility of case management services to persons with serious and persistent mental illness. The group was established by the MHD in response to the need for a forum made up of practitioners and county administrators to examine issues related to case management and to find solutions to them. During this planning period, the Case Management Implementation Group has worked on the following:

- Development of a survey of county case management practices. The survey was administered to local agencies in September 1990 in an effort to obtain primary information about administration of the program and specific information about amounts of time spent by case managers in various activities. The Division analyzed the data and presented a brief summary of initial conclusions and supporting data to the group.

- Review of a draft of the Individual Community Support Plan developed by a subcommittee of the group made up of six local agency case managers.

- Monitoring providers of case management services. The monitoring project has been completed by the Department's Social Services Monitoring Division. Upon completion of data analysis, the Division is sharing these data with the implementation group in order to:

    - Assess local compliance with laws and rules,
    - Establish technical assistance and training materials and methods for local providers, and
    - Develop appropriate Rule 74 (case management) revisions, by assessing:
        - The clinical basis for the proposed changes;
        - Local responsiveness to the revised case management rule provisions; and
        - The fiscal impact of revisions on county budgets.

The group has reviewed preliminary drafts of amendments to the rule developed by the Health Care Management Division and MHD, to provide more flexibility and ease of administration by local agencies.

Anoka Alternatives: The Anoka Alternatives Project was initially a one-year pilot project to develop alternatives for clients who would otherwise continue to reside in a metropolitan area RTC. Funding of $500,000 for service development and implementation was appropriated for SFY 1991 for service development and implementation. Counties developed flexible, individually tailored treatment plans which provide the services needed for each person, including mechanisms for support for individual preferences as to where services should be delivered, assertive intervention and support plans on behalf of the individual, and efforts to work with and support community members such as landlords, employers and family or friends as well as the individual with mental illness. These methods were designed to maximize access to mental health services for persons considered difficult to treat in their home community. The project has been considerably more successful than envisioned, serving many more persons than anticipated. Due to this success, the 1991 Legislature appropriated $600,000 in new funding for the biennium.

OBRA Alternative Disposition Plans: The PASARR portion of PL 100-203 requires states to relocate residents of MA-certified nursing facilities who have a mental illness and who have been determined to be inappropriately residing in the facility. States were permitted to submit Alternative Disposition Plans (ADPs) that identified the numbers of persons and the timelines states would follow to relocate these persons. Minnesota submitted a plan in 1989. A total of 143 residents will require relocation; all relocations are expected to be completed by June, 1992.

A total of $1,495,399 in State funds to support ADP activities were awarded to counties to assist with relocation efforts during the FY 90-91 biennium. Eleven counties with financial responsibility for residents currently found to need relocation applied for these State dollars. In the FY 91-92 biennium, $2.8 million dollars was allocated to continue this effort. Thirteen counties have applied for these funds to continue the relocation effort and/or to maintain persons already relocated to the community.

These funds, now part of the Division's on-going budget base, are being used to develop new community-based services and/or to enhance and expand existing services to meet the specific needs of this population. Funding is flexible and is geared to meet the specific needs of each individual. For example, dollars can be used for rental subsidies and the enhancement of an array of mental health and social services to assist the individual with transition to community settings. It is projected that the cost of individual ADPs will average about $1,200 per person per month, including room and board. Development of more services

for these individuals is expected to enhance the capacity of the State's overall mental health system as well.

Older Adults: Beginning in 1988, eight demonstration projects were established to address the needs of older adults, including reducing or eliminating barriers to mental health services for older adults through use of outreach activities, and providing coordinated, appropriate networks of mental health services for older adults. Projects varied, but frequent components included peer counseling programs, in home visits to initiate assistance with services, news coverage to make the services more acceptable, and advisory committees with strong senior citizen representation, which later became strong advocates for continuation of the projects. These project components were designed to enhance access to needed mental health services among a group which traditionally underutilizes such services. Several projects developed additional funding sources so that the projects will continue once the demonstration funds are no longer available for this effort.

Homeless Persons: In 1987, prior to the availability of McKinney Act funding, the Legislature appropriated $350,000 for Minnesota's three largest cities (Minneapolis, St. Paul and Duluth) to provide mental health services for homeless persons with serious and persistent mental illness. With the FY 1987 and FY 1988 McKinney Act funds, the ability to assist homeless persons with mental illness was expanded to five more communities, resulting in a small mental health service network which is accessed by both homeless service providers and persons who are homeless. In 1991, Minnesota contributed $346,000, a match of $2.87 for every $3.00 of federal funding for the homeless program.

Many of the essential services provided by the projects improve access to the mental health service system for persons who are homeless. Outreach is particularly important in improving access to this group, which has been difficult to reach, and outreach activities were also the most common activity engaged in by the projects, comprising 41% of all project activities. Practical support where it is most needed can also enhance access; housing support comprised 12% activities for persons who are homeless. Finally, case management may be particularly useful for persons typically disaffiliated with the traditional service system, since they may require interventions in multiple service systems. Case management comprised 13% of project activities. Direct provision of mental health services comprised 25% of activities engaged in across the various homeless projects.

Indian Mental Health Projects: Using 25% of its ADM service funding, the MHD continues to work closely with Indian communities to expand the array of mental health services for Indian adults and children. Access to mental health services is

enhanced through use of culturally appropriate services and assistance in building county-tribal linkages in the provision of needed mental health services.

Children's Community-Based Mental Health Services: The Comprehensive Children's Mental Health Act stresses the need for pooled funding across service systems. County mental health agencies are strongly encouraged to collaborate with education, health, and corrections agencies in funding wrap-around services for children and their families. The eight children's mental health demonstration project counties have been successful in pooling funding with other local agencies for service development, especially with regard to day treatment services. Given the budgetary constraints on new funding, such efforts are particularly promising in enhancing access to services.

By SFY 1993, $3.7 million in State funds will be available for provision of children's community-based mental health services through the Department of Human Services. Table 7 in Requirement V indicates 1990 funding used for children's mental health service provision across State agencies, including Mental Health, Medical Assistance, Education, and Corrections.

Children's Health Plan: Minnesota was the first state in the nation to offer low cost health insurance for children, and it is still unique in including outpatient mental health coverage. For $25 per year, children under the age of 18 who are not eligible for Medical Assistance or otherwise insured for outpatient services, and who are in families with income at or below 185 percent of the federal poverty level, can receive comprehensive primary and preventive care services under the Minnesota Children's Health Plan. In addition to doctor and clinic services, prescription drugs, vision care and eyeglasses and outpatient hospital services, the Plan covers up to $1,000 per child per benefit year for diagnostic mental health testing and assessment services and outpatient, group, family and individual psychotherapy. More than 27,000 children have been served by the Children's Health Plan in approximately two and one-half years; with the age expansion to age 18 on January 1, 1991, the number of applications has more than doubled. The Children's Health Plan also offers wrap-around coverage to the State's Services for Children with Handicaps Program. Through the Combined Program, primary and preventive care services, including outpatient mental health services, are offered to children who meet the Children's Health Plan eligibility criteria and who would otherwise be restricted to services specifically related to their physical handicapping condition.

c. Description of problems encountered:

Counties have been slow to begin utilizing ADP funding, most probably because such flexible funding requires adoption of new service delivery models.

Some advocates continue to fear that changed county planning requirements will weaken State authority to mandate appropriate service development and delivery.

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

Legislative changes in county mandates for services resulted in mechanisms to ensure essential services, to promote reasonable efforts to acquire funding for services on the part of the county, and to reduce inequitable burdens upon counties with widely disparate resources.

The Rule 15 revision process is well underway. It will provide consistent definitions of mandated CSP services to be provided in each county, and is expected to be promulgated by January 1, 1992.

Rule 74 case management revisions are underway for both adult and children's services, with an emergency rule to be promulgated by January, 1992.

In the FY 91-92 biennium, $2.8 million dollars was allocated to continue the OBRA-87 ADPs. Thirteen counties have applied for these funds to continue the relocation effort and/or maintain persons already relocated to the community. An appropriation of $600,000 was received for continuation of the Anoka Alternatives project to expand services for difficult-to-serve persons in the community.

Three projects for older adults developed alternative funding sources in order to continue projects that Advisory Committees viewed as highly successful in recruiting and serving older adults.

Children's mental health services received increased funding during the 1991 legislative session, which will permit expanded service availability during the current biennium. The increase occurred despite a "hold-the-line" approach to appropriations in many departments.

Minnesota's Children's Health Plan is unique in offering low cost health insurance for children which includes outpatient mental health coverage. More than 27,000 children have been served by the Plan, and with the age expansion to age 18 on January 1, 1991, applications have more than doubled.

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:

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:

Adult Screening for Inpatient and Residential Treatment: Minnesota Statutes required the establishment 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 adults admitted to residential treatment, acute care hospital inpatient treatment, and regional treatment center inpatient treatment. That group, established in August, 1989, submitted a preliminary recommendation as part of the Division's 1990 Report to the Legislature.

In 1990, members modified their previous recommendation, concluding that screening as a distinct service should not be mandated by the State due to the costs of service implementation, duplication with other processes, such as hospital pre-admission certification, and the clinical complexity of the process. Instead, the task force recommended that the functions of screening be included in several ongoing activities. In addition, members felt that screening functions, while not a separate service, should be responsive clinically to both emergency and non-emergency situations. See Requirement VI for a full listing of task force recommendations.

In 1991, the Department obtained statutory changes to eliminate screening as a separate service within the adult mental health system and to add requirements for contractual agreements to assure compliance with admission, continued stay, and discharge criteria for publicly funded services. (Inpatient services funded under General Assistance Medical Care and Medical Assistance would not be subject to these contractual requirements because these services are not arranged or directly funded through the county.)

Compulsive Gambling Assessments: State statutes require that DHS develop a rule by 1993 to provide the guidelines needed to implement the provision that probation officers include a compulsive gambling screen as part of the pre-sentence investigation for specified felon convictions. By February 1992,

the DHS Mental Health Division must also submit a report to the Legislature on progress toward meeting the rule requirement. The Mental Health Division will involve the Department of Corrections in the development of this new rule.

Homeless Persons: During 1991, 3,152 homeless individuals with mental health problems received services from mental health providers in eight Minnesota areas where homeless people congregate. Outreach, considered one of the essential services provided by the homeless projects, comprised 41% of project activities, and have been successful in engaging the mental health provider system in providing services to the persons who are the hardest to find and maintain contact. Many projects have been successful in providing training for, or directly providing, mental health assessments for homeless persons.

OBRA-87: 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 physical 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 pre-admission teams who then refer those applicants in need of further evaluation to the county local mental health authority. Approximately 20,000 persons have received Level I assessments. Prospective residents in need of mental health diagnostic assessments (Level II assessments) are then referred to an independent mental health professional. Final determination for nursing facility 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 indicated, mental health services for persons with a major mental illness who require nursing facility care will be recommended to the nursing facility or attending physician for further action. These individuals are being reviewed annually, at a minimum, to assure that their mental health needs are being addressed. Approximately 2,000 persons have received Level II Screening as a result of the PASARR process.

Children's Screening for Inpatient and Residential Treatment: Minnesota Statutes require county boards to screen all children 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. The screening was required to also comply with permanency planning statutes.

The same statute required the establishment of a task force to review existing screening mechanisms for children which address the issues pertinent to admission criteria and need for continued care for children admitted to residential treatment facilities or acute care hospital inpatient treatment.

Initial conclusions and preliminary recommendations were submitted as part of the Division's 1990 Report to the Legislature. Additional study of screening issues and mechanisms was recommended to address inconsistencies and to identify successful models from which to build an effective and coordinated screening system for children. The task force continued to meet during 1990 to examine the needs of children with respect to screening mechanisms. (See Requirement VI for a description of final task force recommendations.)

The Department obtained statutory amendments to address the issues raised by the task force. Counties are required to assure, in contracts for residential and acute inpatient care, that providers adhere to admission, discharge, and continued stay criteria and that placements be made on the basis of clinical need. Coordination in planning, continuity of care between service providers, and appeal mechanisms are also required in contracts with service providers.

Screening is now required before children are admitted, except for emergency admissions to acute care inpatient hospitals, when a three working day delay is permitted. For care provided under General Assistance Medical Care and Medical Assistance in an acute care inpatient hospital, no additional screening beyond that already required under DHS Rule 48 is necessary.

Screening requires both diagnostic and functional assessments by mental health professionals and the identification of community service needs. Counties are required to collect summary data on screening recommendations and the degree to which these are followed in placement decisions, as well as reasons for not following the screening recommendations.

c. Description of problems encountered:

Not all eligible counties have applied the nursing facility screening process (PASARR) consistently; as a result, the criteria used to identify persons in need of services has varied.

For both adults and children, the need for community-based alternatives to institutional treatment challenges counties to learn new ways of thinking about services. Such changes in

approach are often difficult, and result in under-identification of clients who could be appropriately served in the community.

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

Outreach has comprised 41% of the activities in homeless grant counties, reaching 3,152 homeless persons.

Approximately 20,000 persons received Level I OBRA Screening and 2,000 have received Level II Screening in 1991.

Screening requirements for out-of-home placements of adults and children have been changed to reflect contemporary practice standards and to assure that such placements are based on clinical need.

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

a. The original milestone:

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:

The PASARR portion of P.L. 100-203 requires relocation of residents of MA-certified nursing facilities who have a mental illness and who have been determined to be inappropriately residing in the facility. States were permitted to submit Alternative Disposition Plans (ADPs) that identified the numbers of persons and the timelines states would follow to relocate these persons. Minnesota submitted a plan in 1989. A total of 143 residents will require relocation, with all relocations expected to be complete by June, 1992.

A total of $1,495,399 in State funds to support activities of the ADP was awarded to counties to assist with relocation efforts during the FY 90-91 biennium. Eleven counties with financial responsibility for residents found to need relocation applied for these State dollars. For the FY 91-92 biennium, $2.8 million dollars has been allocated to continue this effort. Thirteen counties have applied for these funds to continue the relocation effort and/or to maintain persons already relocated to the community.

Funds are to be used to develop new community-based services and/or to enhance or expand existing services to meet the specific needs of this population. Funding is flexible and is

geared to meet the specific needs of each individual, based upon the short and long term needs and choices. For example, grant funds can be used to assist, through rental subsidies, in obtaining stable and affordable housing of the client's choice. Clients can receive assistance with such items as the payment of damage deposits, initial utility installation, purchase of security and personal safety devices and miscellaneous household furnishings. Funds can also be used to enhance wrap-around mental health and social services to assist the individual with transition. It is projected that the cost of individual services will average about $1,200 per person per month, including room and board.

c. Description of problems encountered:

As of July, 1991, federal regulations to implement the mental health portion of OBRA-87 were still not final. Start-up of the State funded ADP project involves complex service coordination among consumers, private provider county contractors, several different organizational units with each county, three DHS Divisions, and two State agencies. The complexity of the process, coupled with the lack of clarity about final regulations (five drafts have been proposed) has resulted in a slow start-up.

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

Seventy-three persons have been discharged from nursing homes. Planning is underway for others expected to be relocated during the next fiscal year.

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

a. The original milestone:

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:

Case Management: Proposed modifications to Rule 74 (the administrative rule governing program standards and Medicaid reimbursement) should, by targeting those most in need of this service (i.e, persons with serious and persistent mental illness) and emphasizing normal environments, help assure that out-of-home placements of adults and children are, to the maximum extent possible, appropriate and necessary. (See Requirements VII and VIII).

Adult Screening for Inpatient and Residential Treatment: Final recommendations of the task force on adult screening included that counties should be required to assure that placement decisions are based on the clinical needs of the adult as identified by the individual, family or significant others (if appropriate), referral agency and the mental health professional involved. They also recommended that any screening functions undertaken by a county must be separate and distinct from ongoing case management services being provided to a client. These two recommendations, adopted in statute, help assure that services will be based on need, rather than service availability, and that service decisions are independent of program considerations.

Community-based Housing: Since the inception of the Housing Support Pilot Project, the Division has informed counties about the availability of local housing authority funds. In 1991, each of the eleven project counties was asked to develop an arrangement or agreement with a local housing authority to provide support and make certificates and vouchers available for persons with mental illness. Throughout last year, the MHD has been active in providing information to counties and local housing authorities on how to work together to provide housing funds and support services to persons with mental illness. The Housing Finance Agency has initiated a Home Ownership for Persons with Disabilities Task Force which is researching the possibilities of programs for persons with mental illness to own their homes. The Division makes recommendations to HUD on Section 202 funding available to non-profit groups for provision of housing to persons with mental illness.

The 1991 Legislature approved the Governor's Mental Health Housing Initiative, which included appropriations for a new housing subsidy program to serve 582 people beginning July 1, 1992; additional housing support services pilot projects beginning July 1, 1992; alternative services to downsize 25 community residential facilities that are now considered Institutions for Mental Disease (IMD) because they exceed 16 beds; development of alternative services for 100 people in 7 other IMDs which are certified as nursing facilities, so that they can be removed from IMD status by July 1, 1992; and increased Departmental flexibility to use existing Rule 12 funds for housing support services (These funds were previously limited to residential treatment.)

Anoka Alternatives Project To address overcrowding at the Anoka-Metro Regional Treatment Center (AMRTC) due to insufficient community services and financial resources to meet the needs of persons with serious and persistent mental illness, the 1990 Legislature authorized that $500,000 be used for alternative services for people being discharged from the facility. This initial one-time FY 1991 funding was awarded to the six metro counties served by the AMRTC.

The enhanced mental health and supportive services eligible to be reimbursed by these grants include an array of services, including housing support services, housing subsidies, home care services, family supports, enhanced foster care, enhanced community support services, friendly visitor services, transportation assistance, parenting supports and transition services. To date, Anoka Alternatives funding has been used to provide parenting classes, child care while the parent is receiving outpatient services, transportation to outpatient services, visitor services, and 24-hour access to a mental health worker.

Counties had projected that they would be able to assist between 35 and 50 persons to move out of the RTC with services created by these one-time dollars. By the end of SFY 1991, 85 persons had been discharged, and discharge planning was occurring with an additional 63 persons.

While project dollars have been very useful in helping these persons receive enhanced services to achieve discharge, the impact has not been limited to these individuals. An additional 30 persons have been referred to the project. Although a few were found not ready for discharge, others were found to be eligible for discharge with services already available in their home communities, once consumers and county, AMRTC, and Division staff discussed options. The project has thus demonstrated the effectiveness of the collaborative discharge planning process as well as the need for flexible funding for individualized planning.

County, AMRTC, and State administrative and staff commitment to this project has been commendable. Creative programming based on individual needs and choice as well as coordination by county and RTC staff and providers has produced successful results. As a result of this success, the Legislature authorized $600,000 for the next biennium to continue this project. An additional 24 persons are anticipated to be discharged, with funding to continue as appropriate to meet the service needs of those discharged in 1991. This project is viewed as a prototype and valuable tool to assist counties in expanding service capacity. Data on this project can be found in Table 3.

TABLE 3

ANOKA ALTERNATIVES PROJECT REPORT BY COUNTY FY 92

County	# of Persons Maintained from Previous Grant	Anticipated Number of Clients to be Discharged 6/30/92	Total Discharges to Date 9/12/91	Percent of Goal Achieved to Date	Number Discharged To Rule 36	Number Discharged to Own Apartment or Home	Number of Persons Discharged to Other	Approximate Number in Planning	(This grant cycle) Number Discharged/ Returned to RTC	** Number Redischarged	Number Discharged from Rule 36 to Create Opening
Anoka	5-7	4	3	75%	2	0	1 Foster	2			
Dakota	6	2	0					2			
Hennepin	40	20	13	65%	5	8		20		3	
Ramsey	11	16	4	25%		1	*3	11		2	
Sherburne	1	2	0					1			
Washington	6	2	1	50%	1			2			
Total	70	46	21	46%	8	9	4	38		5	

Number New Discharges by Month	Number Persons Redischarged
July 5	3
August 9	1
September 7	1

The range in length of stay for discharged patients was 181 days to 9,895 (27 years) with an average LOS of 935 days (2.56 years)

* Of the three persons in this category: 1 - transitional housing; 1 - board and lodge; 1 - nursing home

** Number redischarged includes persons who were discharged in the last grant cycle (7/90 - 6/91) were readmitted to the RTC and then were redischarged this grant cycle

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Mental Health Division
9/12/91

Olmsted County Project: In 1990, a 16-bed community residential facility in Rochester was closed because of an extended pattern of low-occupancy. This facility had been one of the most expensive in the State. The Mental Health Division agreed that these service funds would not be lost to the community. Following the recommendations of the Division, Olmsted County (where Rochester is located) completed a needs assessment for the use of these funds. Olmsted County proposed and received approval to convert these funds to housing support services and housing subsidies, consistent with the Division's priority of developing services to meet the housing needs of persons with major mental illness. The alternative use of these residential funds was also approved for the other two counties whose residents had been served by the former facility.

These three counties have now expanded their housing support services and project to serve over 80 clients with the funds which had formerly served 16 persons in a residential treatment setting. Some of the funds are being used to enhance the services/staffing at the only remaining residential program in Olmsted County. Two of the counties are providing rent subsidies to clients to enable the clients to afford appropriate community housing. Both of these counties have developed cooperative, formal work relationships with their local public housing authorities. The housing authorities are enthusiastically cooperating, and are administering the rent subsidies. All three counties offer low-income housing, client damage deposits, furniture vouchers, utility deposits, and emergency funds. The success of this project provided support for the MHD legislative request that similar conversions of funds be made possible statewide, approved by the 1991 Legislature.

OBRA-87: A total of $1,495,399 in State funds to support activities of the Alternative Disposition Plan was awarded to counties to assist with relocation efforts during the FY 90-91 biennium. Eleven counties with financial responsibility for residents currently found to need relocation applied for these State dollars; $2.8 million dollars has been allocated for the FY 91-92 biennium to continue this effort. Thirteen counties have applied for these funds to continue the relocation effort and/or to maintain persons already relocated to the community.

These funds are being used to develop new community-based services and/or to enhance and expand upon pre-existing services to meet the specific needs of this population. Funding is flexible and geared to meet the specific needs of each individual. For example, dollars can be used for rental subsidies and the enhancement of an array of wrap-around mental health and social services to assist the individual with transition to community settings. It is projected that the cost of individual ADPs will average about $1,200 per person per month, including room and board.

Older Adults: Beginning in 1988, eight demonstration projects were established to address the needs of older adults, using Federal Alcohol, Drug Abuse, and Mental Health Services Block Grant funds to serve underserved or special populations and NIMH special project funds. The goals of the grants included reducing or eliminating barriers to mental health services for older adults through use of outreach activities, and providing coordinated, appropriate networks of mental health services for older adults, thereby minimizing service gaps and duplications.

Strategies to combat the stigma associated with seeking mental health services, which were particularly evident in rural areas among the older population, included:

- Peer counseling programs, in which peer counselors were secured from senior citizen organizations and given structured training in mental health issues;
- In home visits to initiate assistance with services;
- News coverage to make the services more acceptable to older adults; and
- Advisory committees with strong senior citizen representation, which later became strong advocates for continuation of the projects.

Three projects developed additional funding sources so that they are continuing now that demonstration funds are no longer available for this effort. The variety of funding sources, which includes foundations and counties, indicates in itself the perceived value of the projects. Funding obtained from public bodies tended to be the result of the advisory groups having sufficient political awareness to gain the attention of local elected officials.

Homeless Persons: In FY 1991, approximately 3,152 homeless individuals with mental health problems received services from mental health providers in eight Minnesota areas where significant numbers of homeless people congregate. The essential services provided by the projects were outreach, mental health services, medical services, training, case management and housing support. Minnesota contributed $346,000, a match of $2.87 for every $3.00 of federal funding for the homeless program.

Indian Mental Health: Minnesota's Indian Mental Health Projects have continued to provide services to children and adults during 1991, utilizing continuation funding from the Alcohol, Drug Abuse, and Mental Health Block Grant. Projects continue to operate in the following communities: Bois Forte; Fond Du Lac; Grand Portage; Leech Lake; Lower Sioux; Mille Lacs; Shakopee Mdewakanton Sioux; Upper Midwest American Indian Center; and Upper Sioux (See Appendix II for more information on these programs).

During the past year, there has been an expanded focus on American Indian children as a result an increasing number of teenage suicides attempts among this group. The Department has been able to utilize unexpended federal funds to support a new project on the White Earth Indian Reservation (which has had the greatest incidence of adolescent suicides during the past year). Although current levels of funding have not allowed for the development of other new programs or expansions of existing projects, the Division continues to provide technical assistance and consultation to existing projects to promote coordination and linkages with the surrounding communities and counties in which the projects are located.

Refugee Mental Health: Since the completion of the Refugee Assistance project in July of 1989, the Refugee Mental Health Advisory Council continued to meet during 1990 to focus its efforts on refinement of its future role and direction, assessment of the mental health needs of the refugee populations throughout the State, and potential linkages with the Division in promoting mental health service development to address the increasingly complex and challenging mental health issues facing the refugee communities.

After a year of struggling with these issues, the Council decided to officially disband as of January, 1991. Despite this decision, the Division continues to provide technical assistance and consultation to members of the refugee consumer and provider communities to share information on State and federal opportunities for funding, service development, and service expansion.

Joint DRS-CSP Projects: The Division and DRS are collaborating on the development of a Request for Proposals for demonstration projects to provide supported employment services for persons with mental illness. Both agencies have committed funding for the development of these projects, which are expected to be implemented in the fall of 1991.

Compulsive Gambling: During SFY 1992, DHS plans to begin implementing an integrated community-based treatment program for persons who are compulsive gamblers and their families. "Integrated" refers to the intent to provide treatment services through the existing community mental health and human service systems. State funds for up to five pilot demonstration projects will be awarded in late fall of 1991, using the Request For Proposals process.

Mental Illness/Chemical Dependency (MI/CD): The Mental Health Division has participated in strategic planning focus groups facilitated by the Chemical Dependency Division and Hazelden (a large local Chemical Dependency treatment center). The purpose of this process was to define steps the Department can implement

to offer services for the individual who has both mental illness and chemical dependency.

Willmar RTC has a pilot project in which persons with both mental illness and chemical dependency are provided services in an inpatient MI/CD program. Licensing arrangements for the program were developed jointly by the MHD, Chemical Dependency Division, and Licensing Divisions, in conjunction with staff from the facility. The goal of the program is to provide concurrent, integrated MI/CD treatment services.

Mental Health and Chemical Dependency Division staff have provided on-site technical assistance, with recommendations for the program provided jointly at a meeting with the Willmar Regional Treatment staff. Technical assistance involves assessing the cross training tools, the MI/CD program and the staff utilized in the treatment program. These recommendations are being utilized in the further development of an integrated program.

Diffusion Network Project: The Diffusion Network Project is intended to help rehabilitation facilities and consumers establish new programs or expand existing programs to serve persons with serious and persistent mental illness and/or with traumatic brain injury. The goal is to help establish community-based programs that lead to community employment, community living and social integration.

Children's Services

Children's Screening for Inpatient and Residential Treatment: Counties are now required to screen children before admission to acute care inpatient hospitals, except for emergency admissions. A process has been established to assure independent evaluation of all children admitted to RTCs for whom Medical Assistance is expected to provide reimbursement.

Funding for Children's Mental Health Demonstration Projects: The MHD has funded eight children's mental health demonstration projects since 1988, utilizing ADM block grant monies. The projects will be self-sustaining in 1992 and new uses of the required children's ADM "set-aside" funds will be developed. (See the 1990 Plan submission for a complete description of these projects.)

Funding for Children's Case Management and Home Based Mental Health Services: In 1988, the Department promulgated Rule 74, relating to case management for both adults and children with serious and persistent mental illness. The fiscal note for Rule 74 assumed that counties would provide case management to about 1,000 children with serious and persistent mental illness, and

that approximately 500 of those children would be funded through Medical Assistance.

The 1989 Comprehensive Children's Mental Health Act included a statewide mandate for case management for children with severe emotional disturbance, effective in July of 1991. The Department had estimated that twice as many children would qualify as having a severe emotional disturbance as compared to the earlier "serious and persistent mental illness" criteria. However, since the effective date for expanded eligibility did not occur until 1991, the 1989 Legislature did not appropriate any funding relating to the new mandate, nor did it amend MA coverage to include the expanded severe emotional disturbance target population.

To assist counties in providing case management services to children with severe emotional disturbance and their families, the 1991 Legislature appropriated $1.25 million for services for non-MA eligible children through the Children's Community-Based Mental Health grant program. The Division will solicit proposals from county agencies to develop or expand family community support services and case management services to children with severe emotional disturbance and their families. The new legislative appropriation of $2.7 million for family community support services and case management services will be available to counties through grants available beginning April 1, 1992.

To assist counties in providing services to children when these services cannot be reimbursed under Medical Assistance, the Division is developing service standards based on the priorities listed in the amended law. Funding appropriated beginning July, 1991, must be used by county boards to provide family community support services and non-MA case management services before professional home-based family treatment, day treatment and therapeutic support of foster care services can be provided.

The 1989 Legislature allocated funding to begin MA-reimbursed professional home-based family treatment services for children with severe emotional disturbance, beginning in January, 1991. Due to limited staff in both the Mental Health and Health Care Divisions, the statutory starting date for Medical Assistance reimbursement of this new service will be April, 1992.

Family Community Support Services Development: During the past year, the Department has worked in collaboration with counties, service providers, families, and advocates to design and implement family community support services. This array of services is designed to help each child with severe emotional disturbance to remain with the child's family in the community by improving the child's ability to manage basic activities of daily living, function appropriately in home, school, and community settings, and participate in leisure time after school or in

summer community youth activities. These services must also be designed to: improve overall family functioning as clinically appropriate to the child's needs; reduce the need for, and use of, more intensive, costly or restrictive placements; and reduce the number of admissions and duration of out-of-home placements, if an out-of-home placement is indicated through the child's diagnostic assessment.

Family community support services include:

- client outreach;
- medication monitoring;
- assistance in developing independent living skills;
- assistance in parenting skills necessary to address the needs of the child with severe emotional disturbance;
- assistance with leisure and recreation;
- crisis assistance, including crisis placement and respite care;
- professional home-based family treatment;
- foster care with therapeutic supports;
- day treatment;
- assistance in obtaining respite care and special needs day care; and
- assistance in obtaining financial resources.

In November, 1990, the Division solicited proposals from county agencies for pilot projects to demonstrate innovative ways to provide family community support services (FCSS) to children with severe emotional disturbance and their families. The Division received 39 proposals representing 53 counties. Both metro and out-state counties submitted proposals which demonstrated their ability to plan, design, and implement services based on the Child and Adolescent Service System Program model of service delivery. Counties needed to demonstrate that services would be: child centered and family focused; culturally sensitive; responsive to the unique needs of children with severe emotional disturbance and their families; and designed, delivered, and funded through interagency collaboration and coordination.

Grants were awarded in February 1991, for the 15-month period from April 1, 1991 to June 30, 1992. The Division will again solicit proposals the fall of 1991 for a 15-month grant to initiate or expand family community support and case management services, using the 1991 appropriation for Children's Community-Based Mental Health grants.

<u>Children's Services Joint Training:</u> One major effort to promote community-based services has been a series of regional interagency conferences aimed at increasing awareness of children's mental health issues, the principles and service requirements of the Comprehensive Children's Mental Health Act,

and the development of early identification and intervention services as required by law.

A second major effort involved conducting a series of regional trainings on interagency coordination. These trainings targeted members of county Local Coordinating Councils throughout the State. The purpose of these trainings was to assist Local Coordinating Councils in developing strategies for identifying barriers to collaborative service development and mechanisms to promote coordinated services across service systems.

The Division has received a National Institute of Mental Health Child and Adolescent Service System (CASSP) grant to design and implement a series of trainings throughout the State during 1992. A training curriculum is being designed utilizing evaluation information from the eight child mental health demonstration projects that are currently providing coordinated, collaborative services to children with severe emotional disturbance and their families. Training available under this grant will be expanded through use of funding provided by the Minnesota Department of Education.

Each of these three efforts promote collaborative development of a local array of services designed to support and maintain children in the least restrictive setting.

c. Description of problems encountered:

Shifting from a facility-based continuum of care system to a housing support/CSP flexible system based on individual need has been and will continue to be a major change for consumers and providers.

The process of planning for on-going service provision to older adults was not sufficiently emphasized in the first year, so that changes would become more integrated with existing service systems. With limited funding available, local providers and county boards have tended to focus on mandated services even with programs showing demonstrable benefits. Some benefits, such as reduction of crisis intervention needs, are difficult to measure.

Although the administrative systems have been in place for counties to bill MA for case management since January 1, 1989, actual billings for children have been far less than expected.

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

Services for older adults are more visible and acceptable. Awareness of options for coordination and mutual support has been enhanced by linking professionals and community leaders. Three

of five projects funded under a federal grant for mental health services to older adults have continued under alternate funding following completion of the 3-year grant cycle, demonstrating local support for project outcomes.

Eighty-five difficult-to-serve patients of Anoka Metro RTC have been relocated to community settings with funding for their continued support, exceeding the projected number of 35 to 50 persons. Although the project initially received one-time funding, additional funding ($600,000) has been obtained for continuation in the next biennium.

Housing support services are being expanded as a result of legislative appropriations under the Housing Initiative.

Thirty-five inappropriately placed nursing facility residents are being provided with needed services in the community.

A total of 3,152 homeless persons with mental illness are being provided with services in the community in seven counties.

A program for serving people with mental illness and chemical dependency is continuing to evolve into an integrated model. Thirty-nine grants for Family Community Support Services were awarded in 1991, providing initial funding for services to children in 53 of Minnesota's 87 counties.

Legislative funding has been expanded to $4.8 million for community-based children's mental health services for SFY 92-93. New services are currently being provided in 53 counties as a result of the 1990 legislative appropriation.

Collaborative training has been provided for LCCs and multi-agency staff in the identification of children needing mental health services and in the implementation of service models.

Requirement V. Describing financial resources and staffing necessary to implement the requirements of the plan.

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

a. The original milestone:

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:

The following section describes available and new funding sources for adult and children's services, trends in funding, fiscal incentives and fiscal recommendations for adult and children's services, human resource development efforts, and efforts to maximize or develop new resources for mental health services.

Description of Funding Sources for Adult Mental Health Services:
The Division has aggressively pursued available funding sources for mental health services. Figure 6, below, provides a funding flow chart for mental health service funding administered by the Department. Under the Comprehensive Adult Mental Health Act, the county is the local mental health authority responsible for provision of a comprehensive array of mental health services and, therefore, most funds flow through the counties. Major exceptions are Medical Assistance, which is paid directly to providers due to federal requirements, and RTC funding. The following describes the major DHS funding sources for mental health services:

Rule 12 grants ($11 million for FY 90) fund treatment and program services at community residential facilities licensed under Rule 36. Counties must provide a match of 25 percent, but the match can come from non-county sources. The 1991 Legislature appropriated an additional $408,000 for each of the next two years to be used by counties to increase salaries of staff below "top management" working in these programs.

Rule 14 grants ($11 million for FY 90) fund non-MA-eligible community support services and case management for adults with serious and persistent mental illness. Counties must provide a match of 10 percent, but the match can come from non-county sources. Additionally, $248,000 was provided for staff salary increases for each of the next two years, as above, for these programs.

Of the federal Mental Health Block Grant, about $500,000 were targeted in FY90 to serve special adult populations, including American Indians and elderly persons. No local match is required for the American Indian projects. Most other projects are funded on a three-year demonstration basis, with an expectation that other funding must be arranged to pay for an increasing share of the project each year.

The federal PATH grant (formerly the McKinney Mental Health grant), about $400,000 for FY 91) is matched by state funds (about $300,000 for FY 91 to provide mental health services for homeless persons with serious mental illness.

State Special Project funds for adults include $500,000 in FY 91 for the Anoka Alternatives project, which provides 100% State funding for community services for people being discharged from the Anoka Metro RTC, and $200,000 in FY 91, to be used in combination with Rule 14 funds for housing support services demonstration projects. The latter projects include a 10% matching requirement.

Community Social Services Act (CSSA) funds include, for FY 91, approximately $45 million from the Federal Social Services Block Grant (formerly Title XX), approximately $51 million from state CSSA funds and about $270 million in county tax funds. These are "generic" social service funds for all disabilities and all age groups. For 1990, counties planned to spend about 14%, or $52 million, of these funds for adult mental health services. These are the most flexible funds available to counties and are used when other funds are inadequate to meet client needs.

General Assistance (GA) is a public assistance program for low-income adults who are unable to work and who do not qualify for other public assistance. Minnesota Supplemental Aid (MSA) is a state supplement for federal Supplemental Security Income (SSI). People with mental illness are estimated at around 20% of all people receiving GA, MSA and SSI. These programs are the primary funding sources for room and board costs for Rule 36 facilities. The specific funding source used, and the amount paid from each source, depend on the client's individual eligibility. In FY 90, GA paid about $3.5 million, MSA about $6.5 million and SSI about $4.3 million for clients of Rule 36 facilities. State law had required counties to pay 15% of the non-federal share of MSA and 25% of GA, but the county share was eliminated after January 1991.

Regional Treatment Centers (RTCs) are funded directly by the Legislature through a separate appropriation. The net State cost for RTC adult mental health services in FY 90 was about

$50 million, with an additional $16 million funded by Medical Assistance for eligible individuals. State law requires counties to pay 10% of the cost for non-MA eligible adults.

Medical Assistance (MA) and General Assistance Medical Care (GAMC) cover inpatient services, outpatient services, day treatment and case management within very specific limits. MA includes 53% federal funding and is subject to federal requirements. GAMC is a totally state funded program for low-income people who do not qualify for MA. Although not subject to the same federal rules as MA, GAMC coverage for mental health services is similar to that of MA. State law had required counties to pay 10% of the non-federal share of MA and GAMC, but the county share is eliminated after January 1991. In FY 89, MA paid about $37 million for adult mental health services other than RTCs; GAMC paid about $12 million.

ADULT MENTAL HEALTH SERVICES
CURRENT DHS FUNDING FLOW

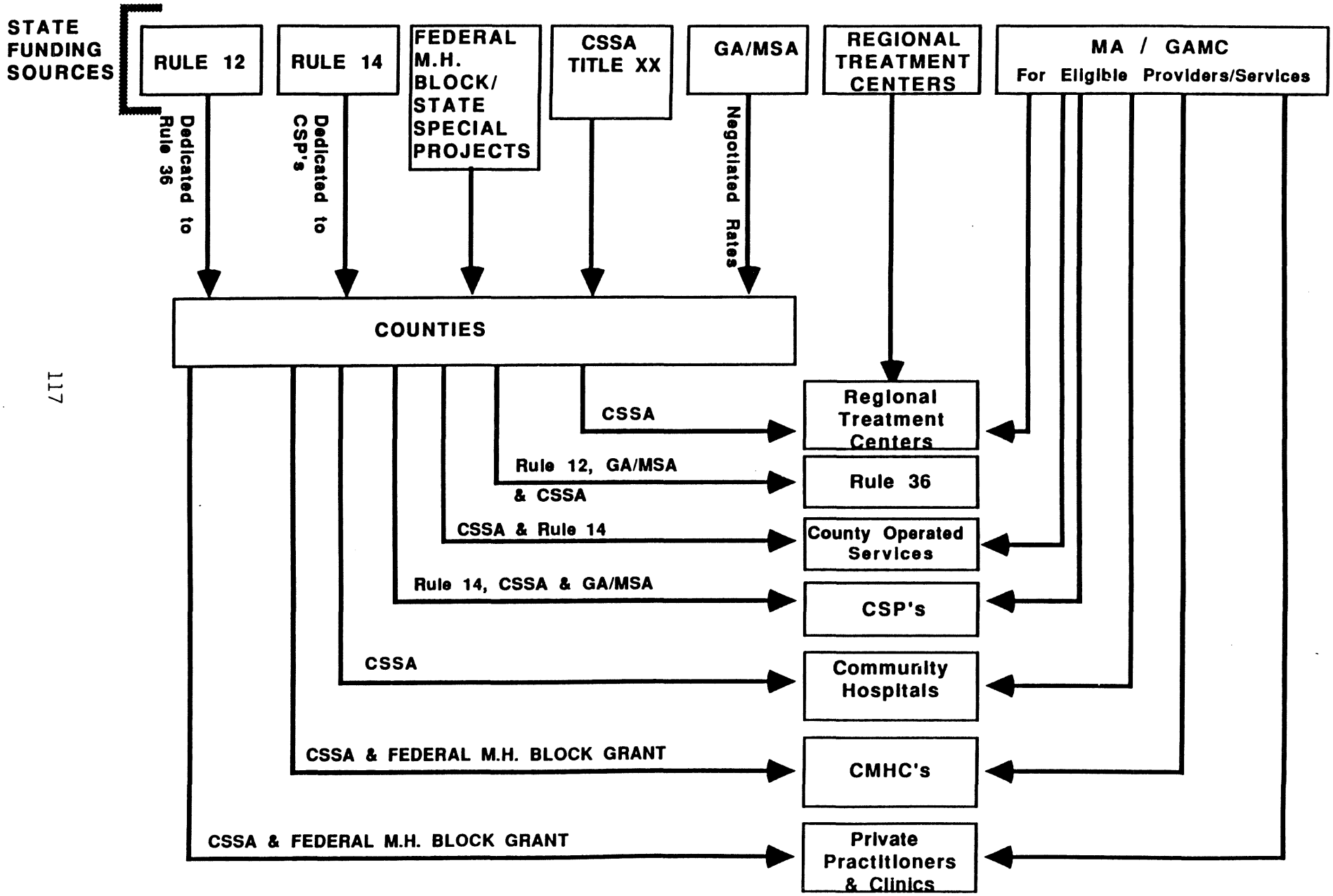
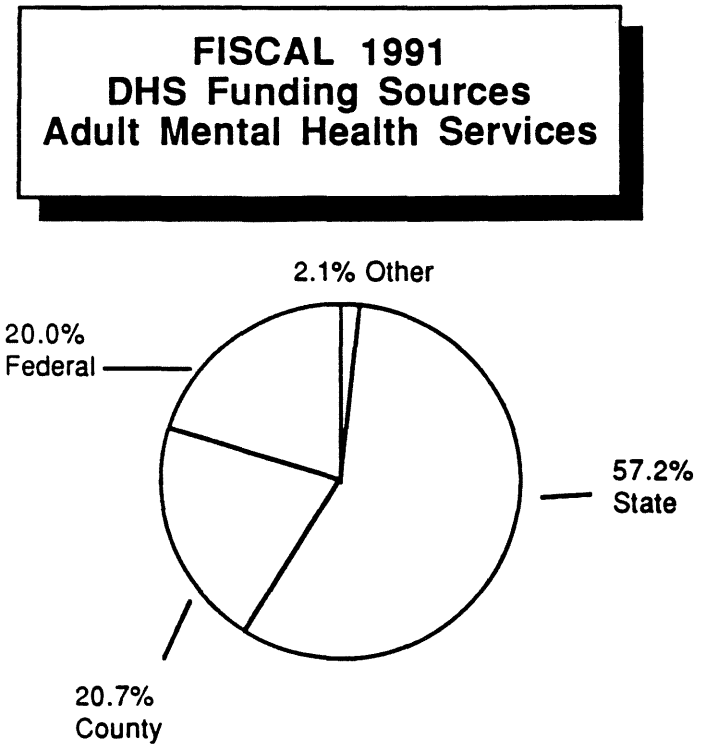


Figure 2, in Part A, Section 1, illustrates total estimated FY 91 DHS expenditures for adult mental health services, by service category, including county matching funds for state grants. The largest expenditures are in the inpatient and residential categories. Total expenditures include 54.5% inpatient, 13.2% community residential, 31.7% community non-residential (outpatient), and .6% state administration.

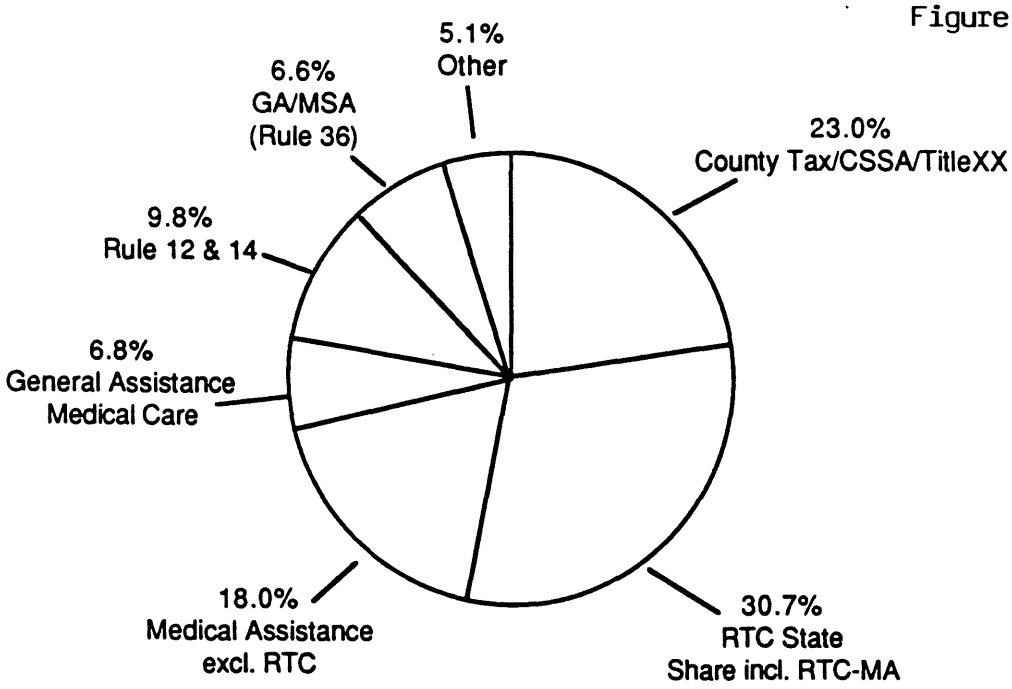
Figure 7 shows funding source by level of government, while Figure 8 shows the same funds by program. The single largest funding source for mental health services is the RTC state share (including MA for RTCs).

Figure 7



Federal, State and County Funding

Figure 8



Funding by Program Category

Feb 1991

Financial Trends: The primary state funding sources for mental health services for adults with serious and persistent mental illness are the state appropriations for RTCs, State Mental Health Grants (including Rule 12 and Rule 14), and state payments through Medical Assistance (MA) and General Assistance Medical Care (GAMC). Table 4 shows expenditure trends for these three major appropriations for the last seven years. MA/GAMC outpatient expenditures have experienced the largest percentage growth - 174%, while the RTC funds have experienced the largest dollar growth - an increase of over $33 million.

The basic trend, especially for MA/GAMC, is toward more focus on outpatient/community services, as opposed to inpatient services. However, the change is very gradual and most of the dollars are still expended for inpatient services. At the current rate of change, inpatient expenditures from these funding sources will continue to far exceed outpatient expenditures far into the next century.

Figures 9 and 10 compare client data to expenditure data for RTCs and Rule 12/14 programs. It is noteworthy that RTC costs have increased 89% over the past seven years, while RTC average client numbers have increased only 6%. At the same time, state grants for community programs have increased 129%, while Rule 36/CSP clients have increased 113%.

Seven-Year Comparison
Key Expenditures for Mental Health Services - Adults

Table 4

Key Expenditures	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	
Rule 12 (Residential Rule 36)	$7,453,500	$8,526,900	$9,192,100	$9,934,000	$10,894,000	$11,144,000	$11,445,000	
Rule 14 (Community Supp. Programs)	$2,780,000	$3,028,792	$3,704,363	$4,983,000	$7,396,000	$8,502,962	$11,140,000	
Mental Health Special Projects	$0	$0	$0	$40,000	$960,000	$500,000	$847,000	
Total State Grants Community MH	$10,233,500	$11,555,692	$12,896,463	$14,957,000	$19,250,000	$20,146,962	$23,432,000	
RTC Adult MH state share excl. MA	$28,683,460	$30,131,683	$34,429,112	$41,795,030	$48,090,620	$50,021,844	$53,616,050	
Medical Assistance for RTC-MH	$8,708,569	$8,418,173	$8,938,709	$8,606,973	$10,235,022	$16,026,192	$17,177,718	
RTC Adult Total excl. co. and priv.	$37,392,029	$38,549,856	$43,367,821	$50,402,003	$58,325,642	$66,048,036	$70,793,767	
MA/GAMC Inpatient excl. RTCs	$17,433,677	$21,680,812	$25,071,598	$25,889,092	$28,094,424	$31,933,015	$33,272,652	
MA/GAMC Outpatient	$8,433,287	$11,249,606	$13,090,929	$14,413,114	$16,592,584	$20,135,298	$23,142,377	
Percent Change		FY 85 to FY 86	FY 86 to FY 87	FY 87 to FY 88	FY 88 to FY 89	FY 89 to FY 90	FY 90 to FY 91	FY 85 to FY 91
Rule 12 (Residential Rule 36)		14.4%	7.8%	8.1%	9.7%	2.3%	2.7%	53.6%
Rule 14 (Community Supp. Programs)		8.9%	22.3%	34.5%	48.4%	15.0%	31.0%	300.7%
Mental Health Special Projects		Not applicable	Not applicable	Not applicable	Not applicable	(47.9%)	69.4%	Not applicable
Total State Grants Community MH		12.9%	11.6%	16.0%	28.7%	4.7%	16.3%	129.0%
RTC Adult MH state share excl. MA		5.0%	14.3%	21.4%	15.1%	4.0%	7.2%	86.9%
Medical Assistance for RTC-MH		(3.3%)	6.2%	(3.7%)	18.9%	56.6%	7.2%	97.3%
RTC Adult Total excl. co. and priv.		3.1%	12.5%	16.2%	15.7%	13.2%	7.2%	89.3%
MA/GAMC Inpatient excl. RTCs		24.4%	15.6%	3.3%	8.5%	13.7%	4.2%	90.9%
MA/GAMC Outpatient		33.4%	16.4%	10.1%	15.1%	21.4%	14.9%	174.4%

RTC includes Security Hospital, but does not include state nursing homes.

Reliable cross-year data not available for CSSA or GA/MSA expenditures for MH. Available data indicates no significant change in state CSSA or GA/MSA for MH between 1982 and 1991.

Estimated projections are used for FY 90-91 MA/GAMC and FY 91 RTC. MA/GAMC includes state, federal and county shares.

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Mental Health Division

SEVEN-YEAR COMPARISON
RULE 14, RULE 36 AND RTCS

FIGURE 9

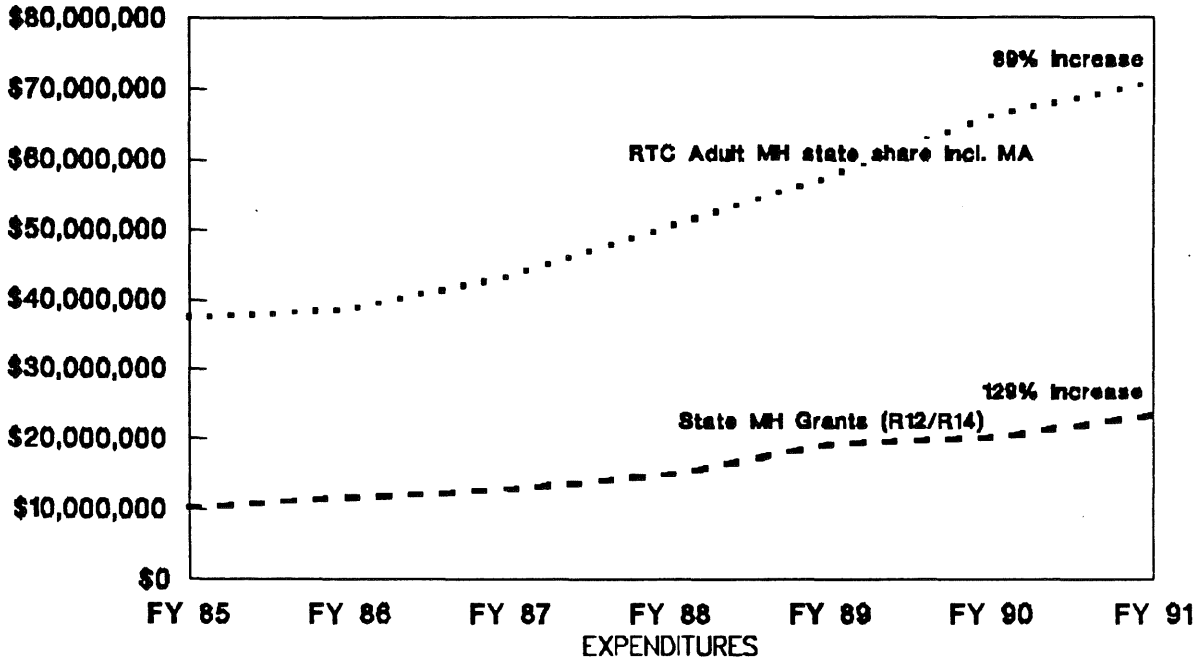
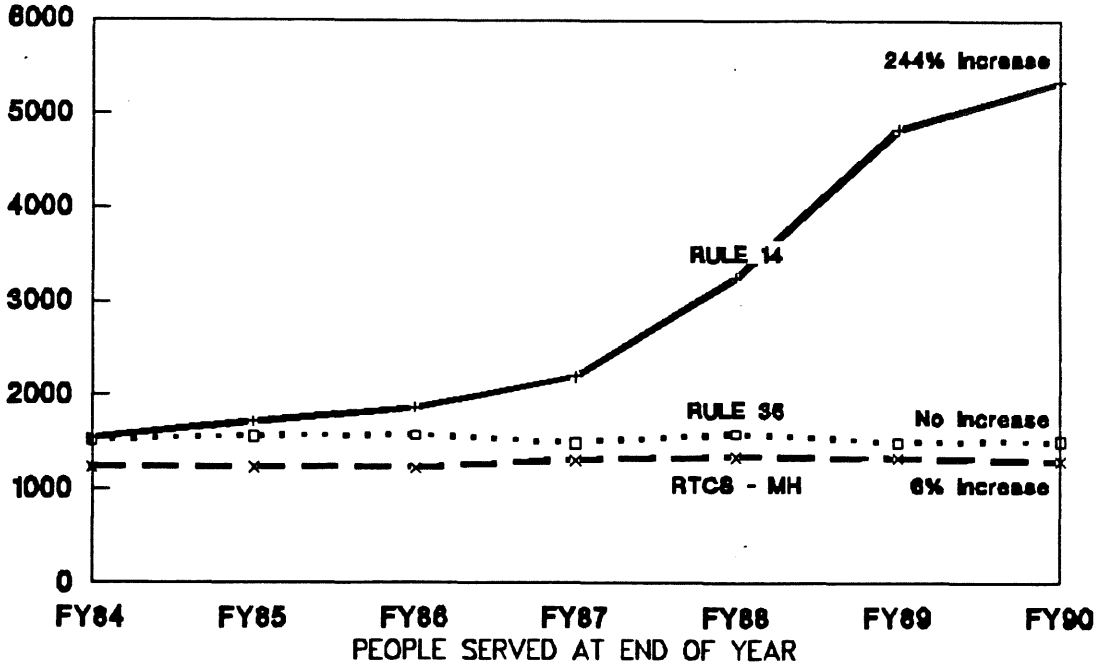


FIGURE 10



"County funds", which usually refers to all county discretionary funds, including county taxes, state social service block grants under CSSA and federal social service block grants (formerly "Title XX"), are used in addition to funding sources listed above. Over the last seven years, total state and federal block grants for social services for all populations have remained almost unchanged, with no allowance for inflation, while total county tax funding for social services has increased from $152 million in 1985 to $267 million in 1990. This has resulted in an overall increase in "county funds" of 47% across six years.

Unfortunately, reliable reporting systems have not been in place to track the mental health share of these expenditures in a consistent manner. In 1987, it was estimated that 20%, or about $50 million, of 1985 county funds was for adult and children's mental health services.

County plan data for 1990 indicates that counties budgeted about 24%, or about $89 million, of their total county funds for adult and children's mental health services. This would indicate an increase of 74% over six years. However, due to inconsistent reporting methods, it is not clear how much of this increase is due to changes in reporting methods, e.g., counting children's mental health under the mental health category instead of under the children's category.

The Comprehensive Mental Health Act requires counties to continue to spend for mental health services an amount equal to the total expenditures for services to persons with mental illness in the counties' approved 1987 Community Social Services Act plans. This requirement relates only to county funds. This means that counties receiving new state or federal categorical funds for existing county expenditures must redirect their county funds towards expanded mental health services. The 1987 base established in law relates to a combined total for adult and children's mental health. Reliable figures are not available to separate the 1987 base into children's and adult amounts.

The Mental Health Acts passed in 1987 and 1989 (for children) changed and clarified basic definition of target populations and mental health services. Because these have occurred since counties prepared their 1987 plans, the validity of 1987 plan data for the maintenance of effort requirement is questionable. There may be a need to establish a new base, perhaps using 1990 data.

Fiscal Incentives and Comparative Costs: Minnesota's complex funding system has raised concerns as to whether the funding system "drives" clients towards inappropriate services. This concern was especially valid five years ago, when there was little dedicated funding for community mental health services.

As a result, community support programs were simply nonexistent in most counties.
DHS's proposed version of the original Comprehensive Mental Health Act in 1987 included a consolidation of funding from ten different funding sources. Variations of a "Mental Health Fund" passed both the House and Senate, but were ultimately voted down in the legislative conference committee. A key concern on the part of advocates and counties related to the probable loss of the entitlement feature associated with some of the funds which would be included. The entire fund would have been allocated to counties on a formula basis, with little ability to vary funding based on changes in total need per county. The option of putting all mental health funding on an entitlement basis was considered, but was determined to be budgetarily and politically impossible.

Although no progress has been made in the area of consolidation of existing funds, significant progress has occurred as far as increased funding for community alternatives. For example, since 1987:

Rule 14 funding for adult community support services has increased by over $7 million per year, thus enabling services to be provided for consumers in all 87 counties. (Since Rule 14 and RTC funding are both 90% state share, the issue here is not one of fiscal disparity in percentage terms, but more an issue of the total dollars available and the resulting service capacity.)

General Assistance Medical Care coverage has been expanded by over $1 million per year to include outpatient mental health services and day treatment. (Before, GAMC covered only inpatient services.)

Medical Assistance has been expanded to include case management for persons with serious and persistent mental illness. Current expenditures are about $1.7 million per year, with total expenditures eventually expected to rise to $3.8 million for adults.

Table 5 estimates comparative costs per person per day for various settings. However, differences among clients in different settings should be noted. Although there are overlaps, the most disabled clients tend to be placed in RTCs, and the least disabled served in non-residential community supportprograms. Community support programs have demonstrated they can serve very disabled clients; however, available cost data averages in all clients served in each setting.

COMPARATIVE COSTS OF SERVICES

EST. FY 91 TOTAL COST PER ADULT PER DAY

	Residential Setting			
Service Programs	RTC	Rule 36 IMD	Rule 36 Non-IMD	Supported Housing
RTC	$197.49	$.00	$.00	$.00
Case Management	$3.08	$3.08	$3.08	$3.08
Room and Board	$.00	$25.60	$22.50	$21.00
Rule 36 Program	$.00	$25.18	$52.03	$.00
Day Treatment	$.00	$12.13	$12.13	$20.00
CSP excl. Day Trtmt.	$.00	$5.51	$5.51	$30.00
Outpatient MH	$.00	$2.24	$2.24	$2.24
Pharmacy	$.00	$2.71	$2.71	$2.71
Periodic Hospitalization	$.00	$2.96	$2.96	$2.96
Non-MH Medical Services	$.00	$2.76	$2.76	$2.76
Total	$200.57	$82.17	$105.92	$84.75

EST. FY 91 COUNTY SHARE PER ADULT PER DAY

	Residential Setting			
Service Programs	RTC	Rule 36 IMD	Rule 36 Non-IMD	Supported Housing
RTC	$19.75	$.00	$.00	$.00
Case Management	$1.02	$1.02	$.62	$.62
Room and Board	$.00	$.00	$.00	$.00
Rule 36 Program	$.00	$6.30	$13.01	$.00
Day Treatment	$.00	$4.00	$2.43	$4.00
CSP excl. Day Trtmt.	$.00	$1.82	$1.82	$6.00
Outpatient MH	$.00	$.74	$.45	$.45
Pharmacy	$.00	$.27	$.14	$.14
Periodic Hospitalization	$.00	$.30	$.15	$.15
Non-MH Medical Services	$.00	$.28	$.14	$.14
Total	$20.77	$14.71	$18.74	$11.48

Actual county share varies depending on availability of pilot projects and on individual client needs and eligibility.

State Administrative Costs: The most recent national data available (1987) indicates that Minnesota's per capita spending for state mental health agency administrative costs was the lowest for all 50 states. (The national data regarding administrative costs is not separated by adult v. children's mental health.) Even after adding in increases approved by the Legislature since 1987, Minnesota's current state administrative costs still rank among the lowest ten states nationally (in comparison to other states' 1987 data.)

New Funding for FY 1992-93:

Self-Help Groups. In the 1991 Human Services Omnibus Bill, money was appropriated from the mental health special projects fund for grants to two nonprofit charitable mental health self-help groups. One grant will be used to provide support services to people with major depression. The other grant will provide employability support services to people with mental illness delivered by people who have or have had a mental illness.

Gambling. In 1990, funds from the new State lottery were used for the development of a compulsive gambling program. The 1991 Legislature increased the biennial appropriation for the compulsive gambling treatment programs from $600,00 to $1.4 million. The law also included the following new innovative provisions: (a) posting of the State compulsive gambling hotline telephone number at all legal gambling sites, para mutual betting sites and State lottery retail sales locations, and (b) a problem gambling screening be conducted as a part of the probation officers pre-sentence investigation of felon convictions involving embezzlement of funds. The MHD will circulate an RFP to award State grant funds for new community based pilot demonstration treatment programs for compulsive gamblers and family members. The intent is to integrate the gambling treatment services within existing mental health treatment resources.

Supported Employment. Minnesota is a participant in the Diffusion Network Project of the Research and Training Center at the Stout Vocational Rehabilitation Institute at the University of Wisconsin-Stout in Menomonie, Wisconsin, funded by the Rehabilitation Services Administration. The project provides an initial one-time grant to two new programs each year for three years. Two programs have started. One program, in Duluth, Minnesota, will serve adults with serious and persistent mental illness. Eventually, there will be 6 of these demonstration projects in operation; they will provide important information on the establishment of quality supported employment program models.

The Division and the Department of Rehabilitation Services are collaborating on the funding for and development of a Request for

Proposals for demonstration projects to provide supported employment services for persons with mental illness, as agreed upon in the Interagency agreement. Both agencies have committed funding for the development of these projects, which are expected to be implemented in the fall of 1991.

Housing. The 1991 Legislature approved the Governor's Mental Health Housing Initiative, for a net increase of $299,000 in State fiscal year 1992 and $1,622,000 in State fiscal year 1993 to its budget base. The Mental Health Housing Initiative is made up of the following three components:

- development of a pilot rental subsidy program to enable about 400 adults with serious and persistent mental illness to live in decent, affordable housing. About 200 of these people are now homeless, 50 are living in regional treatment centers (RTCs) and the other 150 are in negotiated rate facilities.

- expansion of housing support services from 10 counties to 40, including the ability to allow counties to convert current Rule 12 funding from residential facility-based services into housing support services.

- downsizing of 22 existing Institutions for Mental Disease (IMD) to improve services for another 400 people and maximize federal reimbursement for 290 of those 400 who would be eligible for medical assistance (MA) if they were not in an IMD.

Budgeted items include the following:

- $1 million for a new housing subsidy program to serve 400 people beginning July 1, 1992;

- $500,000 new funds for additional housing support services pilot projects beginning July 1, 1992;

- increased flexibility to use existing Rule 12 funds for housing support services (These funds are now limited to residential treatment.);

- $750,000 for alternative services to downsize 18 community residential facilities that are now considered Institutions for Mental Disease (IMD) because they exceed 16 beds; and

- $882,000 plus administrative funds to develop alternative services for 100 people in seven other IMDs which are certified as nursing facilities; this will enable these facilities to change their character

sufficiently to be changed from IMD status by July 1, 1992.

Current Special Projects:

Anoka Alternatives. To address overcrowding at the Anoka-Metro Regional Treatment Center (AMRTC) due to insufficient community services and financial resources to meet the needs of persons with serious and persistent mental illness, the 1990 Legislature authorized that $500,000 be used for alternative services for people being discharged from the facility. This one-time FY 1991 funding was awarded to the six metro counties served by the AMRTC.

The enhanced mental health and supportive services eligible to be reimbursed by these grants include housing support services, housing subsidies, home care services, family supports, enhanced foster care, enhanced community support services, friendly visitor services, transportation assistance, parenting supports and transition services. Anoka Alternatives funding has been used to provide parenting classes, child care while the parent is receiving outpatient services, transportation to outpatient services, someone stopping in to visit on a regular basis, and 24-hour access to a mental health worker, if needed.

Counties had projected that they would be able to assist between 35 and 50 persons to move out of the RTC with services created by these one-time dollars. Eighty-five persons were discharged and discharge planning was occurring with an additional 60 persons as a result of this project.

While project dollars have been very useful in helping these 80 persons receive enhanced services to achieve discharge, the impact has not been limited to these individuals. An additional 30 persons have been referred to the project as requiring additional services. Each of these was reviewed by the discharge planning team. Although a few were found not ready for discharge, others were found to need no additional services beyond those currently available in their home communities, once county, AMRTC, and Division staff discussed options. The project has thus demonstrated the effectiveness of the collaborative discharge planning process as well as the need for flexible funding for individualized planning.

County, AMRTC, and State administrative and staff commitment to this one time, short-term project has been commendable. Creative programming based on individual needs and choice as well as coordination by the county, RTC and providers has produced successful project results. As a result of this success, the Legislature authorized $600,000 for the next

biennium to continue this project. An additional 24 persons are anticipated to be discharged and funding will continue as appropriate to meet the service needs of those discharged in 1991. Table 3, in Requirement IV provides statistical information on the project.

Olmsted County Project. In 1990, a 16-bed residential facility in Rochester, one of the most expensive in the State, was closed because of an extended pattern of low-occupancy. The Division committed that these service funds would not be lost to the community. Following the recommendations of the Division, Olmsted County (where Rochester is located) completed a community mental health services needs assessment for the use of these funds. The three most affected counties proposed and received approval to convert these funds to an alternative use for housing support services and housing subsidies. These three counties have now expanded their housing support services, and project to serve over 80 clients with the funds which had served 16 in a residential treatment setting. Some of the funds are being used to enhance the services/staffing at the only residential program in Olmsted County. Two of the counties are providing rent subsidies to clients to enable the clients to afford decent community housing. Both counties have developed cooperative, formal work relationships with their local public housing authorities. The housing authorities are enthusiastically cooperating, and are administering the rent subsidies. All three counties offer low-income housing, client damage deposits, furniture vouchers, utility deposits, and emergency funds.

Housing Support Projects. Amendments in 1989 to the Comprehensive Adult Mental Health Act included a mental health housing mission statement. This mission statement gave the commissioner the responsibility to ensure that housing services were provided as part of a comprehensive mental health service system. Since the addition of the Housing Mission Statement, the Mental Health Division has been incorporating its principles in the grant programs it develops and administers.

The 1988 legislature allocated $500,000 for the development and implementation of housing support pilot projects. The purpose of these projects was to provide supportive services to persons with mental illness to remain and live in safe, stable and affordable housing of their choice. The selection of this housing was to be from those living environments available to the general public. Initial pilot projects began in November, 1988. By the end of the first fiscal year, ten counties had eleven projects implemented. The Department requested and received approval from the Legislature to continue the pilot projects in FY 1990-91.

The projects served 448 persons in FY 90 utilizing $535,000 for housing support services. It is projected that 490 persons will be served in FY 91 with $549,445 in allocations.

In May, 1990 a fulltime mental health program consultant position was established to oversee the housing support pilot projects and Stewart B. McKinney Mental Health Services for Homeless Persons (MHSHP) program. Additionally, this staff person is responsible for providing technical assistance regarding implementation of the housing mission statement and coordination with housing and housing support agencies

Since the inception of the Housing Support Pilot Project, the Division has informed counties about the availability of local housing authority funds. In 1991, each of the eleven projects was asked to develop an arrangement or agreement with a local housing authority to provide support and make certificates and vouchers available for persons with mental illness. Two counties have developed housing subsidies delivered through the local housing agency. Another four have received special funds for vouchers and also have formal arrangements with local housing agencies. These arrangements have been developed with the Division taking a primary role. In the counties that have their own subsidies, the State developed a method of changing facility based shelter into rental subsidies and housing support.

Homeless Persons. In FY 1991, approximately 3,152 homeless individuals with mental health problems received services from mental health providers in eight Minnesota areas where homeless people congregate.

In 1987, prior to availability of McKinney funding, the Minnesota State Legislature appropriated $350,000 for Minnesota's three largest cities to provide mental health services for homeless persons with serious and persistent mental illness. With the FY 1987 and FY 1988 McKinney funds, the ability to assist homeless persons with mental illness was expanded to five more communities, and a small mental health service network was born that both homeless service providers and homeless persons have come to depend upon.

The McKinney grant has been an incubator for growth in mental health services to homeless people. For example: the Duluth project made a successful application to purchase a $1 HUD home and convert it into a transitional home for homeless persons with serious and persistent mental illness; the Moorhead project began a drop-in center for homeless persons with mental illness which a local shelter now runs full time; the Crookston project has assisted the community in breaking down racism by coordinating a

celebration of ethnic diversity; and law enforcement classes in the Range area will include information on how to handle crises for homeless persons with mental illness. Minnesota contributed $346,000 in 1991, a match of $2.87 for every $3.00 of federal funding for the homeless program.

OBRA-87 Relocations. 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.

An estimated 143 residents will require relocation, with all relocations to be completed by June, 1992. $1,495,399 in State funds to support activities of the ADP were awarded to counties to assist with relocation efforts during the FY 90-91 biennium. Eleven counties with financial responsibility for residents currently found to need relocation applied for these State dollars. $2.8 million dollars has been allocated for the FY 91-92 biennium to continue this effort. Thirteen counties have applied for funds to continue the relocation effort and/or maintain persons already relocated to the community. These funds are to be used to develop new community-based services and/or to enhance and expand upon pre-existing services to meet the specific needs of this population. Funding is flexible and is geared to meet the specific needs of each individual. For example, dollars can be used for rental subsidies and the enhancement of an array of wrap-around mental health and social services to assist the individual with transitioning to the community. It is projected that the cost of individual services will average $1,200 per person per month, including room and board.

Counties have been encouraged to explore stable housing reflective of the client's choice. Rental subsidies as well as payment for damage deposits, utility hookup, security devices and miscellaneous household furnishings are also accessible through the State ADP grant funds. Preliminary findings indicate that the majority of persons (n=16) discharged from nursing facilities are residing in apartments or adult foster care homes. Two persons with a long history of institutional care were relocated

from nursing facilities to a community residential treatment (Rule 36) setting.

Older Adults. The projects serving older adults demonstrated that barriers to service delivery can be overcome. Some projects proved to be so worthwhile that, even in difficult budget times, funds could be secured for continuation of the projects.

Beginning in 1988, eight demonstration projects were established to address the needs of older adults. Federal Block Grant monies for underserved populations and NIMH special project funds were used to fund these projects. The purposes of the grants included reducing or eliminating barriers to mental health services for older adults through use of outreach activities and providing coordinated, appropriate networks of mental health services for older adults, thereby reducing or eliminating gaps in, or duplication of services.

Several projects have developed additional funding sources so that the projects will continue once the demonstration funds are no longer available for this effort. The variety of funding sources indicates in itself the perceived value of the projects. Some of these funding sources include county funding, mental health center funding, MA reimbursement, health clinic reimbursement funds, charitable gambling funds, community education funding, a grant from the local electrical company, a State-funded grant, and funding from private sources, including churches and individual fundraisers such as card and seed sales. Funding from public bodies tended to be the result of the advisory groups having sufficient political awareness to get the attention of local elected officials.

Downsizing IMDs. The MHD participated in several efforts to provide normalized living arrangements for persons with mental illness. 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 the potential to enhance programs and to enable them to provide service to more challenging clients.

The 1991 Legislature allocated $1.5 million to downsize 25 existing IMDs to improve services for 582 people and maximize

federal reimbursement for 472 of those 582 who would be eligible for Medical Assistance if they were not in an IMD. These dollars will be used to develop and provide mental health and support services that consumers will need to live in less restrictive settings. In 1991, before these funds became available, 43 people became eligible for Medical Assistance due to MHD efforts to reduce IMD beds.

There are 1,375 community residential treatment beds in Minnesota. This number will decrease as the State implements its plans for downsizing large facilities, including those declared as IMDs. It is anticipated that some of the funding will then be diverted into housing support services, in much the same manner as was accomplished in Olmsted County. (See Olmsted County Project above).

The following represents Rule 36 IMD targets for FY 1991-1992:

	F.Y. 1991	F.Y. 1992
Number of Rule 36 IMDs downsized	9	14
Number of Rule 36 clients made eligible for MA	43	472

Funding Increases for Staff in Community Services. The Legislature provided Rule 12 and 14 funding for a 3% wage increase for personnel below top management in community support and residential treatment programs effective July 1, 1991. This is the only cost of living increase in the mental health area. For Rule 14 grants, this equates to an across-the-board increase of 2.5% over the FY 91 awards.

Indian Mental Health. During 1990, the Division continued its support of Indian Mental Health projects, utilizing 25 percent of the Federal Alcohol, Drug Abuse, and Mental Health Block Grant funds. From January through September of 1990, the projects served a total of 2,721 Indian men, women and children. A total of $379,689 was awarded in 1990 for the continuation of 10 Indian mental health projects. The Indian Mental Health Advisory Council identified a high level of unmet mental health service need in Indian communities and an absence of State funding for Indian mental health service development and implementation. A majority of the Minnesota Chippewa tribes, Sioux communities, Minnesota Indian Affairs Council and urban Indian organizations passed resolutions supporting the Indian Mental Health Advisory Council's efforts to seek additional mental health funding. Unfortunately, this State funding was not appropriated during the

Data Reporting Systems: Enhancements in data reporting systems permit more effective use of staff time at both the State and

local level, and sharpen the areas targeted for needed change, program development, increased funding and other program changes. The Community Mental Health Reporting System (CMHRS) was fully operational in January, 1990. It provides the Division with the capability of providing both routine semi-annual and annual reports and ad hoc reports, and 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 existence of CMHRS has been critical in eliminating burdensome monitoring aspects of the county planning process.

The Mental Health Statistics Improvement Project (MHSIP), funded by a three year NIMH grant to help organizations providing mental health services develop improvements in their data systems, functions as an adjunct to the CMHRS. Improvements include installation of national data standards and use of these standards to serve local management decisionmaking. Two contracts have been let to support implementation work at two Community Mental Health Centers and a third contract developed for the CSP vendor. These contracts will support changes to local data systems. The result is expected to be more complete and comparable data for local decision-making and an enhanced ability of the Division to perform its supervisory role with respect to delivery of mental health services.

Human Resource Development: The Division is currently in the final year of an NIMH funded Human Resource Development (HRD) Capacity Building Project . When completed, the MHD should be able to monitor, plan for, and influence the size, quality, use, and distribution of the mental health services work force. The major capacity building goals of the HRD Project are:

- To create an identified focal point or mechanism for State mental health human resource development;
- To establish a public/academic liaison as well as linkages with other related agencies;
- To develop a State Human Resource Development Plan, which is integrated with the State Mental Health Plan; and
- To have the capacity to collect and analyze data on the mental health workforce in relation to organizational, client and service event data.

The HRD Project has initiated a needs assessment to identify existing mental health human resource needs to support human resource planning. The needs assessment is designed to identify problems and strengths in the areas of recruitment, retention, utilization, pre-service education, distribution, and others.

The Project has been working in conjunction with the Mental Health Statistics Improvement Project (MHSIP), MHD Technical Support Unit and Licensing Division to address the Division's needs for mental health human resource information. The HRD Project has reviewed existing human resource data streams and determined that existing streams cannot be combined into any kind of comprehensive data system capable of integration with client and service event data systems. The Division is now pursuing creation of a machine readable form for reporting mental health human resource information data. Use of this data collection instrument, along with planned adaptations to the Community Mental Health Reporting System, will allow the Division to evaluate mental health services in regards to effective utilization of staff and to identify workers or skills and abilities in short supply.

Finally, the HRD Project has established a variety of intra- and inter-agency linkages to coordinate human resource development activities and the creation of a unified mental health human resource development focal point within the Division, thereby improving the Division's ability to respond effectively to identified human resource issues.

Public-Academic Liaison Initiative: 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."

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 have mental illness;

- 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 has been made for the Public Academic Liaison Initiative. Therefore, no new activities have been started directly as a result of the Initiative. However, many ongoing Division activities, as well as new activities funded by the NIMH Human Resource Development (HRD) capacity building grant facilitate the public/academic liaison function. These include the following:

DHS' Institutional Review Board, with representatives from Minnesota's medical schools, DHS, and such organizations as the Institute for Disability Studies and the Minnesota Hospital Association, has chosen to advocate for research within the regional treatment center system. This membership affords some liaison capacity between DHS and academic institutions interested in researching the biological origins and treatment of mental illness.

The DHS's Affirmative Action Office has developed recruiting relationships with colleges and universities with minority students throughout the country. The Minority Recruitment Shortage Occupation Project has focused on the areas of occupational therapy, physical therapy, and speech pathology.

In July of 1990, the Minnesota Higher Education Coordinating Board (HECB) joined the Western Interstate Commission for Higher Education (WICHE), which operates a mental health program which assists member states in four areas: 1) development of mental health decision support and data systems; 2) mental health human resource development; 3) rural mental health policy development; and 4) public/academic liaison development. When the HECB joined, WICHE extended an invitation for Minnesota to participate in the WICHE Mental Health Program, even though the Division was unable to pay the annual dues of $15,000. More recently, however, WICHE has requested a phased-in dues schedule which is likely to preclude Division participation.

University faculty are routinely sought out to serve as representatives on a variety of advisory groups. Currently, faculty from higher education institutions sit on the following advisory and work groups: HRD Project; Compulsive Gambling; Education/Prevention/Research Subcommittee of the State Mental Health Advisory Council; and Early Identification/Intervention.

University faculty have worked with the Division in developing research projects of interest to both the Division and the University. Faculty in the Departments of Sociology, the Institute on Community Integration, University of Minnesota, the Department of Family Practice and Community Health at the University of Minnesota Medical School have or are currently collaborating with DHS staff in preparing proposals in the areas of interagency coordination of children's mental health services, a consumer-run supported housing program, and homeless persons

with mental illness. Other faculty have sought Division input into types of practical training sites for a proposed practitioner program in psychology, which the Division supported.

The HRD project recently completed a survey of Minnesota higher education academic programs in disciplines which frequently prepare persons to work in mental health services on issues such as program capacity, enrollment demographics, curriculum content, and student opportunities for practical experience. Results will be used as a basis for PALI, outlining the current scope of higher education/service system collaboration, needs and opportunities.

The MHD has obtained assistance from the State/University Collaboration Project (S/UCP), a joint effort of the Pew Memorial Trust and the American Psychiatric Association offering in-depth consultation to states wishing to develop or enhance existing State/university collaborations as well as regional workshops. The HRD Project has coordinated assistance from S/UCP as part of its workplan. The S/UCP held a two-day Midwest Regional Workshop about collaboration in St. Paul in June, 1990, in which staff from DHS joined representatives from the University of Minnesota Department of Psychiatry and the Minnesota Association of Community Mental Health Programs. Consultants from Washington State's Institute for Mental Illness Research and Training and the University of Washington Department of Psychiatry conducted an S/UCP consultation on January 11, 1991 with DHS, University of Minnesota and other interested groups. As a result, DHS and the University of Minnesota Department of Psychiatry reached an agreement to pursue the following collaborative activities:

- Working together to provide continuing medical education and outreach in an effort to reduce the isolation of psychiatrists practicing in public sector settings in Minnesota;

- Working together to review and simplify procedures necessary to secure approval for research projects conducted in State-operated facilities while retaining standards of scientific merit and the protection of human rights.

- Using existing DHS funds for psychiatric services to pursue a contract with the Department of Psychiatry to employ a Department of Psychiatry faculty person as a Research Coordinator, with additional responsibilities for outreach to psychiatrists working in community based mental health programs at the Anoka-Metro Regional Treatment Center.

- The Department of Psychiatry agreed to consider the need to develop a public-community focus as it recruits for faculty positions.

While the S/UCP 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 in the future. Based on the recommendations of the Pew/APA consultation, the DHS may apply for a PALI grant in a future funding cycle to extend the scope of the PALI efforts.

Diffusion Network Project: Minnesota is participating in the Diffusion Network Project of the Research and Training Center at the Stout Vocational Rehabilitation Institute at the University of Wisconsin-Stout in Menomonie, Wisconsin. This project, which has funding from the Rehabilitation Services Administration, is intended to help rehabilitation facilities and consumers to establish new programs or expand existing programs to serve persons with serious and persistent mental illness and/or with traumatic brain injury. The goal is to help establish community-based programs that lead to community employment and living and social integration. The project's goals are to:

- develop replicable community-based program models, and
- diffuse these program models to other facilities and consumer groups.

The project provides an initial one-time grant to two new programs each year for three years. Also, and more importantly, the project provides three years of technical assistance and consultation to help facility staff and consumers to develop and evaluate the new programs.

Following an application and selection process, two programs have started. The Duluth-based program will serve adults with serious and persistent mental illness. Eventually, there will be 6 of these demonstration projects in operation; and they will provide important information on the establishment of quality supported employment program models.

Strengthening Human Resources Through Provider Training/Technical Assistance: Many of the Department's activities involve provider training and/or technical assistance. These include training activities at regional and metropolitan area information meetings (200 persons received training through these presentations), CSP annual conferences (training was provided to 550 registrants at the last CSP annual conference), training involved in special initiatives (e.g., DHS offers 60 hours of special skills training for community service provider agency personnel in compulsive gambling treatment issues), granting of awards for projects involving training, collaborative arrangements to develop and/or deliver training (e.g., PALI/S/UCP) and others.

Thorough technical assistance/training is necessary for the successful implementation of adult case management. Training will be developed to meet the needs of case managers with respect to the revisions, which, by statute must be completed by July 1, 1993. The Mental Health Division recognizes the need for a Statewide comprehensive training package, and will develop a proposal for HRD grant money for this purpose.

Adult Case Management Reimbursement, Rule Revision and Training: Local providers of Rule 74 case management services have expressed concern about the relatively small amounts of federal and state financial participation that local agencies are realizing from this program. The MHD is working collaboratively with other state offices to assure increased Title XIX revenue to local agencies. In addition, the Division is providing technical assistance to local agencies based upon the results of the Case Management Survey.

Strengthening local capabilities to provide mental health case management has been a high priority for the MHD. A wide variety of techniques and methods have been incorporated in disseminating information and developing skills at the provider level, including:

- Regional Area Informational Meetings, or AIMs, have been held across the state to share information regarding state and local program developments. A total of 200 persons participated in each of four AIM trainings in the last fiscal year.

- Day-long, county-specific meetings are arranged on a continuous basis on all aspects of case management administration and practice, focusing on intra-county coordination, information sharing and assisting counties in establishing effective policies and procedures for increased Medical Assistance billing.

- Face-to-face and telephone contacts assist local agencies and providers in solving on-going problems regarding all phases of case management service delivery.

- The Community Support Programs Conference track of four sessions on Case Management, providing training to approximately 150 persons. The sessions were designed to assist local providers in a number of areas including the administration of programs so that reimbursement could be maximized.

- Technical assistance issue papers and methodology through information taken from surveys, reporting data, personal contact with providers.

The Division is continuing these efforts and will establish new and innovative case management training techniques as well as enhancing those already used. The Division will establish a series of training modules to be presented on a regional basis that address problems and issues regarding the administration of Rule 74 Case Management. Plans are also underway for the development of a statewide Mental Health Case Management Conference.

Medical Assistance Rehabilitation Option: During the past year, staff of the Mental Health and Health Care Programs Divisions worked together to develop a cooperative proposal for a major expansion of the Medical Assistance rehabilitation option for adult mental health. In the past, the only mental health utilization of the option has been for day treatment. The proposal, developed for the 1991 Legislature, focussed on capturing federal reimbursement for rehabilitation services which are now state-funded in community residential facilities. The MHD projected this proposal would bring in over $1,000,000 in new federal funds in FY 93 to be used for expanded community services. Originally the MHD projected this could be done using existing state funds with no risk of increased state costs. This proposal was described in the Governor's budget as one of four components in the Mental Health Housing Initiative.

Unfortunately, as the Governor's budget was going to the printer, new information was received indicating that this proposal would in fact result in substantially increased state costs. The new information indicated that federal law would not allow implementation of these services solely in residential settings: if the services were implemented under Medical Assistance, services provided in non-residential settings had also to be reimbursed.

The MHD has effective control over the number of beds in residential facilities and, therefore, could guarantee to the Legislature that the cost of this option would not exceed the currently available state match, were it limited to residential settings. However, the same control does not exist in relation to services provided in non-residential settings. DHS decided that, in the current budget situation, it could not accept the open-ended funding liability that would be associated with establishment of an entitlement for community support-type rehabilitative services. During the next two years, the MHD plans to continue to work on ways to expand Medical Assistance rehabilitative services.

Provider Legislation: In 1987, at the same time Minnesota mandated licensure for social workers and marriage and family counselors, the Legislature also established a Board of Unlicensed Mental Health Service Providers (BUMP). This was an effort to deal with an unknown number of unregulated practitioners who were providing some kind of mental health service to the public. All mental health service providers not otherwise licensed or regulated were required to identify themselves and pay a fee to the Board. The law also defined a code of conduct for unregulated mental health providers and the Board was empowered to discipline individuals who violated that code. Board members were appointed by the Governor and were to be primarily representatives of the professions to be "regulated", including chemical dependency counselors, professional counselors, and clergy. The legislation was aimed at consumer protection in an area where, it was believed, significant exploitation has occurred. To ensure that the process received appropriate and timely review, the Board of Unlicensed Mental Health Providers was scheduled to sunset on June 30, 1991.

Review of BUMP revealed several major problems, including the following:

- Although the BUMP Board was set up as a regulatory mechanism, the process provided no significant benefits to those who complied. Registrants were required to pay a fee but were not permitted to display any State-sanctioned credentials.

- Membership on the Board was primarily practitioners who either wanted to promote the full legal regulation of their profession, or those who wish to prevent any legal regulation of their group. In other words, the primary motive of those who fall under the jurisdiction of the board is to escape that jurisdiction in one way or another. Only about five hundred individuals registered. Group after group won legal exemption from jurisdiction.

- The expectation was that the Board would be self-supporting. The motives that drove the BUMP Board mitigated against the possibility that it could ever be self-supporting.

BUMP reviewers concluded that the purpose of the Board of Unlicensed Mental Health Service Providers, protection of the public, was not being served by this legislation. Reviewers determined that client protection was best achieved through:

- Educating consumers about mental health service providers and their rights as clients;

- Providing a single point for accepting and investigating complaints by consumers about mental health service providers not otherwise regulated; and

- Disciplining unregulated mental health service providers who violate the legislatively established code of conduct.The responsibility for compiling information on client exploitation and providing redress is very similar to other consumer protection functions. This function should be thought of as a permanent task of State government like other client protection activities.

In 1991, the Minnesota Legislature permitted the Board of Unlicensed Mental Health Service Providers to sunset and, in its place, established an Office of Mental Health Practice within the State Department of Health. The functions of the Office are consumer education, investigation of complaints against unlicensed mental health practitioners, and enforcing disciplinary actions as appropriate. This Office will be funded out of revenues generated by mental health provider licensing boards, such as the Board of Social Work and the Board of Psychology. The code of conduct remains in statute, as does the obligation to report actions that may violate this code.

Funding for Children and their Families

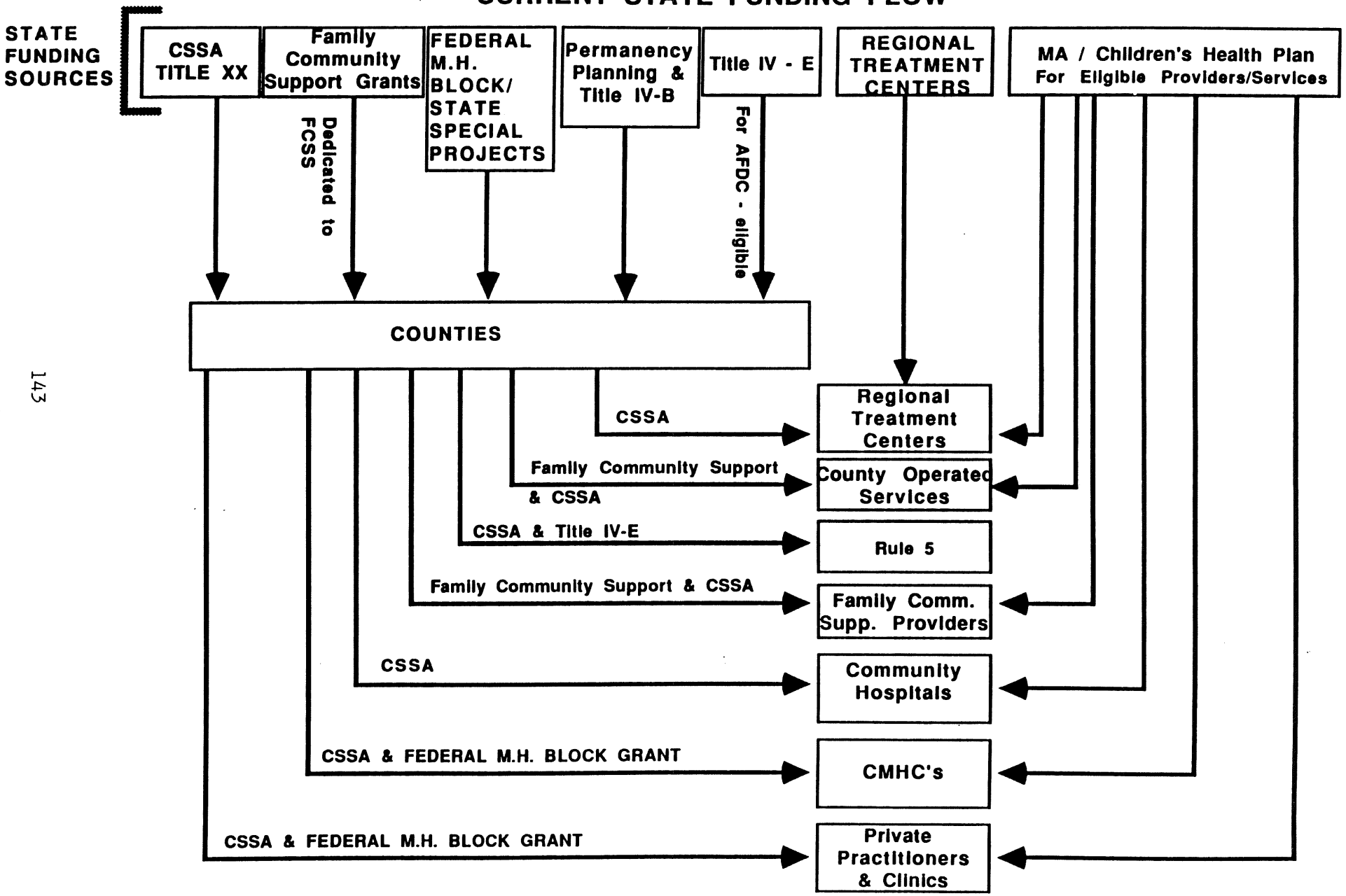
Description of Funding Sources. Because the county is the local mental health authority responsible for provision of a comprehensive array of mental health services, most funds flow through the counties, as is illustrated in Figure 11. The major exceptions are Medical Assistance, which is paid directly to providers, and RTC funding.

Figure 11

CHILDREN'S MENTAL HEALTH SERVICES

2/91

CURRENT STATE FUNDING FLOW



The following is a brief description of major DHS funding sources for children's mental health services:

- Federal Mental Health Block Grant funds (about $674,000 for children's mental health for FY 91) are targeted to underserved populations, including eight demonstration projects for children's mental health and ten projects serving American Indians. No local match is required for the American Indian projects. The demonstration projects are funded on a three-year basis with an expectation that local or other funding must be arranged to pay for an increasing share of the project each year.

- Community Social Services Act (CSSA) funds include, for FY 91, approximately $45 million from the Federal Social Services Block Grant (formerly Title XX), approximately $51 million from state CSSA funds and about $270 million in county tax funds. For 1990, counties planned to spend about 10%, or $37 million, of these "generic" funds for children's mental health services. These, the most flexible funds available to counties, are used whenever other funds are inadequate to meet client needs.

- Medical Assistance (MA) covers inpatient services, outpatient services, day treatment and case management within very specific limits for eligible children. MA includes 53% federal funding and is subject to federal requirements. State law previously required counties to pay 10% of the non-federal share of MA; that requirement was eliminated in January, 1991, except for RTC services, which will require county payment of 50% of the non-federal share. In FY 89, MA paid about $14 million for children's mental health services (other than RTCs).

- Since children's costs in RTCs are almost completely reimbursed from Medical Assistance, insurance, and other funds, the RTC state appropriation is used for operating capital until the other funds are collected. In FY 90, Medical Assistance paid about $4 million for children's services in RTCs. The state share (42%) for these Medical Assistance payments was about $1.7 million. (Note that the county share of non-federal funds for RTC placements was changed by the 1991 Legislature.)

- The Children's Health Plan (CHP) is a new program which began covering outpatient mental health services on July 1, 1990. CHP is a totally state-funded program for low-income children who do not qualify for MA. Until January 1991, CHP included only children under 9 years of age. Ages 9-17 were

added January 1, 1991. Although CHP is not subject to the same federal rules as MA, CHP coverage for outpatient mental health services is similar to MA (with the exception of an annual cap of $1,000 per child for mental health services and limits on the types of services covered.)

- State grants to counties for family community support services began in April, 1991, at an annual level of $1.2 million. These grants fund county costs for new family community support services required by the Comprehensive Children's Mental Health Act. No local match is required, but counties must maintain their previous spending for mental health services. (These grants will become part of the larger Children's Comprehensive Mental Health Grant Program in April, 1992.)

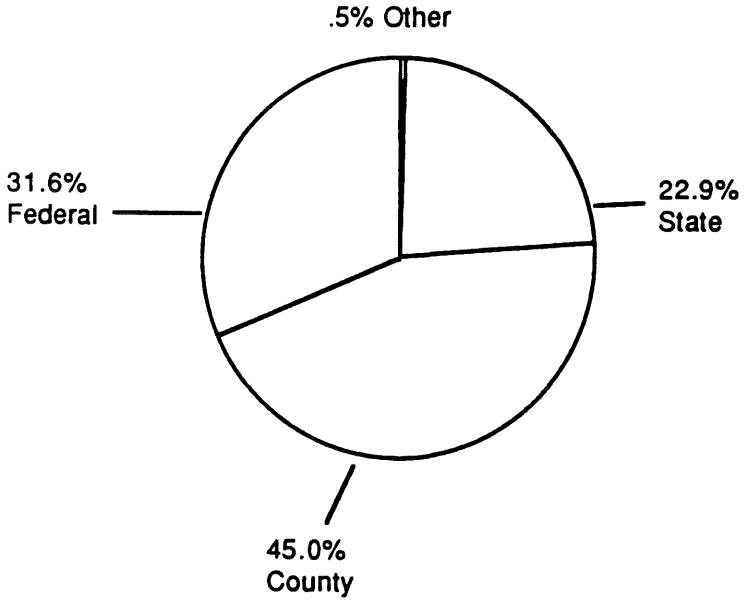
Figure 12 indicates funding source by level of government. The single largest funding source for children's mental health services is county funds.

Figure 13 illustrates total estimated FY 91 DHS expenditures for children's mental health services, by service category, including county matching funds for state grants. The largest expenditure is in the residential category. Total expenditures include 23.8% inpatient, 37.3% community residential (including therapeutic support of foster care), 38.7% community non-residential (outpatient) and .2% for state administration.

Figure 14 compares adult and children's state, county and federal shares. Note that the state share for adult mental health services averages 57%, but the state share for children's mental health services is only 23%.

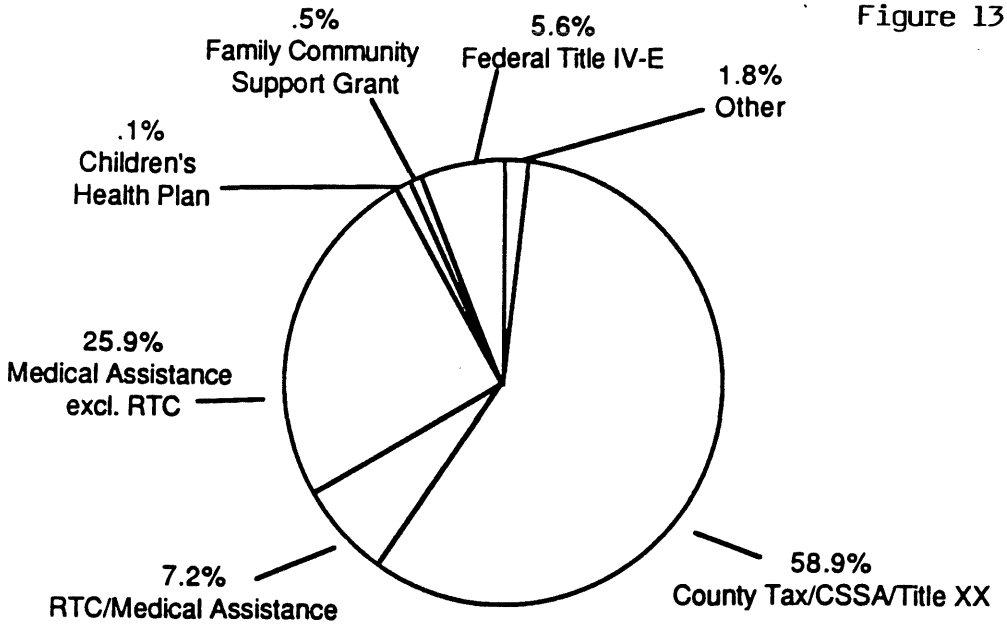
Figure 12

FISCAL 1991
DHS Funding Sources
Children's Mental Health Services



Federal, State and County Funding

Figure 13

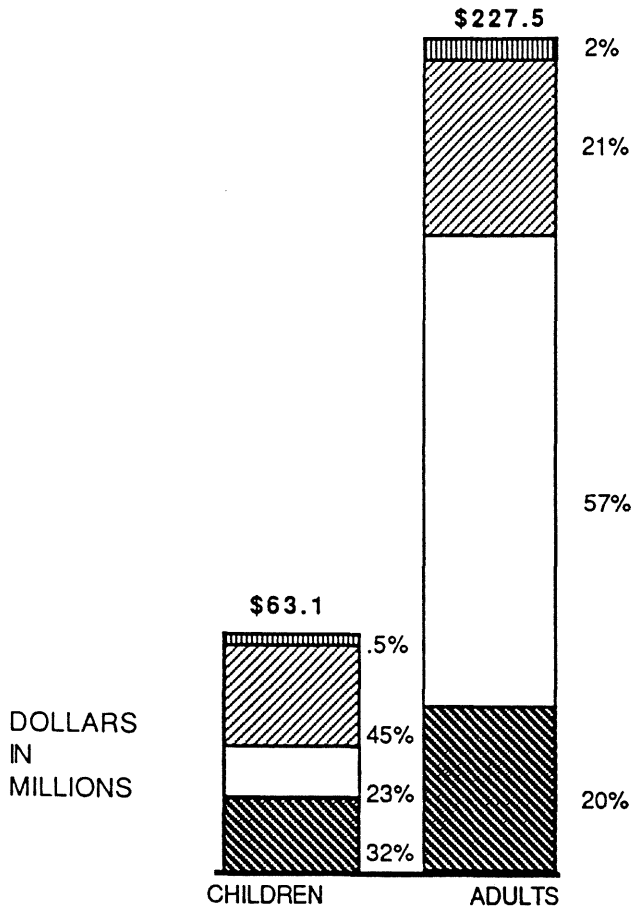


Funding by Program Category

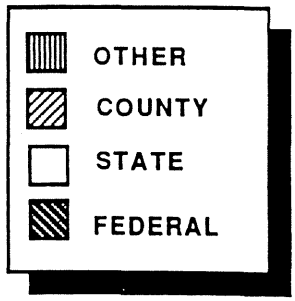
Feb 1991

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

(ESTIMATED; FISCAL 1991)



State funds equal 23% of all DHS funding for mental health services for children, 57% of all funding for mental health services for adults

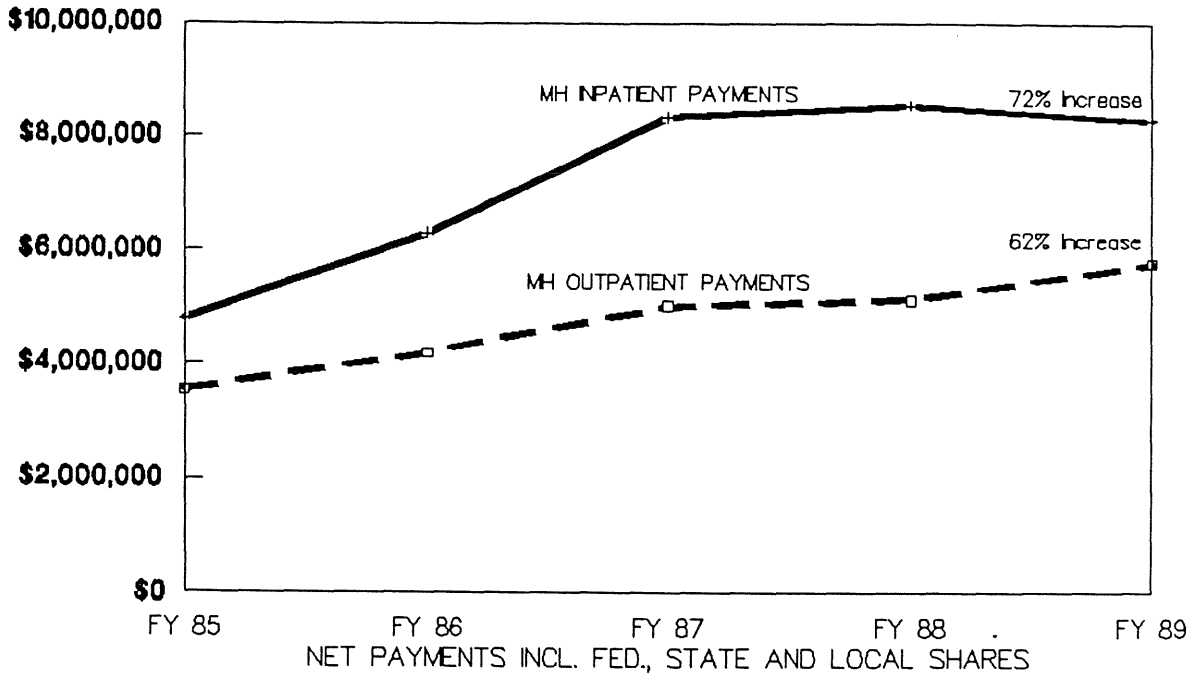


Feb 1991

Trends in Medical Assistance Expenditures for Children: Medical Assistance is the only major funding source for children's mental health services which can provide reliable multi-year data regarding clients and expenditures. Figures 15 and 16 show client and expenditure trends for this funding source for the last five years. MA inpatient expenditures for children's mental health increased significantly between FY 85 and FY 87, but now appear to have leveled off. MA outpatient expenditures for children's mental health have increased steadily and are now increasing faster than inpatient expenditures.

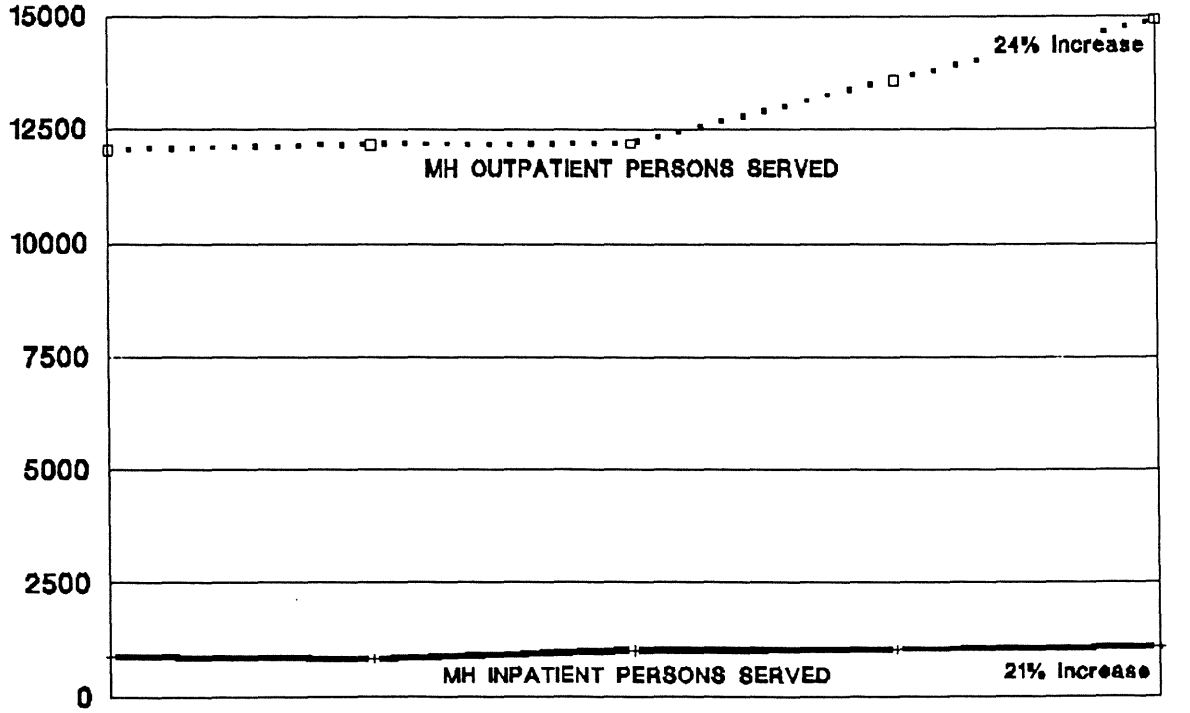
MEDICAL ASSISTANCE FOR CHILDREN'S MH SERVICE INPATIENT VS OUTPATIENT

FIGURE 15



NET PAYMENTS INCL. FED., STATE AND LOCAL SHARES

FIGURE 16



CHILDREN (0–18) SERVED DURING THE FISCAL YEAR

Adjusts for HMO data based on client eligibility. RTC use was not included in analyses.

Trends in County Funding for Children: As indicated in the discussion of adult funding, available data indicates that counties have increased their funding for adult and children's mental health services (combined) by 74% over the past six years. Unfortunately, reliable reporting systems have not been in place to track these expenditures in a consistent manner. It is not clear how much of this increase is due to changes in reporting methods, e.g., counting children's mental health under the mental health category instead of under the children's category.

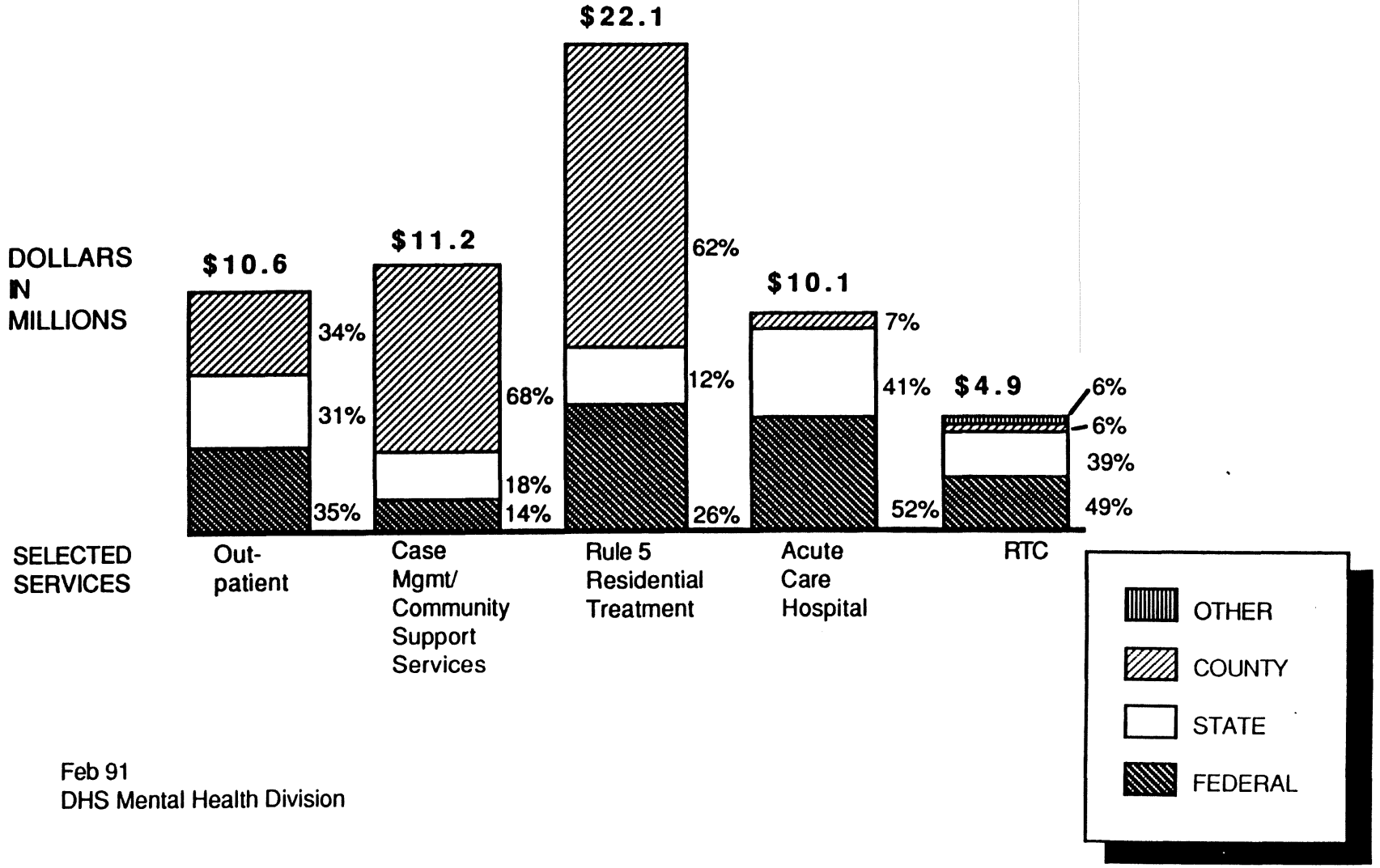
On the whole, it appears that most counties have been very supportive of providing mental health services, especially children's mental health. Most counties are reporting much higher commitment of county funds for mental health services than the minimum required by law.

Fiscal Incentives and Comparative Costs for Children's Services. Minnesota's complex funding system has raised concerns as to whether the funding system "drives" clients towards inappropriate services. This concern seems especially valid for children's mental health services. Funding disparities for different services seem to be greater for children's mental health than for adult mental health. Figure 17 shows average state, county and federal shares for key children's mental health services. Note particularly the large disparity between county share for RTC services (6%), compared to county share for case management and community support services (68%), or county share for community residential treatment (62%). As a result, family community support services were almost nonexistent in many counties until state funding for these services became available in April, 1991.

Figure 17

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

(ESTIMATED; FISCAL 1991)



Feb 91
DHS Mental Health Division

Rule 5 Residential Treatment Services: The 41 facilities currently licensed under Rule 5 admitted approximately 1,684 children with mental illness, emotional disturbance, or "unknown" diagnoses in FY 1989. Counties projected expenditures of $22,257,824 for 1,589 children in 1991. Earlier estimates (1988) of expenditures indicated that approximately 15% were reimbursed by federal Title IV-E funds, with the remainder estimated to have come from county funds, including funding through CSSA.

Funding Expansion: Progress has occurred in expanding funding for community alternatives. For example, since 1987:

- Medical Assistance has been expanded to include case management for persons with serious and persistent mental illness. Current expenditures for children are only about $60,000 per year, but total expenditures are eventually expected to rise to $1.2 million per year.

- New funding for family community support services for children with severe emotional disturbance began in April, 1991, at a rate of $1.2 million per year.

- The 1989 Legislature approved expansion of Medical Assistance for professional home-based treatment for children with severe emotional disturbance. This service is now expected to begin in 1992, with total expenditures eventually expected to rise to $7 million per year.

Very little reliable information is available regarding the comparative cost per child in different settings. The following is a summary:

- A 1990 study conducted by a work group of executive and legislative staff found an average per diem of $109 for Rule 5 community residential treatment.

- The "official" FY 91 per day rates for RTC adolescent mental health programs are $218.40 for Brainerd and $190.60 for Willmar. However, these rates are based on average calculations for the entire mental health program at each facility. Since the children's programs are a relatively small part of each facility, the rates primarily reflect the cost of the adult programs. Actual per day costs for the children's units are probably higher.

- The average Medical Assistance payment for children's psychiatric hospitalization in calendar year 1989 was $337 per day.

- In 1988, DHS surveyed the few programs providing the new services required by the Comprehensive Children's Mental

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- In 1988, DHS surveyed the few programs providing the new services required by the Comprehensive Children's Mental

Health Act. The fiscal note indicated the following estimated per day per child costs for the Act:

- $6 for family community support services
- $3 for case management
- $14 for professional home-based family treatment
- $14 for therapeutic support of foster care

The major missing piece is an estimate of the total package of services which a child might need in the community as an alternative to institutionalization. It is assumed that most children with severe emotional disturbance would receive at least 2 or 3 of the community services listed above, plus a number of outpatient "ancillary" services (physician, psychologist, etc.)

For adults with serious and persistent mental illness, special analyses have been done to identify the true costs of serving an adult with serious and persistent mental illness in a community program. No comparable analyses have been done for children, partly because a similar group (e.g., children in IMDs) has not been identified in MA records, and partly because of insufficient staff time for children's mental health analyses.

State Interagency Coordinating Council Funding Activities: 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 monthly, on the average, since the end of the 1989 legislative session in order to design a system which would identify children at risk or in need of mental health services and offer prevention and treatment. One of the recommendations of this committee was to examine pooled funding to enhance access to resources and eliminate duplicative service and eligibility requirements.

The Committee undertook a project to obtain data on the provision of services to children with emotional disturbance, the first phase of which involved identification of the various funding sources currently available for mental health services, funding amounts, and the number of children being served. By meeting together and agreeing to a common format for presenting fiscal data and client numbers, it was possible to determine that most of the funding for children's services is not duplicative, but rather that it is typically used for different services.

In Tables 7 and 8, the matrix separates clinical services from instructional and educationally-related services provided with funds from the Department of Education and local school districts. The MHD typically funds clinical services whereas the Department of Education funds instructional services, even though both of these services may be subsumed under outpatient services, Family Community Support Services, residential services, or

others. For example, both education and human services systems pay for services to children in residential treatment. However, educational funding is utilized for specialized instruction, whereas human services funding provides treatment and room and board. This format permits, for the first time, the addition of unduplicated financial expenditures for children across State departments. The numbers of children served are not unduplicated counts, and hence cannot be added across departments.

Table 6

SERVICES FOR CHILDREN WITH EMOTIONAL DISTURBANCE
CHILDREN SERVED

Services	Human Services* CY 1990 Clients**	MA/GAMC SFY 1990 Clients**	Education 1990 Clients	Corrections 1990 Clients
Special Instruction			9,553	
Emergency Services	14,772			
Screening	2,237			400
Early ID, Intervention	5,301		344	
Outpatient Serv.				
Clinical Serv.	15,075	13,378		
Related Serv.			459	
Case Management	2,524	20	688	
FCSS:				
Day Treatment				
Clinical Serv.	1,358	361		
Instruction			459	
Home-Based Treatment	1,933			
Therapeutic/Foster Care	594			
Other FCSS	2,852			
Residential/RTC				
Clinical Serv.	1,775			45
Instruction			773	
In-patient Acute Care Serv.	290	551		
Total:			12,276	425

* These totals are unduplicated within services not across services. They also do not include children for whom services were provided by Medical Assistance. Totals are provided by counties in biennial county children's mental health plans.

** Totals are unduplicated within services, but not across services.

Table 7

SERVICES FOR CHILDREN WITH EMOTIONAL DISTURBANCE
FEDERAL, STATE, AND LOCAL FUNDING

Services	Human Services FY 1990 Funding*	MA/GAMC Chares FY 1990**	Special Education 1990 Funding	Corrections FY 1990	TOTAL:
Special Instruction			$ 40,328.141		$ 40,328,141
Education/ Prevention	$ 332,122				$ 332,122
Emergency Services	$ 629,702				$ 629,702
Screening	$ 285,074			$ 40,000	$ 326,574
Early ID, Intervention	$ 201,573		$ 1,456,744		$ 1,658,317
Outpatient Services					
Clinical Services	$ 4,097,597	$ 4,805,000			$ 8,977,597
Related Services			$ 1,942,325		$ 1,942,325
Case Management	$ 3,504,587	$ 11,500	$ 2,913,487		$ 6,429,574
FCSS:					
Day Treatment					
Clinical Services	$ 4,008,094	$ 543,130			$ 4,551,224
Instruction			$ 1,942,325		$ 1,942,325
Home Based Treatment	$ 1,862,122				$ 1,862,122
Therapeutic Foster Care	$ 1,251,078				$ 1,251,078
Other FCSS	$ 498,008				$ 498,008
Residential/RTC:					
Clinical Services***	$20,267,149	$ 4,233,877		$ 696,400	$ 25,231,026
Instruction			$ 4,680,078		$ 4,680,078
In-patient Acute Care Services	$ 305,190	$ 7,050,000			$ 7,355,190
State Administration	$ 99,000		$ 80,000		$ 179,000
TOTAL:	$37,341,296	$16,643,507	$ 53,343,100	$ 736,400	$108,174,403

* Totals are derived from 1990-91 county children's mental health plans.
** Totals are approximated and are not equal to payments on a claim-by-claim basis; they do not include amounts from pre-paid plans.
*** Include Room and Board costs.

New Funding for Children's Mental Health Services (FY 1992-1993):

Funding for non-MA Case Management and Home-Based Services. In 1988, the Department promulgated Rule 74, relating to case management for both adults and children with serious and persistent mental illness. The fiscal note for Rule 74 assumed that counties would provide case management to about 1,000 children with serious and persistent mental illness, and that approximately 500 of those children would be funded through Medical Assistance.

The 1989 Legislature passed the Comprehensive Children's Mental Health Act, including a statewide mandate for case management for children with severe emotional disturbance, effective July 1991. The Department had estimated that twice as many children would qualify as having a severe emotional disturbance as compared to the earlier "serious and persistent mental illness" criteria. However, since the effective date for expanded eligibility did not occur until 1991, the 1989 Legislature did not appropriate any funding relating to the new mandate, nor did it amend MA coverage to include the expanded severe emotional disturbance target population.

The 1991 Legislature approved most elements of the Governor's Children's Mental Health Initiative, including:

- $4.8 million in increased funding to expand grants to counties for non-MA family community support services and case management. With continuation of the current $1.2 million per year for family community support, this appropriation will bring all counties up to the greater of $22,000 per county per year or $2.25 per capita (based on the number of children in the county's population). In addition, the Department will issue an RFP this fall, with a probable application due date of January 1, 1992. Increased funding will be available effective April 1, 1992. The legislation requires that family community support services be the first priority for these funds; case management is the second priority.

- an increase in the county share for RTC services for children with severe emotional disturbance; counties will be required to pay 50% of the non-federal share for MA-eligible children after January 1, 1992. (Counties are already required to pay 100% of the residual cost of RTC services for non-MA eligible children.) This change is expected to save the State $1.6 million in 1992-93.

- $1,265,000 to begin MA coverage for case management and home-based services for children with severe emotional disturbance. This is in addition to federal matching funds and about $1 million in new State funds already in the budget base for home-based services; emergency rules will be written by January 1, 1992.

Child and Adolescent Service System Grant (CASSP): During 1990, the Department was successful in obtaining a $101,000 CASSP grant from the National Institute of Mental Health for federal fiscal year 1991 (second year funding is $160,000). This enabled the Department to hire a mental health consultant to develop curriculum and to plan for training at State and local levels on strategies for multiple system collaboration and service coordination. (The State Department of Education will provide an additional $100,000 to assist in training efforts.) Receipt of this grant also enables Minnesota to participate in the CASSP network of states, which providing access to information regarding service development, policies, and funding strategies for children with severe emotional disturbance and their families across the nation.

Children's Demonstration Projects: During the past year, the Division has continued to work closely with the eight Children's Mental Health Demonstration Projects which serve children with severe emotional disturbance. Funding for these projects comes from the federal Alcohol, Drug, and Mental Health Block Grant. These projects continue to collaborate in the development of services and to address many of the system and funding barriers which, in the past, have hindered development and implementation of coordinated mental health services. Most of the eight projects have progressed to the point of collaborative service development and delivery. The general experience of the demonstration projects supports the need for collaboration with the schools as vital to the successful implementation of the Comprehensive Children's Mental Health Act. Four of the eight projects have developed day treatment programs which are jointly funded, staffed and operated with school districts. Funding will be available for these projects only until March of 1992, when new pilot projects will be developed. It is hoped that alternative sources of funding will be available to support the continued work of these counties as leaders in the implementation of the Comprehensive Children's Mental Health Act.

Human Resource Development Support of Children's Services: The Division has provided training and technical support for children's mental health demonstration projects, the creation of family community support services, interagency collaborative efforts, and others. This training and technical assistance has been provided by Division staff, CASSP Project staff, and contracted trainers through site visits, Statewide conferences, and regional workshops. Input from local and State level

advisory groups indicates a shortage of personnel with the proper skills for serving children and adolescents with emotional disturbance. The Division will investigate the possibility of submitting an NIMH HRD grant proposal to support the HRD needs associated with implementing children's mental health services.

c. Description of problems encountered:

The Division has studied the possibility of Medicaid reimbursement for residential treatment services for children with severe emotional disturbance. Due to proposed changes at the federal level, the Department will not pursue Medicaid funding for residential treatment at this time.

RTC funding is requested by a separate division from the MHD, which oversees community-based service development. Increased costs of RTC treatment may have detracted from service development in the latter.

The Federal Mental Health Block Grant for FY 1989 was $200,000 less than for FY 1988. The two-year spending provision delayed the immediate impact of the reduction, but it gradually required a significant cutback in both the demonstration projects and State staffing during FY 1990 and 1991. No significant increases are expected in this grant for FY 1992 and 1993.
The reduction in federal McKinney Act funds will result in curtailment of the number of grants and persons served soon if funding is not restored to the initial level.

Because of the potential costs to the state budget, the Medical Assistance Rehabilitation Option could not be used for services provided in residential treatment facilities.

Many of the collaborative agreements reached between the Department and the University of Minnesota Medical School during the S/UCP consultation process are on hold following the resignation of the Medical Director for the Department of Human Services. These activities have the support of the Commissioner, and will resume once this position is filled.

Although the administrative systems have been in place for counties to bill MA for case management for children with serious and persistent mental illness since January 1, 1989, actual billings for children have been far less than expected.

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

The DHS and the University of Minnesota Department of Psychiatry reached an agreement to pursue several collaborative activities. However, due to the interests of the present faculty of the

Department of Psychiatry, these activities are more modest than originally hoped.

The Legislature approved most funding elements of the Governor's proposed Children's Mental Health Initiative.

A number of Division efforts have focused on enhancing the county's ability to more effectively access a variety of available funding sources, including federal funds. The State has streamlined procedures and improved its data system capabilities as well as its technical assistance activities in order to maximize efficient transfer of information while upgrading and equalizing service requirements.

REQUIREMENT VI. Providing activities (programs) to reduce the rate of hospitalization of individuals with serious mental illness.

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

a. The original milestone:

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

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:

Adult Screening for Inpatient and Residential Treatment: State Statutes had required that, beginning January 1, 1992, the county boards "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.

The same statute required the establishment of a task force on residential and inpatient treatment services for adults. The purpose of the task force was 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. That group, established in August, 1989, submitted its initial conclusions and preliminary recommendations as part of the Division's 1990 Report to the Legislature. One recommendation of the group was for additional study to address current screening issues, identify inconsistencies, and identify successful models for use in the development of an effective and coordinated system.

As a result, the task force continued meeting, discussing issues which had not been resolved in its previous work. In 1990, members modified their previous recommendations, concluding that screening as a distinct service should not be mandated by the State due to the costs of service implementation, duplication with other processes, such as hospital admission pre-certification, and because of the clinical complexity of the process. Instead, the task force recommended that the functions of screening be included in several ongoing activities. In addition, members felt screening functions, while not a separate service, should be responsive to both emergency and non-emergency situations.

Final recommendations of the task force are as follows:

- Screening as a mandated service for adults should be repealed, with requirements reflected in Recommendations 2 and 3, below, added to Minnesota Statutes.

- Counties should be required to assure that placement decisions are based on the clinical needs of the adult as identified by the individual, family or significant others (if appropriate), referral agency and the mental health professional involved.

- Each entity providing inpatient hospital or residential 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. Contracts should assure linkages between the county, as the funder of services for individuals receiving publicly funded services, and service providers to ensure comprehensive planning and continuity of care between needed services, in accordance with data privacy requirements. Appeal mechanisms should also be included in these contracts.

- The current revision of Rule 36 should address general admission, continued stay, discharge criteria, and an appeal mechanism which can be readily accessed by the individual or the individual's legal representative.

- Any screening functions undertaken by a county must be separate and distinct from ongoing case management services being provided to a client unless the case management model used for mental health services in Minnesota is modified.

- DHS should establish a work group to examine the feasibility and costs of requiring third party payers to cover all costs of treatment which have prior authorization until such time as concurrent review shows the treatment to be inappropriate. The work group should include representatives of the hospital associations, third party payers, DHS' Surveillance and Utilization Review unit and Mental Health Division, and the State Mental Health Advisory Council.

In 1991, the Department obtained statutory changes to eliminate screening as a separate service within the adult mental health system and to add requirements for contractual agreements to assure compliance with admission, continued stay, and discharge criteria for publicly funded services. (Inpatient services funded under General Assistance Medical Care and Medical Assistance would not be subject to these contractual requirements because these services are not arranged or directly funded through the county.)

In addition, the Division continues to work with the Residential Program Management Division in studying the feasibility of a new process for independent screening of voluntary admissions to RTCs. Recent changes in RTC policies, developed with the assistance of the MHD and implemented in March, 1991, more strictly control informal admission to these facilities. Voluntary admissions now require the same guidelines as for committed persons, including that the individual must display the need for active treatment that is best provided in an RTC, or for which no alternate settings is available.

Homeless Persons: The Mental Health Services for Homeless People has been successful in engaging the mental health provider system in providing services to the persons who are the hardest to find and maintain contact. In FY 1991, 3,152 homeless individuals with mental health problems received services from mental health providers in eight Minnesota areas where homeless people congregate. Outreach, considered one of the essential services provided by the homeless projects, comprised 41% of project activities. Many projects have been successful in providing training for, or directly providing mental health assessments for homeless persons.

OBRA-87: 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 physical 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 pre-admission 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, 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 20,000 persons will have received Level I

assessments during 1991, with approximately 2,000 receiving Level II assessments.

Children's Screening for Inpatient and Residential Treatment: 1987 Minnesota Statutes required county boards to screen all children 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 in a regional treatment center, screening must occur within five working days of admission. Screening is to be designed to determine whether the proposed treatment:

- is necessary;
- is appropriate to the child's individual treatment needs;
- cannot be effectively provided in the child's home; and
- provides a length of stay as short as possible consistent with the individual child's need.

The same statute required the establishment of a task force to study mechanisms for screening of children to evaluate existing and available mechanisms designed to determine and review 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.

Required to report to the Legislature in 1990 on how existing mechanisms could be changed to accomplish the goals of screening described in statute, the task force submitted its initial recommendations as part of the Division's 1990 Report to the Legislature, but recommended additional study of screening issues and mechanisms to address inconsistencies and to identify successful models from which to build an effective and coordinated screening system for children. Therefore, the task force continued to meet to examine the particular needs of children with respect to screening mechanisms. Final recommendations, which include modifications of the original recommendations, are as follows.

- Screening mechanisms, which are a part of screening required for all out-of-home placements of children under the Permanency Planning Act, should include both diagnostic and functional assessments of the child by a mental health professional and should address services needed to maintain the child in the community.

- Screening mechanisms for emergency inpatient hospitalization should be different from those for residential placement so that care providers are not

required to initiate both a pre-certification process under Medical Assistance Rule 48 and a screening team process under MS 245.4885.

- The absence of less restrictive, community-based alternatives should be included as an appropriate consideration for Medical Assistance pre-certification of admission to acute care inpatient hospitalization for children.

- Screening should be required before, rather than after, admission, except for situations which require emergency admission to inpatient hospital units. In the latter instance, screening should be required within three working days.

- Counties should assure in contracts for residential and acute care hospital inpatient care that providers adhere to admission, discharge, and continued stay criteria. (These contracts should not be required when reimbursement is under General Assistance Medical Care or Medical Assistance.)

- Assurances of coordination in planning and continuity of care between service providers and appeal mechanisms should be included in service contracts between counties and providers.

- Summary data should be collected by counties on screening recommendations. This data should include the degree to which these are followed in placements, as well as the reasons recommendations are not followed.

The Department obtained statutory amendments to address these recommendations. Counties are required to assure, in contracts for residential and acute care inpatient care, that providers adhere to admission, discharge, and continued stay criteria. Coordination in planning and continuity of care between service providers and appeal mechanisms are also required in contracts under these amendments.

Screening is now required before children are admitted, except for emergency admissions to acute care inpatient hospitals, when a three working day delay would be permitted. For care provided under General Assistance Medical Care and Medical Assistance in an acute care inpatient hospital, no additional screening beyond that already required under DHS Rule 48 is necessary. Screening requires both diagnostic and functional assessments by mental health professionals as well as addressing needed community services. Counties are required to collect summary data on screening recommendations and the degree to which these are followed in placement decisions, as well as reasons for not following the screening recommendations.

In addition to the statutory amendments, a subgroup of the task force worked with staff from the Mental Health and Audits Divisions to propose revisions to DHS Rule 48, which governs admission of children to acute care hospital services under Medical Assistance. Staff from the Hospital Reimbursements Unit of the Audits Division will utilize this material in revisions of Rule 48, undertaken in August, 1991. In addition, a process has been established to assure independent evaluation of all children admitted to RTCs for whom Medical Assistance is expected to provide reimbursement.

c. Description of problems encountered:

Adults:

- Mechanisms for, and logistics of, screening were inconsistent across services, systems, and counties. Each facility and each clinician could set individual criteria for admission.

- Criteria for admission, especially to acute care hospital psychiatric programs, focused more on administrative issues than on clinical factors or judgments.

- 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.

- 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 is perceived as reducing 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 encouraged them.

Children:

•Screening mechanisms being used were disjointed and separate, even though they may have accomplished their intended individual goal;

•In the absence of integration, balance was lost, and the result was that the focus of the screening activity became either the rationing of care (under-treatment) or the filling of beds (over-treatment);

• Screening mechanisms tended not to be multidisciplinary in nature;

• Rather than being based on clinical factors, admission to, or denial of, inpatient or residential program services was based on administrative considerations; these non-clinical factors are believed to have excluded children from needed programs as often as they resulted in admission to inappropriate programs.

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

Screening requirements for out-of-home placements of adults and children have been changed to reflect contemporary practice standards.

PASARR requirements are being followed, with approximately 20,000 persons receiving Level I assessments and 2,000 receiving Level II assessments in FY 91.

Outreach activities comprise 41% of activities of homeless projects.

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

a. The original milestone:

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 or contracts for 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 the review and revision of county mental health plans. This was 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 evaluation of the county's success in meeting this objective is also helpful in targeting resources and technical assistance as needed.

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 RTCs and community-based services, from both staff and consumer perspectives, was helpful in targeting means to reduce hospitalization through appropriate planning efforts.

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. In August, 1990, the Division reorganized to focus more on specialist expertise 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. The 1991 Legislature approved the Governor's Mental Health Housing Initiative, which included: $1 million for a new housing subsidy program to serve 400 people beginning July 1, 1992; $500,000 new funds for additional housing support services pilot projects beginning July 1, 1992; increased flexibility to use existing Rule 12 funds for housing support services (These funds were previously limited to residential treatment); $750,000 for alternative services to downsize 18 community residential facilities that are now considered

Institutions for Mental Disease (IMD) because they exceed 16 beds; and $882,000 plus administrative funds to develop alternative services for 100 people in seven IMDs certified as nursing facilities.

Two methods were used to assess the number of persons in RTCs who could reasonably be expected to live successfully in community settings. In June of 1989, Dr. Henry Steadman and his firm, Policy Research Associates, Inc. (PRA) of Delmar, New York contracted for a clinical survey of all residents of RTCs with a mental illness. Using an instrument used in New York State hospitals to assess level of care needed, PRA had RTC staff do assessments of all residents with a mental illness diagnosis. PRA used two procedures to estimate the number of current RTC clients who could reside in the community. The first procedure was a statistical procedure previously used in New York and other states which was based on the clinical ratings of clients. They reported that at least 22% of the RTC patients assessed in mental health treatment units could live in the community. Other refinements to the statistical procedure could lead of up to 49%.

The second estimation procedure for community readiness utilized staff judgments. The RTC staff thought that 270 (25%) of the adult and geriatric mental health patients could either definitely or probably be appropriate for discharge to the community. In June, 1990, PRA surveyed a sample of community program staff to rate 1,505 clients in Rule 14 and Rule 36 programs. Rule 36 Category I clients were not statistically different in their psychiatric symptomatology scores from RTC clients with a voluntary legal status. These surveys clearly indicate that a significant number of RTC clients could be served in the community.

Anti-stigma campaign materials, which were distributed in June, 1990, and used in the January, 1991 Anti-Stigma week, are intended to reduce some of the stresses faced by clients in community settings by preventive educational efforts. Although these issues 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.

Dakota County Project: Dakota County, a geographically large county which is part of the 7-county metropolitan area, has for two years worked with an advisory group of consumers, providers and county staff to look at reorganization of the county's mental health service delivery system. As a result of this work, the county sought and obtained legislative support for a pilot project to design and plan a mental health services delivery system that would reduce the number of commitments to Regional

Treatment Centers and improve service delivery to persons with mental illness.

The goals of the project were to (1) maximize local community-based living and treatment alternatives for Dakota County residents with serious and persistent mental illness who would otherwise be committed to State facilities; and (2) offer better accessibility and coordination with other community services and resources. The pilot project was planned for implementation during State fiscal year 1992, and would have required new service development, modification of existing services, and development of legislative proposals for presentation to the 1993 Legislature. The goals of the project and the activities of the county were supported by MHD staff.

Unfortunately, the project was not funded in the 1991 legislative session. However, the enthusiasm of county residents and staff for continuation of the project, even without the mandate and funding, remains strong. The county, with MHD and State Mental Health Advisory Council support, intends to focus during the next year on development in the following service areas:

- Housing options for persons with serious and persistent mental illness;

- Commitment and forced medication (Jarvis) hearings in order to streamline these processes; and

- Community Support Programs, including housing support services.

It is hoped that the county, through this project, will develop new models of service delivery that can be replicated in other areas of the State in order to improve services to this target population.

Client Outcome Study: The client outcome study, described in further detail under Requirement II and Requirement XII, is intended to assess the effectiveness of community support programs Statewide. Information on client satisfaction and quality of life measures will be obtained, with extensive consumer input to determine validity, reliability and appropriateness of the questions. Information from this study will be combined with rehospitalization data to provide a measure of CSP effectiveness. Initially, analysis will be statewide, but it is anticipated that provider-specific analyses will also be possible. The instrument has been developed and is ready for further refinement through analysis of validity and reliability followed by field testing. The eventual instrument, expected to be finalized by late 1992, is expected to be useful in targeting needed areas of improvement in CSP services which can be linked to rehospitalization data. This linkage should be helpful in

reducing the rate of hospitalization through highlighting those services which appear to be most useful in preventing or reducing the rate of rehospitalization.

Alternatives to Anoka Metro RTC Hospitalization: The Anoka Alternatives Project, a state-funded project designed to provide community-based services for difficult-to-serve persons who would otherwise continue to reside in the Anoka-Metro RTC, and the arrangement for contract beds in community hospitals for short-term commitment stays, are both promising alternatives to RTC hospitalization which appear to reduce the rate of hospitalization (see earlier objective under this requirement for further information on these programs). Initial data has been obtained regarding the numbers of persons requiring rehospitalization who participated in the Anoka Alternatives program, which is being compared with rates for persons leaving the RTC without this program. Data includes both rates of rehospitalization and length of stay for persons requiring additional hospitalization. The findings appear to be very promising, but are preliminary, and require additional time for evaluation of the program's effectiveness. Anecdotal evidence of the program's promise with difficult-to-serve clients is supplied by the recent release, after six months of systematic planning and transitional services, of an individual who was hospitalized as a young adult for the next 27 years. (Table 3, above, provides data from the first year of the project.)

Persons leaving the RTC under the Anoka Alternatives program who require rehospitalization are placed into contract beds, unless RTC placement is clinically indicated, so that they can maintain uninterrupted community services (e.g., their apartments, CSP services, or other support services), which is not possible with RTC placement. Thus, the likelihood of their returning to supportive arrangements in the community is enhanced with use of the contract beds for short-term treatment. Thus far, only 13 Anoka Alternatives clients have required rehospitalization, and of those, six have been returned to the community.

Persons discharged from RTCs in the period January through June, 1991, had an average length of stay of approximately 214 days, compared with 38.5 days in the contract beds for the entire period during which the beds have bee utilized. When the start-up period of the program is disregarded, average lengths of stay drop considerably for the two programs. (Changes in the way data is maintained by other DHS Divisions make obtaining more precise data impossible.)

Analysis of client characteristics indicates that there is no difference in the characteristics of clients served in the RTCs and in contract beds. Hence, contract beds appear to markedly reduce the rate of hospitalization.

Fiscal Equity for Community-Based Services to Children: The 1991 Legislature approved a Division proposal that, effective January 1, 1992, counties be required to pay one-half the non-federal share of Medical Assistance payments for Regional Treatment Center (RTC) inpatient and State-operated residential treatment for children with severe emotional disturbance, thus removing a financial incentive believed to have encouraged some counties to place disproportionate numbers of children in the two RTC children's programs.

Trends in MA Reimbursements for Inpatient vs. Outpatient Services to Children: At the present time, Medical Assistance is the only major funding source for children's mental health services which can provide reliable multi-year data regarding clients and expenditures. The most recent data available is from 1989. MA inpatient expenditures for children's mental health increased significantly between FY 85 and FY 87, but now appear to have leveled off. MA outpatient expenditures for children's mental health have increased steadily and are now increasing faster than inpatient expenditures. From 1987 to 1989, the number of children served with MA funds on an inpatient basis was similar, whereas the increase in the number served on an outpatient basis during that time exceeded 20%.

c. Description of problems encountered:

Until counties have more experience in developing services specific to the needs of individual clients, there will be some residual resistance to developing a full local array of community based services, especially for children and adults traditionally considered difficult-to-serve in the community.

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

The MHD 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. The 1991 Legislature approved the Governor's Mental Health Housing Initiative and appropriated additional funding for continuation of the Anoka Alternatives project.

Contract beds appear to be successful in reducing the rate of hospitalization, averaging 38.5 days versus approximately 214 days in RTCs with similar clients.

A study assessed the number of persons in RTCs who could reasonably be expected to live successfully in community settings and this data is being utilized in system planning.

A change in fiscal policy made the financial cost to counties of placing children in RTCs more nearly equal to the costs of community residential treatment.

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

a. The original milestone:

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

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

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.

Since 1981, the joint efforts of the Legislature, private sector, Division and counties to bring Rule 36 facilities up to licensure standards have 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 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 (mental illness and hearing impairment, chemical dependency or behavioral aggression), and some older, larger facilities have closed. In FY 1990, there were 1,679 licensed beds in 79 licensed facilities; 76 of these facilities 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 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. Preliminary data on the Anoka Alternatives Project suggests that it may provide an effective means of preventing rehospitalization.

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 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 to the objective of reduction of hospitalization by reducing placements in larger, less "home-like" facilities. Passage of the 1991 Mental Health Housing Initiative by the Legislature will permit downsizing of 214 additional Rule 36 IMDs.

Rule 14 Grants: Grants are awarded to counties under provision of Rule 14 for non-residential services to persons with serious and persistent mental illness. Program's purpose 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. In FY 1991, all counties in the State were offered Rule 14 grants and 86 of 87 submitted applications approved for funding.

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 development process, the MHD meets 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. The increased emphasis on employability is expected to result in more successful community placement and consequently reduced vulnerability to rehospitalization.

The Division is continuing to revise Rules 14/15 and Rule 36, both of which will be promulgated during the current fiscal year.

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 and Rule 12 have been required by 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:

Provision of CSP varies from county to county due to (1) historical funding patterns; (2) limited funding in some counties; and (3) differences in expertise and commitment of counties and providers to serving this population.

Until FY 1991, funding was not available for development of appropriate, individually tailored alternative services for those individuals discharged or relocated from RTCs and nursing facilities.

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

Rules governing grants to community support programs are in the final stages of revision; these revisions will simplify application and reporting procedures, facilitating their use in maintaining persons with mental illness in the community. Program reports are now generated in such a manner as to facilitate their use in service development by county and state staff.

Nine Rule 36 IMDs were downsized, making 43 clients eligible for MA funding of ancillary services, such as doctor's visits, dental care, and medication.

CSP services are available to clients residing in 100% of State counties.

IMD alternatives funding is now available for the development of individual specific services for those discharged from AMRTC and downsized or converted IMD nursing facilities.

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

a. The original milestone:

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:

Reduction of Population of RTC's: During FY 1989 the average monthly population for individuals with mental illness in the RTCs was 1,354. This was reduced to 1,312 for FY 1990, a 3.1% reduction.

State Level Coordination: The Director of the MHD meets with her counterpart in the Residential Program Management Division (the Division which hires and supervises the mental health work force in the RTCs), and the director of the HRD project meets frequently with the Residential Program Management Division liaison. In addition, one staff member has assumed primary responsibility for liaison functions with both the DHS medical director and the Residential Program Management Division. Reorganization of DHS has placed management of both the RTCs and the MHD under the same Assistant Commissioner, a step which is viewed as improving opportunities for collaboration to assure appropriate residential and community service development. This new structure is expected to reduce criticism that RTC and community-based service development have been uncoordinated.

Anoka Alternatives Project: The Anoka Alternatives Project was implemented due to the increased number of commitments and resulting pressure for RTC beds in the metro area. The project was designed to create discharge options for long-term and "revolving door" patients for whom discharge options were severely limited due to lack of community resources. The patients discharged thus far have a range in length of stay (LOS) of 51 to 6,178 days (16.9 years), with an average LOS of 535 days. (The average length of stay of all patients discharged from AMRTC during 1991 was approximately 214 days.)

This project has enabled the discharge of 85 individuals who would not have been discharged or would not have been discharged as quickly or effectively, thereby opening a number of beds for use by committed patients on the waiting list for access to RTC treatment. Through the provision of the enhanced services and through quality discharge planning, most of the individuals discharged have been effectively maintained in the community. The recidivism (RTC rehospitalization) rate has been about 10% thus far. Over time the project results will be compared with the approximate 50% readmission rate previously experienced by the RTC.

Planning is currently occurring with about 60 additional RTC patients for whom enhanced services are needed to expedite discharge. This number is nearly one-third of the patient population at AMRTC.

The enhanced mental health and supportive services eligible to be reimbursed by these grants include an array of services: housing support services, housing subsidies, home care services, family supports, enhanced foster care, enhanced community support services, friendly visitor services, transportation assistance, parenting supports and transition services. Anoka Alternatives funding has been used to provide parenting classes, child care while the parent is receiving outpatient services, transportation to outpatient services, someone stopping in to visit on a regular

basis, and 24-hour access to a mental health worker, if needed. Creative programming based on individual needs and choice as well as coordination by the county, RTC and providers has produced successful project results.

One of the most significant outcomes of the Anoka Alternatives Project was the intensive coordination of discharge planning between the Division, the counties, and the RTCs. The cooperative process caused the involved parties to work together in ways they previously had not in order to review and plan for the needs of individuals. Because funds were available in a flexible way, the planning teams could develop specific services need by the individual. This process allowed for a move away from the previous dependence on a continuum type service delivery system (i.e., reliance on residential programs before independent living) to actually discharging individuals from the RTC to apartment settings with the needed supports in place.

As a result of this success, the Legislature authorized $600,000 for the next biennium to continue this project. An additional 24 persons are anticipated to be discharged and funding will continue as appropriate to meet the service needs of those discharged in 1991. The intensive supports appear to be reducing the recidivism rate (return to AMRTC, after discharge) and have made it possible for nearly 50% of the individuals in the project to live in their own homes or apartments.

The most effective training regarding discharge planning occurred as a result of "modeling" in the discharge planning process. Through their involvement in the project, case managers and RTC staff were exposed to new options and new ways of arranging services for individuals. A one-day formalized training for approximately 175 case managers, providers, county and RTC staff was held last November. The training centered around the topics of client choice, "housing as housing" concepts, and information on state of the art provision of community support services.

In addition, the Division provided scholarships to 12 line staff from the RTCs to the Annual State Community Support Program conference. The purpose was to familiarize RTC line staff with the array and effectiveness of community-based services.

Contract Beds for Short-Term Commitment Stays: In order to reduce waiting time for admission of committed patients to RTCs, the Department has contracted with two metropolitan hospitals for the provision of inpatient psychiatric hospital services. These two hospitals provide acute care hospital inpatient mental health services for up to twenty committed persons who meet the criteria for short-term treatment and are General Assistance Medical Care eligible. The purpose of this alternative treatment program is to prevent a delay in treatment for committed persons who may otherwise be placed on waiting lists for regional treatment

center services. Admission, continued stay and discharge criteria have been developed for the contract programs.

Staff from the community hospital programs work closely with the DHS Medical Director and with staff psychiatrists of the Anoka Metro Regional Treatment Center, which serves the catchment area in which the programs are located so that treatment review panels can be initiated to assure appropriate medication if needed. County case managers coordinate discharge plans with the hospital case managers.

Payment for medical management services in the hospitals is through the General Assistance Medical Care program. The hospitals have been assigned separate provider numbers for inpatient services as well as physician services, with the hospitals reimbursed with a prospective per diem rate. AMRTC has a shared services agreement with each facility to provide billing services of the Anoka RTC psychiatrists. Total cost of the program in its first year of operation is approximately $1.5 million.

Although educating metropolitan area counties about the Alternative Treatment program has required significant time, from August 1990, 65 persons have been hospitalized at the contract hospitals. The average length of stay is 41 days, compared with approximately 214 at AMRTC. Case reviews have indicated that those persons admitted to these new programs are identical to those who, without this program availability, would have been committed to the AMRTC program. Several other counties are currently considering arranging similar contracts for provision of beds.

Initially, the contract bed program affected the Anoka-Metro Regional Treatment Center's waiting list, causing a decline in the number of persons awaiting admission. Since that time, however, other factors have caused temporary increases in the waiting list. The primary factor appears to be the existence of court-ordered hearings (Jarvis hearings) on involuntary medication administration. These hearings, while protecting individual rights, have significantly added to the length of stay for those persons refusing medications.

Policy for medication upon release: A survey of discharge medication practices in the regional treatment centers was completed in 1991, as a result of concerns raised about disparities between RTCs by counties having clients in several different facilities. The survey revealed a variation in the amount of medication dispensed and/or the prescription provided to patients at the time of discharge.

Each RTC has developed a medication policy, with the length of time medications are given to individuals at discharge varying

from one to seven days. The variation reflects the degree to which the RTC has developed arrangements with counties to assure speedy enrollment for financial assistance. Prescriptions are given to the individuals up to 30 days with refills negotiable.

Joint information meetings on discharges to community living: The DHS Medical Director and staff from the Mental Health and Residential Program Management Divisions conducted meetings at the six regional treatment centers in May, 1991, inviting persons from the RTCs and the counties directly involved with discharge planning and community based services to attend. The purpose of the meetings was to gather information about the patient/client transition between the regional treatment center and community based services.

Seventy-one counties were represented at the six meetings, with discussions focused on the discharge planning process and available community resources. Positive feedback has been given by regional treatment centers and county staff about these meetings. Participants were eager to give first hand information concerning problems of service delivery during the discharge process of an individual to the community. Suggestions have been offered that similar meetings be held in order to address other issues such as problems with admission to a regional treatment center.

The conclusions and recommendations from these meetings are summarized below:

- More case management staff is needed. This is true in all catchment areas; however, the problem is exacerbated by large travel distances in certain areas (e.g., 3 hours each way to an RTC in some areas). The case management Rule was also perceived as problematic. Recommendations were for legislative action to mandate revision of Rule 74, including addressing the case management client ratio and targeting resources first to persons with serious and persistent mental illness.

- Timeliness of notification by RTC staff is perceived as uneven and inconsistent, and may represent a systems problem. This particularly affects case manger's ability to be more involved with the planning process prior to discharge, and results in inefficient scheduling. Recommendations were for the development and implementation of standardized policy and procedures for timely notification of county case managers.

- Client participation in the discharge process varied from county to county and from RTC to RTC. It was recommended that both county and RTC staff actively encourage and

support client participation in the discharge planning process.

- Medical Assistance eligibility procedures are of concern because financial assistance plays a significant role in medication compliance and other parts of the treatment program and discharge plan. It was recommended that the Department establish a task force to address procedures to facilitate the determination of financial eligibility prior to the time of client's hospital discharge.

- There is a lack of housing options, including more affordable independent living, supportive living, semi-structured housing and negotiated rate facilities. Recent legislation will expand these options.

- Community services, particularly employment opportunities, crisis management, housing and psychiatric services, are lacking. This was felt to be a critical gap, and that it was the primary role of the MHD to aid counties through development of county plans and technical assistance.

- RTC psychiatric services should be extended into the community for medication management/follow-up and for assessment of the client's treatment/service plan. Recommendations were that DHS' Medical Director should coordinate efforts to develop shared service agreements between counties and RTCs for psychiatric time as needed.

Information obtained in these meetings is being utilized in revisions to Rule 74, which governs Medical Assistance reimbursement for case management services, and in planning for training of county and RTC staff.

RTC voluntary admission, discharge, continued stay criteria for adults with mental illness: New policies for informal admission of persons with mental illness to a regional treatment center for observation, evaluation, diagnosis or treatment were implemented in March 1991. To be accepted as a voluntary patient, at the time of admission a person must exhibit essentially the same characteristics as those who are committed, but must have the capacity to give informed consent for admission and treatment of mental illness. One of these characteristics is the need for active treatment that is best provided in an RTC setting or for which no alternative setting is available. If a person is not appropriate for informal admission, other alternatives may be considered, including a 72-hour emergency hold order, civil commitment or referral to an alternative placement or treatment source.

An individual's continued hospital stay is appropriate if policy criteria are met. These include continued documented evidence of

symptoms which require active psychiatric treatment, informed consent, and a finding by the RTC utilization review committee that the initial admission and continued hospital stay is appropriate.

For the first time, RTC policy indicates that discharge planning is the joint responsibility of the county social service agency in cooperation with RTC staff, an addition which is expected to clarify the respective roles of the two agencies. Although the policies are too new to be evaluated, counties and the regional treatment centers are in the initial phases of implementing this policy.

Out-of-State Placement for Children: Although this does not directly address the issue of reduction of hospitalization, given the current requirements in Minnesota which favor treatment in the community environment to the extent feasible rather than residential placement, the issue of out-of-State placement of children may be indirectly germane. The State is less able to assure reduction of hospitalization for children if significant numbers of children are placed outside the State.

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 placed by their parents without county involvement or public funding support. Reasons for using out-of-State facilities include: proximity; emergencies; specific treatment needs best met in out-of-State facilities; cost; program reputation; or difficulty of placement (dual diagnosis, long histories of treatment failure). Action by the 1991 Legislature established a Legislative task force to study issues related to the provision of "Specialized Mental Health Services" for children, including services which might preclude the need for out-of-State placement. The task force's report is due in January, 1992

c. Description of problems encountered:

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

The Anoka Alternatives Project has enabled the discharge of 85 people and reduced waiting lists for RTC treatment. The Legislature authorized $600,000 to extend this project into the next biennium.

The Department has been restructured so that Residential Management and Community Based Services are under the same assistant commissioner. This is a critical step to planning for a comprehensive system of mental health care.

Uniform RTC voluntary admission policies are in place.

Data from county and RTC staff with respect to case management and training needs are currently being utilized in MHD planning.

Out-of-State placement of children is an increasing concern, with a special legislative task force required to study the issue over the fall of 1991.

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

a. The original milestone:

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.

Rules 14 & 15: Rule 14 is the fiscal management procedure rule for State community support program funding for persons with serious and persistent mental illness. Rule 15 is the program standards rule for community support services for persons with serious and persistent mental illness. Rules 14/15 have been in the process of rule revision for the past three years. It is expected that these rules will be promulgated by January 1, 1992.

Rule 15 will be separate from Rule 14 and will provide consistent definitions of mandated CSP services to be provided in each county. Additionally it requires orientation and annual training of CSP staff and individual service plans for CSP clients. These changes should ensure that minimum services are provided in all counties, which in turn should help prevent unnecessary hospitalizations. The proposed revision places priority for service on persons being discharged from RTCs and Rule 36 facilities.

Rule 36: The MHD took part in several efforts to determine how to provide normalized living arrangements for persons with mental illness. 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 Rule 36 was developed, and numerous advisory committee meetings were held during 1989 and 1990.

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 was 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. However, due to the immediate increased cost of such an approach, it was deferred by the Department until a later legislative session. (See Requirement V for a fuller discussion of this issue.)

The proposed revision of Rule 36 establishes a service priority for persons with serious and persistent mental illness who reside in, or are at risk of being placed in, inpatient settings, and for persons who are homeless and needing residential treatment services. These priorities are designed to assure appropriate services are available for these targeted populations in the community. The revised rule is expected to be promulgated in early 1992.

Based upon data collected from 780 clients receiving Rule 36 residential treatment services in Minnesota, 86% had been hospitalized at sometime before entering the program, 64% were hospitalized within a year before entering the program, 15% were hospitalized while in the program and 34% within 6 months after the program. Clearly, client utilization of services provided by these facilities affects their need for acute care and regional treatment center hospitalization.

Rule 5: Rule 5 is the licensing rule governing residential facilities providing services to more than 10 children and adolescents with "emotional handicaps". Rule revision was begun by Division staff in January 1991. The 1991 Legislature mandated that a revised rule governing residential treatment services for children with severe emotional disturbance be in effect by July 1, 1992.

The revised Rule 5 will reflect the statutory requirements of the Comprehensive Children's Mental Health Act. By July 1, 1991, all children referred for residential treatment must be screened prior to admission by a mental health professional who is not financially affiliated with any residential treatment facility, inpatient hospital, or regional treatment center. The screening must establish that the child has severe emotional disturbance and is in need of residential treatment services. The Act also

requires admission, continued stay, and discharge criteria and clinical supervision by a qualified mental health professional of program services and individual treatment plans. These changes are particularly targeted to reducing the rate of unnecessary out-of-home placements.

The rule will also reflect the new legislative requirement that special mental health consultants must be used as necessary in assessing and providing appropriate treatment to children of cultural or racial minority heritage. The revised rule will also have clear treatment standards which meet the intent of the Comprehensive Children's Mental Health Act and will include significant involvement of the family as partners in the child's treatment.

The Rule 5 revision will also include standards for restrictive procedures, cultural competence, physical plant requirements, health care procedures, staff qualifications, and staff training to assure the protection and safety of the children served and compliance with the intent of the Comprehensive Children's Mental Health Act.

Rule 77 (Children's Case Management Standards): In 1989, the Legislature passed the Comprehensive Children's Mental Health Act, including a Statewide mandate for case management for children with severe emotional disturbance, effective July 1991. In 1989, the Department promulgated Rule 74, relating to case management for both adults and children with serious and persistent mental illness, eligible for Medical Assistance (MA).

To assist counties in providing case management services to children with severe emotional disturbance and their families, the 1991 Legislature provided funding for grants to counties to establish, operate, or contract with private providers for case management services for children who are not eligible for MA. The 1991 Legislature also mandated the promulgation and adoption of emergency rules for case management services for children with severe emotional disturbance and their families by January 1, 1992. Staff time has been reallocated to meet this statutory mandate. Children with serious and persistent mental illness may continue to have case management services provided under the current Rule 74, which sets case management service and MA reimbursement standards for persons with serious and persistent mental illness. In addition, work on developing an expanded MA rehabilitation option to cover a case management component will begin after promulgation of the emergency rules discussed above. (EPSDT will be used as the gatekeeping mechanism for this option, as provided for under OBRA-89.)

c. Description of problems encountered:

Under the Administrative Procedures Act (Minnesota legislation), permanent 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. 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's Mental Health Plans.

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

Four major adult rules have undergone revision and will be promulgated in 1991. Others, including four critical children's rules, are in the process of revision, with permanent revisions to follow in 1992. Revisions and proposed changes reflect current standards and promote community based treatment, based on the individual's clinical needs. These are intended to result in reduction of hospitalization of both children and adults..

Findings from several recent reports and studies (on community residences, inpatient and residential screening, and board and lodging facilities with supportive services for adults) were incorporated into Rule 36 and 14 revisions, and will be used in guiding Rule 74 revisions.

REQUIREMENT VII. Providing case management services for individuals with serious mental illness who receive substantial amounts of public funds or services; the term "individual with serious mental illness" to be defined under State laws and regulations.

The Minnesota 1987 Comprehensive Adult Mental Health Act defines both case management services and "persons with serious and persistent mental illness." These definitions were provided in the 1989 and 1990 plan submissions, as was the definition of children's case management services for children with severe emotional disturbance.

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

a. The original milestone:

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

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

Case management is one of the services required by the Comprehensive Mental Health Acts 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 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.

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, assistance payments, social services, education; and
- have difficulty in accessing 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. However, the States' interpretation of the "brokerage" model necessary under HCFA's targeted case management option, and the limitations it requires on provision of other direct services by case managers, is viewed as problematic by both counties and advocates.

Case management services were first required of counties for persons with serious and persistent mental illness in January, 1989. By June, 1991, 100% of the State's counties offered the service. (It should be noted that the State statutory definition of serious and persistent mental illness [SPMI] does not include those with acute mental illness, unless those persons also are experiencing an acute episode of mental illness, in addition to meeting the criteria for SPMI.)

Rule 74. The current case management rule (Rule 74) provides for billing of Medical Assistance for mental health case management. However, problems have existed since the outset of this program, including dislike of the "brokerage" model, that deter local agencies from billing up to their full potential. Among the problems noted are that county agencies:

- lack expertise in the billing process;
- do not have incentives to bill, thus affecting the funds available locally for the provision of this service;
- find that the systems for tracking eligibility for the program are faulty;
- and have workers whose caseloads are so large they do not have time to post their time so that it can be billed.

The Department is revising the case management rule in response to feedback from consumers and providers as well as to meet the requirements of new State legislation which calls for revision to:

- Make improvements in rule flexibility;
- Increase the rate of reimbursement for case management services;
- Establish a comprehensive coordination of services;
- Require county case managers to arrange for standardized assessments of side effects of psychotropic medications;
- Establish a reasonable caseload limit for case managers;
- Provide reimbursement for transportation costs for case managers; and

- Review the eligibility criteria for case management services covered by Medical Assistance.

The required revision of Rule 74 must be completed by July 1, 1992. The Health Care Management Division continues to work with the MHD on a set of specific rule proposals that would allow for greater Title XIX reimbursement by local agencies while increasing flexibility in service provision (see Requirement VII for a more complete discussion of case management).

Providers argue that the rule should allow them more discretion in offering case management services. Advocates state, however, that if prescriptive language were not in the rule, the case managers would not contact clients with the frequency that is currently expected under the rule.

Providers further argue that the current model does not allow the case manager to establish the supportive relationship necessary for effective case management to occur. They state that the rule should allow greater flexibility in allowing case managers to provide, perhaps not therapeutic services but at least support services. The Medical Assistance program, on the other hand, stipulates that, with regard to targeted case management, such service cannot be associated with provision of any other mental health service.

The MHD continues to work with the Health Care Management Division on revisions to the program and reimbursement standards found in Rule 74 in order to facilitate provision of high quality service and reasonable reimbursement rates.

Development of a Children's Case Management Model and Rule-Making (Rule 77): Case management services are activities that are coordinated with family community support services and designed to help the child and the child's family obtain needed mental health, social, education, health, vocational, recreation, and related services. Case management is intended to ensure that children with severe emotional disturbance and their families receive the services they need, that services stress interagency coordination and collaboration, and that services are appropriate to the changing needs of children and their families.

The Comprehensive Children's Mental Health Act requires Minnesota counties to develop and implement this key service. Since it is the most critical and complex service mandated by the Comprehensive Children's Mental Health Act, it is vital that case management is developed and supported by the local agencies that have the opportunity and responsibility to implement this service. The 1991 Legislature provided authority for emergency rulemaking, directed that Rule 77, the program standards rule, be promulgated by January 1, 1992, and provided funding for these services for non-MA eligible children.

Until April 1992, case management services must be offered at minimum to those children who were eligible for case management under the criteria in effect in January, 1989. This criteria includes the definition of "serious and persistent mental illness" as first described in the 1987 Mental Health Act. Only about 50 children have received Rule 74 case management services. However, counties report provision of case management to 925 children with county funds. In addition, the Legislature directed Rule 74 revision to cover provision of services to children with severe emotional disturbance. This revision must also be completed by January 1, 1992.

The MHD and the Health Care Management Division are working with consumers, advocates, providers and county social services to identify and hopefully resolve the remaining difficulties with case management services. For adults with serious and persistent mental illness, continued discussion on flexibility and other models which may lead to a more appropriate level of case management in the long term are necessary. Other modifications are needed in the short term to increase service accessibility.

For children with severe emotional disturbance, the new Rule 77 reflects the current expectations of families and providers for the highest possible quality case management services. An unintended consequence is that the requirements for case management under the revised Rule 74 (for MA eligible children) as compared to the more flexible case management under the new Rule 77 could conceivably lead to separate service standards for children's case management services for those who are not MA eligible.

c. Description of problems encountered:

Providers feel Rule 74 is inflexible and that MA regulations work against supportive relationships with clients needed for effective case management. Counties have large caseloads and lack billing expertise, which keeps local agencies from billing to their full potential. County administrators claim that MA guidelines are too complex and burdensome for insufficient reimbursement. Advocates insist caseloads are too high, and without prescriptive directives, are convinced clients will not be seen as often as required.

The federal guidelines for MA eligible children are seen by many as supporting a more restrictive standard for case management for children than the more flexible Rule 77 case management standards for children would permit.

Federal requirements for case management under the revised Rule 74 (for MA eligible children) as compared to the more flexible case management under the new Rule 77 could lead to separate standards for children's case management services for those who

are not MA eligible. The creation of two separate standards was not expected or anticipated as the MHD responded to consumers, parents and providers in designing a case management model in the best interests of children.

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

All of Minnesota's counties offer case management services to adults with serious and persistent mental illness. Funding is available through Rule 14 grants and through Medical Assistance (for individuals who are MA eligible).

For FY 92-93, $100,000 in new funding has been appropriated for children's case management. Rule development is underway, with emergency rules to be promulgated by January, 1993.

REQUIREMENT VIII. Providing for the Implementation of the Case Management Requirements in the Preceding Paragraph in a Manner which Phases in Beginning in Fiscal Year 1989 and Provides for the Substantial Completion of the Phasing in of the Provision of such Services by the End of Fiscal Year 1992.

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

a. The original milestone:

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

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

County Mental Health Plans: Biennial adult and children's county plans describe the "what and how" of the local mental health systems as planned by counties. The Division assesses the county's commitment to providing mental health case management services through objectives written to accomplish the case management task, the size of the projected case management budget and projected numbers of staff projected to be needed to do the work. The Division compares Community Mental Health Reporting System (CMHRS) data with plan objectives and targets and assesses progress toward meeting Statewide service goals.

For case management services, the information is used to assess the following:

- The degree of statewide compliance with Rule 74 occurring in Minnesota.
- The degree of compliance by specific counties.
- Specific performance items that stand out as needing some remedial efforts.
- Areas where local providers are strong and can be complemented.
- Weaknesses in the model in general; and
- Areas where modifications may strengthen the program.

Implementation: Counties were first required to make available case management to all persons (adults and children) with serious and persistent mental illness in January, 1989. By June, 1991, 100% of the State's counties offered the service. Recent data from the FY 1991 Minnesota Mental Health Budget Report indicate about 32,400 persons in Minnesota have a serious and persistent mental Illness. If one accepts an estimate that about 25% of such persons are in need of and would accept publicly funded services, then the target group of such persons would number about 8,125 persons.

According to the Case Management Survey results, local agencies provided mental health case management services to 8,556 persons in June, 1990. About 19% (1605) of these persons received county social work services and not Rule 74 Case Management either because they refused Rule 74 services or did not qualify under the law as having a serious and persistent mental illness.

In order to increase numbers of persons receiving case management services, the Division is providing training to local case management providers on methods for more effective outreach to persons identified as having a serious and persistent mental illness but who have not become involved in the service system. Effective outreach services viewed as critical to a complete case management program. Outreach is seen as more than identification of potential case management clients. It involves education of persons and families about the benefits of case management and the provision of assistance as needed to facilitate service acceptance. The Division is focusing training to provide such outreach in an effective and non-intrusive manner.

Monitoring and Evaluation: The Division has worked collaboratively with the Monitoring Division to establish a monitoring instrument and protocol to evaluate county and contracted provider compliance with case management law and rule. Upon completion of data analysis, the Mental Health Division will share it with the Case Management Implementation Group in order to assess local compliance and to establish technical assistance and training materials and methods for local providers.

The DHS Monitoring Division has developed a valid, user-friendly monitoring instrument with which to monitor mental health case management services in Minnesota. The Monitoring Division recently completed a sample review of about 120 cases on persons receiving Rule 74 case management services and is currently analyzing the data in order to prepare a detailed report.

The information provided by this report will be used by the Division in assessing the following:

- Statewide compliance with the Mental Health Case Management Rule;
- County specific compliance with the Mental Health Case Management Rule;
- Specific performance items suggesting a need for remedial efforts and technical assistance;
- Strengths of local providers which should be complemented; and
- Areas where modifications may strengthen the program.

The Division is currently comparing Community Mental Health Reporting System (CMHRS) data with county Mental Health Plan

objectives and targets and assessing progress as part of its review of biennial county plans for 1992 and 1993.

Case Management Implementation Group: The Case Management Implementation Group has assisted the Division in efforts to increase the availability and accessibility of case management services to persons with serious and persistent mental illness. The group was established by the MHD in response to the need for a forum made up of practitioners and county administrators to examine issues related to case management and find solutions to them. Early in its development, the group met quarterly but more recently has met about every six months, last meeting on April 1, 1991. It is the Division's hope that the Case Management Implementation Group will assist in planning for State and local collaboration through the various areas of involvement listed below.

During this planning period the Case Management Implementation Group has worked on the following:

Case Management Survey. This survey was administered to local agencies in September 1990 in an effort to obtain primary information about administration of the program and specific information about amounts of time spent by case managers in various activities. Prior to the April meeting of the group, the Mental Health Division had analyzed the data and presented a brief summary of initial conclusions and statistical abstract data. The MHD is providing technical assistance to local agencies based on the results of the case management survey.

Individual Community Support Plan. The group reviewed a draft of the Individual Community Support Plan, developed by a subcommittee of the group made up of six local agency case managers, for use as a Statewide form.

Monitoring. The case management Implementation Group has worked with the MHD on monitoring providers of case management services. Upon completion of data collection and analysis, the Mental Health Division is sharing it with the implementation group in order to:

- Assess local compliance with laws and rules,
- Establish technical assistance and training materials and methods for local providers, and
- Develop appropriate Rule 74 revisions, by assessing the following:

    - The clinical basis for the proposed changes,
    - Local responsiveness to the revised case management rule provisions, and
    - Fiscal impact of revisions on county budgets.

The group reviewed a preliminary draft of amendments to the rule as developed with the Health Care Management Division to provide for more rule flexibility and ease of administration by local agencies.

Of the total number of persons receiving mental health case management services in the sample, approximately 19% were reported as not meeting the statutory criteria for having serious and persistent mental illness.

Case Management Training Package and Technical Assistance and Training Plans: Training is being developed to meet the needs of case managers with respect to Rule 74 revisions, which by statute must be completed by July 1, 1993 (see Requirement VII). The Mental Health Division recognizes the need for a Statewide comprehensive training package. A review of activities and findings to date follows:

1. Of the total persons receiving Rule 74 Case Management in Minnesota, about 55% are also eligible for Medical Assistance (40% Medicaid and 15% GAMC/IMD). This is slightly higher than the Department's original estimate of 50%. When one calculates the percentage of MA eligible persons compared to the total number of persons receiving any kind of mental health case management service, the figure is closer to 45%, however. To assist counties in reviewing cases where case management is being provided to persons not eligible for Rule 74, training will focus on the following:

- What kind of disabilities and service needs do individuals have?

- Have persons been found to be eligible for Rule 74 Case Management service due to serious and persistent mental illness, but then not been offered the service?

- Are the disabilities or problems of these persons such that they should be referred to other units within the local social services agency (e.g., Developmental Disabilities, Chemical Dependency, Adult Protection, Elderly Programs)?

- Should local social service agencies serve these people or should they be referred to other coordinating agencies (e.g., Public health, Area Agencies on Aging)?

2. To assist counties in identifying cases where persons are receiving Rule 74 services but are not eligible for Medical Assistance, the following questions are being answered as part of a MHD directed Technical Assistance Plan:

- Are people eligible for MA but refuse to apply?

- Can outreach efforts be made by case managers, CSP workers, or others to persuade the person to apply?

- Are people ineligible because Income Maintenance has deemed them ineligible through a determination that either income or assets are over standard without pursuing with the potential recipient appropriate methods to reduce either?

- Are potential recipients encouraged and assisted to appeal decisions denying eligibility for these programs?

3. The percentage of time reported as being spent on billable activities (before factoring in client eligibility) was closer to 42% rather than the 70% originally assumed. The survey showed that large amounts of time are being dedicated to paperwork in the form of case documentation (3.3%), charting (14.5%), reports (4.2%) and other paperwork activities such as correspondence. In order to assist county agencies in evaluating these facets of their billing, the technical assistance will focus on the following:

- Is time being inappropriately spent in non-billable activities such as duties that should be referred to Community Support Program or pre-petition screening personnel?

- Is time being unnecessarily spent on routine non-billable activities such as excessive documentation or other paper work which could be eliminated in favor of billable activities?

- Are case managers carrying out activities that are billable but are not posting that time because of misunderstandings on the part of the workers or their administrations? (E.g., many counties do not realize that out-of-county travel is not included in the six hour billable limit per month.)

Training is also aimed at assisting case managers to more clearly understand the definitions of billable activities. Individual Community Support Plan and Functional Assessment Forms are currently being revised and developed, and information-sharing will be facilitated among counties. Additional multi-faceted technical assistance will continue to be offered to assist providers in becoming more familiar with:

- Basic billing practices
- Intra-agency coordination, communication and oversight responsibility

- Program eligibility tracking systems
- Problems associated with lack of timeliness and misposting
- The MA and GAMC provider manual

4. Of the persons who have a serious and persistent mental illness and are receiving case management, about 43% were reported to have services paid fully by the county. Thirty-three percent were reported as not eligible for MA/GAMC, while 10% were reported as being MA/GAMC eligible but not enrolled. To assist counties to review cases where persons are receiving Rule 74 Case Management and are eligible for MA/GAMC but are not enrolled, technical assistance will focus on the following:

- Do persons accept an offer of case management but refuse to apply for MA/GAMC?

- Are billable activities being carried out by case managers but not being posted on invoices for payment due to heavy caseloads or internal administrative problems?

Training: Strengthening local capabilities to provide case management has been a high priority of the MHD. A wide variety of techniques and methods have been incorporated in disseminating information and developing skills at the provider level:

- Regional Area Informational Meetings, or AIMs, have been held across the State to share information regarding State and local program developments. These meetings are informal gatherings where consumers as well as local agencies and providers give feedback on program effectiveness and administrative issues. Case management discussions have been a vital part of each of the four AIMs held during the winter and spring. (A total of 200 persons participated in this training.)

- County-specific meetings are arranged on a continuous basis on all aspects of case management administration and practice, focusing on intra-county coordination, information sharing and assisting counties in establishing effective policies and procedures for increased Medical Assistance billing. Twenty-five such sessions have been held since January, 1990.

- Face-to-face and telephone contacts assist local agencies and providers in solving on-going problems regarding all phases of case management service delivery.

- The Community Support Programs Conference in May 1991 included a track of four sessions on Case Management, providing training to approximately 150 persons. The

sessions were designed to assist local providers in a number of areas including the administration of programs so that reimbursement could be maximized.

- The MHD also develops technical assistance issue papers and methodology through information taken from surveys, reporting data and personal contact with providers. Five such issue papers have been produced.

The Division is continuing these efforts and will establish new case management training techniques as well as enhancing those already used. The Division will establish a series of training modules to be presented on a regional basis that address problems and issues regarding the administration of Rule 74 case management. Plans are also underway for the development of a Statewide Mental Health Case Management Conference.

1989 Refugee Amendment: In 1989, the Minnesota Legislature 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.

Clozaril Policy: Individuals eligible for MA taking Clozaril must have a county case manager to assist in assuring compliance and to assure that the weekly white blood count test is drawn at the designated laboratory. If the individual refuses case management services, the physician will be notified of the refusal so that an alternative method of monitoring the testing can be devised. Medical Assistance will pay for the case manager's monitoring of the weekly WBC test, when the individual is on Medical Assistance. The impact on the role of the county case manager cannot be evaluated since the system is currently being implemented. It will require a year after implementation to evaluate the effectiveness of the policy.

Children's Case Management: The Comprehensive Children's Mental Health Act requires Minnesota counties to develop and implement this key service. Since it is the most critical and complex service mandated by the Comprehensive Children's Mental Health Act, it is vital that case management is developed and supported by the local agencies that have the opportunity and responsibility to implement this service. The 1991 Legislature provided authority for emergency rulemaking and directed that Rule 77, the program standards rule, be promulgated by January 1, 1992.

To assist counties in providing case management services to children with severe emotional disturbance and their families, the 1991 Legislature provided funding for grants to counties to establish, operate, or contract with private providers for case

management services for children who are not eligible for MA. The 1991 Legislature also mandated the promulgation and adoption of emergency rules for case management services for children with severe emotional disturbance and their families by January 1, 1992. Staff time has been reallocated to meet this statutory mandate.

Until April, 1992, case management services must be offered at minimum to those children who were eligible for case management under the Rule 74 criteria in effect in January, 1989. This criteria includes the definition of "serious and persistent mental illness" as first described in the 1987 Mental Health Act. Although about 50 children have received Rule 74 case management services, counties report provision of case management to 925 children with county funds. In addition, the Legislature directed Rule 74 revision to cover provision of services to children with severe emotional disturbance. This revision must also be completed by January 1, 1992.

In addition, work on developing an expanded MA rehabilitation option to cover a case management component will begin after promulgation of the emergency rules discussed above, using EPSDT as the gatekeeping mechanism as provided under OBRA-89.

c. Description of problems encountered:

The most prominent issues associated with the implementation of mental health case management in Minnesota appear to be caseload size, inadequate reimbursement, perceived prescriptiveness of the rule governing service standards and criticism of the targeted case management model.

County administrators claim that MA guidelines for reimbursement of case management services are too complex and burdensome and provide insufficient reimbursement.

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

A recent survey found that the average caseload in the State was about 46:1. The proposed revision of Rule 74 will reduce this ratio to 40:1.

Only about 50 children have received Rule 74 case management services. However, counties report provision of case management to 925 children with county funds.

The MHD is providing MA reimbursement training to county staff to assist in maximizing county's share of federal funds for case management.

The MHD is revising the case management rule (Rule 74) to meet the requirements of new mandates and to respond to feedback from consumers and providers. Changes include making caseloads and reimbursement more reasonable and increasing Rule flexibility.

REQUIREMENT IX. Providing for the establishment of and implementation of a program of outreach to, and services for, individuals with serious mental illness who are homeless.

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

a. The original milestone:

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:

McKinney Act Projects. In 1987, prior to availability of McKinney funding, the Minnesota Legislature appropriated $350,000 for Minnesota's three largest cities to provide mental health services for homeless persons with serious and persistent mental illness. With the FY 1987 and FY 1988 McKinney funds, the ability to assist homeless persons with mental illness was expanded to five more communities, resulting in a small mental health service network which is accessed by both homeless service providers and persons who are homeless.

Essential services provided by the projects include: outreach (41%), mental health services (25%), medical services referrals (5%), training (4%), case management (13%), and housing support (12%). In FY 1991, Minnesota contributed $346,000, a match of $2.87 for every $3.00 of federal funding for the program.

Mental health assessment is an essential part of each project's activities. Some urban projects have had extremely high success rates in training homeless shelter workers in mental health assessments, thereby increasing the accuracy of referrals for services from mental health staff. In rural areas, staff often function in multiple roles, conducting active outreach to find homeless persons, assessing their mental health needs, referring them to appropriate housing, securing appropriate services, and consulting and working with homeless shelter staff and others.

Homeless Runaway/Throw Away Children: A representative from the Minnesota Homeless and Runaway Youth Providers Network attended the CASSP Project Directors' meeting in Baltimore and identified the need to involve representatives from the Minnesota Association of Runaway and Youth Services and Youth Intervention Programs Association in the CASSP statewide planning and training efforts. A workplan was developed outlining the following goals and activities:

- A representative of homeless and runaway youth will be a member of the CASSP advisory committee;

- The annual report to be submitted by Local Coordinating Councils to the State will be reviewed by homeless and runaway youth representatives to provide input and direction for the State on how to identify the needs of this target population and develop local services. Strategies for incorporating needs assessment data for this target group with the county reporting process for children and youth with mental health needs as mandated in the Children's Comprehensive Mental Health Act will be explored.

- The State Interagency Coordinating Committee will receive information on runaway and homeless children and youth. The Department will seek support from other State agencies to identify this area as one of the priority areas to be developed in planning and implementing statewide training across State agencies.

- The CASSP project coordinator and other Department staff, as needed, will be involved with a minimum of one training activity sponsored by the runaway and homeless youth professional organizations in the State.

c. Description of problems encountered:

While the homeless projects have done an excellent job of identifying persons in need of services, federal funding has not increased.

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

The Mental Health Services Program for Homeless People has been successful in meeting the following stated objectives:

- to provide services to homeless persons with mental illness so that they can receive the basic needs of life, one of those basic needs being mental health services;

- to support the efforts by homeless service providers to assist homeless persons with mental illness; and

- to engage the entire mental health provider system in providing services to the persons who are the hardest to find and maintain contact.

In FY 1991, 3,152 homeless individuals with mental health problems received services from mental health providers in eight Minnesota areas where homeless people congregate. 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.

Joint workplanning has been done with agencies serving Homeless Runaway/Throwaway Youth.

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

a. The original milestone:

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

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:

Descriptions of McKinney Act Homeless grants: Each of the current eleven homeless projects is encouraged to develop a project which is responsive to local community needs and conditions. Hence, the homeless projects vary considerably. For example, northern St. Louis county, a sparsely populated and geographically large northern area of Minnesota, is comprised of several small towns of over 10,000 people surrounded by heavily wooded areas. Housing is readily available, but unemployment is very high due to the demise of the taconite industry, so that many have lost their houses. The Moorhead area is a rich farming area (the Red River Valley, noted for potatoes and sugar beets) just across the border from North Dakota. It has many migrant workers from spring to fall, which are defined as homeless in Minnesota's 1988 CHAP), and some North Dakotans cross the border to receive services, since, unlike Minnesota, North Dakota does not have a General Assistance program. Many of the rural program sites are relatively isolated from other services specifically for homeless persons, and are making a major contribution toward developing a network of service providers and services for homeless people in these areas. In contrast, Hennepin County, which contains Minneapolis, the State's largest city, shelters an estimated 46% of the State's homeless population, and has done so since 1987. Ramsey County, which contains St. Paul, the capital and second largest city, has done an excellent job of training homeless service providers to do an initial assessment for mental illness. Staff in the urban area of Minneapolis-St. Paul function as trainers, coordinators and support staff for shelter staff.

The variety of activities conducted by the homeless projects includes on-call support and assistance 24 hours a day to shelter workers, leasing a transitional house where homeless individuals with mental illness can live until more permanent arrangements can be made, searching local and State parks and abandoned and wooded areas to find homeless people, traveling 16,000 miles in one year to provide outreach and face-to-face training to 14 local law enforcement agencies, maintaining rental contracts with local landlords and screening and matching individuals' needs and personalities with available openings, purchasing a $1.00 HUD house for a transitional home, and developing program contracts with clients and their representatives, identifying and then providing individual services necessary to maintain independent living, among many others (see Appendix II, Descriptions of McKinney Act Homeless Grants, for a more detailed description of each homeless project).

Homeless Projects and Law Enforcement. In Hennepin County, the Mental Health Unit project serving homeless persons with mental illness, a part of the Community Service Unit, began a monthly round table discussion with law enforcement officials to make sure that persons with mental illness are served properly. The ACCESS project in Ramsey County began a roundtable with the law enforcement officials modeled after the Hennepin County experience. On the Iron Range, the homeless project is responsible for working closely with 14 different law enforcement agencies. A law enforcement group has asked this latter project to develop training for new law officers who may come in contact with homeless persons with mental illness.

Cultural Diversity and Homelessness. The Polk County Homeless Project in the Red River Valley has been a catalyst for bringing stability to a community dealing with cultural diversity issues. A staff person became the community coordinator for a celebration that was designed to diffuse the racial tensions between the predominantly Hispanic, migrant worker homeless population and the white home/farm owners in the community.

Supported Housing: A mental health housing mission statement was enacted in law in 1989. This mission statement gave the commissioner the responsibility to ensure that housing services are provided as part of a comprehensive mental health service system. Since the passage of the Housing Mission Statement, the Mental Health Division has been incorporating its principles into the grant programs it develops and administers.

The 1988 Legislature allocated $500,000 for the development and implementation of housing support pilot projects. The purpose of these projects was to provide supportive services to persons with mental illness to remain and live in safe, stable and affordable housing of their choice. The selection of housing was to be from those living environments available to the general public.

Initial pilot projects began in November, 1988. By the end of the first fiscal year, ten counties had eleven projects implemented. The Department requested and received approval from the Legislature to continue the pilot projects in FY 1990-91. The projects served 448 persons in FY 90 utilizing $535,000 for housing support services; 490 persons are projected to be served in FY 91 with $549,445 in allocations.

In May, 1990, a fulltime mental health program consultant position was established to oversee the housing support pilot projects and Stewart B. McKinney Mental Health Services for Homeless Persons (MHSHP) program. Additionally, this staff person is responsible for providing technical assistance regarding implementation of the housing mission statement and coordination with housing and housing support agencies.

A housing support consumer satisfaction survey was conducted in May, 1990. Surveys were completed by 91 persons. The results indicated that consumers received a variety of supportive services and were satisfied with services they received. The types of assistance most commonly received included finding a place to live, maintaining their home (cooking, cleaning, budgeting), mental health emergencies, moving, locating furniture and housing supplies and obtaining public housing services. Consumer satisfaction surveys were also conducted in May 1991. Findings from the most recent survey will be used to shape the expansion of housing support services in 30 additional counties.

These housing support projects have shown that increasing supportive services enables persons with serious and persistent mental illness to obtain and maintain safe and affordable housing of their choice. However, the projects have also shown that safe, affordable, stable housing is not available statewide. Additional work with State, local and federal housing agencies is needed to develop such housing and coordinate services.

Local Housing Authority Funds. Through the Mental Health Division's participation in the National Association of Housing and Redevelopment Officials (NAHRO), an organization to which all local housing authorities belong, a positive relationship has developed with that organization. NAHRO has invited Division staff to participate in their twice-a-year conferences as well as in their legislative committee. In the last legislative session, NAHRO supported the Mental Health Division's Housing Initiative. Several local housing authorities were consulted on the Mental Health Housing Initiative legislation passed by the 1991 State Legislature. HUD also gave significant input into the development of this legislation. Additionally, through the Division's Housing Support Pilot Projects, seven counties have agreements or arrangements with their local housing authority, two are in the process of developing an agreement and the other two have been asked to develop an agreement in the next year.

A Mental Health Division staff is a representative on the State Comprehensive Housing Affordability Strategies (CHAS) task force. The State has also initiated a Home Ownership for Persons with Disabilities Task Force which is researching the possibilities of programs for persons with mental illness to own their homes. The Mental Health Division reviews the HUD 202 projects that are available to non-profit groups in the State, provides technical assistance to HUD 202 project developers as they develop proposals, review the proposals, and comment to HUD on the supportive service part of the proposal.

c. Description of problems encountered:

Although housing continues to be a need identified by counties, resources to provide housing and housing support remain limited.

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

McKinney Act Homeless projects are each oriented to respond to very different local needs and conditions. Linkages between law enforcement agencies and homeless projects have been established in several communities.

Housing support projects are expected to serve 490 persons in FY 91 with $549,445 in allocations. Projects have demonstrated that increasing supportive services enables persons with SPMI to obtain and maintain housing of their choice. Funding to expand the number of these projects to 30 has been obtained from the Legislature.

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

a. The original milestone:

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:

State Level Coordination of Children's Mental Health Services: Minnesota Statutes direct the coordination of the development and delivery of children's mental health services on the State and local levels. The Departments of Human Services, Health, Education, State Planning, Corrections and Commerce, along with a representative of the Minnesota District Judges' Association Juvenile Committee, are directed to meet at least quarterly to:

- educate each agency about the policies, procedures, funding, and services in agencies serving children with emotional disturbance;

- develop mechanisms for interagency coordination on behalf of children with emotional disturbance;

- identify programmatic, policy or procedural barriers that interfere with delivery of mental health services for children across 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;

- identify mechanisms for better use of federal and State funding in the delivery of mental health services for children; and

- report on policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.

The Committee has been meeting approximately monthly since 1989 and undertook a project to obtain data on the provision of services to children with emotional disturbance. Phase I involved identification of the various funding sources currently

available for mental health services, funding amounts, and the number of children being served.

In its 1990 Report to the Legislature, the Committee included recommendations for enhancing and improving the delivery of services to children with emotional disturbance. Recommendations which addressed the functioning of the State agencies represented on the committee and the progress made in their implementation are by 1991 as follows:

- State agencies should collaboratively develop training needed for multi-system service providers, such as physicians, educators, public health nurses, and child protection workers, to help them clearly identify the target population for children's mental health service provision and to provide information on connecting with decision-makers who control access to services in other systems.

A task force of representatives of State agencies developed a work plan for provision of training. Materials developed by that group were the basis of the proposal funded by NIMH (CASSP grant). In addition, the Department's contract with the Department of Health for training providers of EPSDT services was expanded to include awareness of issues related to emotional disturbance. A series of day-long training on the topic was provided in the spring of 1991, with involvement by the Department of Education on some portions. Division staff also worked with Department of Education staff in the latter Department's development of the handbook covering emotional/behavioral disorders for special education.

- The Departments of Human Services and Education should cooperate in developing mental health community education programs and school curricula to assist families and children in recognizing symptoms which may indicate the need for mental health services.

No specific activities were been undertaken in this area. However, the Mental Health Division continues to distribute Children and Youth at Risk of Emotional Disturbance: Risk Factors and Symptoms, the booklet developed and widely disseminated in January, 1990. An addition brochure on the same topic is being distriubted.

- State agencies should assure that children and adolescents with severe emotional disturbance are commonly defined and eligibility criteria are compatible to the greatest extent possible. Where compatibility is not possible, differences should be based on State or federal

law or rule and should be clearly delineated. In particular, the Department of Education should study and recommend to the Legislature local and Statewide definitions and eligibility criteria for children with emotional disturbance.

The Department of Education has studied and recommended, in consultation with staff from other agencies, a rule on statewide eligibility for services to children with emotional/behavioral disorders (E/BD) for ages birth through 21. The proposed rule, approved during the 1991 legislative session, attempts to achieve compatibility with criteria used by other Departments.

• To the extent feasible, State agencies should encourage co-location of service eligibility determination sites locally in order to facilitate access to services.

The Department of Education's recently released document, "Challenge 2000: Success for All Learners", urges the establishment of "comprehensive and accessible community parent resource centers statewide". The recommendation calls for centers to be located in all neighborhoods and communities statewide to give parents ready access to needed resources and to health and social service professionals. Members of the State Interagency Coordinating Committee contributed to the content and recommendations of that document.

• Pooled funding and shared resources, rather than categorical funding, to address the needs of the target population should be studied as a means to address [compartmentalization of funding]. If funding streams must remain discrete for federal purposes, State agencies should provide models for collaborative use of funds by local agencies.

The Department of Human Services obtained statutory changes in 1991 permitting integration of what would otherwise be separate funding streams for various mental health services for children. The primary objective was to maximize county flexibility to meet locally-identified needs. The legislation permits phased-in development of an integrated children's mental health fund, beginning with Family Community Support Services, in 1992.

The Department's RFP for development of pilot Family Community Support Services stresses the advantages of leveraging funds from other systems, such as schools and corrections, with the dollars available under this RFP in order to promote cooperative service development. "Challenge 2000" also urges the promotion of

cost-effective service delivery through collaborative funding.

The Interagency Committee has responded to requests from the Children's Subcommittee of the State Mental Health Advisory Council and other groups to research and describe agency responsibility for ensuring provision of services to children.

• Training on appropriate use of the Data Practices Act and the Tennessen Warning should be provided to staff of agencies working with children and families. Children, families, and service providers should be provided information regarding the need for and benefit of information sharing for the purpose of coordinated service planning and delivery.

Staff from the Children's Mental Health Demonstration Projects have provided training to county staff and service providers on methods by which information may be shared within existing law.

• The Departments should develop interagency agreements to assure coordinated development of early identification and intervention services among systems serving children. The agreements should address identification of children having, or at risk of developing, emotional disturbance.

Discussion among participants on the Interagency Committee continues in order to determine the most effective approaches to interagency agreements.

c. Description of problems encountered:

True collaboration between large bureaucratic agencies requires a considerable amount of time to develop. Not all agencies are equally vested in the process.

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

Specific collaborative efforts are in place, including joint staffing and funding of several specific projects, and the active envolvement of staff from various departments in numerous planning and training activities.

Shared data on funding of services and the number of children to whom these services to whom they are provided has been obtained.

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

a. The original milestone:

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

The 1990 Plan described mental health services mandated for children, as provided in the State's 1989 Comprehensive Children's Mental Health Act.

Development of Children's Case Management Model and Rule-Making: Case management services are activities that are coordinated with family community support services and designed to help the child and the child's family obtain needed mental health, social, education, health, vocational, recreation, and related services. Case management is intended to ensure that children with severe emotional disturbance and their families receive the services they need, that services stress interagency coordination and collaboration, and that services are appropriate to the changing needs of children and their families.

The Comprehensive Children's Mental Health Act requires Minnesota counties to develop and implement this key service. Since it is the most critical and complex service mandated by the Comprehensive Children's Mental Health Act, it is vital that case management is developed and supported by the local agencies that have the opportunity and responsibility to implement this service.

The 1991 Legislature mandated the adoption of an emergency rule (Rule 77) to govern implementation of case management services for children with severe emotional disturbance by January 1, 1992, with permanent rule adoption by January 1, 1993. Until April 1992, case management services must be offered at minimum to those children who were eligible for case management under the criteria in effect in January, 1989, which includes the definition of "serious and persistent mental illness" as first described in the 1987 Mental Health Act.

To comply with this legislation, the Department has implemented Rule 74 under the federal Medicaid targeted case management option for children with serious and persistent mental illness. The rule is being revised to permit reimbursement for services to children with severe emotional disturbance. The possibility of development of the federal rehabilitation option to allow expansion and flexibility in case management services for children with severe emotional disturbance (more in keeping with the CASSP principles of interagency collaboration and coordination, and family participation in service development) is currently being explored. In addition, emergency Rule 77 will be promulgated by January, 1992 to provide service standards for children's case management. These standards will permit an interagency team approach to facilitate coordination among

agencies in the local system of care serving children with severe emotional disturbance.

Family Community Support Services (FCSS) Development: During the past year, the Department has worked in collaboration with counties, service providers, families, and advocates to design and implement family community support services. This array of services is designed to help each child with severe emotional disturbance to remain with the child's family in the community by improving the child's ability to manage basic activities of daily living, function appropriately in home, school, and community settings, and participate in leisure time after school or summer community youth activities. These services must also be designed to: improve overall family functioning as clinically appropriate to the child's needs; reduce the need for, and use of, more intensive, costly or restrictive placements; and reduce the number of admissions and lengths of stay in out-of-home placements, if an out-of-home placement is indicated through the child's diagnostic assessment.

Family community support services include:

- client outreach;
- medication monitoring;
- assistance in developing independent living skills;
- assistance in developing the parenting skills necessary to address the needs of the child with severe emotional disturbance;
- assistance with leisure and recreation;
- crisis assistance, including crisis placement and respite care;
- professional home-based family treatment;
- therapeutic support of foster care;
- day treatment;
- assistance in obtaining respite care and special needs day care; and
- assistance in obtaining financial resources.

In November, 1990, the Division solicited proposals from county agencies for pilot projects to demonstrate innovative ways to provide FCSS to children with severe emotional disturbance and their families. The Division received 39 proposals representing 53 counties. Both metropolitan and out-state counties submitted proposals which demonstrated their ability to plan, design, and implement services based on the Child and Adolescent Service System Program model of service delivery. Counties needed to demonstrate that services would be:

- child-centered and family-focused;
- culturally sensitive;
- responsive to the unique needs of children with severe emotional disturbance and their families; and

designed and funded through interagency collaboration and coordination.

Grants were awarded in February 1991, for the 15-month period from April 1, 1991 to June 30, 1992. Based on 1991 state appropriations for family community support services, the Division will again solicit proposals the fall of 1991 for a 15-month grant to initiate or expand family community support and case management services with additional funding appropriated by the 1991 Legislature as part of the new Children's Community-Based Mental Health Grants.

Rule 47 Revision: Following the direction of the 1991 Legislature, the Health Care Management Division and the MHD are revising Rule 47, the general administrative rule for Medical Assistance reimbursement, to include reimbursement of professional home-based family treatment services for children with severe emotional disturbance. Emergency rulemaking will be complete by January, 1992, with a permanent rule to be completed a year later. Reimbursement for these services to MA-eligible children will be available in April, 1992.

Rule 5 Revision: Rule 5 is the licensing rule governing residential facilities providing services to more than 10 children and adolescents with "emotional handicaps". Counties are mandated to provide these services. Rule 5 was last revised in 1971 and is recognized as needing revision. Rule revision was begun by Division staff in January 1991. The 1991 Legislature mandated that a revised rule governing residential treatment services for children with severe emotional disturbance be in effect by July 1, 1992.

The Rule 5 Advisory Committee meets monthly to seek public input and recommendations. Public hearings must begin in January 1992 in order to meet the July 1, 1992 deadline. Although the public comment period is somewhat limited due to the expedited timeline for rule revision, Division staff have been meeting informally with providers, family members, county staff, and other State agencies since January, for the purpose of soliciting input for the revision.

The Division has studied the possibility of Medicaid reimbursement for Rule 5 treatment services, using the "under 21" option. Due to the likelihood of changes at the federal level, the Department will not pursue Medicaid funding for residential treatment at this time. However, the Department may seek this federal funding in the future, contingent upon decisions made at the federal level regarding reimbursement for residential treatment services for children with severe emotional disturbance.

The revised Rule 5 will reflect the statutory requirements of the Children's Comprehensive Mental Health Act. By July 1, 1991, all children referred for residential treatment must be screened prior to admission by a mental health professional who is not financially affiliated with any residential treatment facility, inpatient hospital, or regional treatment center. The screening must establish that the child has severe emotional disturbance and is in need of residential treatment services. The Act also requires admission, continued stay, and discharge criteria and clinical supervision by a qualified mental health professional of program services and individual treatment plans. Special mental health consultants must be used as necessary in assessing and providing appropriate treatment to children of cultural or racial minority heritage. The revised rule will also have clear treatment standards which meet the intent of the Comprehensive Children's Mental Health Act and will include significant involvement of the family as partners in the child's treatment.

Rule 5 revision will also include standards for restrictive procedures, cultural competence, physical plant requirements, health care procedures, staff qualifications, and staff training to assure the protection and safety of the children served and compliance with the intent of the Comprehensive Children's Mental Health Act.

Local Coordinating Councils (LCCs): Minnesota Statutes set specific duties of the county board in connection with children's mental health. These duties include: (1) developing a system of affordable and locally available children's mental health services; and (2) coordinating the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability and cost effectiveness of mental health services to children.

Each LCC must develop:

- Interagency agreements to coordinate services;
- An annual report of unmet children's mental health needs and priority areas for service development, by October 1; and
- An annual report on information collected, including a description of services provided by each agency represented on the council, various sources of funding and actual expenditures, description of the number and characteristics of children and families served, and an estimate of unmet needs by October 1, 1991.

The latter reports are to be compiled by the MHD for presentation to the Legislature in 1992.

The Division continues to work with LCCs through the provision of technical assistance and training at the regional level to assist them in developing activities and strategies to fulfill their role in the development and oversight of children's mental health services at the local level. LCCs will be a primary focus of CASSP training efforts, described below.

CASSP Training: The goal of the CASSP project is to utilize specific information, technical assistance, and training activities to achieve the goal of implementing child mental health legislation, systems change, and coordination of services to children and youth with severe emotional disturbance and their families. This will be done utilizing the following: commissioners' seminar; statewide conferences; training of trainers; parent education and training; models for collaboration; transition planning; and technical assistance and information dissemination regarding current practices. The planning and delivery of training will focus on the Comprehensive Children's Mental Health Act and interagency approaches to community and family-based models of service and strategies for providing mental health services across agencies. Participants, many of whom will be LCC members, will be trained in group process, best practice models for community and family-based services, leadership skills, assessment, individual treatment planning across agencies, family advocacy, and creative approaches for pooled funding and the development of interagency agreements.

Task Force on Children's Specialized Residential Treatment Services: The Minnesota Legislature established a joint committee to study the need for specialized residential treatment programs for children with emotional disturbance who exhibit violent or destructive behavior and for whom local treatment programs are not feasible due to the small number of children who need the services and the specialized nature of the services required.

The joint committee must report its findings to the Legislature by December 1, 1991. The report must include an estimate of the number of children who need specialized services and the extent to which these children are now being served in other states. In addition, the report must include recommendations for actions needed to develop resources within Minnesota and mechanisms by which the commissioner shall approve out-of-state placements of children for whom the commissioner is responsible for partial payment of specialized treatment costs. Division staff will participate with this group.

Minority Specialists: The 1989 Comprehensive Children's Mental Health Act requires that mental health services for children with severe emotional disturbance be based on individual clinical, cultural, and ethnic needs. Services must be designed and

delivered in a culturally-sensitive and age-appropriate manner. The Act was amended to assure that special mental health consultants (mental health practitioners or professionals with special expertise in treating children from a particular cultural or racial minority group) are used as necessary to assist counties in assessing and providing appropriate treatment for children of cultural or racial minority heritage. Applicants for new MHD children's unit positions must demonstrate an understanding and ability to work with children and families of differing cultural and ethnic backgrounds.

Family Community Support Service projects funded by the State were required to demonstrate the provider's understanding, and ability to plan, develop and implement services that meet the needs of minority children with severe emotional disturbance and their families. Family community support outreach services to minority families and communities must take into account local minority cultural norms and values to assure that these services are culturally relevant and accepted by community members. Case management training includes information about the characteristics of racial and ethnic minority groups and appropriate and culturally-relevant models of services for children and families from minority populations. All Division children's services staff have participated in training on cultural competencies.

MHD Monitoring of County Plans for Children's Services: The following are high priority issues which are likely to result in denial of approval of biennial children's mental health plans:

- continued failure to utilize Medical Assistance for case management for eligible children;

- significantly inadequate or inappropriate services for children with severe emotional disturbance, without an adequate plan to correct the problem;

- unusually high utilization of inpatient or residential services, without an adequate plan to move towards less restrictive alternatives; and

- continued non-compliance with conditions specified in the State approval letters for the 1990-91 children's mental health plans.

c. Description of problems encountered:

The lack of funding to counties for service provision and to the Division for developing service standards, consultation, and technical assistance has delayed implementation of the Act.

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

FCSS grants were awarded to provide funding for service development in 53 counties; children with severe emotional disturbance and their families are receiving family community support services in these counties. New funding will be available to counties April, 1992, through the new Children's Community-Based Mental Health Grants.

Rule development is underway for residnetial treatment services licensure, case management service standards and MA reimbursement, and professional home-based family treatment serivces.

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

To develop new high quality services for children with emotional disturbance

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

The 1991 Legislature approved most elements of the Governor's proposed Children's Mental Health Initiative:

- $2.7 million in new funding to expand grants to counties for non-MA family community support services and case management. This will allow continuation of the current $1.2 million per year for family community support, plus an increase which is estimated to bring all counties up to the greater of $22,000 per county per year or $2.25 per capita (based on number of children in the county's population). A bulletin to counties provided estimated allocations per county for children's mental health grants. In addition, the Department will issue an RFP this fall, with a probable application due date of January 1, 1992. Increased funding will be available effective April 1, 1992. The legislation requires that family community support services be the first priority for these funds; case management is the second priority.

- $1,265,000 to begin MA coverage for case management and home-based services for children with severe emotional disturbance. This is in addition to federal matching funds and about $1 million in State funds already in the budget base for home-based services; emergency rules must be written by January 1, 1992.

- an increase in the county share for RTC services for children with severe emotional disturbance; counties will be required to pay 50% of the non-federal share for MA-eligible children after January 1, 1992. (Counties are already required to pay 100% of the residual cost of RTC services for non-MA eligible children.) It is hoped that this change will discourage inappropriate placements in RTCs by equalizing costs between these placements and placements in community-based residential treatment facilities.

Family Community Support Services (FCSS) Funding: In 1990, the Mental Health Division solicited proposals from county agencies for pilot projects to demonstrate innovative ways to provide FCSS to children with severe emotional disturbance and their families. FCSS must be designed to help each child with severe emotional disturbance to function and remain with the child's family in the community, by improving the child's functioning within the home and school setting. Family community support grants were made to counties for a fifteen-month period from April 1, 1991 through June 30, 1992. The dollar amounts of these awards were based on a minimum of $1.00 per child (based on the latest available census data) or a base of $10,000. Initial awards were made to thirty nine counties for service provision in fifty-three counties for children and their families.

The 1991 Legislature appropriated an additional $2.7 million for the expansion of family community support services and the development of case management services for non-MA eligible children during the next biennium. The Division will solicit a Request for Proposal during the fall of 1991 for a 15-month grant to develop FCSS in those counties which have not yet developed these services, expand FCSS in counties that were recipients of the 1991 FCSS grants, and provide case management services for non-MA eligible children as part of the Children's Community-Based Mental Health Grants.

Funding for MA Case Management and Home-Based Services: In 1988, the Department promulgated Rule 74, relating to case management for both adults and children with serious and persistent mental illness. The fiscal note for Rule 74 assumed that counties would provide case management to about 1,000 children with serious and persistent mental illness, and that approximately 500 of those children would be funded through Medical Assistance.

The 1989 Legislature passed the Comprehensive Children's Mental Health Act, including a statewide mandate for case management for children with severe emotional disturbance, effective July 1991. The Department had estimated that twice as many children would qualify as having a severe emotional disturbance as compared to the earlier "serious and persistent mental illness" criteria. However, since the effective date for expanded eligibility did

not occur until 1991, the 1989 Legislature did not appropriate any funding for the new mandate, nor did it amend MA coverage to include the expanded severe emotional disturbance target population.

Although the administrative systems have been in place for counties to bill MA for this service since January 1, 1989, actual billings for children have been far less than expected. Only 50 children have received MA-reimbursed case management services, although counties report provision of these services to more than 900 children with other funding. Emergency revisions to Rule 74 which adds elibility for children with severe emotional disturbance and more flexibility in service provision (as discussed in Requirements VI and VII) are expected to increase increase the number of children for whom MA is billed for this service.

The 1989 Legislature allocated funding to begin MA-reimbursed professional home-based family treatment services for children with severe emotional disturbance beginning in January 1991. Due to limited staff in both the Mental Health and Health Care Divisions, the starting date for Medical Assistance reimbursement of this new service will be April, 1992. Emergency revisions to Rule 47, the general MA reimbursement rule, will provide this service under the Medicaid Rehabilitation Option, using EPSDT as the gatekeeping mechnaism.

Children's Mental Health County Demonstration Projects: Using federal ADM Block Grant set-aside funds, eight counties were funded through a Request for Proposal process in late 1988 to demonstrate the implementation of the Comprehensive Children's Mental Health Act. The eight sites were funded are located throughout the State, in both urban and rural areas. These projects have accumulated vast amounts of knowledge as they have developed services which are community-based and collaboratively-developed across multiple service systems.

These projects have now assumed an expanded role in assisting the Division in disseminating information to other counties for their use in designing and implementing high quality, collaborative mental health services. With second year CASSP grant funding, the Division will utilize the expertise of staff from the demonstration projects to serve as mentors to other representatives of the systems of care as they attempt to implement the Comprehensive Children's Mental Health Act in their local communities throughout the State.

The Division assists with the development of a quarterly newsletter published by the eight child mental health demonstration projects, providing information regarding the service implementation efforts of these projects. The newsletter has been an excellent vehicle for distributing this information

to a wide audience of over 400 individuals and agencies across the State.

For the second year of the Children's Demonstration projects, the Division contracted with an independent evaluator to evaluate the eight projects. Data obtained indicates that projects expanded from serving an initial 59 children in March, 1989 to 176 in September, 1990. (The largest number of children [92] have been served by the Itasca County project, which has a heavy emphasis on early identification.) Children in the projects have consistently been school-aged, between 6 and 17 years, and are predominantly male Caucasians. At least two-thirds of the children being served are from families with a yearly household income of less than $20,000. Pilot counties had reported involvement by an average of three child-serving agencies prior to start of the grant. That number had grown to an average of 12.6 agencies by September, 1990.

Provision of day treatment, prevention and education, professional home-based family treatment and outpatient services were the services most frequently added in the pilot projects over the period of the grants. These services, as well as case management, are the most frequently provided services. Of the 176 children served over the period, 20% were placed out-of-home, but none were placed out-of-state. Coordination and cooperation are seen by the projects as having increased. Services typically not provided are being explored, as are possibilities of sharing resources and coordinating efforts to provide enhanced services.

Early Identification and Intervention: Early Identification and Intervention (EI/I) services are intended to provide a framework in every community across multiple service systems to identify children in need of, or at risk of needing, mental health services and to intervene as early as possible to prevent or reduce the severity of emotional disturbance in children. EI/I services must promote access to needed mental health services for children of all ages at the earliest sign of mental health problems. Through early identification, children will be more effectively served, with more successful outcomes for children and families and reduced costs to the communities responsible for meeting the mental health needs of children and families.

A multi-agency EI/I task force developed a vision for these services across the State and continues to provide direction to the Division in assisting communities to implement services throughout the State. Two recent activities in which the Division worked collaboratively with this group include regional trainings on child mental health awareness attended by representatives from education, health, public health, mental health, and social services and the development of the brochure on the "Mental health Needs of Children and Youth"; 250,000 copies of this brochure were made available throughout the State

beginning in August, 1991 by the Departments of Human Services, Health, Corrections to counties, providers, advocacy groups, and families.

Outreach and information dissemination efforts are being conducted collaboratively across agencies and systems serving children with emotional disturbance. Division staff have worked collaboratively with staff from the Departments of Education and Health in designing and delivering a series of five trainings for 175 people throughout the State which focused on the identification of mental health issues in children. Staff also developed a brochure regarding mental health issues in children at various developmental stages which provided information on significant signs and symptoms that may indicate emotional disturbance.

The Division has participated in the development of a screening tool for use by early childhood screeners and has also chaired a task force on early identification and intervention for children in need of mental health services.

Emotional/Behavioral Disorders Network Group: The Planning and Networking Committee for Children and Adolescents with Emotional and/or Behavioral Disorders (EBD) conducted a study to identify the needs of children experiencing an emotional or behavioral disorder in Minnesota. From the results of the study, the committee identified the following key points:

- The current system is not adequately addressing the needs of youth with E/BD;
- The stigma associated with emotional or behavioral disorder must be effectively dealt with before desired changes will take place;
- Children need comprehensive services including prevention, early identification, and case management;
- To be accessible and functional, services must be coordinated across agencies through effective interagency collaboration;
- High quality E/BD teachers and support staff must be recruited and retained to provide effective classroom instruction;
- Parents must be included as partners. They must be respected, supported, and listened to by providers of mental health services; and
- Funds utilized for service development must be viewed as an investment in the future.

To address the recommendations of the committee, a mission for serving children and youth experiencing, or at-risk of experiencing, E/BD was developed based on identified needs and best practices as demonstrated through the Minnesota Comprehensive Children's Mental Health Act:

> The Minnesota Department of Education respects and promotes a coordinated system wherein public officials and service providers work together with families and utilize child-centered decision- making processes , leverage resources, and share in activities and training that result in accessible, comprehensive services for youth experiencing, or at risk of experiencing, emotional/behavioral disorders.

E/BD Handbook: The Department of Education in cooperation with the Department of Human Services has developed a resource manual entitled "Developing Quality Services for Children and Youth Experiencing an Emotional/Behavioral Disorder". Representatives from the Departments of Education, Health, Human Services, and Corrections participated in a planning and networking committee convened by the Department of Education to identify the needs of children and youth experiencing emotional/behavioral disorders. Thirty-two focus group interviews were held around the State with people from multiple systems concerned about children and youth with emotional or behavioral disorders (E/BD). The results of the focus group interviews were used as a guideline for the development of a resource manual based on a shared mission and vision of children's mental health services in Minnesota. The manual will provide a basis for future curriculum development and shared training between the Departments of Education, Health, Human Services, and Corrections.

The sharing of human and fiscal resources between the Departments of Human Services and Education has occurred as a result of the development of the resource handbook on services to children with emotional/behavioral disorders. Personnel time from each department has been allocated for collaborative work in developing a resource manual to be used in training activities with representatives from multiple service systems during the 1991-92 year. Both departments have agreed to share the publication, printing, and dissemination costs.

The collaborative interagency relationship that exists between the Departments of Human Services and Education will enhance training activities and ultimately local service delivery through the modeling of partnerships and shared human and fiscal resources that can be replicated at the local level.

Homeless Runaway/Throw Away Children: A representative from the Homeless and Runaway Youth Providers Network, along with the CASSP Coordinator, attended the CASSP Project Directors' meeting

in Baltimore and identified the need to involve representatives from the Minnesota Association of Runaway and Youth Services and Youth Intervention Programs Association as members of the CASSP advisory committee. Alternative youth service providers have a wealth of information and knowledge to contribute to the development and implementation of training activities for community-based systems of care. The needs of homeless and runaway youth and their families will also become a target group for the collection of data when developing needs assessment instruments and establishing a data bank for identification of training needs across agencies.

c. Description of problems encountered:

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

The 1991 Legislature approved most elements of the Governor's proposed Children's Mental Health Initiative, including $2.7 million in new funding to expand grants to counties for non-MA family community support services and case management, $265,000 to begin MA coverage for case management and home-based services for children with severe emotional disturbance, and an increase in the county share for RTC services for children with severe emotional disturbance. It is hoped that this change will discourage inappropriate placements in RTCs.

The Department of Education and the MHD developed a resource handbook entitled "Developing Quality Services for Children and Youth Experiencing an Emotional/Behavioral Disorder", as well as brochures on identification of symptoms of emotional disturbance.

Staff from the Departments of Education, Health, and the MHD designed and delivered a series of five statewide trainings for 175 people on the identification of mental health issues in children.

REQUIREMENT XI. Consulting with representatives of employees of state institutions and public and private nursing homes who care for individuals with serious mental illness

This requirement crosses components of several objectives which have been previously described. In brief, 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 implementation has involved extensive consultation with nursing home employees and others involved with the identification and/or relocation of older persons inappropriately residing 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:

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:

The Human Resource Development project has an advisory group with representatives from academic institutions and unions which will form the basis for building linkages. (See Appendix II for a listing of advisory group members.) Members have completed a survey of academic institutions' 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 cooperation. 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.

A consultation by the PEW/APA State/University Collaboration Project (S/UCP) was primarily 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 has lent support to the University of Minnesota Departments of Nursing and Social Work proposals for NIMH clinical training grants 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. The MHD also helped coordinate the submission of a University of Minnesota Department of Psychiatry research proposal to NIMH's Community Support Program.

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."

No appropriation was made for the Public Academic Liaison Initiative. 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 minority enrollees throughout the country. The Minority Recruitment Shortage Occupation Project has focused 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.

In addition, Division staff have consulted with several University of Minnesota faculty members to provide input into grant applications.

c. Description of problems encountered:

The State PALI legislation has no funds attached.

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

Linkages have been developed with academic institutions and other mental health agencies to address common problems. Linkages have been used in developing, reviewing and/or supporting research proposals and in recruiting minority student interns in RTCs.

REQUIREMENT XII. 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:

To enhance leadership of State and local advisory councils.

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

Overview: The State Mental Health Advisory Council and its Children's Subcommittee have a task force to participate in the development of the State plan. This task force has also participated in the commentary to be submitted with the plan. The Advisory Council and Subcommittee is composed of citizen members, family members, consumers, providers, elected officials, county commissioner and other. The task force is fairly representative of the larger bodies (see Appendix II for membership list).

The Council and Subcommittee have been involved with the Mental Health Division in the implementation of the Comprehensive Mental Health Act in an on-going advisory capacity. The members have monitored the planning process through monthly meetings and as participants of groups to review rule modifications, grant eligibility criteria, grant awards, and county plan reviews.

The 1991 Legislature approved State funding for a position to staff the State Advisory Council. That position is involved in mental health related policy, planning and budgeting as staff to the Council and Subcommittee on Children's Mental Health. The Council and Subcommittee members are actively involved with Division biennial budget reviews, and are generally consulted about upcoming Legislative recommendations.

About one-half of the Advisory Council are newly appointed, assuming membership responsibilities in August, 1991. Minnesota Statutes, which created the State Council, was amended during the 1991 Legislature to allow the Council to select its own chair. The first appointed chair in 1987 will retire from the Council in January, 1992. A new chair will be selected by the Council in the fall, 1991.

Role of Local Advisory Councils: Local mental health advisory councils (LACs) are often involved in the decision-making process for local resource allocations. Areas where LACs have provided valuable input usually focus on the prioritizing of mental health

services, which is crucial to the allocation of resources. LACs also have been decisive in the selection of service provider contracts, and have sometimes played a role in determining the terms of contracts. Counties in which LACs have taken a lead role in this area include Ramsey, Hennepin, Wabasha and Hubbard.

Support and training for LACs: The 1987 Mental Health Act and 1989 Comprehensive Children's Mental Health Act mandated local mental health advisory councils (LACs) for each county (counties may combine councils). Representation on the councils is to include consumers, family members of consumers, parents of children with emotional disturbance and persons who received mental health services as a child or adolescent. Mental health professionals are also required to serve on these councils. A major goal of the councils is to increase consumer/family and provider collaboration.

The Division provides one full-time staff person for the support and training of LACs. Training of LACs focuses primarily on two areas: (1) information and training regarding the mental health system to empower LACs; and, (2) training in group dynamics and effective meeting management and techniques. Emphasis in LAC training is placed on the importance of continued representation from consumers and family members (see below), so that meaningful decisions regarding the allocation of mental health resources can be made on a local level, from a broad base of community representation. Training stresses the role of LACs in county service development through involvement with the budget process and county commissioners, and State service development, through involvement with State legislators.

Federal grant to train consumers: In 1991, Minnesota was awarded an NIMH systems improvement grant which will be used to train consumer and family members of LACs. Training will be conducted by the League of Women Voters, which has been involved in mental health advocacy in Minnesota for several years. The training will provide a more concentrated approach to consumer and family members on LACs than currently provided by MHD staff, with emphasis on recruitment of new members, systems knowledge, advocacy and leadership skills. It is anticipated that one of the two staff members hired by the League will be a consumer.

LAC newsletter: In addition to regular mailings to LACs, a quarterly 4-page newsletter is widely distributed to LAC members. The newsletter, in an attractive easy-to-read layout, provides in one place information on legislative developments, news from the MHD and State Advisory Council and other features on national and State mental health developments. The most popular regular feature of the newsletter is a page devoted to news from LACs around the State, as well as tips for effective LAC meetings.

c. Description of problems encountered:

Counties and communities have varying degrees of commitment to using LAC input. Methods for seeking consumer participation on the LACs vary; many consumers are intimidated by their minority status on the LACs.

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

Participation by consumers, advocacy groups and providers of services has been institutionalized in State policy.

Training of LAC members has occurred. A quarterly newsletter is distributed to LAC members.

The ongoing relationship with the Council and Subcommittee, although advisory in nature, enhances the level of communication and spirit of cooperation over time between the MHD and the community of advocates. The role of LACs in the county planning process is becoming more visible. Members are in varying developmental stages regarding their own understanding and level of participation.

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

a. The original milestone:

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

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

New Local Coordinating Council Protocols and Procedures: As mandated by the 1991 Legislature, Local Coordinating Councils (LCCs) are required to submit annual reports to the Department of Human Services by October 1, 1991, on the mental health needs of children and families within their communities. A standard protocol and procedures for reporting community needs is being developed and will be incorporated into county mental health planning requirements for future biennia.

The annual report by LCCs will be used to assist counties in identifying the areas of strengths and needs for community- and family-based services and in planning local budgets for service delivery. By focusing on individual needs of children and their families, there will be increased opportunities for expansion of services and programs based on the "real needs and issues" facing the local consumers of mental health services. Budget planners will have an established data base regarding individual needs of local consumers rather than the number of services/programs available within the community.

Legislative change to require information to LACs: In 1991, Minnesota amended its mental health acts to provide more authority to local advisory councils (LACs) and further legislatively ensure their involvement in local decision-making. The new language provides that the county board must

> with the involvement of the local adult (and children's) mental health advisory council(s)...develop a biennial...mental health component of the community social services plan...which considers the assessment of unmet needs in the county as reported by the local adult (and children's) mental health advisory council(s)....

Furthermore, the legislation gives LACs authority to request information from the county by providing that "the county shall provide, upon request of the local adult (and children's) mental health advisory council(s), readily available data to assist in the determination of unmet needs." MHD staff has been orienting LACs to the new legislation to ensure their awareness of their role and authority in order to focus on local planning to meet needs.

Local Plan Needs Assessment Techniques: LAC input is part of every county mental health plan for adults and children in Minnesota. Each plan has a designated area for LACs to identify unmet needs for adults and children in the county. MHD staff assigned to LACs provides assistance in completing the plans. Beginning three months prior to the due date for plans, as well as ongoing throughout the year, MHD staff emphasizes the importance of LAC involvement in county planning. Information is shared between the LACs through an LAC newsletter.

The State Advisory Council has requested copies of the LAC needs assessments for 1991-92 so that the Council might coordinate more effectively with the local system. Thirty of over 90 LACs have responded to the request for their assessment of the most prevalent needs, as determined by the members of the LACs with assistance from the county social services staff. The areas most frequently identified for adults were the following:

- Support services - maintenance/expansion of CSP or day treatment
- Crisis services - crisis facilities, in-home crisis services, psychiatric services
- Housing - affordable housing, community adult foster care, transitional housing between group homes and independent living;
- Education - public education about mental illness, education of law enforcement and emergency personnel, information on accessing services

For children, the following were identified:

•Education - community education, education of parents, education/training of teachers and others who work with children/adolescents
•Services - more services, affordable services, more professionals/staff, funding, day treatment programs
•Access and coordination - interagency planning/review/coordination, central intake, early identification and assessment, flexibility, decentralization
• Support groups - for parents and/or children
• Prevention

c. Description of problems encountered:

There are over 90 LACs (including both councils which focus on either adults or children and those which provide advice on both groups) in the State at varying stages of development. The ability of the LACs to conduct a needs assessment is dependent upon their relationship with local social service agencies. In some counties, LACs are fairly self-directed, while in others they are totally dependent upon the social services staff. The needs assessments conducted by LACs vary, but generally is a thoughtful collection of opinions about that which is most needed by residents in their county. This information becomes a part of the county mental health planning process and is reviewed by the Division.

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. For example,

• the MHD utilized a statewide survey of case managers to define the extent of problems with the present rule and to suggest solutions;

• the experiences of consumers were used to guide directions for change in Rule 36 revision;

• early identification/intervention services were developed with the assistance of a multidisciplinary interagency group established for that purpose; and

• State and national surveys were used to guide directions in both service development and rule revision.

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

a. The original milestone:

To provide active outreach in order to elicit consumer input.

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

Technical Assistance and Training of LACs: While emphasis in the first year of MHD staff work with LACs was primarily on orientation (of both MHD staff and LAC members) and recruitment of consumers and family members, training and information emphasis in the second year focused more on meaningful involvement of LACs in service and budget decisions, on both the local and State levels. The annual CSP conference continues to be the major vehicle for assembling LAC members in one place for concentrated training. With scholarships to one member per county, LAC representation at the conference was strong. Five sessions were exclusively devoted to issues for LACs, including how to be proactive, how to organize meetings, political perspectives from State and local representatives and a session especially for rural LACs.

In addition, the State Advisory Council has increased its efforts to receive feedback from LACs. During the past legislative session, a network of information sharing with LACs was developed by the State Council. Frequent updates on legislation were sent to LACs prior to scheduled meetings as they occurred. Staff assigned to LACs increased frequency of LAC meetings attended during the legislative session in an effort to keep LACs both informed and involved. Minutes of each State Advisory Council meeting (and its Children's Subcommittee) are sent to LACs, along with any other helpful information that may increase the empowerment of the LACs.

The MHD also continues to fund consumer travel to the Alternatives conference, which has received strong feedback from all who have attended for the exposure to national consumer trends, as well as the networking and contacts made.

Legislative change to require information to LACs: In 1991, Minnesota amended its mental health acts to provide more authority to local advisory councils (LACs) and further legislatively ensure their involvement in local decision-making. The new language provides that the county board must "with the involvement of the local adult (and children's) mental health advisory council(s)...develop a biennial...mental health component of the community social services plan...which considers the assessment of unmet needs in the county as reported by the local adult (and children's) mental health advisory

council(s)...." Furthermore, the legislation gives LACs authority to request information from the county by providing that "the county shall provide, upon request of the local adult (and children's) mental health advisory council(s), readily available data to assist in the determination of unmet needs." MHD staff has been orienting LACs to the new legislation to ensure their awareness of their role and authority.

Consumers as members of State and local advisory councils: Minnesota statutes require that the State advisory council, and each local advisory council (LAC) have representation of consumers, family members, parents of children with emotional disturbance and persons who received child or adolescent mental health services.

Several steps have been, or are being, taken by the MHD to ensure consumer/family involvement. These include the development of the systems improvement grant for concentrated training and recruitment of consumer and family LAC members. Additionally, the MHD staff assigned to LACs is himself a consumer and emphasizes the importance of consumer input on LACs, and occasionally shares personal experiences in an effort to increase the comfort level of consumers present at LAC meetings.

Other methods to facilitate and maintain consumer involvement are also stressed. Materials to familiarize LAC members with mental health system issues are distributed, and information obtained from national conferences regarding trends in the nationwide consumer movement is frequently relayed. Staff also ask LACs to consider that, while Minnesota statute requires at least one consumer, parent, family member, etc., additional input from these groups is encouraged. LACs are also cautioned to avoid an over-balance of provider or county agency representatives, so that true collaboration may be achieved.

Fiscal Support and Program Content for Consumer to Attend the CSP conference: The Division sponsors an annual statewide Community Support Program (CSP) Conference. This three-day conference involves the primary stakeholders in CSP including consumers, families, county mental health advisory councils, advocacy groups, and representatives of minority groups, county staff, providers, regional treatment centers, and the Division. The Division gives a grant to a county to plan and organize the conference. The grant funds stipends which enable consumers and members of county mental health advisory boards to attend the conference. These stipends enable at least one consumer from each county to attend the conference, and minority group consumers to attend. The annual conference contract mandates that consumers must be involved in all steps of the planning process.

For the 1991 conference, consumers were involved in the grant award process, the planning committee, and over 25% of all conference presentations were made by consumers or family members. The conference program content included presentations on:

- a new three year training project to empower consumers and family members on participation on county mental health advisory councils,
- advocates' perspectives on the mental health systems,
- the experience of consumers with case management services,
- cultural issues of consumers with hearing impairment,
- issues facing consumers who work in the mental health field,
- strategies for development of consumer leadership,
- combating stigma,
- decent and affordable housing issues,
- professional/consumer codependency,
- consumers as parents,
- the importance of humor in recovery by a consumer theater group, and
- recovery and rights protection in a keynote speech by a consumer.

Client Outcome Study: The client outcome study represents an effort which directly solicits consumer input into service evaluation; information obtained from this survey is expected to be useful to LACs in developing the mental health service plans.

A client satisfaction survey was conducted for a random sample of consumers of the eleven housing support pilot projects during FY 1990 and FY 1991. In 1990, ninety of the 200 surveys distributed were completed and returned to the MHD, while for 1991, eighty-four of 200 surveys were completed. Surveys were based partially on Lehman's Quality of Life measures regarding housing situations. A method for measuring client outcomes and using these measures in an ongoing system to assess the effectiveness of community support programs has been developed by the Division and will be tested in late 1991 and 1992. The method consists of a consumer survey questionnaire designed to obtain data on client satisfaction and quality of life. To these two dimensions of outcome will be added that of rehospitalization patterns, derived from the Division's service utilization database. The test phase will include several alternative means of delivering the survey instrument: a) mailings by the Division, b) phone calls by the Division, c) mailings by case managers, d) mailings by providers. The delivery method that achieves the highest response rate and quality of data will be used in the ongoing system. In addition, the test phase will determine questions with low validity and/or reliability and other problems inherent in the construction of the instrument.

Initially, this method will be aimed at assessing the effectiveness of community support programs statewide. In the future, the method may be expanded to allow individual provider analysis, and modified for use with residential and family community support programs.

c. Description of problems encountered:

Counties express frustration with effectively recruiting and maintaining consumer members on LACs.

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

Consumers are becoming involved in providing input or in the planning process itself. This tends to focus attention on the consumer as important 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.

Legislative changes were obtained to require input from LACs, which must include consumer representation, in county planning processes.

Training of LAC members is underway, and feedback is being received by the State Advisory Council from that group's local counterparts.

3. Indicators of "Substantial Implementation": 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 Comprehensive Adult Mental Health Act. This Act, promulgated in 1987 and amended in 1989, specifies a full range of basic services which counties must provide to adults with mental illness, among other requirements.

- Passage of the Comprehensive Children's Mental Health Act. Enacted in 1989, this Act specifies a full range of basic services which counties must provide to children with emotional disturbance, among other requirements.

- Major improvements in county Mental Health Plans. Extensive State-level reviews of county plans, coupled with technical assistance and delay of funding in cases of serious deficiencies, ensured that plans were adequate to respond to the needs of persons with mental illness statewide. Plans were reviewed and approved for both adult and children's services in all of Minnesota's counties. Since the last FY Progress Report, the planning process was streamlined to eliminate duplicative and/or administratively burdensome requirements while still maintaining basic elements of essential planning requirements. Counties are now required to provide essential services and to include fiscal elements and need projections in advance to determine fiscal capability and justifications for changes in plans for services.

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

- Continued efforts to downsize facilities in the community (IMDs). Additional funding has been received which will affect services to about 400 people in 22 facilities.

- Development statewide of case management services for adults and children. All of the 87 counties provide case management services which meet mental health quality standards promulgated in 1989 for adults with serious and persistent mental illness (see Table 1, in Part A, Section 1). However, Medical Assistance was billed for only 50

children in the last fiscal year, while counties indicated serving over 900 additional children during that time period with county funds. On-site monitoring is now underway to determine to what extent these latter services conform with the State's case management standards.

· Implementation of OBRA-87 requirements. The State has provided funding and technical assistance to counties to assist in developing and implementing alternative disposition plans which return persons to their home communities. Seventy-three persons have been relocated.

· Consumer involvement throughout the mental health system. This includes mandatory involvement in State and local advisory councils, in Rule revision, in the annual CSP statewide meeting both as (paid) participants and speakers, and other activities.

· Availability of Community Support Programs (CSPs) for adults with serious and persistent mental illness in all 87 counties. The number of people receiving CSP (Rule 14) services in 1990 increased 75% over 1987, with proportional funding increases (see Table 1, in Appendix I for county by county estimates of the number of persons served and expenditures). Statewide annual 3-day Community Support Program meetings provide extensive networking opportunities, and technical assistance efforts have also been extensive to implement these services.

· Implementation of Family Community Support Services . Progress is being made in implementing services for children with severe emotional disturbance and their families; family community support services were available in 61% of counties in 1991.

· Emergency 24-hour "Hot-line" services. These services, one of the basic array of mental health services for adults and children, are available in 100% of Minnesota counties.

· Involvement of local advisory councils in county plan development and other activities affecting mental health service provision at the local level. Consumers are involved in annual CSP programs (e.g., 25% of presentations were by consumers, and consumers were funded from every county to attend), rule revision, task forces, grant reviews and other activities affecting mental health services. Training programs have been implemented to increase consumer involvement and expertise and parent training is underway as part of CASSP grant activities.

· Greater emphasis on community alternatives and normalized living environments. Supported housing, housing subsidy and

alternatives to institutionalization projects, downsizing IMDs, State OBRA alternative disposition grants, and expansion of and increased flexibility in the use of Rule 36 community residential facility funds all emphasize community alternatives to institutionalization. Services for homeless persons with mental health needs include basic food and shelter and attempts to link the person with the mental health system as well as to offer preventive services.

· Increased collaboration with other State agencies. Collaboration is occurring across agencies to coordinate efforts at the State level for adults with mental illness and children with emotional disturbance on issues such as identification/outreach, chemical dependency, employment, and housing. Collaborative efforts include joint planning, training, funding and information sharing, among others.

· Screening mechanisms are in place for adults and children being considered for out-of-home placements; services are to be based on clinical needs, with extensive client protections.

· Development and implementation of a Commmunity 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, but progress is substantial in accessing other data systems and obtaining individual-specific and provider-specific information to assess compliance.

· Extensive revisions 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 developed include Rule 36 community residential services, Rule 14 community support services funding, Rule 15 CSP service standards, Rule 29 outpatient services, Rule 74 case management services, and others. In addition, emergency rules are being promulgated for children's case management service standards (Rule 77), children's community-based mental health services grants (Rule 78), children's residential treatment licensing standards (Rule 5), and Medicaid reimbursement for professional home-based family treatment services (Rule 47).

· Increased emphasis on employment . A variety of employment programs are available for persons with mental illness.

· Development of and/or expansion of programs for underserved populations. A variety of programs in urban and rural areas have been developed for American Indians, older adults, and homeless persons with mental illness, with

creative methods frequently being used to increase access and decrease the stigma associated with mental health services. Methods of continuing successful projects once demonstration funding is no longer available have been developed for some projects at the local level.

· Implementation 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. Funding for adult mental health services supervised or administered by the Department of Human Services totaled approximately $227,524,000 in 1991, which represented an increase of 51% over such expenditures in 1987. Community non-residential expenditures increased the most, by 75.5%, all community-operated services for adults increased 47%, and State-operated inpatient expenditures increased 57% (see Table 2 for more detailed comparisons). Figures 1 and 2 illustrate the changes in funding patterns for regional treatment centers (RTCs), community residential facilities (Rule 12/36) and community services (Rule 14) from FY 85 to the present.

· Expansion of funding for children's mental health services. Total funding for mental health services for children was approximately $63,086,000, an increase of 58% over 1987 expenditures. Expenditures for community non-residential services increased 111% over 1987 levels (See Figure 3 for a comparison of expenditures by service by year). The 1991 Legislature appropriated $4.8 million in increased funding for non-MA family community support services and case management for children, $211,000 to begin MA coverage for case management and $1 million for home-based services for children with severe emotional disturbance, in addition to federal matching funds, for a total of $2.5 million for services covered by MA. Expansion of the Children's Health Plan to age 18 for reimbursement of outpatient services to low income children who do not qualify for Medical Assistance was approved by the 1989 Legislature. Increased funding totalling $1.2 million is projected for the FY 92-93 biennium for Children's Health Plan outpatient mental health expenditures. MA inpatient expenditures for children's mental health have leveled off; MA outpatient expenditures have increased steadily and are now increasing faster than inpatient expenditures.

· Substantial efforts to continue and/or expand successful projects. The Housing Support projects, which were originally 11 projects in 10 counties, received new funding

to expand to 20 more counties in FY 93. Olmsted County's successful redirection of funds formerly used for an expensive, underutilized residential facility has resulted in legislative approval of this model for other counties. Anoka Alternatives, originally a one-year project aimed at seeking community-based alternatives and support services for RTC residents, has been continued with new funding. Children's services provided by the children's demonstration projects will be continued through State community-based services grants. Three of the projects to older adults with mental illness are being continued with new and often innovative sources of funding.

Progress on each of these activities during the past year and others is described more fully in Part 2, Plan Objectives Achievement. 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 mandated to provide a full array of critical services and that monitoring to ensure compliance is in place, that mental health plans are operating in all 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 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 entering into a phase of planned, coordinated, consumer-responsive and statewide mental health service expansion. However, planning and funding has been more accelerated for adult than for children's services, largely due to the base for adult mental health services which had been established prior to 1987.

4. Anticipated Problems for "Full" Implementation.

Children's Services: The level of funding available and concomitant staffing at the State level for children's mental health services has delayed the development and/or implementation 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.

Review of County Plans: Revision of guidelines used in the last county plans was needed to streamline the process for both county and State staff. This has been accomplished.

5. Reconsideration of Plan.

The basic goals are substantially unchanged. Objectives have been streamlined, however, and the language simplified and updated to reflect more specific and more current work tasks. Some objectives have been altered or deleted to reflect accomplishments to date.

For example, the objective "To redesign and implement the mental health planning process" is similar to the former objective "To achieve positive and innovative change in the planning and delivery of local mental health services", but is more specific about current issues and methods. Another objective, "To participate in opportunities to promote mental health research" was subsumed under the broader 1989 objective, "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."

Other changes reflect accomplishment of the original objective, and hence the new objectives reflect the next step in this area, rather than an essential change. For example, a change reported in the 1990 Plan from the 1989 Plan objectives in the area of data reporting systems was the change from the 1989 objective, "To implement the new community mental health reporting system (CMHRS)" to the updated objective "To enhance the State reporting capacity and data quality of the Community Mental Health Reporting System", since the CMHRS had been implemented at that time.

A few changes, however, reflect new areas of emphasis. New State objectives are indicated below, and reflect more comprehensive service planning for both adults and children. Since these were not formally stated in the set of 1989 objectives, progress in these areas has been subsumed under the most appropriate objective(s) from that time. The new objectives are informative, however, in understanding the major directions of the MHD for the future.

Additional Objectives Undertaken in 1991

- To expand housing options for persons with serious and persistent mental illness through development of a housing initiative.

- To initiate development of appropriate standards for new children's mental health services.

- To implement a process for the discharge of Anoka-Metro Regional Treatment Center patients who no longer require RTC levels of care.

- To reorganize Division so that opportunities for professional consultation with counties are optimized.

- To prepare a long term plan for mental health funding consolidation.

- To implement State and federal statutory requirements as they relate to planning and reporting.

- To implement Mental Health Statistics Improvement Project prototype in 2 to 3 community mental health centers and 3 to 5 community support programs.

- To identify Mental Health Statistics Improvement Project elements which can be incorporated with MMIS, RTC and Licensing data systems.

- To review and analyze Community Survey Data.

- To analyze case management survey results.

The 1989 objectives were selected for the current report in order to maintain consistency and because they were considerably more detailed. Some of the newer objectives, as well as some changed objectives which were similar to the 1989 objectives, were addressed in the current fiscal year, but they were less suitable, by themselves, for addressing a broader picture which will continue over the next several years. It is expected that annual "workplans" will be developed which will continue to add new objectives, modify older objectives, and replace objectives which have been achieved as appropriate.

One of the issues which has been raised by the State Mental Health Advisory Committee concerns the applicability of the 1989 objectives to children's mental health services. At the time these objectives were developed, it was the intention of the Mental Health Division that they would apply to both children and adults, rather than create two separate sets of objectives for the two populations within a work group which has significant overlap. Any special issues, concerns or needs of children and their families which cannot be addressed by these objectives will, as with any other issues which are not adequately addressed by this Plan, be subject to modification, including the addition of new workplan items as needed. However, the Division's original intention of creating one set of standards, albeit a flexible set which is amenable to change as needed for different circumstances, is still in effect.

PART B
OVERSIGHT OF PLAN IMPLEMENTATION

PART B. OVERSIGHT OF PLAN IMPLEMENTATION

1. Titles and Agency Identification. Titles and agencies of individuals responsible for overseeing implementation of the Plan are shown in Appendix II. Responsibility for the operation of Regional Treatment Centers (RTCs) and community-based mental health services are newly lodged with the Assistant Commissioner of the Department of Human Services, James Stoebner. The State Mental Health Advisory Council and its Children's Subcommittee relate directly to him. The Mental Health Division (MHD), which is responsible for community base mental health services, is under the direction of Jerri Sudderth. Mental Health Division staff and their responsibilities are also shown in Appendix II.

2. Resource Support. Support for each of these functions is provided through State legislative appropriations. Funding for some MHD staff is provided through the federal Alcohol, Drug Abuse and Mental Health Act Block Grant.

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

4. Consultation with representatives of employees of various long-term care facilities. Representatives of the Residential Program Management and Health Care Management Divisions are participants in State Mental Health Advisory Council meetings. A representative of the Regional Treatment Center system is also a regular member of that group. Members of the State Council and Children Subcommittees have provided input into the State Plan development process, and the document has been shared with the unions (AFSCME, Middle Management Associates, Minnesota Association of Professional Employees, and Minnesota Nurses Association). Representatives of various DHS divisions (Residential Program Management, Long Term Care, Health Care Management) have reviewed the content of the Plan submission. Input for the OBRA-87 Alternative Disposition Planning Process is 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 Department include participation from community-based service providers and RTCs, as well as consumers, counties and advocates.

Minnesota Department of Human Services
Mental Health Division

OPTIONAL SUBMISSION

MINNESOTA RESONSE TO 1990 PLAN REVIEW

September 30, 1991

OPTIONAL SUBMISSION

MINNESOTA RESPONSE TO 1990 PLAN REVIEW

The following material represents the Department's response to comments included in the NIMH's review of Minnesota's 1990 P.L. 99-660 plan submission. References are to the outline used by NIMH reviewers in that document.

I.A. Actual implementation progress through 1990 was not limited to case management services for adults. Data found in Requirement II demonstrates that service development and delivery for the array of services required by the State's Comprehensive Adult Mental Health Act (1987) and Comprehensive Children's Mental Health Act (1989) is occurring. Implementation dates for availability of children's mental health services were set by statute for a later time period than for adults. This is largely due to the recognition that the children's "system" was not so well developed as that for adults when the 1987 state law was passed. Nevertheless, Requirement II of the 1991 submission shows that service availability improved for both children and adults.

It is true that substantial new State funding was made available in 1989 for what is called "State Alternative Disposition Plan grants" in response to OBRA-87 requirements. These funds, as well as those state funds allocated for use in the Anoka Alternatives project, are not incidental to achievement of planning objectives. In fact, they are instrumental to that accomplishment. In each instance of use of these funds, service capacity of the county, and of the State, is enhanced as services tailored to individual client need are developed. Not only are client-specific services provided, but local capacity for provision of those services within the county grows. Critical education and understanding occur as county staff and providers learn that it is possible to transform a system from one largely focussed on bed capacity to one based on the individual needs of persons with mental illness and emotional disturbance. In addition, staff are learning that clients considered to be difficult-to-serve can be supported outside institutional settings. These lessons are being generalized beyond the specific individuals requiring relocation under OBRA-87 and beyond those persons discharged from the Anoka Metro Regional Treatment Center, as is evidenced in the enthusiasm being shown by counties as they plan alternative uses for grants which previously provided funding for adults in Rule 36 (community residential treatment) facilities and in approaches being utilized by counties in developing local services for children with severe emotional disturbance.

The reference to an "absence" of liaison with Medicaid is apparently the result of insufficient description of joint activities between the MHD and various Medicaid divisions within the Department. In fact, the OBRA-PASARR process, IMD downsizing and conversion, and development of rulemaking for children's services (case management, professional home-based family treatment, and family community support) have each required substantial collaboration with these divisions. Meetings between MHD staff and staff from Medicaid divisions have occurred weekly on average.

I.C. Minnesota's mental health system, until implementation of the 1987 Act got underway, was largely, although not completely, residentially based. This was due partly to lack of knowledge of other treatment and support options and partly because of legislative reluctance to modify funding which had provided state hospital services for persons with mental illness. Data found in the 1991 Progress Report (Requirement II) points to changes in this system. It should be noted that community and union lobbying efforts to legislators continue to make difficult a massive transition from reliance on a state hospital system. (Because earlier processes within the developmental disabilities area significantly reduced the number of individuals with these conditions being served in state hospitals, the reluctance of unions and communities to support efforts to reduce further the jobs provided in these institutions has grown.) Even so, the number of persons served in state hospitals has decreased slightly. With respect to community residential treatment, the State has made progress in reducing reliance on facilities in favor of provision of alternatives to institutionalization. (See Requirement VI of the current submission.)

In developing their 1990-1991 biennial county mental health plans, counties were required to address provision of services to children and adults from underserved ethnic and racial minority cultures. They also addressed service provision to those children and adults who have dual disabilities such as developmental disabilities, chemical dependency, and hearing impairments. (See Requirement IV for a discussion of current efforts to improve delivery of services to individuals with mental illness and chemical dependency.)

I.D. Reviewers may have overlooked discussion in previous plan submissions which described the interagency agreement with the Department of Jobs and Training's Division of Rehabilitation Services (DRS). This agreement has produced a close working relationship on employment-related issues. (See Requirement I of the current document for a discussion of joint funding of services.) The current submission also addresses the addition of a representative from DRS to the State Interagency Coordinating Committee to assure development of linkages for children needing services. (See Requirement I.)

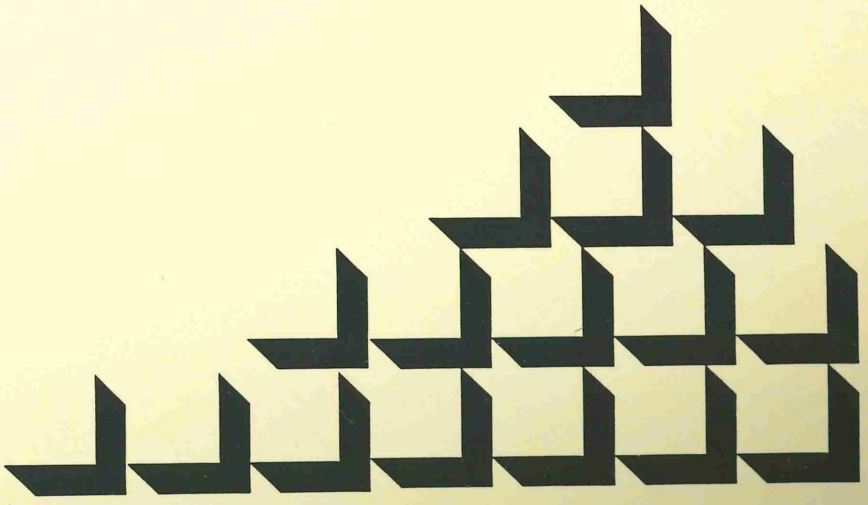
It is true that screening procedures for out-of-home placement were in early stages of development for both children and adults at the time of the submission of the 1990 plan update. However, new requirements, as recommended by task forces on both children's and adult screening, were passed by the 1991 Legislature and are now in effect. (See Requirements IV and VI.)

I.F. The review comment that case management is focussed on residential care has no basis in fact. Both targeted case management as required by Rule 74 for persons with serious and persistent mental illness, which is being revised to include children with severe emotional disturbance, and the model for children's case management being promulgated in emergency Rule 77 are based on individual client need. In no instance do these models give preference to residential treatment. Services are provided based on needs identified in the individual community support plan, or, in the case of children, in the individual family community support plan. Linkages are required between the case manager and those children and adults who require residential treatment so that appropriate services are assured during such treatment and on return to the community.

II. Local Advisory Councils (LACs), as defined by state law, are required to be involved in local development of the mental health service system. It is the State's responsibility, under a state-supervised, county-administered system such as is in place in Minnesota, to assure compliance with State and federal law. LACs were made aware of possible sanctions against counties which were not in compliance with provisions of these laws. In several instances, these local advisory groups were very active in working with both county staff and county boards in bringing about changes which permitted rapid lifting of sanctions imposed by the state. However, it should be noted that LACs remain advisory, and that responsibility for assurance of compliance remains with the Department.

A discussion of specific efforts to assure services to the State's refugee population can be found in Requirement IV of the current submission.

Appendices to
P.L. 99-660 & P.L. 101-639
Plan
September 30, 1991



Minnesota Department of Human Services

Mental Health Division

COMPARISON OF 1987 TO 1990 CHANGES IN CSP/DAY TX. USE
ADULTS

COUNTY	(1) FY 1987 CSP/DAY TX CLIENTS	(2) CY 1987 CSP/DAY TX EXPEND.	(3) CY 1990 CSP/DAY TX CLIENTS	(4) CY 1990 CSP/DAY TX EXPEND.
Aitkin	2	$8,635	30 *	$48,132
Anoka	54	$212,666	110	$639,300
Becker	6	$824	43	$51,100
Beltrami	92	$137,979	96	$181,497
Benton	2	$946	69	$66,497
Big Stone	2	$5,182	21	$32,939
Blue Earth	41	$31,658	227	$325,329
Brown	13	$27,594	52	$50,095
Carlton	39	$44,635	45	$63,408
Carver	35	$67,240	45	$98,597
Cass	21	$61,920	4 *	$84,945
Chippewa	28	$23,751	66	$46,500
Chisago	8	$137,122	27	$69,943
Clay	3	$3,863	111	$104,312
Clearwater	*		19	$46,556
Cook	*		11	$20,591
Cottonwood	20	$44,646	4 *	$37,460
Crow Wing	26	$105,000	69	$137,238
Dakota	84	$161,416	233	$475,169
Dodge	2	$5,441	15	$43,596
Douglas	2	$5,586	46	$55,000
Faribault	11	$11,910	34	$136,410
Fillmore	2	$1,251	29	$39,178
Freeborn	14	$36,612	21	$65,800
Goodhue	101	$75,096	68	$168,010
Grant	1		7	$40,600
Hennepin	1,198	$3,227,051	1,806	$4,082,936
Houston	37	$16,575	38	$36,706
Hubbard	17	$34,945	27	$66,500
Isanti	2	$21,475	42	$38,013
Itasca	8		65 *	$139,852
Jackson	1	$1,174	18	$33,249
Kanabec	3	$21,065	32	$55,747
Kandiyohi	134	$308,965	322	$275,815
Kittson	8	$9,455	12	$46,288
Koochiching	4	$3,818	36 *	$66,586
Lac qui Parle	3	$12,409	26	$38,993
Lake	37	$34,600	33	$32,295
Lake / Woods	3	$2,069	0 *	$1,175
Le Sueur	4	$1,813	13	$33,000
Lincoln	2	$737	15	$40,567
Lyon	1	$8,937	72	$143,886
McLeod	27	$21,219	32	$70,000
Mahnomen	10	$12,613	13	$36,663
Marshall	18	$22,524	18	$37,000
Martin	22	$24,777	60	$183,857
Meeker	101	$45,422	81	$79,716
Mille Lacs	2	$3,675	34	$63,200
Morrison	145	$101,649	71	$102,903
Mower	64	$122,840	95	$185,500

COMPARISON OF 1987 TO 1990 CHANGES IN CSP/DAY TX. USE
ADULTS

COUNTY	(1) FY 1987 CSP/DAY TX CLIENTS	(2) CY 1987 CSP/DAY TX EXPEND.	(3) CY 1990 CSP/DAY TX CLIENTS	(4) CY 1990 CSP/DAY TX EXPEND.
Murray	2	$2,533	12	$56,119
Nicollet	26	$55,449	14	$71,000
Nobles	22	$61,274	8 *	$45,531
Norman	6	$7,091	9	$36,711
Olmsted	105	$272,476	96	$266,779
Otter Tail	72	$91,046	75	$134,300
Pennington	5	$632	48	$46,122
Pine	2	$1,313	35	$39,095
Pipestone	10	$22,190	0 *	$36,614
Polk	124	$95,290	69	$130,153
Pope	3		0 *	$16,000
Ramsey	523	$1,059,032	1,283	$2,931,623
Red Lake	9	$8,273	14	$38,946
Redwood	11	$6,774	28	$58,773
Renville	61	$66,152	78	$85,000
Rice	34	$25,617	64	$93,500
Rock	8	$17,752	1 *	$22,107
Roseau	1		15	$52,590
St. Louis	517	$649,224	739	$667,000
Scott	6	$98	37	$72,352
Sherburne	47	$50,677	46	$62,400
Sibley	12	$1,189	30	$44,000
Stearns	7	$110,978	191	$286,240
Steele	2	$7,965	60	$57,086
Stevens	2	$21,000	13	$33,023
Swift	18	$18,447	50	$68,000
Todd	3	$2,018	21	$59,000
Traverse	1	$443	7	$32,644
Wabasha	24	$19,279	35	$61,081
Wadena	11	$17,465	38	$53,102
Waseca	2		30	$36,122
Washington	110	$203,025	193	$723,898
Watonwan	1	$6,244	18	$92,098
Wilkin	1		18	$46,318
Winona	91	$199,549	115	$256,006
Wright	134	$95,586	45	$96,253
Yellow Medicine	2	$2,654	16	$59,049
Minnesota	4,475	$8,469,516	8,014	$15,985,284
% Of Prevalence Estimate Served	13.9%		25.0%	

NOTE: COLS 1 AND 2 ARE ESTIMATES BASED ON REPORTING BY CSP GRANT PROGRAMS IN FY 1987 & COUNTY REPORTS FOR CY 1987.

COL. 3 IS BASED ON INFORMATION FROM CMHRS AS REPORTED BY COUNTIES FOR CY 1990. AN * AFTER COLS. 1 OR 3 INDICATES THAT THERE WAS INCOMPLETE REPORTING FOR THAT COUNTY.

COL. 4 IS DATA FROM COUNTY MENTAL HEALTH PLANS FOR CY 1990.

COMPARISON OF 1987 TO 1990 CHANGES IN MENTAL HEALTH CASE MANAGEMENT
ADULTS

COUNTY	(1) CY 1987 CASE MANAGEMENT CLIENTS	(2) CY 1987 CASE MANAGEMENT EXPEND.	(3) CY 1990 CASE MANAGEMENT CLIENTS	(4) CY 1990 CASE MANAGEMENT PLANNED EXPEND.
Aitkin	26	$15,310	20	$20,254
Anoka	392	$285,869	369	$489,400
Becker	73	$19,237	91	$30,000
Beltrami	64	$10,888	89	$54,863
Benton	60	$29,112	Did Not Report*	$67,222
Big Stone	26	$21,895	48	$13,000
Blue Earth	112	$58,609	154	$76,808
Brown	75	$92,631	67	$72,000
Carlton	65	$40,137	59	$45,000
Carver	77	$159,849	33 *	$68,456
Cass	62	$70,341	2 *	$18,389
Chippewa	44	$31,882	42	$61,388
Chisago	25	$13,644	41	$30,000
Clay	55	$54,027	73	$24,323
Clearwater	37	$22,632	98	$13,119
Cook	32	$9,306	29	$24,126
Cottonwood	34	$16,953	48	$25,026
Crow Wing	147	$92,117	179	$175,000
Dakota	475	$457,823	414	$395,258
Dodge	25	$26,302	32	$33,271
Douglas	45	$24,053	88	$30,000
Faribault	22	$8,970	35	$17,153
Fillmore	15	$7,241	35	$16,364
Freeborn	66	$31,036	98	$60,000
Goodhue	66	$14,947	114	$52,329
Grant	27	$12,001	21	$10,207
Hennepin	1,471	$1,804,203	2,415	$2,656,833
Houston	73	$54,120	83	$31,000
Hubbard	55	$26,889	114	$37,600
Isanti	32	$34,639	49	$57,130
Itasca	14	$36,907	74 *	$50,000
Jackson	48	$15,376	81	$13,680
Kanabec	12	$5,764	28	$14,400
Kandiyohi	95	$24,146	142	$78,300
Kittson	18	$13,482	3	$9,200
Koochiching	45	$30,173	56	$89,866
Lac qui Parle	22	$17,593	31	$17,593
Lake	3	$14,184	3 *	$5,720
Lake / Woods	2	$206	1	$2,123
Le Sueur	20	$4,811	2 *	$25,000
Lincoln	10	$16,716	28	$24,451
Lyon	58	$48,835	78	$86,724
McLeod	39	$15,608	92	$35,000
Mahnomen	2	$4,052	18	$8,000
Marshall	21	$14,500	43	$31,800
Martin	47	$16,970	70	$23,119
Meeker	82	$32,332	69	$36,720
Mille Lacs	30	$37,563	52	$60,000
Morrison	14	$1,219	75	$16,080
Mower	68	$42,522	1 *	$124,010

COMPARISON OF 1987 TO 1990 CHANGES IN MENTAL HEALTH CASE MANAGEMENT
ADULTS

COUNTY	(1) CY 1987 CASE MANAGEMENT CLIENTS	(2) CY 1987 CASE MANAGEMENT EXPEND.	(3) CY 1990 CASE MANAGEMENT CLIENTS	(4) CY 1990 CASE MANAGEMENT PLANNED EXPEND.
Murray	15	$14,894	16	$33,825
Nicollet	103	$44,106	102	$33,000
Nobles	88	$43,588	62	$40,000
Norman	20	$8,928	31	$13,000
Olmsted	246	$202,590	262	$96,408
Otter Tail	119	$57,139	159	$80,000
Pennington	46	$29,389	62	$30,000
Pine	30	$27,238	30	$91,397
Pipestone	13	$6,975	21	$15,000
Polk	59	$16,495	159	$32,000
Pope	15	$6,758	36	$17,500
Ramsey	652	$1,372,894	1,361	$2,337,576
Red Lake	8	$1,086	24	$4,900
Redwood	57	$28,614	62	$20,000
Renville	64	$42,010	85	$70,000
Rice	33	$49,853	85	$25,000
Rock	21	$16,976	25	$14,250
Roseau	27	$24,746	25	$18,055
St. Louis	615	$391,538	733	$725,000
Scott	162	$91,468	100	$75,000
Sherburne	61	$57,135	99	$90,000
Sibley	34	$19,936	44	$17,000
Stearns	227	$108,971	242	$148,325
Steele	31	$29,392	52	$79,962
Stevens	15	$8,405	13	$25,000
Swift	36	$40,247	42	$35,000
Todd	20	$6,917	31	$29,160
Traverse	13	$5,251	11	$13,000
Wabasha	29	$19,601	76 *	$36,144
Wadena	17	$28,316	33	$8,000
Waseca	34	$28,859	41	$21,214
Washington	191	$111,305	385	$263,736
Watonwan	18	$4,388	31	$11,581
Wilkin	*		27 *	$13,121
Winona	180	$89,837	133	$126,189
Wright	84	$53,195	127	$59,892
Yellow Medicine	22	$14,901	33	$13,888
Minnesota	7,833	$7,043,563	10,747	$10,220,427

NOTE: COLUMNS 1 AND 2 ARE BASED ON DATA PROVIDED BY COUNTIES FOR CY 1987 FOR PROVIDED CASE MANAGEMENT AND EXPENDITURES.
COLUMN 3 IS BASED ON INFORMATION FROM CMHRS AS REPORTED BY COUNTIES FOR CY 1990. AN * AFTER COLS. 1 OR 3 INDICATES THAT THERE WAS INCOMPLETE REPORTING FOR THAT COUNTY.
COLUMN 4 IS DATA FROM COUNTIES' MENTAL HEALTH PLANS FOR CY 1990.

CY 1990 CLIENT COUNT INCLUDES 8,022 PERSONS IDENTIFIED AS PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI) OR 25% OF THE ESTIMATED 32,083 ADULTS WITH A SERIOUS AND PERSISTENT MENTAL ILLNESS. A SEPARATE SPMI COUNT IS NOT AVAILABLE FOR 1987.

APPENDIX II

STATE MENTAL HEALTH ADVISORY COUNCIL

June 25, 1991

Monte Aaker - represents MN Housing Finance Agency

Burton Abramson - provider/represents Minnesota Psychiatric Society; term expires: 1-95

Howard Agee - represemts MN Alliance for the Mentally Ill; term expires: 1-92

Jennifer Anderson - provider of county social services; term expires: 1-95

Representative Kathleen Blatz - member of State Legislature; term expires: 1-95

Craig Brooks - provider of county social services; term expires: 1-92

Patricia Carlson - provider of county social services; term expires: 1-95

William Conley - represents the MN Mental Health Association; term expires: 1-92

LaRue Dahlquist - family member of person with mental illness; term expires: 1-95

John Doman - provider of children's mental health services; term expires: 1-95

Peter Glick - provider of children's mental health services; term expires: 1-92

Lewis C. Freeman - general member; term expires: 1-95

Cynthia Hart - family member of person with mental illness; term expires: 1-92

Ron Hook - Dept. of Human Services, Health Care Management Division, represents state Medical Assistance program

Jim House, Dept. of Jobs & Training - represents state vocational services

Teresa Jahn - family member of person with mental illness; term expires: 1-92

Darlene Johnson - county commissioner (rural); term expires: 1-95

Steve Johnson - family member of person with mental illness; term expires: 1-92

Kathy Kosnoff - represents Mental Health Law Project; term expires: 1-95

Arlene Lesewski - general member; term expires: 1-92

Barbara Lyman - family member of person with mental illness; term expires: 1-92

Paul McCarron - county commissioner (urban); term expires: 1-92

Donald Michaletz - consumer of mental health services; term expires: 1-95

Larry Olson - provider at state hospital/general member; term expires: 1-95

Jo Rohady - provider/represents Minnesota Nurses Association; term expires: 1-92

Norma Schleppegrell,**Chair of Advisory Council** - provider & family member; term expires: 1-92

Representative Gloria Segal - member of Minnesota Legislature & parent of person with mental illness; term expires: 1-92

Zigfrids Stelmachers - provider/represents MN Psychological Association; term expires: 1-92

Jim Stoebner, Assistant Commissioner of Community Mental Health Admin. & Regional Treatment Centers, DHS - represents state mental health and social services agency

Elaine Timmer - provider/CEO at state hospital; term expires: 1-95

APPEMDIX II

SUBCOMMITTEE ON CHILDREN'S MENTAL HEALTH

Barbara Amram - provider of school-based mental health services; term expires: 1-95

Bonnie Bray - Department of Education, special education

Louise Brown - family and children's services advocate; term expires: 1-92

Patricia Carlson - county social services director, State Advisory Council member; term expires: 1-92

Ruth Carlson - Department of Health, maternal and child health

Susan Carstens - juvenile justice/local corrections department; term expires: 1-92

Paula Childers - parent of child with emotional disturbance; term expires: 1-92

William Dikel - provider of services for children and adolescents; term expires: 1-92

Vern Dorschner - parent of child with emotional disturbance; term expires: 1-92

Susan Erbaugh - provider of hospital-based mental health services; term expires: 1-92

Louise Farnham - provider of community-based mental health services; term expires: 1-95

Elsie Groth - parent of chidren with emotional disturbance; term expires: 1-92

Jo Gundry - provider of community-based mental health services; term expires: 1-95

Ann Jaede - State Planning Agency

Dixie Jordan - family member of child with emotional disturbance; term expires: 1-95

Decorah Mach - provider/represents MN Nurses Association; term expires: 1-95

Brenda Otto - provider with county social service agency; term expires: 1-95

Keith Pederson - parent of child with emotional disturbance; term expires: 1-95

Liz Prebich - County Commissioner (rural); term expires: 1-95

Richard Quick - Department of Corrections, juvenile release

Tom Rice - Department of Finance

Julie Lee - Department of Commerce

David Sanders - provider/represents MN Psychological Association; term expires: 1-92

Representative Gloria Segal - member of MN Legislature, parent of adult child with mental illness; term expires: 1-92

Jim Stoebner, Assistant Commissioner of Community Mental Health Regional Treatment Center Administration, DHS - represents state mental health agency

Ed Swenson - provider of community-based mental health center services; term expires: 1-95

Gordon Wrobel - educator of children with emotional disturbance; term expires: 1-95

APPENDIX II

MENTAL HEALTH ADVISORY GROUPS AND TASK FORCES

The Mental Health Division has established the following rule advisory groups:

Rule 5 (Children's Residential Treatment Licensure Standards) Advisory Committee

Rules 14 and 15 (Community Support Program and Funding Standards) Advisory Committee

Rule 29 (Third Party Reimbursement Approval Standards) Advisory Committee

Rule 36 (Adult Residential Treatment Licensure) Advisory Committee

Rule 47 (Medical Assistance Reimbursement Standards for Professional Home-based Family Treatment) Advisory Committee

Rule 74 (Case Management Program and Medical Assistance Reimbursement Standards for Persons with Serious and Persistent Mental Illness) Advisory Committee

Rule 77 (Children's Case Management Program Standards) Advisory Committee

Rule 78 (Children's Community-based Treatment Funding Standards) Advisory Committee

In addition, the Division receives advice from or has established the following groups, and participates as a member of the following committees:

State Mental Health Advisory Committee

Children's Mental Health Subcommittee

Case Management Implementation Group

MHSIP Advisory Committee

Indian Mental Health Advisory Committee

HRD Advisory Committee

Compulsive Gambling Advisory Committee

Early Identification/Intervention Work Group

CASSP Grant Advisory Committee

CSP/Consumer Training Grant Advisory Committee

Grant Review Committees

Rule 12 (Residential Treatment Facility Funding) Grants

Housing Support Grants

McKinney Act Homeless Funding Grants

Family Community Support Services Grants

Rule 14 (Community Support Program Funding) Grants

Anoka Alternatives Grants

Indian Mental Health Grants

State Coordinating Committees on which MHD staff participate include:

Children's Mental Health State Interagency Coordinating Committee

State Transition Interagency Committee

Governor's Action for Children

Division of Rehabilitation Services Supported Employment Committee

Division of Rehabilitation Services Interagency Work Group

APPENDIX II

Descriptions of McKinney Act Homeless Grant Projects

Anoka County, a suburban county just northwest of Minneapolis, purchases services from Rise, Incorporated. Rise has hired a full time equivalency outreach/service worker. There are no shelters in Anoka County but there are several transitional houses and vouchered sites. The contractor leased a transitional house where four homeless individual with mental illness can live until more permanent arrangements could be made.

Outreach/service workers locate homeless persons with mental illness from referrals as well as searching places where homeless persons are known to frequent. They offer the person a place to stay and an opportunity to have their basic needs met along with a connection to mental health services. The Rise project has successfully worked with the Anoka County Affordable Housing Coalition, Minnesota Coalition for the Homeless and the Elim Transitional Housing program. They have produced a brochure, distributed in places where homeless persons are known to frequent, that informs providers and homeless persons about the project. The project also works with the local law enforcement agencies so that referrals can be made in an efficient and effective manner. Anoka's project is heavily based on providing supportive housing, making use of the non-traditional provider systems that homeless persons use. The County plans to serve 250 new homeless persons in the next year with 70% being persons with serious and persistent mental illness.

The Blue Earth County project, developed within the Community Support Program, has one outreach worker to serve homeless persons with serious and persistent mental illness. Staff persons walk the streets, take trips around the area in search of homeless persons, and visit the shelter and transitional housing programs and drop-in centers. One of the most innovative parts of the outreach effort is the use of "care packages", which contain an assortment of donated personal hygiene products and a brochure about the project, at rural sites where homeless persons have camped out. Most of the time spent in this project is on outreach, mental health services and case management. Blue Earth plans to serve 120 new homeless persons during state fiscal year 1992.

Hennepin County contains Minnesota's largest city, Minneapolis. The county regularly shelters at least 46% of Minnesota's homeless population and has done so since 1987. The county hired seven staff in their Community Services Unit specifically to provide mental health services for homeless persons. Four of the staff work directly with the McKinney Homeless Primary Health Care services. The other three staff, a senior clinical psychologist, a clinical psychiatric nurse and a mental health

social worker, work with persons assessed by the Primary Health Care Team, train staff at shelters and drop-in centers, and also have shelter and drop-in "office hours" to see those people who need to talk to someone about their mental health problems. All staff offices are co-located with homeless service providers. Almost two-thirds of all people seen by Access Unit staff have some kind of mental illness. Outreach, identifying and referring persons with mental illness for mental services and case management are the services most often provided by Access Unit staff. In FY92 the county expects to serve 500 new homeless persons of which 60% will be persons with serious and persistent mental illness.

The Mental Health Unit, a part of the Community Service Unit, has also has monthly round table discussions with law enforcement officials to make sure that persons with mental illness are served properly. The county contact person for MHSHP has been the round table organizer. Minneapolis has a local Homeless Coalition in which Access project staff members participate. Staff also link with all Community Service Units. The county, which has a policy that no homeless person should be without shelter, purchases shelter services and works closely with staff at these shelters. The Minneapolis/Hennepin County Task Force on Homelessness has set a goal of providing 76 new units of housing for persons with mental illness. The Task Forceis over half-way to accomplishing this goal.

Vail Place, in Hennepin County provides program services both on and off site. All services are coordinated with the local CSP's, the Regional Treatment Center, Hennepin County case managers, and other related residential facilities. The program provides a wide variety of information to individuals and groups related to housing, technical assistance, and available resources, as well as individual support services and assistance to those transitioning to independent living (budgeting, hygiene, cooking, safety, transportation, etc). Long-term support is offered through regular group meetings. This project has helped bridge service gaps through both the dissemination of helpful and accurate housing related information as well as the "hands-on" approach by the housing staff.

Ramsey County contains St. Paul, the capital and second largest city in the state. Ramsey County Human Services contracted with a private mental health provider, which hired three case managers and one case aide to work with homeless service providers and homeless persons with serious and persistent mental illness. They have offices near the two largest shelters, make weekly visits to each shelter and drop-in center, and use a pager system to allow providers access at all times.

Project staff have done an excellent job of training homeless service providers to do an initial assessment for mental

illness. Consequently, 81% of those referred to project staff had a mental illness and almost three-fourths had a serious and persistent mental illness. The project plans to serve 525 new homeless persons next year, with 65% having serious and persistent mental illness. Project staff work with all the homeless services providers and also with the McKinney Service Task Force, a forum for sharing work experiences and needs as well as planning. They also have begun a roundtable with law enforcement officials. Ramsey County has a state-funded Housing Support Pilot Program to serve homeless persons with housing and housing services.

St. Louis County's largest city is Duluth (93,000 people), located on Lake Superior in northeastern Minnesota. St. Louis County contracts with the county's Community Support Program provider, Human Development Center (HDC), to serve the Duluth area of the County. HDC has hired 1.55 FTE Outreach workers. HDC staff work closely with a network of homeless services called Central Hillside United Ministries (CHUM) that provides shelter, transitional housing, food shelves and a drop in center, to provide mental health services to the homeless people served by CHUM. As a spin off from the MHSHP project, HDC purchased a $1.00 HUD house and began a transitional home for persons with mental illness. HDC is a provider of the Housing Support Pilot Program. The staff for housing support and homelessness work together under one supervisor and interact regularly. They have also begun a mental health emergency shelter for four persons. Staff walk the streets of Duluth searching for persons who are homeless and who have a serious and persistent mental illness. They also provide services to persons with mental illness in the transitional housing and all those referred by CHUM, county and local social services. HDC plans to serve 45 new homeless persons, 80% wit serious and persistent mental illness. They plan on providing 1800 duplicated count contacts.

St. Louis County's project staff are housed and integrated with CSP staff. Referrals are made to the project by CSP as well as other agencies. Referrals are assessed and an appropriate housing plan developed that includes assistance with locating and obtaining housing as well as independent living skills training andsupportive services including medication monitoring. Preference is given to clients in hospitals, Rule 36 and board and lodge facilities. We do assist some clients in maintaining or upgrading housing. A revolving loan fund is available to assist with security deposits and other moving expenses. CSP has a moving service that is available on an ability to pay basis. (Typically this service is provided at no charge to clients unless thy have ample resources).

St. Louis County, the largest geographical county in Minnesota, has several cities with more than 10,000 people, although most of the county is wooded and sparsely populated,

particularly in the northern part of the county. There is no shortage of housing, but unemployment has caused many persons to lose their homes. Therefore, when additional funds became available in 1988, northern St. Louis County was chosen as a site for a rural demonstration project to serve homeless persons with mental illness. The Range Mental Health Center provides mental health services in northern St. Louis County. Through the Community Support Program, RMHC hired a staff person at .66 FTE to travel to small communities and back roads of the county in search of homeless persons with mental illness. The staff person visits state and local parks, abandoned buildings and wayside rests as well as 14 cities. There are no other services specifically for homeless persons in this part of Minnesota. The staff person also spends .34 FTE on the Housing Support Pilot Program, trying to locate housing for each homeless persons with whom he works. Project staff traveled over 16,000 miles last year, providing outreach and face-to-face training to fourteen local law enforcement agencies. A crisis shelter on the main floor of the RMHC Annex duplex, below the MHSHP staff residence, has been used to shelter homeless persons with serious and persistent mental illness. In FY92, the Range Mental Health Center plans to serve 65 additional persons who are homeless.

St. Louis County's Range Mental Health Center's supported housing project provides outreach services to more than fifty individuals in need of supportive services. Without these services, these individuals would be at risk for more restrictive housing, such as Rule 36 or institutional placement. Outreach services provided include assistance appeals, food and meal preparations, recreation and socialization activities, shopping, budgeting and housekeeping. Staff are also proficient at and spend considerable time in systems interventions. Considerable effort and time is put into working with landlords, neighboring tenants, social services, and housing authorities.

Blue Earth County has a housing coordinator who works closely with Blue Earth County Mental Health managers. This working relationship assures that individuals at RTCs, Rule 36 facilities and board-and-care facilities are referred for timely housing service prior to their discharge from the facilities. Affordable housing is a goal of this project. The housing coordinator assists clients in accessing subsidized housing apartments and Mankato Housing Authority vouchers and certificates.

Carver County has one housing support staff person who works 26 hours a week with the program. There are four housing support workers; each works up to 25 hours a month with individual housing support program consumers. All of these positions report to the Community Support Program Coordinator for clinical supervision and program supervision. Housing staff spend most of their time with clients in their homes, assessing, teaching and assisting with the skills that enable people to live

independently. Close coordination with HRA, CSP and Rule 74 case management is maintained.

Moorhead, in Clay County, is located across the Red River from Fargo, North Dakota. Because North Dakota has no General Assistance (GA) program while Minnesota does, some North Dakotans come to Minnesota for services. The Red River Valley uses many migrant workers (who are defined as being homeless in Minnesota's 1988 CHAP) to provide farm labor. Lakeland Mental Health Center hired two (generic) case managers to work with the homeless service providers in Moorhead. Because there was no place for homeless persons to go during the day, this project interested the Moorhead City Council in beginning a drop-in center for homeless persons with mental illness. During the morning, homeless persons are welcome to come to the center. In the afternoon the drop-in center is targeted to serve only persons with mental illness. Staff use the mornings to do assessments of mental illness and the afternoon to provide mental health services and case management and make referrals. The drop-in was so successful that the project staff could no longer manage it alone, and turned the staffing responsibilities over to a homeless shelter. The project will continue to use the site as a place to find and interview homeless people. In the evening, the staff go to the two shelters to screen and locate more appropriate housing for homeless persons with mental illness.

Most of the services provided are outreach and mental health. Homeless persons with mental illness are referred to the county CSP program for the other essential services, as well as to the Housing Support Pilot Project which works with public housing (staff work with the latter program as well as the shelter). They expect to serve 225 additional homeless persons in State FY92.

Clay County's Housing Support Program services are provided by two full-time staff who work with clients to develop and enhancethe client's social, independent living, coping and interpersonal communication skills. A majority of clients served reside in area high-rises managed by the city's PHA program. Services are provided on an outreach basis, near or at the client's place of residence. Through the use of "in vivo" support services, program staff will continue to teach and support clients in the development of the psychosocial skills necessary to live independently and successfully in the community.

Polk County is also a part of the River Red Valley, with Crookston, the largest town, having only 9,000 people. Many migrant workers come to this area from early spring until fall. In the summer, there are as many homeless persons sheltered in the county as there are in Ramsey County, Minnesota's second largest county. The Northwest Mental Health Center coordinates a

homeless project to provide mental health services. Working from the only shelter system in the county, the staff assess homeless persons and offer services to them. They also provide the community with information to help them understand homelessness and mental health problems, as well as what the community could do to assist these people in need. In addition, project staff have planned community coordination efforts, such as a community celebration that was designed to diffuse the racial tensions between the predominantly Hispanic homeless population and the white home/farm owners in the community.

Northland Counseling Center's HSP, in Itasca County, assists clients by providing information about public and private housing alternatives, assisting in choosing suitable housing and moving, providing supervised workers and ongoing support to help maintain independent housing, lending rental deposits, cleaning equipment, and a collection of donated furnishings.

LINK is a multi-agency undertaking, involving the family service departments of Kandiyohi, Chippewa, Lac qui Parle, Meeker, Renville, and Swift Counties, as well as Willmar Regional Treatment Center (WRTC) and West Central Community Services Center. It also interfaces with the Housing and Redevelopment Authority of Willmar, Community Action Agency of Willmar, and the Housing and Redevelopment Authority of Benson. Involvement of Rule 36 facilities and providers of acute care mental health services is determined by specific client circumstances. Project LINK, a component of the Center's Community Support Program (CSP), provides an intense housing service to SPMI clients. Project services include helping clients procure safe, affordable housing and funds for rent and utility deposits; assisting clients to understand rental and lease conditions and requirements; and assisting clients in negotiating needed repairs/services. The project provides focused and intense assistance to help clients adjust to the community and to learn and/or further develop the skills essential to meet their own needs in an acceptable manner within the community.

Two different service options are available through Olmsted County's Housing Support Services: Agency Sponsored Housing (ASH) and Community Housing (CH). ASH - THOMAS Group, Inc. maintains (4) rental contracts (4) with area landlords to provide living units. Staff screen individuals and try to match available openings with individual needs and personalities with that of potential housemates. Persons can remain in ASH for as long as they choose. ASH is independent living, not supervised living. CH - The focus of Community Housing is to assist participants to locate and maintain housing of their choice. Once persons find housing, they receive ongoing support to help maintain their independent living situation.

Otter Tail County Housing Support Project assists clients to live in the community through various services, such as referral to assistance programs and liaison/follow-up with community resource agencies, location and mediation with appropriate housing resources, independent living skills teaching and monitoring, medication management, on-call crisis assistance, recreation and social activities, and transportation assistance. Generally, the staff provides regular contact with clients on an individual basis as well as offers regular group recreational andsocial outings. Clients are assessed according to their particular needs, and assisted upon request, with a variety of supportive services available to them. In addition, staff are available, as needed, for crisis situations.

APPENDIX II

Indian Mental Health Projects

The Bois Forte Reservation Project, located in the northernmost part of the State in St.Louis and Koochiching Counties, serves the Deer Creek and Vermillion communities. Mental health services provided include education and prevention, outreach services, and transportation services for clients referred to the Range Mental Health Center in Virginia. The mental health center provides consultation and additional support services. The project is supervised by a master's-level Indian social worker who also provides direct services such as individual and family counseling. Project outreach services are provided by two mental health workers who work directly with the schools and communities. The Bois Forte project received $58,421 for 1990.

The Fond Du Lac Reservation Project, Cloquet, provides individual, family and group counseling, outreach, education/prevention, support and referral services. Services are provided by two Indian mental health professionals in collaboration with the Human Development Center in Duluth, as well as by a traditional healer. The Fond Du Lac project received $70,365 during 1990.

Grand Portage Reservation, located near the Canadian border in Cook County, is very isolated, with community support services located about 35 miles away in Grand Marais and residential services available in Duluth (110 miles away). Services provided by a wellness technician include client outreach, individual and family counseling, education and prevention, and consultation to the Cook County Community Support Program. The Grand Portage project received $35,410 for 1990.

The Indian Health Board, located in the heart of the urban Indian population in south Minneapolis, is a comprehensive health care clinic providing a range of services. Mental health services are provided by mental health professionals and paraprofessionals who provide outreach services. Services provided with $30,576 of project funds include outreach, education and prevention, psychosocial rehabilitation, and assistance in independent living skills.

Leech Lake, one of the state's three largest reservations, is located fourteen miles east of Bemidji. Mental health services are provided by two mental health workers. Services include outreach, education/prevention, case management, and advocacy services. This project is fortunate to have local access to the Indian Health Services Hospital for 24-hour emergency services. The project coordinates services with the Upper Mississippi Mental Health Center and also provides services to the Bemidji area. The Leech Lake project received $61,602 for 1990.

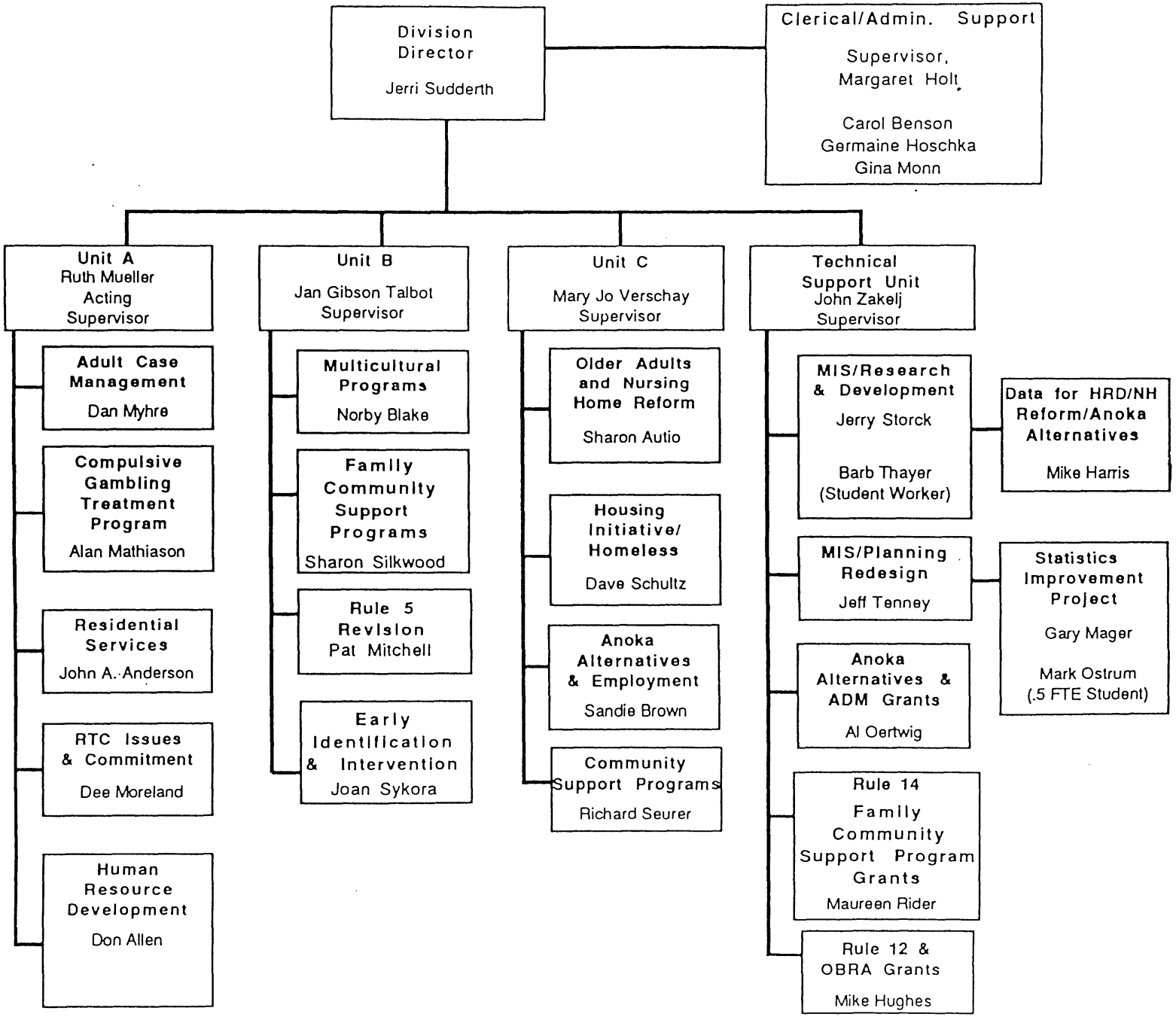
The Lower Sioux Community is a tiny community located in the southwestern part of the state in Morton. A mental health worker provides outreach and education/prevention services. The mental health services of Redwood and Yellow Medicine Counties are also utilized. The Lower Sioux Community received $14,228 for 1990.

Mille Lacs, in the north central part of the State, includes portions of the four counties of Aitkin, Mille Lacs, Pine and Kanabec. Mental health services provided under the grant include client outreach, individual and family counseling, and education/prevention provided by the project mental health professional, with additional consultation and coordination provided by the Northland Mental Health Center. This project also utilizes the services of a traditional healer. Mille Lacs received $47,996 for 1990.

Shakopee Mdewakanton Sioux Community is located in Scott County, about 30 miles southwest of the metropolitan area. Mental health services provided by a mental health worker include outreach, education/prevention, and coordinationwith Scott County and metro area clinics and hospitals for 24-hour emergency services. The Shakopee Mdewakanton Sioux Community received $11,457 for 1990.

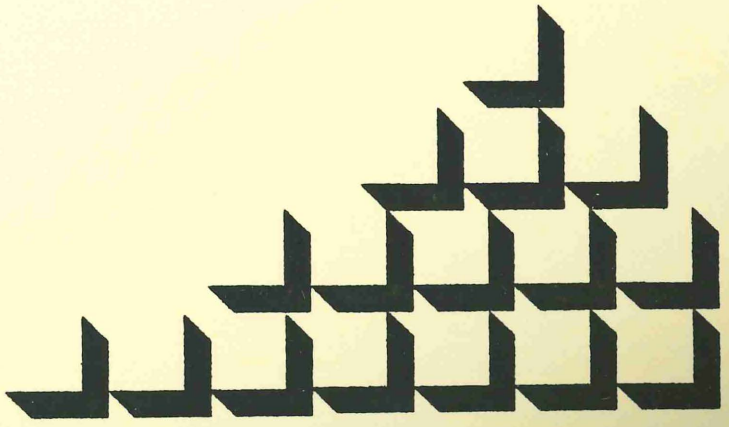
The Upper Midwest American Indian Center project serves a significant Indian population and is the only Indian mental health program in the north Minneapolis area. The project's mental health advocate provides education/prevention and client outreach services, and coordination and linkage with the Hennepin County Community Support Program. The Upper Midwest American Indian Center received $28,105 for 1990.

The Upper Sioux Community project is also located in the southwestern part of the state in Yellow Medicine County. Mental health services provided by the mental health outreach worker include client outreach and education/prevention services. Coordination and linkages occur with the Western Human Development Center in Marshall. The mental health project of the Upper Sioux Community received $21,529 for 1990.


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 A. Anderson
RTC Issues & Commitment
Dee Moreland
Human Resource Development
Don Allen
Unit B
Jan Gibson Talbot
Supervisor
Multicultural Programs
Norby Blake
Family Community Support Programs
Sharon Silkwood
Rule 5 Revision
Pat Mitchell
Early Identification & Intervention
Joan Sykora
Unit C
Mary Jo Verschay
Supervisor
Older Adults and Nursing Home Reform
Sharon Autio
Housing Initiative/ Homeless
Dave Schultz
Anoka Alternatives & Employment
Sandie Brown
Community Support Programs
Richard Seurer
Technical Support Unit
John Zakelj
Supervisor
MIS/Research & Development
Jerry Storck
Barb Thayer
(Student Worker)
Data for HRD/NH Reform/Anoka Alternatives
Mike Harris
MIS/Planning Redesign
Jeff Tenney
Statistics Improvement Project
Gary Mager
Mark Ostrum
(.5 FTE Student)
Anoka Alternatives & ADM Grants
Al Oertwig
Rule 14 Family Community Support Program Grants
Maureen Rider
Rule 12 & OBRA Grants
Mike Hughes

PLANNING COUNCIL COMMENTS
on the

State Comprehensive Mental Health Services Plan



State Advisory Council on Mental Health

St. Paul, Minnesota

September 30, 1991

PLANNING COUNCIL COMMENTS

Summary

The State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health were created by the Minnesota Legislature to advise the Governor, state departments, and Legislators on matters pertaining to policies and programs affecting adults with serious and persistent illness and children with severe emotional disturbances. The Council members are appointed by the Governor and represent consumers of mental health services, family members of persons having a mental illness, service providers, elected officials and others interested in the creation of a sustainable mental health system.

In the Public Health Service Act, Section 1916 (e), the federal government requires states to establish and maintain a state mental health planning council. The State Advisory Council fulfills this requirement, serving as an advocate organization for persons with serious and persistent mental illness and emotionally disturbed children and youth.

Under this federal law, the State Advisory Council has the additional responsibility of serving as the required planning body that must monitor, review and evaluate the allocation and adequacy of the mental health services within the state. The state, in turn, must utilize the State Council to review and comment upon the development and implementation of the State Comprehensive Mental Health Services Plan, as required under Public Law 99-660 as amended by Public Law 101-639. As an independent advisory and planning body, the Council has the responsibility to submit these formal comments to the Governor and to U.S. Secretary of Health and Human Services as part of the State Plan.

The State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health meet monthly; a separate task force was established specifically to work with the Division on Mental Health, review the Plan, and make recommendations for the Plan. Their suggestions included editorial changes and activities that we consider modest and somewhat measurable (see attached), and would indicate progress toward full implementation in 1992. These activities are grouped according to the federal requirements and are direct service oriented rather than relating to the internal Division process objectives. These potential activities and this commentary were approved by the Council and Subcommittee members.

Our Comments are offered in the spirit of cooperation, but as advocates we must insist that the vision and mission for a comprehensive mental health system in Minnesota has yet to be realized. The Council and Subcommittee members have invested a vast amount of time and energy in the oversight of the developing mental health system and we do not wish to cast a negative tone to this document. We believe that the role of the Council is to reflect the current status of the mental health system and to suggest means by which the state might implement the objectives described in this Plan.

Despite the progress that is documented in the State Plan, the Council and Subcommittee members find that our accomplishments fall far short of the need for mental health services. Our state has made major progress relative to the past, but not all mental health services are accessible statewide, such as emergency services beyond a 24 hour Hotline, or day treatment for more than 15 to 20 children in one county and for one school district. We do not have a uniform system with a known entry point, an array of support services or the assurance of a network that would provide a safety net.

We know the components of mental health a system, how to identify "good" programs and how to form coalitions to approach the legislature. We have realized the success of demonstration projects funded by short term competitive grants. What we lack is the leadership and the political will to provide the necessary private and public resources to do what it is we know how to do.

Plan Objectives Achievement/State and Local Accomplishments

The State Plan format requires the state to report at length on the achievements of plan objectives relative to old objectives. Although the Plan may be reconsidered and new objectives submitted, the focus of this report is to show what has been done thus far to meet federal requirements. The Council does not disagree with or discredit the objectives or the accomplishments cited in the State Plan, but would prefer a greater emphasis on what the state intends to do to continue the implementation of the Plan. The Council has witnessed much progress over the past five years, and agrees that with new funding initiatives approved by the 1991 Legislature, further improvements will be felt by consumers in their daily lives. Indeed, the Council has been one of the chief proponents of the programs or services now in existence and described in this report.

The report correctly highlights the progress we have witnessed -- legislative appropriations, state regulations and limited private sector participation -- all of which in time will begin to have a positive influence on housing, employment, and support services for adults with mental illness. For instance, the report on accomplishments describes the new funding for housing subsidies, and supported employment grants that will supply data for analysis and, hopefully, further funding. Although the progress is not yet measurable, the framework is in place and we have high expectations that all the incremental steps will lead to real improvements in the lives of some consumers.

But we are also aware that there is a growing need for crisis intervention services so that we might maintain people in the community, rather than see them "fail" due to lack of community resources. Once re-established in the community, the critical link to the "system" relies upon the case manager, a person who is expected to "broker" services; the average case management ratio of clients to managers is now 46:1. Professionals question the effectiveness and quality of case management in such an arrangement.

Because case management continues to be criticized and debated, the Advisory Council sponsored legislation to direct the state to make improvements in case management funding and program standards. This was approved by the legislature and rule revisions are in process, but we will continue to study appropriate models (targeted or rehabilitation options), access problems and reimbursement under the federal medical assistance program.

Overall, the Council and Subcommittee perceive that this report about our successes, as yet not measurable, exaggerates what we believe to be the reality. Some of the data that the Department is able to collect indicates that our accomplishments fall short of the estimated need. In 1990, the Council and Subcommittee members sponsored five public hearings throughout the state to hear from Minnesotans and learn of their perceptions about our mental health system. The information obtained from those hearings indicated that Minnesotans believe that there is indeed a developing mental health system for adults. Access to services and professionals has improved but few believed that the state has shown a commitment to quality mental health services.

Most striking was the testimony from parents and children who again reminded us all that the present arrangement for services is not suited to the needs of children with emotional disturbance. Parents and providers alike informed us that when a child does not "fit" into the only funded service available to the child, it is the child who is labeled as the failed client rather than acknowledging that the (non-

existing) system failed the child. Many believe that there has not been any real progress made toward full implementation due to a fundamental lack of state and local leadership and commitment to the goals cited in our state law and in the federal requirements. Some say that the state as a whole has not embraced the concept of mental health.

Signs of Substantial Progress

Mental Health Services for Adults

Critical to an organized community-based system of care is the degree to which the state directs funding for the development of that system and in preference to the state operated system of institutional care. The state report shows an ability to reduce reliance on hospitalization, but the success by increments are not part of a larger plan for the reduction in the use of our state hospitals.

While it is correct to point out the increases in the numbers of persons served and the availability of services, it is also necessary to cite statistics that show the largest expenditures of mental health dollars for FY 1991 were for community and state operated inpatient (54.5%) and residential (13.2%) treatment. The single largest public fund for mental health services is the Regional Treatment Center state share at 30.7% (see State Plan) -- although the goal of the 1987 Comprehensive Mental Health Act and the sixth federal requirement (to reduce the rate of hospitalization) is to reorient the system away from institutional care and toward recovery. The Council acknowledges the legitimate need for **appropriate** hospitalization and treatment of certain mental illnesses. But the priority of the Advisory Council continues to be the establishment of a less restrictive, community-based service system that is designed to meet the specific needs of an individual. While the state plan indicates that we might be taking steps to achieve this goal, the presumption that we must continue to use state hospitals for mental illness still exists. There is at this time no overriding state plan to reduce our reliance upon the use of state hospitals, nor any plan that will redirect state expenditures to local community-based services.

The Department of Human Services has been restructured so that residential management and community based services are in the same service unit, under one Assistant Commissioner on Mental Health. The Council views this action as a first step to the planning for a comprehensive system of mental health care. To the Council, this is a major accomplishment, and one that has been recommended for several years. The Council is hopeful that this action will lead to a thoughtful and reasoned approach to the reduction in the inappropriate use of state hospitals. Council members will continue to encourage the Department to proceed in a systematic fashion to examine the demand for and supply of state hospitals beds. Because the 1992 legislative session will focus on future bonding and/or recapitalization of one to three Regional Treatment Centers, such an honest analysis of our state-operated hospitals is critical to the creation and funding for a comprehensive mental health system.

Mental Health Services for Children

The Children's Comprehensive Mental Health Act of 1989 was passed with a $1.3 million appropriation, and then reduced in 1990. Although the 1991 Legislature approved the Governor's recommendation of $2.7 million in new state funding, for a total biennial appropriation of $4.8 million, this amount will serve less than 20% of the current unmet need. The Advisory Council and Subcommittee have projected that at least $24 million would be necessary to fully implement the Act. As with adult mental health services, our FY 1991 state expenditures finance the more restrictive treatment setting, out-of-home placements: 23.8% inpatient and 35.1% community residential treatment. State expenditures for community non-residential services was 40.8%.

Although the Children's Mental Health Act specifies a full range of basic services that counties must provide, they are not required to do so if they do not have available resources. The new state funding for children's services will not fully implement the Act or meet the federal requirements by September, 1992. Granted, the Department of Human Services could be more creative in fostering service improvements in the absence of funding, such as greater focused communication across the divisions within the department, and additional technical assistance to ensure that services start up uniformly and efficiently across the state.

The magnitude and complexity of a service system for children demands that other departments and local agencies be involved. There has been some progress made toward collaborative arrangements between agencies on both the local and state levels as has been demonstrated by the eight demonstration projects funded through the ADM Block Grant monies. This highly successful project encourages state agency representatives to explore uniform arrangements across the state; it would seem highly productive for the state agency to ensure that the lessons they have learned about interagency cooperation and day treatment programs be shared with all counties and school districts in Minnesota.

The interagency report from the State Coordinating Council has been under development for several months; it is expected to identify the gaps between agencies and recommendations for future interagency collaboration to improve service delivery. The State Advisory Council and Subcommittee realized the necessity for a statewide interagency agreement to pool resources and direct local access to these additional resources for children with emotional disturbances. The Council recommended that the state legislature assign accountability to an agency to assure children a quality education as well as mental health care. Such a proposal was considered by an Education Committee but not approved.

Anticipated Problems for Full Implementation

Across State Agencies

One concern expressed by the Council and Subcommittee is that the responsibility for this Plan rests solely with the Department of Human Services and specifically with the Division on Mental Health. All ten federal requirements pertain to the regulatory functions of the Department. The Plan is expected to be a one dimensional accounting for a multi-dimensional service system. There appears to be no expectation that other state departments - education, corrections, commerce and health - have any role or function in the implementation of a public mental health system, although representation from those state agencies is required for state planning councils.

A example of this lack of statewide planning, and lack of federal leadership, is the sanctioned allowance of discriminatory insurance practices against those who have a mental illness. Due to discriminatory practices, the mental health system will continue to develop within a public health care setting, increasingly subsidized by state expenditures if the private sector is not required to provide equal access to mental health care. It appears that the slogan of "health care is a right" applies only to physical health care, for the inequities found in mental health coverage allows the denial of benefits to adults and children in need of mental health care. This one-sided responsibility for coverage will not enable the development of a comprehensive community-based mental health system.

It is our opinion that the state as a whole has not made a unified commitment to the implementation of the state or federal Comprehensive Mental Health Acts. As one member phrased it, the usefulness of this Plan for Minnesota seems limited: "The state should have a plan for what it hopes to accomplish and a report describing accomplishments towards it goals - but the federal format requirement inhibits

its usefulness to anyone - probably even the federal reviewers." The Mental Health Division does not have the authority to suggest that they alone set the course for the state, assume responsibility for the actions of other state departments in the executive branch, and commit the state to large expenditures for mental health care. Without mandated coordination and inter-department commitment, however, it is difficult to imagine how a mental health system might function.

Across Local Agencies

Presumably, the Division objectives to carry out the federal requirements would relate to the necessary and similar guidelines set by the Division for the implementation of our state Comprehensive Mental Health Act. By state law counties must implement state mandated services; they are supervised by the state department, and monitored through county plans and a newly established reporting system. The county mental health plans, however, do not reflect the same state objectives as stated in the State Plan, but rather county objectives for the implementation of the state law. Because there is no connection between the state objectives in meeting federal requirements and the county objectives, the Council sees a discontinuity with no clear planning directives for a mental health system. The lack of a uniform plan across levels of government and agencies, coupled with inadequate state funding and no federal assistance, is an indication to the Council that we are more than a few years away from full implementation.

The State Plan/report describes the change in the county mental health planning process and suggests that extensive reviews followed by technical assistance leads to an adequate county mental health plan to meet the needs as assessed by local advisory councils (LACs) and the counties. The report also discusses the extent to which the planning process has been expanded so that local advisory councils are now expected to participate more fully in the process. The counties must "consider" the needs assessment as determined by the LACs; previous to this change, the counties were only expected to seek LACs approval of their plan. Since the new process is in effect as of August 1, 1991, it is not yet known if this change will actually enhance the role of the local advisory councils. It is certain that LACs will require assistance in this new role as a proactive player in the planning process. It does not necessarily follow that all LACs will do equally well in assuming the new role.

The State Council requested copies of the needs assessments determined by the local advisory councils for their 1992 county plans. Approximately half of the 90 LACs responded; a summary of their recommendations to the counties for county plans is attached.

System-wide

Minnesota stands at the precipice of a major decision during the next legislative session which will have a significant impact on the development of an organized community-based system of care. The state will consider the extent to which we must recapitalize certain state hospitals, and/or approve bonding for a multi-million dollar new facility in the metropolitan area and two others in greater Minnesota. There has been some discussion about the extent to which recapitalization would in fact downsize the state operated system. However, there has been no official plan at this time, nor agreement between the legislature and the Department, on the total number of state hospital beds that will be needed in the next century. Any student of the economics of health care has learned that a new multi-million dollar commitment of state funds will enhance or create a demand for a ready supply of hospital beds.

The Council has taken a position against the future bonding for state hospitals citing the actions of more progressive states to downsize their state hospital capacity. The state of Minnesota, however, continues to rely on hospitals for mental health care because we lack sufficient community support

services. While the Council recognizes that quality inpatient services are essential to a community support system, allocating the greater share of the mental health resources to state hospitals rather than community settings is counter-productive. There have been three separate studies on "bed analysis" or "needs analysis" conducted by three state hospitals for those regions only. These studies were specific to the need for beds in the region and not designed to critically analyze the **need or appropriateness** for future hospital services for persons with mental illness, as the Advisory Council requested of the Department two years ago.

Clinical surveys conducted by Dr. Henry Steadman of residents in RTCs and clients of community programs clearly indicated that at least 25% or 270 residents in state hospitals could be well served in community programs. With the development of community-based services and the resulting community placements there would be drastic reduction in the use of long-term inpatient care. The evidence supports our contention that it is possible to change and improve this system. With an expansion of community resources, more people with serious and persistent mental illness would be able to live in their communities and we would reduce our reliance on state hospitals.

The Council fears that a decision on recapitalization will be made or rejected in the absence of a systematic plan for mental health services based on a scientific determination of the need, and under the influence of a strong lobby to preserve all six state hospitals. To the planning council, this major policy decision will have a dramatic impact on the future development of an organized community-based mental health system. The Council has suggested that future funding for hospitalization consider contract beds in the community mental health centers and the expansion of other mental health services.

Reconsideration of the Plan

Minnesota has made progress relative to the past; the Planning Council Comments do not mean to cast doubt on what has been accomplished or suggest that the Plan objectives be reconsidered. Our Comments intend to be a straightforward portrayal of the real problems faced by persons with a serious mental illness and emotional disturbances. Since the federal requirements for service implementation only pertain to those who meet this description, people having a major mental illness (not considered to be seriously mentally ill) are not considered to be included in the targeted population.

Our weakest link is consumer involvement on the Council and Subcommittee and for Department advisory activities. Although we attempt to attract more individual participation by those who have experienced a mental illness, it is a **constant recruiting effort** that is too easily set aside.

The State Council and Subcommittee members support the Department as it works toward the implementation of the federal requirements and suggests that there be greater involvement by the Commissioner of Human Services and other high-ranking officials. As mentioned above, the Council has submitted activities they consider reflective of new areas of emphasis.

The Council and Subcommittee members suggest that the state deliberate and answer what Sheila A. Pires of the Human Service Collaborative states is a baseline policy issue that must be resolved:

> "...determining when mental health will assume a lead responsibility and for which population..., and when mental health will assume a supportive role, as well as the nature of that role." (p.5, State Child Mental Health Planning,funded by NIMH, July, 1991.)

Suggested Activities for the Implementation of the State Plan for Adults

The Council attempted to be visionary and yet modest in their deliberation of the following activities; some may be more utopian than realistic, but all are intended to improve the lives of those persons with a mental illness.

Fed.Requirement 1. Establishing and implementing an organized community-based system of care for individuals with serious mental illnesses and children with serious emotional and mental disorders.

a) Direct a greater proportion of mental health dollars going to community program development and maintenance.

b) Establish a mechanism, if permissible under federal medical assistance program, to permit use of medical assistance funds to support community based crisis and rehabilitation services.

c) Increase the level of medical assistance reimbursement for services for persons with serious mental illness.

d) Establish crisis beds within allowable proximity to all communities.

Fed.Requirement 2. Specifying quantitative targets to be achieved in the implementation of such a system, including numbers of individuals with serious mental illnesses residing in the areas to be served under the system.

a) A minimum of 20% of the Regional Treatment Centers (RTC - six state hospitals) budget per year for the next 3 years must be shifted to community based programs.

b) Develop innovative housing and support options so that 20% of the RTC population has housing arrangements that will enable discharge (include subsidy for persons in their own apartments); establish a flexible funding resource for housing emergencies such as unexpected hospitalization (when rent must be paid for short term), damage deposits to acquire housing, and moving expenses.

Fed.Requirement 3. Describing services, available treatment options, and available resources to be provided for individuals with SMI to enable them to gain access to mental health services, including treatment, prevention, and rehabilitation services.

a) Pursue the revisions of the federal medicare regulations and private health insurance policies so that people are able to maintain a treatment plan without having to meet "spend-down" requirements (medication and profession services - including clozaril and other new drugs).

b) Department of Human Services must collaborate with other state agencies to develop a statewide access system for mental health services.

Fed.Requirement 4. Describing health and mental health services, rehab. services, employment services, housing services, educational services, medical and dental care, and other support services...

(No specific suggestions here but those under #1 are relevant to this requirement.)

Fed.Requirement 5. Describing financial resources and staffing necessary to implement the requirements of the plan.

a) Establish in conjunction with relevant professional education programs a mechanism to train individual in the full range of comprehensive treatment options (including community based services) within a multidisciplinary setting (MD, psych., social worker, RN, vocational rehab.specialist).

b) Examine the relationship between financing, programs and state objectives, analyzing the extent to which financing reinforces or impedes the implementation of our state policies on mental health care.

What are the financial incentives supporting community-based services rather than institutional care? What changes in accounting, monitoring and management would be required to integrate the financing decisions and the policies on mental health programs?

Fed.Requirements 6-8. Providing activities to reduce the rate of hospitalization...
Providing case management services for individuals...who receive substantial amounts for public funds...
Providing for the implementation of case management services...in a manner which phases in...such services by the end of fiscal year 1992.

a) Establish on-going state wide education about SPMI.

b) Recognize the importance of family relationships and encourage family input into plans of care and support services for persons with mental illness; small examples by the department might be establishing internal policies that expect family involvement -- 1) establish a policy to actively solicit the information and participation from families, and 2) obtain federal grants for family education.

c) Increase the number of county case managers required to implement this service by 20% per year in order to decrease the caseloads and increase the number of individuals served; recognize the importance of family relationships for the individual in the case management plan.

d) Revise Rule 74 (state case management standards for medical assistance reimbursement), in collaboration with medical assistance program, so that the rehabilitation model is the federally approved reimbursable model under medical assistance.

Fed.Requirement 9. Providing for the establishment and implementation of a program of outreach.

No specific suggestion for this requirement.

Fed.Requirement 10. Describing a system of integrated social, educational, juvenile, substance abuse services which together with health and mental health services should be provided in order for children and adolescents with serious emotional and mental disorders to receive care appropriate for their multiple needs, including services to be provided by local school systems under the Education of the Handicapped Act.

See below.

Suggested Activities for the Implementation of the State Plan for Children

The Subcommittee on Children's Mental Health attempted to be visionary and yet modest in their deliberation of the following activities; some may be more utopian than realistic, but all are intended to improve the lives of those children with severe emotional disturbances.

Fed.Requirement 1. Establishing and implementing an organized community-based system of care for individuals with serious mental illnesses and children with serious emotional and mental disorders.

Fed.Requirement 2. Specifying quantitative targets to be achieved in the implementation of such a system, including numbers of individuals with serious mental illnesses residing in the areas to be served under the system.

a) Direct a greater proportion of mental health dollars going to community program development and maintenance.

b) Establish a mechanism, if permissible under federal medical assistance program, to permit use of medical assistance funds to support community based crisis and rehabilitation services.

c) Increase the level of medical assistance reimbursement for services for children with severe emotional disturbance.

d) Establish crisis beds within allowable proximity to all communities.

e) By September, 1992, every county will have established some components of the family, community support services (as defined in state statute).

f) Build interdepartmental coordination to establish a holistic approach to children's services within the Department of Human Services (for example to include Mental Health Division, Medical Assistance, Social Services).

g) Children's Community-Based Mental Health Grant awards in 1992 will not limit the allocation amount for day treatment.

h) In 1992, the Mental Health Division will assist counties in the development of regional workshops on day treatment services to be conducted by experts in that area of work.

Fed.Requirement 3. Describing services, available treatment options, and available resources to be provided for individuals with SMI to enable them to gain access to mental health services, including treatment, prevention, and rehabilitation services.

a) Build on the recommendations of the Early Identification and Intervention task force to mandate procedures and monitor the practice of EII skills in all local system of care.

b) Develop Interagency agreements by September, 1992, to clarify human and fiscal resources needed to implement Early Identification and Intervention Services.

c) In 1992, the MHD will identify and provide a listing of day treatment programs (through the use of Department Bulletin), their locations, the interagency agreements associated with the

programs, noting those programs that are designed to include parental involvement and those that are specific designed for ethnic populations.

Fed.Requirement 4. Describing health and mental health services, rehab. services, employment services, housing services, educational services, medical and dental care, and other support services...

a) The Minnesota Comprehensive Children's Mental Health Act includes all such support services. The task force continues to advocate for further implementation of this Act by:

(1) requiring every county to apply for and be awarded funding for components of the Children's Community-Based Mental Health Grant;

(2) greater cooperation from and use of medical assistance program for case management and home-based services; and

(3) a clear statewide interagency agreement to pool resources and provide access to these additional resources for mental health services for children.

The task force considers these three activities as on-going, measurable, and will show state progress by September, 1992.

Fed.Requirement 5. Describing financial resources and staffing necessary to implement the requirements of the plan.

a) By September, 1992 the Mental Health Division (MHD) will develop a human resource task force specific for children's mental health services, and will include persons of color to ensure cultural diversity, and identify the service gaps that exist within ethnic communities.

b) By September, 1992 the Department of Human Services will have a proposal for a statewide policy for flexible funding which will enable counties to develop community based services.

c) By September, 1992 the MHD will have obtained data on children in the community corrections system having mental health problems, and will have a proposal for intervention services for those children.

d) By September, 1992 the state will have identified the number of children receiving out-of-state mental health treatment services (specialized services); a program proposal and budget recommendation to provide those children access to in-state programs; and a progress report on the start-up of such programs.

Fed.Requirement 6. Providing activities to reduce the rate of hospitalization...

The task force recommends the activities under Requirement #1 as necessary to meet this requirement.

Fed.Requirement 7. Providing case management services for individuals...who receive substantial amounts for public funds...

Fed.Requirement 8. Providing for the implementation of case management services...in a manner which phases in...such services by the end of fiscal year 1992.

a) By September, 1992 the state will have established a uniform measurement to evaluate outreach activities to ensure that all children with SED in all counties actually receive case management services by mental health professionals.

Outreach activities must be cross-cultural and include: parents, schools, health care providers, mental health professionals, child advocates, day care providers.

b) By September, 1992 the measurable number of children receiving case management services, under medical assistance, will have increased by at least 20%.

Fed.Requirement 9. Providing for the establishment and implementation of a program of outreach.

No specific suggestions for this requirement.

Fed.Requirement 10. Describing a system of integrated social, educational, juvenile, substance abuse services which together with health and mental health services should be provided in order for children and adolescents with serious emotional and mental disorders to receive care appropriate for their multiple needs, including services to be provided by local school systems under the Education of the Handicapped Act.

a) By September, 1992 the state will have developed a statewide mission for community mental health services for children similar or the same as the CASSP model on which to base future legislative and local activities;

b) By September, 1992 the state will have a proposal for a policy to establish flexible funding for services for children and their families which will include all institutions of care;

c) By September, 1992 the state will establish a clear statewide interagency agreement to pool resources and provide access to these additional resources for mental health services for children.

The task force recommends that this formal interagency agreement include the following:

* clear descriptions of the roles and responsibilities of all state agencies in agreement,

* signatures by all state Commissioners with the defined responsibilities,

* technical assistance described and assigned to specific agencies to be provided by designated employees with expertise in the area as specified in the agreement.

SUMMARY OF ADULT MENTAL HEALTH NEEDS IDENTIFIED BY LACs IN COUNTY PLANS
(Approximately 75 counties reporting)

Affordable housing: 27
Group home/foster care in community: 8
Transition between Rule 36 & independent living: 7
Housing alternatives: 4
Lift moratorium on Board and Lodging: 2
Housing total: 48

Increased/maintained Community Support Programs (CSP): 22
Supportive housing, expand housing supports: 10
Expand CSP beyond SPMI: 8
Volunteers for CSP: 5
Independent Living Skills: 2
CSP total: 47

Education re. nature/causes/stigma of MI: 28
Educate law enforcement/emergency personnel: 4
Education total: 32

Crisis facilities/unit (psych beds): 16
In-home crisis intervention or crisis services: 10
24-hour crisis line: 2
Crisis homes: 1
Crisis services total: 29

Employment, vocational rehabilitation: 22
Programs flexibility for transition between benefits & jobs: 2
Job-related total: 24

Transportation: 23
Psychiatric services: 17
Info on Access to services: 12

Reduce/maintain case management loads: 9
Change Rule 74 broker model: 1
Case management teams: 2
Case management total: 12

Expand/improve/maintain day treatment: 11
Drop-in center/rec optys: 9
Family support groups: 8
MI/CD services: 8
Consumer support groups: 7
Services/education to elderly: 6

SUMMARY OF CHILDREN'S MENTAL HEALTH NEEDS IDENTIFIED BY LACs IN COUNTY PLANS

More (in-home)(affordable) services: 13
More funding: 9
More provider options: 1
Specialized treatment services closer to home: 1
General need for services/funding: 24

Day Treatment: 19
Elementary DT: 2
DT outreach worker: 1
DT ages 11-14: 1
Day treatment: 23

Family Community Support Services: 10
Recreational programs: 4
Big brother/big sister: 4
Specialized coordinated FCSS: 1
Independent Living Skills: 1
Treating families as a whole: 1
Family support services: 21

Community education: 17
Labeling impedes services: 1
Education of community: 18

More early identification/assessment: 15
Central intake process: 1
Independent assessment: 1
Develop referral process/system of service: 1
Identification/assessment/intake/referral: 18

Services at schools: 9
Education/training of teachers: 7
MI Education at schools: 2
School-related issues: 18

Outreach, information on accessing services: 17
Respite care: 15

Interagency coordination or planning/review teams (cooperation): 11
Decentralization/eclectic/flexible system: 3
Lack of focus on SED in system: 1
Coordination/systems improvement: 15

Parent support groups: 14
Therapeutic foster care: 13

Emergency/crisis: 9
Crisis shelter: 1
24-hour crisis line: 1
Emergency/crisis services: 11

Prevention: 10
Prevention before diagnosis: 1
Prevention services: 11

Psychiatric services: 9
Case management: 8
Parenting skills: 7
Transportation: 6