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256E.09 COMMUNITY SOCIAL SERVICE PLANS

Subdivision 1. **Plan proposal.** Beginning in 1989, and every two years after that, the county board shall publish and make available upon request to all county residents a proposed biennial community social services plan for the next two calendar years.

Subd. 2. **Citizen participation.** The county board shall provide opportunities for participation by citizens in the county, including representatives of users of services, in the development of the biennial plan and in the allocation of money for community social services. At least 60 days prior to publication of the proposed plan the county board shall publish the methods proposed to achieve citizen participation in the planning process.

Subd. 3. **Plan content.** The biennial community social services plan published by the county shall include:

(a) A statement of the goals of community social service programs in the county;

(b) Methods used pursuant to subdivision 2 to encourage participation of citizens and providers in the development of the plan and the allocation of money;

(c) Methods used to identify persons in need of service and the social problems to be addressed by the community social service programs, including efforts the county proposes to make in providing for early intervention, prevention and education aimed at minimizing or eliminating the need for services for groups of persons identified in section 256E.03, subdivision 2;

(d) A statement describing how the county will fulfill its responsibilities identified in section 256E.08, subdivision 1, to the groups of persons described in section 256E.03, subdivision 2, and a description of each community social service proposed and identification of the agency or person proposed to provide the service:

(e) A statement describing how the county proposed to make the following services available for persons identified by the county as in need of services; daytime developmental achievement services for children; day training and habilitation services for adults; extended employment program services for persons with disabilities; supported employment services as defined in section 252.42, subdivision 8; community-based employment programs as defined in section 268A.01, subdivision 11; subacute detoxification services; and residential services and nonresidential social support services as appropriate for the groups identified in section 256E.03, subdivision 2;

(f) A statement specifying how the county will collaboratively plan the development of supported employment services and community-based employment services with local representatives of public rehabilitation agencies and local education agencies, including, if necessary, how existing day or employment services could be modified to provide supported employment services and community-based employment services;

(g) A statement describing how the county is fulfilling its responsibility to establish a comprehensive and coordinated system of early intervention services as required under section 120.17, subdivisions 11a, 12, and 14;

(h) The amount of money proposed to be allocated to each service;

(i) An inventory of public and private resources including association of volunteers which are available to the county for social services;

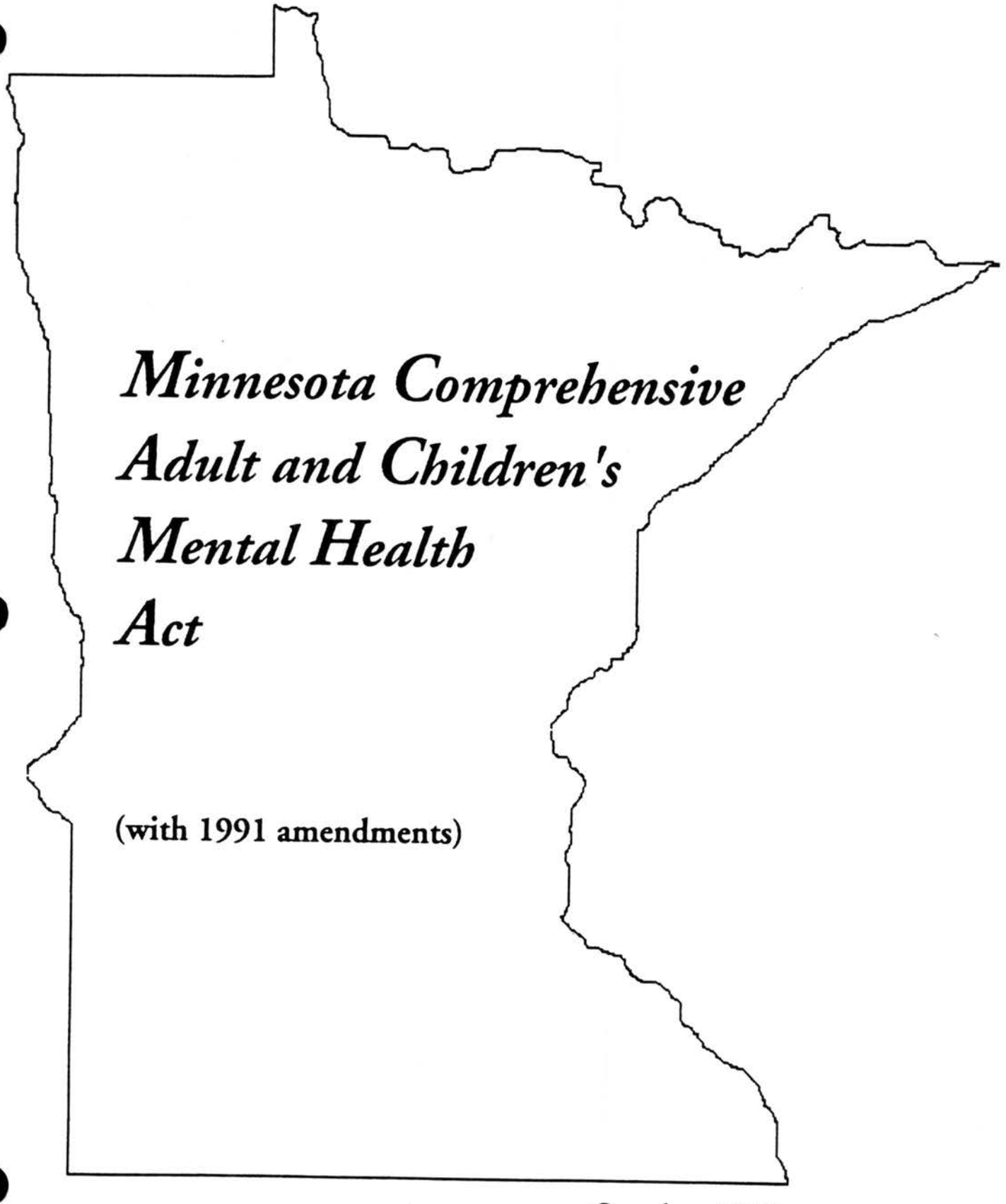
(j) Evidence that serious consideration was given to the purchase of services from private and public agencies; and

(k) Methods whereby community social service programs will be monitored and evaluated by the county;

Subd. 4. **Plan submission.** The county board of commissioners shall submit the biennial community social services plan to the commissioner of human services. The date of publication and submission to the commissioner shall be determined so that the plan is coordinated with the county budgeting process.

Subd. 5. **Public Notice.** The county board shall make available to the public through publication or posting in public buildings the names and locations of agencies responsible for the provision of community social services.

Subd. 6. **Plan amendment.** After providing opportunity for public comment, the county may amend its plan. After approval of the amendment by the county board, the county shall submit its amendment to the commissioner. The commissioner shall certify whether the amendment fulfills the purpose and requirement of law and the rules of the state agency.



Minnesota Comprehensive Adult and Children's Mental Health Act

(with 1991 amendments)

October 1991

MINNESOTA COMPREHENSIVE ADULT AND CHILDREN'S MENTAL HEALTH ACT
(Including 1991 Legislative Amendments)

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MINNESOTA COMPREHENSIVE ADULT MENTAL HEALTH ACT

245.461 POLICY AND CITATION.

Subdivision 1. **Citation.** Sections 245.461 to 245.486 may be cited as the "Minnesota comprehensive adult mental health act."

Subd. 2. **Mission statement.** The commissioner shall create and ensure a unified, accountable, comprehensive adult mental health service system that:

(1) recognizes the right of adults with mental illness to control their own lives as fully as possible;

(2) promotes the independence and safety of adults with mental illness;

(3) reduces chronicity of mental illness;

(4) eliminates abuse of adults with mental illness;

(5) provides services designed to:

(i) increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning;

(ii) stabilize adults with mental illness;

(iii) prevent the development and deepening of mental illness;

(iv) support and assist adults in resolving mental health problems that impede their functioning;

(v) promote higher and more satisfying levels of emotional functioning; and

(vi) promote sound mental health; and

(6) provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.

Subd. 3. **Report.** By February 15, 1988, and annually after that until February 15, 1994, the commissioner shall report to the legislature on all steps taken and recommendations for full implementation of sections 245.461 to 245.486 and on additional resources needed to further implement those sections.

Subd. 4. **Housing mission statement.** The commissioner shall ensure that the housing services provided as part of a comprehensive mental health service system:

(1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;

(2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and

(3) provide necessary support regardless of where persons with mental illness choose to live.

Subd. 5. **Funding from the federal government and other sources.** The commissioner shall seek and apply for federal and other nonstate, nonlocal government funding for the mental health services specified in sections 245.461 to 245.486, in order to maximize nonstate, nonlocal dollars for these services.

HIST: 1987 c 403 art 2 s 16; 1989 c 282 art 4 s 1; 1991 c 292 art 6 s 1,2

245.462 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to 245.486.

Subd. 2. **Acute care hospital inpatient treatment.** "Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the community support services program as defined in subdivision 6 and are designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Subd. 4. **Case manager.** "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711. A case manager must have a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and have at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client. The case manager shall meet in person with a mental health professional at least once each month to obtain clinical supervision of the case manager's activities. Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must complete 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness and must receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of supervised experience is met. Clinical supervision must be documented in the client record.

Until June 30, 1991, a refugee who does not have the qualifications specified in this subdivision may provide case management services to adult refugees with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person: (1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university; (2) completes 40 hours of training as specified in this subdivision; and (3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the clinical supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,
(2) medication monitoring,
(3) assistance in independent living skills,
(4) development of employability and work-related opportunities,
(5) crisis assistance,
(6) psychosocial rehabilitation,
(7) help in applying for government benefits, and
(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711.

Subd. 7. **County board.** "County board" means the county board of commissioners or board established pursuant to the joint powers act, section 471.59, or the human services board act, sections 402.01 to 402.10.

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to an adult in: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least one day a week for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services.

Subd. 9. **Diagnostic assessment.** "Diagnostic assessment" means a written summary of the history, diagnosis, strengths, vulnerabilities, and general service needs of an adult with a mental illness using diagnostic, interview, and other relevant mental health techniques provided by a mental health professional used in developing an individual treatment plan or individual community support plan.

Subd. 10. **Education and prevention services.** "Education and prevention services" means services designed to educate the general public or special high-risk target populations about mental illness, to increase the understanding and acceptance of problems associated with mental illness, to increase people's awareness of the availability of resources and services, and to improve people's skills in dealing with high-risk situations known to affect people's mental health and functioning. The services include the distribution of information to

individuals and agencies identified by the county board and the local mental health advisory council, on predictors and symptoms of mental disorders, where mental health services are available in the county, and how to access the services.

Subd. 11. **Emergency services.** "Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency.

Subd. 11a. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the adult's:

(1) mental health symptoms as presented in the adult's diagnostic assessment;

(2) mental health needs as presented in the adult's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the adult's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Subd. 12. **Individual community support plan.** "Individual community support plan" means a written plan developed by a case manager on the basis of a diagnostic assessment and functional assessment. The plan identifies specific services needed by an adult with serious and persistent mental illness to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships, financial management, housing, transportation, and employment.

Subd. 13. **Individual placement agreement.** "Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of an individual adult to provide residential treatment services.

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness.

Subd. 15. Repealed, 1991 c 94 s 25

Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under sections 256D.06 and 256D.37 to facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

Subd. 17. **Mental health practitioner.** "Mental health practitioner" means a person providing services to persons with mental illness who is qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and has at least 2,000 hours of supervised experience in the delivery of services to

persons with mental illness;

(2) has at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness;

(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or

(4) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness.

Subd. 18. **Mental health professional.** "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by the American nurses association or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: a psychologist licensed under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry; or

(5) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Subd. 19. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to adults with mental illness and are described in sections 245.461 to 245.486.

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

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

(c) For purposes of case management and community support services,

a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless an ongoing community support services program is provided; or

(4) the adult has been committed by a court as a mentally ill person under chapter 253B, or the adult's commitment has been stayed or continued.

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the clinical supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 22. **Regional treatment center inpatient services.** "Regional treatment center inpatient services" means the 24-hour-a-day comprehensive medical, nursing, or psychosocial services provided in a regional treatment center operated by the state.

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under Minnesota Rules, parts 9520.0500 to 9520.0690 or other rules adopted by the commissioner.

Subd. 24. **Service provider.** "Service provider" means either a county board or an individual or agency including a regional treatment center under contract with the county board that provides adult mental health services funded by sections 245.461 to 245.486.

Subd. 25. Repealed, 1989 c 282 art 4 s 64

HIST: 1987 c 403 art 2 s 17; 1988 c 689 art 2 s 64-73; 1989 c 282 art 4 s 2; 1990 c 426 art 2 s 6; 1990 c 568 art 5 s 34; 1991 c 292 art 6 s 3,4

245.463 PLANNING FOR A MENTAL HEALTH SYSTEM.

Subdivision 1. **Planning effort.** Starting on the effective date of sections 245.461 to 245.486 and ending June 30, 1988, the commissioner and the county agencies shall plan for the development of a unified, accountable, and comprehensive statewide mental health system. The system must be planned and developed by stages until it is operating at full capacity.

Subd. 2. **Technical assistance.** The commissioner shall provide

ongoing technical assistance to county boards to develop the adult mental health component of the community social services plan as specified in section 245.478, to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of adults with mental illness residing in the county and extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Subd. 3. **Report on increase in community-based residential programs.** The commissioner of human services shall, in cooperation with the commissioner of health, study and submit to the legislature by February 15, 1991, a report and recommendations regarding (1) plans and fiscal projections for increasing the number of community-based beds, small community-based residential programs, and support services for persons with mental illness, including persons for whom nursing home services are inappropriate, to serve all persons in need of those programs; and (2) the projected fiscal impact of maximizing the availability of medical assistance coverage for persons with mental illness.

Subd. 4. **Review of funding.** The commissioner shall complete a review of funding for mental health services and make recommendations for any changes needed. The commissioner shall submit a report on the review and recommendations to the legislature by January 31, 1991.

HIST: 1987 c 403 art 2 s 18; 1989 c 282 art 4 s 3,4; art 6 s 3; 1991 c 94 s 24

245.464 COORDINATION OF MENTAL HEALTH SYSTEM.

Subdivision 1. **Coordination.** The commissioner shall supervise the development and coordination of locally available adult mental health services by the county boards in a manner consistent with sections 245.461 to 245.486. The commissioner shall coordinate locally available services with those services available from the regional treatment center serving the area. The commissioner shall review the adult mental health component of the community social services plan developed by county boards as specified in section 245.463 and provide technical assistance to county boards in developing and maintaining locally available mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's adult mental health component of the community social services plan and other information as required by sections 245.461 to 245.486.

Subd. 2. **Priorities.** By January 1, 1990, the commissioner shall require that each of the treatment services and management activities described in sections 245.469 to 245.477 are developed for adults with mental illness within available resources based on the following ranked priorities:

(1) the provision of locally available emergency services;

(2) the provision of locally available services to all adults with serious and persistent mental illness and all adults with acute mental illness;

(3) the provision of specialized services regionally available to meet the special needs of all adults with serious and persistent mental illness and all adults with acute mental illness;

(4) the provision of locally available services to adults with other mental illness; and

(5) the provision of education and preventive mental health services

targeted at high-risk populations.

HIST: 1987 c 403 art 2 s 19; 1989 c 282 art 4 s 5; 1991 c 94 s 24

245.465 DUTIES OF COUNTY BOARD.

Subdivision 1. **Spend according to plan; other listed duties.** The county board in each county shall use its share of mental health and community social services act funds allocated by the commissioner according to the biennial mental health component of the county's community social services plan as approved by the commissioner. The county board must:

(1) develop and coordinate a system of affordable and locally available adult mental health services in accordance with sections 245.461 to 245.486;

(2) with the involvement of the local adult mental health advisory council or the adult mental health subcommittee of an existing advisory council, develop a biennial adult mental health component of the community social services plan required in section 256E.09 which considers the assessment of unmet needs in the county as reported by the local adult mental health advisory council under section 245.466, subdivision 5, clause (3). The county shall provide, upon request of the local adult mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) provide for case management services to adults with serious and persistent mental illness in accordance with sections 245.462, subdivisions 3 and 4; 245.4711; and 245.486;

(4) provide for screening of adults specified in section 245.476 upon admission to a residential treatment facility or acute care hospital inpatient, or informal admission to a regional treatment center;

(5) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.461 to 245.486; and

(6) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract with the county to provide mental health services have experience and training in working with adults with mental illness.

Subd. 2. **Residential and community support programs: 1992 salary increase.** In establishing, operating, or contracting for the provision of programs licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and programs funded under Minnesota Rules, parts 9535.0100 to 9535.1600, for the fiscal year beginning July 1, 1991, a county board's contract must reflect increased salaries by multiplying the total salaries, payroll taxes, and fringe benefits related to personnel below top management by three percent. This increase shall remain in the base for purposes of wage determination in future contract years. County boards shall verify in writing to the commissioner that each program has complied with this requirement. If a county board determines that a program has not complied with this requirement for a specific contract period, the county board shall reduce the program's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for programs and counties as necessary to monitor compliance with this provision.

HIST: 1987 c 403 art 2 s 20; 1988 c 689 art 2 s 74; 1989 c 282 art 4 s 6; 1991 c 94 s 1; 1991 c 292 art 4 s 4

245.466 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision 1. **Development of services.** The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable adult mental health services. The county board may provide some or all of the mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward full implementation of sections 245.461 to 245.486 during the period July 1, 1987, to January 1, 1990. County boards must develop fully each of the treatment services and management activities prescribed by sections 245.461 to 245.486 by January 1, 1990, according to the priorities established in section 245.464 and the adult mental health component of the community social services plan approved by the commissioner under section 245.478.

Subd. 2. **Adult mental health services.** The adult mental health service system developed by each county board must include the following services:

(1) education and prevention services in accordance with section 245.468;

(2) emergency services in accordance with section 245.469;

(3) outpatient services in accordance with section 245.470;

(4) community support program services in accordance with section 245.4711;

(5) residential treatment services in accordance with section 245.472;

(6) acute care hospital inpatient treatment services in accordance with section 245.473;

(7) regional treatment center inpatient services in accordance with section 245.474;

(8) screening in accordance with section 245.476; and

(9) case management in accordance with sections 245.462, subdivision 3; and 245.4711.

Subd. 3. **Local contracts.** Effective January 1, 1988, the county board shall review all proposed county agreements, grants, or other contracts related to mental health services for funding from any local, state, or federal governmental sources. Contracts with service providers must:

(1) name the commissioner as a third party beneficiary;

(2) identify monitoring and evaluation procedures not in violation of the Minnesota government data practices act, chapter 13, which are necessary to ensure effective delivery of quality services;

(3) include a provision that makes payments conditional on compliance by the contractor and all subcontractors with sections 245.461 to 245.486 and all other applicable laws, rules, and standards; and

(4) require financial controls and auditing procedures.

Subd. 4. **Joint county mental health agreements.** In order to provide efficiently the services required by sections 245.461 to 245.486, counties are encouraged to join with one or more county boards to establish a multicounty local mental health authority pursuant to the

joint powers act, section 471.59, the human service board act, sections 402.01 to 402.10, community mental health center provisions, section 245.62, or enter into multicounty mental health agreements. Participating county boards shall establish acceptable ways of apportioning the cost of the services.

Subd. 5. **Local advisory council.** The county board, individually or in conjunction with other county boards, shall establish a local adult mental health advisory council or mental health subcommittee of an existing advisory council. The council's members must reflect a broad range of community interests. They must include at least one consumer, one family member of an adult with mental illness, one mental health professional, and one community support services program representative. The local adult mental health advisory council or mental health subcommittee of an existing advisory council shall meet at least quarterly to review, evaluate, and make recommendations regarding the local mental health system. Annually, the local adult mental health advisory council or mental health subcommittee of an existing advisory council shall:

(1) arrange for input from the regional treatment center's mental illness program unit regarding coordination of care between the regional treatment center and community-based services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.462, subdivision 10;

(3) provide to the county board a report of unmet mental health needs of adults residing in the county to be included in the county's biennial mental health component of the community social services plan required in section 256E.09, and participate in developing the mental health component of the plan; and

(4) coordinate its review, evaluation, and recommendations regarding the local mental health system with the state advisory council on mental health.

The county board shall consider the advice of its local mental health advisory council or mental health subcommittee of an existing advisory council in carrying out its authorities and responsibilities.

Subd. 6. **Other local authority.** The county board may establish procedures and policies that are not contrary to those of the commissioner or sections 245.461 to 245.486 regarding local adult mental health services and facilities. The county board shall perform other acts necessary to carry out sections 245.461 to 245.486.

HIST: 1987 c 403 art 2 s 21; 1988 c 689 art 2 s 75-77; 1989 c 282 art 4 s 7-10; 1991 c 94 s 2,24

245.467 QUALITY OF SERVICES.

Subdivision 1. **Criteria.** Mental health services required by this chapter must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical needs, cultural and ethnic needs, and other special needs of individuals being served;

(3) provided in the most appropriate, least restrictive setting available to the county board;

(4) accessible to all age groups;

(5) delivered in a manner that provides accountability;

(6) provided by qualified individuals as required in this chapter;

(7) coordinated with mental health services offered by other

providers; and

(8) provided under conditions which protect the rights and dignity of the individuals being served.

Subd. 2. **Diagnostic assessment.** All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of outpatient and day treatment services must complete a diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the adult's current mental health status and service needs. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance or general assistance medical care reimbursement under chapters 256B and 256D.

Subd. 3. **Individual treatment plans.** All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan within ten days of client intake and must review the individual treatment plan every 90 days after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.

Subd. 4. **Referral for case management.** Each provider of emergency services, day treatment services, outpatient treatment, community support services, residential treatment, acute care hospital inpatient treatment, or regional treatment center inpatient treatment must inform each of its clients with serious and persistent mental illness of the availability and potential benefits to the client of case management. If the client consents, the provider must refer the client by notifying the county employee designated by the county board to coordinate case management activities of the client's name and address and by informing the client of whom to contact to request case management. The provider must document compliance with this subdivision in the client's record.

Subd. 5. **Information for billing.** Each provider of outpatient treatment, community support services, day treatment services, emergency services, residential treatment, or acute care hospital inpatient treatment must include the name and home address of each client for whom services are included on a bill submitted to a county, if the client has

consented to the release of that information and if the county requests the information. Each provider shall attempt to obtain each client's consent and must explain to the client that the information can only be released with the client's consent and may be used only for purposes of payment and maintaining provider accountability. The provider shall document the attempt in the client's record.

Subd. 6. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of persons receiving mental health services are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; and

(2) staff who provide treatment services or case management and their clinical supervisors.

Release of mental health data on individuals submitted under subdivisions 4 and 5, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 4 and 5, results in civil or criminal liability under the standards in section 13.08 or 13.09.

HIST: 1987 c 403 art 2 s 22; 1988 c 689 art 2 s 78-80; 1989 c 282 art 4 s 11-13; 1990 c 568 art 5 s 1,2

245.468 EDUCATION AND PREVENTION SERVICES.

By July 1, 1988, county boards must provide or contract for education and prevention services to adults residing in the county. Education and prevention services must be designed to:

(1) convey information regarding mental illness and treatment resources to the general public and special high-risk target groups;

(2) increase understanding and acceptance of problems associated with mental illness;

(3) improve people's skills in dealing with high-risk situations known to have an impact on adults' mental health functioning;

(4) prevent development or deepening of mental illness; and

(5) refer adults with additional mental health needs to appropriate mental health services.

HIST: 1987 c 403 art 2 s 23; 1989 c 282 art 4 s 14

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** By July 1, 1988, county boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further deterioration of adults with mental illness or emotional crises;

(3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional

during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

HIST: 1987 c 403 art 2 s 24; 1988 c 689 art 2 s 81; 1989 c 282 art 4 s 15; 1990 c 568 art 5 s 3; 1991 c 312 s 1

245.470 OUTPATIENT SERVICES.

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics

approved by the commissioner under section 245.69, subdivision 2; or by contract with a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (4). Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

Subd. 2. **Specific requirements.** The county board shall require that all service providers of outpatient services:

(1) meet the professional qualifications contained in sections 245.461 to 245.486;

(2) use a multidisciplinary mental health professional staff including at a minimum, arrangements for psychiatric consultation, licensed consulting psychologist consultation, and other necessary multidisciplinary mental health professionals;

(3) develop individual treatment plans;

(4) provide initial appointments within three weeks, except in emergencies where there must be immediate access as described in section 245.469; and

(5) establish fee schedules approved by the county board that are based on a client's ability to pay.

HIST: 1987 c 403 art 2 s 25; 1989 c 282 art 4 s 16; 1990 c 568 art 2 s 38 245.471 Repealed, 1989 c 282 art 4 s 64

245.4711 CASE MANAGEMENT SERVICES.

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.

(b) Case management services provided to adults with serious and persistent mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

Subd. 2. **Notification and determination of case management eligibility.** (a) The county board shall notify the adult of the adult's potential eligibility for case management services within five working days after receiving a request from an individual or a referral from a provider under section 245.467, subdivision 4. The county board shall send a written notice to the adult and the adult's representative, if any, that identifies the designated case management providers.

(b) The county board must determine whether an adult who requests or is referred for case management services meets the criteria of section

245.462, subdivision 20, paragraph (c). If a diagnostic assessment is needed to make the determination, the county board shall offer to assist the adult in obtaining a diagnostic assessment. The county board shall notify, in writing, the adult and the adult's representative, if any, of the eligibility determination. If the adult is determined to be eligible for case management services, the county board shall refer the adult to the case management provider for case management services. If the adult is determined not to be eligible or refuses case management services, the local agency shall offer to refer the adult to a mental health provider or other appropriate service provider and to assist the adult in making an appointment with the provider of the adult's choice.

Subd. 3. **Duties of case manager.** Upon a determination of eligibility for case management services, and if the adult consents to the services, the case manager shall complete a written functional assessment according to section 245.462, subdivision 11a. The case manager shall develop an individual community support plan for the adult according to subdivision 4, paragraph (a), review the adult's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

Subd. 4. **Individual community support plan.** (a) The case manager must develop an individual community support plan for each adult that incorporates the client's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual community support plan. The individual community support plan must be developed within 30 days of client intake and reviewed every 90 days after it is developed. The case manager is responsible for developing the individual community support plan based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual community support plan. To the extent possible, the adult with serious and persistent mental illness, the person's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual or family community support plan.

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

(1) the goals of each service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual community support plan.

Subd. 5. **Coordination between case manager and community support services.** The county board must establish procedures that ensure ongoing contact and coordination between the case manager and the community support services program as well as other mental health services.

Subd. 6. Repealed, 1990 c 568 art 5 s 35

Subd. 7. Repealed, 1990 c 568 art 5 s 35

Subd. 8. Repealed, 1990 c 568 art 5 s 35

Subd. 9. **Revision of rules.** (a) The commissioner, by July 1, 1992, shall revise existing rules governing case management services, in order to:

(1) make improvements in rule flexibility;

(2) establish a comprehensive coordination of services;

(3) require case managers to arrange for standardized assessments of side effects related to the administration of psychotropic medication;

(4) establish a reasonable caseload limit for case managers;

(5) provide reimbursement for transportation costs for case managers; and

(6) review the eligibility criteria for case management services covered by medical assistance.

(b) Until rule amendments are adopted under paragraph (a), in-county travel by case managers is reimbursable under the medical assistance program subject to the six-hour limit on case management services.

HIST: 1989 c 282 art 4 s 17; 1990 c 568 art 5 s 4-6; 1991 c 292 art 6 s 5

COMMUNITY SUPPORT AND DAY TREATMENT SERVICES

245.4712 COMMUNITY SUPPORT AND DAY TREATMENT SERVICES.

Subdivision 1. **Availability of community support services.** County boards must provide or contract for sufficient community support services within the county to meet the needs of adults with serious and persistent mental illness who are residents of the county. Adults may be required to pay a fee according to section 245.481. The community support services program must be designed to improve the ability of adults with serious and persistent mental illness to:

(1) work in a regular or supported work environment;

(2) handle basic activities of daily living;

(3) participate in leisure time activities;

(4) set goals and plans; and

(5) obtain and maintain appropriate living arrangements.

The community support services program must also be designed to reduce the need for and use of more intensive, costly, or restrictive placements both in number of admissions and length of stay.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious and persistent mental illness in applying for state and federal benefits, including supplemental security income, medical

assistance, Medicare, general assistance, general assistance medical care, and Minnesota supplemental aid. The help must be offered as part of the community support program available to adults with serious and persistent mental illness for whom the county is financially responsible and who may qualify for these benefits.

HIST: 1990 c 568 art 5 s 7

245.472 RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. **Availability of residential treatment services.** By July 1, 1988, county boards must provide or contract for enough residential treatment services to meet the needs of all adults with mental illness residing in the county and needing this level of care. Residential treatment services include both intensive and structured residential treatment with length of stay based on client residential treatment need. Services must be as close to the county as possible. Residential treatment must be designed to:

(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs;

(2) help clients achieve the highest level of independent living;

(3) help clients gain the necessary skills to function in a less structured setting; and

(4) stabilize crisis admissions.

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under applicable rules adopted by the commissioner and must be clinically supervised by a mental health professional. Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0690, may be allowed to continue providing clinical supervision within a facility, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

Subd. 3. **Transition to community.** Residential treatment programs must plan for and assist clients in making a transition from residential treatment facilities to other community-based services. In coordination with the client's case manager, if any, residential treatment facilities must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the residential treatment facility must notify the client's case manager, so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

Subd. 4. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for residential services are based on the clinical needs of the adult. The county board shall ensure that each entity under contract with the county to provide residential treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of residential services must include provisions guaranteeing clients the right to appeal under section 245.477 and to be advised of their appeal rights.

HIST: 1987 c 403 art 2 s 27; 1988 c 689 art 2 s 84; 1989 c 282 art 4 s 18,19; 1991 c 292 art 6 s 6,7

245.473 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. **Availability of acute care inpatient services.** By July 1, 1988, county boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for adults with mental illness residing in the county. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible; and

(3) facilitate appropriate referrals for follow-up mental health care in the community.

Subd. 2. **Specific requirements.** Providers of acute care hospital inpatient services must meet applicable standards established by the commissioners of health and human services.

Subd. 3. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for acute care inpatient services are based on the clinical needs of the adult. The county board shall ensure that each entity under contract with the county to provide acute care hospital treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of acute care hospital inpatient treatment services must include provisions guaranteeing clients the right to appeal under section 245.477 and to be advised of their appeal rights.

Subd. 4. **Individual placement agreement.** Except for services reimbursed under chapters 256B and 256D, the county board shall enter into an individual placement agreement with a provider of acute care hospital inpatient treatment services to an adult eligible for services under this section. The agreement must specify the payment rate and the terms and conditions of county payment for the placement.

HIST: 1987 c 403 art 2 s 28; 1989 c 282 art 4 s 20; 1991 c 292 art 6 s 8,9

245.474 REGIONAL TREATMENT CENTER INPATIENT SERVICES.

Subdivision 1. **Availability of regional treatment center inpatient services.** By July 1, 1987, the commissioner shall make sufficient regional treatment center inpatient services available to adults with mental illness throughout the state who need this level of care. Services must be as close to the patient's county of residence as possible. Regional treatment centers are responsible to:

(1) provide acute care inpatient hospitalization;

(2) stabilize the medical and mental health condition of the adult requiring the admission;

(3) improve functioning to the point where discharge to community-based mental health services is possible;

(4) strengthen family and community support; and

(5) facilitate appropriate discharge and referrals for follow-up mental health care in the community.

Subd. 2. **Quality of service.** The commissioner shall biennially determine the needs of all adults with mental illness who are served by

regional treatment centers by administering a client-based evaluation system. The client-based evaluation system must include at least the following independent measurements: behavioral development assessment; habilitation program assessment; medical needs assessment; maladaptive behavioral assessment; and vocational behavior assessment. The commissioner shall propose staff ratios to the legislature for the mental health and support units in regional treatment centers as indicated by the results of the client-based evaluation system and the types of state-operated services needed. The proposed staffing ratios shall include professional, nursing, direct care, medical, clerical, and support staff based on the client-based evaluation system. The commissioner shall recompute staffing ratios and recommendations on a biennial basis.

Subd. 3. **Transition to community.** Regional treatment centers must plan for and assist clients in making a transition from regional treatment centers to other community-based services. In coordination with the client's case manager, if any, regional treatment centers must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the regional treatment center must notify the client's case manager, so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

HIST: 1987 c 403 art 2 s 29; 1989 c 282 art 4 s 21; 1990 c 568 art 5 s 8 245.475 Repealed, 1989 c 282 art 4 s 64

245.476 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subdivision 1. Repealed, 1991 c 292 art 6 s 59

Subd. 2. Repealed, 1991 c 292 art 6 s 59

Subd. 3. Repealed, 1991 c 292 art 6 s 59

Subd. 4. **Task force on residential and inpatient treatment services for adults.** The commissioner of human services shall appoint a task force on residential and inpatient treatment services for adults. The task force must include representatives from each of the mental health professional categories defined in section 245.462, subdivision 18, the Minnesota mental health association, the Minnesota alliance for the mentally ill, the Minnesota mental health law project, the Minnesota association of mental health residential facilities, the Minnesota hospital association, department of human services staff, the department of education, the department of corrections, the ombudsman for mental health and mental retardation, and counties. The task force shall examine and evaluate existing mechanisms that have as their purpose review of appropriate admission and need for continued care for clients admitted to residential treatment, acute care hospital inpatient treatment, and regional treatment center inpatient treatment. These mechanisms shall include at least the following: precommitment screening, licensure and reimbursement rules, county monitoring, technical assistance, nursing home preadmission screening, hospital preadmission certification, and hospital retrospective reviews. The task force shall report to the legislature by February 15, 1990, on how existing mechanisms may be changed to accomplish the goals of screening as described in subdivision 1.

Subd. 5. **Report on preadmission screening.** The commissioner shall review the statutory preadmission screening requirements for psychiatric hospitalization, both in the regional treatment centers and other hospitals, to determine if changes in preadmission screening are needed.

The commissioner shall deliver a report of the review to the legislature by January 31, 1990.

HIST: 1987 c 403 art 2 s 31; 1988 c 689 art 2 s 87; 1989 c 282 art 4 s 22-24; art 6 s 4

245.477 APPEALS.

Any adult who requests mental health services under sections 245.461 to 245.486 must be advised of services available and the right to appeal at the time of the request and each time the individual community support plan or individual treatment plan is reviewed. Any adult whose request for mental health services under sections 245.461 to 245.486 is denied, not acted upon with reasonable promptness, or whose services are suspended, reduced, or terminated by action or inaction for which the county board is responsible under sections 245.461 to 245.486 may contest that action or inaction before the state agency as specified in section 256.045. The commissioner shall monitor the nature and frequency of administrative appeals under this section.

HIST: 1987 c 403 art 2 s 32; 1988 c 689 art 2 s 88; 1989 c 282 art 4 s 25

245.478 ADULT COMPONENT OF COMMUNITY SOCIAL SERVICES PLAN.

Subdivision 1. **Submittal.** Beginning in 1993, and every two years thereafter, the county board shall submit to the commissioner the adult mental health component of the community social services plan required under section 256E.09.

Subd. 2. **Content of adult mental health component.** Content of the adult mental health component of the community social services plan is governed by section 256E.09.

Subd. 3. **Format.** The adult mental health component of the community social services plan must be made in a format prescribed by the commissioner.

Subd. 4. **Provider approval.** The commissioner's review of the adult mental health component of the community social services plan must include a review of the qualifications of each service provider required to be identified in the adult mental health component of the community social services plan under subdivision 2. The commissioner may reject a county board's adult mental health component of the community social services plan for a particular provider if:

(1) the provider does not meet the professional qualifications contained in sections 245.461 to 245.486;

(2) the provider does not possess adequate fiscal stability or controls to provide the proposed services as determined by the commissioner; or

(3) the provider is not in compliance with other applicable state laws or rules.

Subd. 5. **Service approval.** The commissioner's review of the adult mental health component of the community social services plan must include a review of the appropriateness of the amounts and types of mental health services in the adult mental health component of the community social services plan. The commissioner may reject the county board's adult mental health component of the community social services plan if the commissioner determines that the amount and types of services proposed are not cost effective, do not meet client needs, or do not comply with sections 245.461 to 245.486.

Subd. 6. **Approval.** The commissioner shall review each county's adult

mental health component of the community social services plan within 60 days and work with the county board to make any necessary modifications to comply with sections 245.461 to 245.486. After the commissioner has approved the adult mental health component of the community social services plan, the county board is eligible to receive an allocation of mental health and community social services act funds.

Subd. 7. **Partial or conditional approval.** If the adult mental health component of the community social services plan is in substantial, but not in full compliance with sections 245.461 to 245.486 and necessary modifications cannot be made before the adult mental health component of the community social services plan period begins, the commissioner may grant partial or conditional approval and withhold a proportional share of the county board's mental health and community social service act funds until full compliance is achieved.

Subd. 8. **Award notice.** Upon approval of the county board's adult mental health component of the community social services plan, the commissioner shall send a notice of approval for funding. The notice must specify any conditions of funding and is binding on the county board. Failure of the county board to comply with the approved adult mental health component of the community social services plan and funding conditions may result in withholding or repayment of funds as specified in section 245.483.

Subd. 9. **Plan amendment.** If the county board finds it necessary to make significant changes in the approved adult mental health component of the community social services plan, it must present the proposed changes to the commissioner for approval at least 30 days before the changes take effect. "Significant changes" means:

(1) the county board proposes to provide a mental health service through a provider other than the provider listed for that service in the approved adult mental health component of the community social services plan;

(2) the county board expects the total annual expenditures for any single mental health service to vary more than ten percent or $5,000, whichever is greater, from the amount in the approved adult mental health component of the community social services plan;

(3) the county board expects a combination of changes in expenditures per mental health service to exceed more than ten percent of the total mental health services expenditures; or

(4) the county board proposes a major change in the specific objectives and outcome goals listed in the approved adult mental health component of the community social services plan.

HIST: 1987 c 403 art 2 s 33; 1988 c 689 art 2 s 89-91; 1989 c 282 art 4 s 26,27; 1991 c 94 s 3-5,24 NOTE: Subdivision 2, as amended by Laws 1991, chapter 94, section 4, is effective January 1, 1993. See Laws 1991, chapter 94, section 26.

245.479 COUNTY OF FINANCIAL RESPONSIBILITY.

For purposes of sections 245.461 to 245.486 and 245.487 to 245.4888, the county of financial responsibility is determined under section 256G.02, subdivision 4. Disputes between counties regarding financial responsibility must be resolved by the commissioner in accordance with section 256G.09.

HIST: 1987 c 403 art 2 s 35; 1988 c 689 art 2 s 92; 1989 c 282 art 4 s 28; 1991 c 292 art 6 s 58 subd 1

245.48 MAINTENANCE OF EFFORT.

Counties must continue to spend for mental health services specified in sections 245.461 to 245.486 and 245.487 to 245.4888, according to generally accepted budgeting and accounting principles, an amount equal to the total expenditures shown in the county's approved 1987 Community Social Services Act plan under "State CSSA, Title XX and County Tax" for services to persons with mental illness plus the comparable figure for Rule 5 facilities under target populations other than mental illness in the approved 1987 CSSA plan.

HIST: 1987 c 403 art 2 s 34; 1988 c 689 art 2 s 241; 1989 c 282 art 4 s 29; 1991 c 292 art 6 s 58 subd 1

245.481 FEES FOR MENTAL HEALTH SERVICES.

A client or, in the case of a child, the child or the child's parent may be required to pay a fee for mental health services provided under sections 245.461 to 245.486 and 245.487 to 245.4888. The fee must be based on the person's ability to pay according to the fee schedule adopted by the county board. In adopting the fee schedule for mental health services, the county board may adopt the fee schedule provided by the commissioner or adopt a fee schedule recommended by the county board and approved by the commissioner. Agencies or individuals under contract with a county board to provide mental health services under sections 245.461 to 245.486 and 245.487 to 245.4888 must not charge clients whose mental health services are paid wholly or in part from public funds fees which exceed the county board's adopted fee schedule. This section does not apply to regional treatment center fees, which are governed by sections 246.50 to 246.55.

HIST: 1989 c 282 art 4 s 30; 1991 c 292 art 6 s 58 subd 1

245.482 REPORTING AND EVALUATION.

Subdivision 1. **Reports.** The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (17).

Subd. 2. **Fiscal reports.** The commissioner shall develop a unified format for quarterly fiscal reports that will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486, 245.487 to 245.4888, and section 256E.08. The county board shall submit a completed fiscal report in the required format no later than 30 days after the end of each quarter.

Subd. 3. **Program reports.** The commissioner shall develop unified formats for reporting, which will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486, 245.487 to 245.4888, and section 256E.10. The county board shall submit completed program reports in the required format according to the reporting schedule developed by the commissioner.

Subd. 4. **Provider reports.** The commissioner may develop formats and procedures for direct reporting from providers to the commissioner to include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4888. In particular, the provider reports must include aggregate information by county of residence about mental health services paid for by funding sources other than counties.

Subd. 5. **Commissioner's consolidated reporting recommendations.** The commissioner's reports of February 15, 1990, required under sections 245.461, subdivision 3, and 245.487, subdivision 4, shall include

recommended measures to provide coordinated, interdepartmental efforts to ensure early identification and intervention for children with, or at risk of developing, emotional disturbance, to improve the efficiency of the mental health funding mechanisms, and to standardize and consolidate fiscal and program reporting. The recommended measures must provide that client needs are met in an effective and accountable manner and that state and county resources are used as efficiently as possible. The commissioner shall consider the advice of the state advisory council and the children's subcommittee in developing these recommendations.

Subd. 6. **Inaccurate or incomplete reports.** The commissioner shall promptly notify a county or provider if a required report is clearly inaccurate or incomplete. The commissioner may delay all or part of a mental health fund payment if an appropriately completed report is not received as required by this section.

Subd. 7. **Statewide evaluation.** The commissioner shall use the county and provider reports required by this section to complete the statewide report required in sections 245.461 and 245.487.

HIST: 1987 c 403 art 2 s 36; 1988 c 689 art 2 s 93; 1989 c 89 s 1; 1989 c 282 art 4 s 31; 1991 c 292 art 6 s 58 subd 1 NOTE: Subdivision 1 was also amended by Laws 1989, chapter 89, section 1. The amendment renumbered it to subdivision 2 to read as follows: "Subd. 2. **Fiscal reports.** The commissioner shall develop a unified format for quarterly fiscal reports that will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and section 256E.08."

245.483 TERMINATION OR RETURN OF AN ALLOCATION.

Subdivision 1. **Funds not properly used.** If the commissioner determines that a county is not meeting the requirements of sections 245.461 to 245.486 and 245.487 to 245.4888, or that funds are not being used according to the approved biennial mental health component of the community social services plan, all or part of the mental health and community social service act funds may be terminated upon 30 days notice to the county board. The commissioner may require repayment of any funds not used according to the approved biennial mental health component of the community social services plan. If the commissioner receives a written appeal from the county board within the 30-day period, opportunity for a hearing under the Minnesota administrative procedure act, chapter 14, must be provided before the allocation is terminated or is required to be repaid. The 30-day period begins when the county board receives the commissioner's notice by certified mail.

Subd. 2. **Use of returned funds.** The commissioner may reallocate the funds returned.

Subd. 3. **Delayed payments.** If the commissioner finds that a county board or its contractors are not in compliance with the approved biennial mental health component of the community social services plan or sections 245.461 to 245.486 and 245.487 to 245.4888, the commissioner may delay payment of all or part of the quarterly mental health and community social service act funds until the county board and its contractors meet the requirements. The commissioner shall not delay a payment longer than three months without first issuing a notice under subdivision 2 that all or part of the allocation will be terminated or required to be repaid. After this notice is issued, the commissioner may continue to delay the payment until completion of the hearing in subdivision 2.

Subd. 4. **State assumption of responsibility.** If the commissioner determines that services required by sections 245.461 to 245.486 and 245.487 to 245.4888 will not be provided by the county board in the manner or to the extent required by sections 245.461 to 245.486 and 245.487 to 245.4888, the commissioner shall contract directly with providers to ensure that clients receive appropriate services. In this case, the commissioner shall use the county's community social service act and mental health funds to the extent necessary to carry out the county's responsibilities under sections 245.461 to 245.486 and 245.487 to 245.4888. The commissioner shall work with the county board to allow for a return of authority and responsibility to the county board as soon as compliance with sections 245.461 to 245.486 and 245.487 to 245.4888 can be assured.

HIST: 1987 c 403 art 2 s 37; 1989 c 282 art 4 s 32; 1991 c 94 s 24; 1991 c 292 art 6 s 58 subd 1

245.484 RULES.

The commissioner shall adopt emergency rules to govern implementation of case management services for eligible children in section 245.4881 and professional home-based family treatment services for medical assistance eligible children, in section 245.4884, subdivision 3, by January 1, 1992, and must adopt permanent rules by January 1, 1993.

The commissioner shall adopt permanent rules as necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4888. The commissioner shall reassign agency staff as necessary to meet this deadline.

HIST: 1987 c 403 art 2 s 38; 1989 c 282 art 4 s 33; 1991 c 292 art 6 s 10,58 subd 1

245.485 NO RIGHT OF ACTION.

Sections 245.461 to 245.484 and 245.487 to 245.4888 do not independently establish a right of action on behalf of recipients of services or service providers against a county board or the commissioner. A claim for monetary damages must be brought under section 3.736 or 3.751.

HIST: 1987 c 403 art 2 s 39; 1989 c 282 art 4 s 34; 1991 c 292 art 6 s 58 subd 1

245.486 LIMITED APPROPRIATIONS.

Nothing in sections 245.461 to 245.485 and 245.487 to 245.4888 shall be construed to require the commissioner or county boards to fund services beyond the limits of legislative appropriations.

HIST: 1987 c 403 art 2 s 40; 1989 c 282 art 4 s 35; 1991 c 292 art 6 s 58 subd 1

245.4861 PUBLIC/ACADEMIC LIAISON INITIATIVE.

Subdivision 1. **Establishment of liaison initiative.** The commissioner of human services, in consultation with the appropriate post-secondary institutions, shall establish a public/academic liaison initiative to coordinate and develop brain research and education and training opportunities for mental health professionals in order to improve the quality of staffing and provide state-of-the-art services to residents in regional treatment centers and other state facilities.

Subd. 2. **Consultation.** The commissioner of human services shall consult with the Minnesota department of health, the regional treatment

centers, the post-secondary educational system, mental health professionals, and citizen and advisory groups.

Subd. 3. **Liaison initiative programs.** The liaison initiative, within the extent of available funding, shall plan, implement, and administer programs which accomplish the objectives of subdivision 1. These shall include but are not limited to:

(1) encourage and coordinate joint research efforts between academic research institutions throughout the state and regional treatment centers, community mental health centers, and other organizations conducting research on mental illness or working with individuals who are mentally ill;

(2) sponsor and conduct basic research on mental illness and applied research on existing treatment models and community support programs;

(3) seek to obtain grants for research on mental illness from the National Institute of Mental Health and other funding sources;

(4) develop and provide grants for training, internship, scholarship, and fellowship programs for mental health professionals, in an effort to combine academic education with practical experience obtained at regional treatment centers and other state facilities, and to increase the number of mental health professionals working in the state.

Subd. 4. **Private and federal funding.** The liaison initiative shall seek private and federal funds to supplement the appropriation provided by the state. Individuals, businesses, and other organizations may contribute to the liaison initiative. All money received shall be administered by the commissioner of human services to implement and administer the programs listed in subdivision 3.

Subd. 5. **Report.** By February 15 of each year, the commissioner of human services shall submit to the legislature a liaison initiative report. The annual report shall be part of the commissioner's February 15 report to the legislature required by section 245.487, subdivision 4.

HIST: 1989 c 282 art 4 s 36

MINNESOTA COMPREHENSIVE CHILDREN'S MENTAL HEALTH ACT

245.487 CITATION; DECLARATION OF POLICY; MISSION.

Subdivision 1. **Citation.** Sections 245.487 to 245.4888 may be cited as the "Minnesota comprehensive children's mental health act."

Subd. 2. **Findings.** The legislature finds there is a need for further development of existing clinical services for emotionally disturbed children and their families and the creation of new services for this population. Although the services specified in sections 245.487 to 245.4888 are mental health services, sections 245.487 to 245.4888 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for continuity of care with other community agencies. At the same time, sections 245.487 to 245.4888 emphasize the importance of developing special mental health expertise in children's mental health services because of the unique needs of this population.

Nothing in this act shall be construed to abridge the authority of the court to make dispositions under chapter 260, but the mental health services due any child with serious and persistent mental illness, as defined in section 245.462, subdivision 20, or with severe emotional disturbance, as defined in section 245.4871, subdivision 6, shall be made a part of any disposition affecting that child.

Subd. 3. **Mission of children's mental health service system.** As part of the comprehensive children's mental health system established under sections 245.487 to 245.4888, the commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that is consistent with the provision of public social services for children as specified in section 256F.01 and that:

(1) identifies children who are eligible for mental health services;

(2) makes preventive services available to all children;

(3) assures access to a continuum of services that:

(i) educate the community about the mental health needs of children;

(ii) address the unique physical, emotional, social, and educational needs of children;

(iii) are coordinated with the range of social and human services provided to children and their families by the departments of education, human services, health, and corrections;

(iv) are appropriate to the developmental needs of children; and

(v) are sensitive to cultural differences and special needs;

(4) includes early screening and prompt intervention to:

(i) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and

(ii) prevent further deterioration;

(5) provides mental health services to children and their families in the context in which the children live and go to school;

(6) addresses the unique problems of paying for mental health services for children, including:

(i) access to private insurance coverage; and

(ii) public funding;

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

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

Subd. 4. **Implementation.** (a) The commissioner shall begin implementing sections 245.487 to 245.4888 by February 15, 1990, and shall fully implement sections 245.487 to 245.4888 by July 1, 1993.

(b) Annually until February 15, 1994, the commissioner shall report to the legislature on all steps taken and recommendations for full implementation of sections 245.487 to 245.4888 and on additional resources needed to further implement those sections. The report shall include information on county and state progress in identifying the needs of cultural and racial minorities and in using special mental health consultants to meet these needs.

Subd. 5. **Continuation of existing mental health services for children.** Counties shall make available case management, community support services, and day treatment to children eligible to receive these services under Minnesota Statutes 1988, section 245.471. No later than August 1, 1989, the county board shall notify providers in the local system of care of their obligations to refer children eligible for case management and community support services as of January 1, 1989. The county board shall forward a copy of this notice to the commissioner. The notice shall indicate which children are eligible, a description of the services, and the name of the county employee designated to coordinate case management activities and shall include a copy of the plain language notification described in section 245.4881, subdivision 2, paragraph (b). Providers shall distribute copies of this notification when making a referral for case management.

Subd. 6. **Funding from the federal government and other sources.** The commissioner shall seek and apply for federal and other nonstate, nonlocal government funding for mental health services specified in sections 245.487 to 245.4888, in order to maximize nonstate, nonlocal dollars for these services.

HIST: 1989 c 282 art 4 s 37; 1990 c 568 art 5 s 9,10; 1991 c 292 art 6 s 11,12,58 subd 1

245.4871 DEFINITIONS.

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.487 to 245.4888.

Subd. 2. **Acute care hospital inpatient treatment.** "Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with severe emotional disturbance and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, if needed, developing a functional assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and

effectiveness of services over time.

Subd. 4. **Case manager.** (a) "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family. A case manager must have experience and training in working with children.

(b) A case manager must:

(1) have at least a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university;

(2) have at least 2,000 hours of supervised experience in the delivery of mental health services to children;

(3) have experience and training in identifying and assessing a wide range of children's needs; and

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families.

(c) The case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) The case manager must meet in person with a mental health professional at least once each month to obtain clinical supervision.

(e) Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of experience is met.

(f) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(g) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(h) Until June 30, 1991, a refugee who does not have the qualifications specified in this subdivision may provide case management services to child refugees with severe emotional disturbance of the same ethnic group as the refugee if the person:

(1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Subd. 5. **Child.** "Child" means a person under 18 years of age.

Subd. 6. **Child with severe emotional disturbance.** For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment

for an emotional disturbance; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of an emotional disturbance; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

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

The term "child with severe emotional disturbance" shall be used only for purposes of county eligibility determinations. In all other written and oral communications, case managers, mental health professionals, mental health practitioners, and all other providers of mental health services shall use the term "child eligible for mental health case management" in place of "child with severe emotional disturbance."

Subd. 7. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision does not include authority to make or terminate court-ordered placements of the child. Clinical supervision must be accomplished by full-time or part-time employment of or contracts with mental health professionals. The mental health professional must document the clinical supervision by cosigning individual treatment plans and by making entries in the client's record on supervisory activities.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 9. **County board.** "County board" means the county board of commissioners or board established under the joint powers act, section 471.59, or the human services board act, sections 402.01 to 402.10.

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; or

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. The services are aimed at stabilizing the

child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services. Day treatment services for a child are an integrated set of education, therapy, and family interventions.

A day treatment service must be available to a child at least five days a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Subd. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written evaluation by a mental health professional of:

(1) a child's current life situation and sources of stress, including reasons for referral;

(2) the history of the child's current mental health problem or problems, including important developmental incidents, strengths, and vulnerabilities;

(3) the child's current functioning and symptoms;

(4) the child's diagnosis including a determination of whether the child meets the criteria of severely emotionally disturbed as specified in subdivision 6; and

(5) the mental health services needed by the child.

Subd. 12. **Early identification and intervention services.** "Early identification and intervention services" means services that are designed to identify children who are at risk of needing or who need mental health services and that arrange for intervention and treatment.

Subd. 13. **Education and prevention services.** (a) "Education and prevention services" means services designed to:

(1) educate the general public and groups identified as at risk of developing emotional disturbance under section 245.4872, subdivision 3;

(2) increase the understanding and acceptance of problems associated with emotional disturbances;

(3) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning; and

(4) refer specific children or their families with mental health needs to mental health services.

(b) The services include distribution to individuals and agencies identified by the county board and the local children's mental health advisory council of information on predictors and symptoms of emotional disturbances, where mental health services are available in the county, and how to access the services.

Subd. 14. **Emergency services.** "Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for each child having a psychiatric crisis, a mental health crisis, or a mental health emergency.

Subd. 15. **Emotional disturbance.** "Emotional disturbance" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements,

work, school, and recreation.

"Emotional disturbance" is a generic term and is intended to reflect all categories of disorder described in DSM-MD, current edition as "usually first evident in childhood or adolescence."

Subd. 16. **Family.** "Family" means a child and one or more of the following persons whose participation is necessary to accomplish the child's treatment goals: (1) a person related to the child by blood, marriage, or adoption; (2) a person who is the child's foster parent or significant other; (3) a person who is the child's legal representative.

Subd. 17. **Family community support services.** "Family community support services" means services provided under the clinical supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis assistance, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Subd. 18. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the child's:

(1) mental health symptoms as presented in the child's diagnostic assessment;

(2) mental health needs as presented in the child's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the child's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Subd. 19. **Individual family community support plan.** "Individual family community support plan" means a written plan developed by a case manager in conjunction with the family and the child with severe emotional disturbance on the basis of a diagnostic assessment and a functional assessment. The plan identifies specific services needed by a child and the child's family to:

(1) treat the symptoms and dysfunctions determined in the diagnostic

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

Subd. 20. **Individual placement agreement.** "Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of a child to provide residential treatment services.

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance.

Subd. 22. **Legal representative.** "Legal representative" means a guardian, conservator, or guardian ad litem of a child with an emotional disturbance authorized by the court to make decisions about mental health services for the child.

Subd. 23. Repealed, 1991 c 94 s 25

Subd. 24. **Local system of care.** "Local system of care" means services that are locally available to the child and the child's family. The services are mental health, social services, correctional services, education services, health services, and vocational services.

Subd. 25. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under sections 256D.06 and 256D.37 to facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a person providing services to children with emotional disturbances. A mental health practitioner must have training and experience in working with children. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and has at least 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances;

(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or

(4) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of emotional disturbance.

Subd. 27. **Mental health professional.** "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by the American nurses association or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be a psychologist licensed under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry; or

(5) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

Subd. 28. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to children with emotional disturbances and are described in sections 245.487 to 245.4888.

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the clinical supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 30. **Parent.** "Parent" means the birth or adoptive mother or father of a child. This definition does not apply to a person whose parental rights have been terminated in relation to the child.

Subd. 31. **Professional home-based family treatment.** "Professional home-based family treatment" means intensive mental health services provided to children because of an emotional disturbance (1) who are at risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement. Services are provided

to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis assistance, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 9545.0900 to 9545.1090, or other rules adopted by the commissioner.

Subd. 33. **Service provider.** "Service provider" means either a county board or an individual or agency including a regional treatment center under contract with the county board that provides children's mental health services funded under sections 245.487 to 245.4888.

Subd. 33a. **Special mental health consultant.** "Special mental health consultant" is a mental health practitioner or professional with special expertise in treating children from a particular cultural or racial minority group.

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and clinical supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning.

HIST: 1989 c 282 art 4 s 38; 1990 c 568 art 5 s 11,34; 1991 c 292 art 6 s 13-15,58 subd 1

245.4872 PLANNING FOR A CHILDREN'S MENTAL HEALTH SYSTEM.

Subdivision 1. **Planning effort.** Starting on the effective date of sections 245.487 to 245.4888 and ending January 1, 1992, the commissioner and the county agencies shall plan for the development of a unified, accountable, and comprehensive statewide children's mental health system. The system must be planned and developed by stages until it is operating at full capacity.

Subd. 2. **Technical assistance.** The commissioner shall provide ongoing technical assistance to county boards to develop the children's mental health component of the community social services plan, as specified in section 245.4888, to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of children with emotional disturbances residing in the county and the extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning

information upon request.

Subd. 3. **Information to counties.** By January 1, 1990, the commissioner shall provide each county with information about the predictors and symptoms of children's emotional disturbances and information about groups identified as at risk of developing emotional disturbance.

HIST: 1989 c 282 art 4 s 39; 1991 c 94 s 24; 1991 c 292 art 6 s 58 subd 1

245.4873 COORDINATION OF CHILDREN'S MENTAL HEALTH SYSTEM.

Subdivision 1. **State and local coordination.** Coordination of the development and delivery of mental health services for children shall occur on the state and local levels to assure the availability of services to meet the mental health needs of children in a cost-effective manner.

Subd. 2. **State level; coordination.** The commissioners or designees of commissioners of the departments of human services, health, education, state planning, and corrections, and a representative of the Minnesota district judges association juvenile committee, in conjunction with the commissioner of commerce or a designee of the commissioner, shall meet at least quarterly to:

(1) educate each agency about the policies, procedures, funding, and services for children with emotional disturbances of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with emotional disturbances;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent;

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children; and

(6) until February 15, 1992, prepare an annual report on the policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.

This report shall be submitted to the legislature and the state mental health advisory council annually as part of the report required under section 245.487, subdivision 4. The report shall include information from each department represented on:

(1) the number of children in each department's system who require mental health services;

(2) the number of children in each system who receive mental health services;

(3) how mental health services for children are funded within each system;

(4) how mental health services for children could be coordinated to provide more effectively appropriate mental health services for children; and

(5) recommendations for the provision of early screening and identification of mental illness in each system.

Subd. 3. **Local level coordination.** (a) Each agency represented in the local system of care coordinating council, including mental health, social services, education, health, corrections, and vocational services

as specified in section 245.4875, subdivision 6, is responsible for local coordination and delivery of mental health services for children. The county board shall establish a coordinating council that provides at least:

(1) written interagency agreements with the providers of the local system of care to coordinate the delivery of services to children; and

(2) an annual report of the council to the local county board and the children's mental health advisory council about the unmet children's needs and service priorities.

(b) Each coordinating council shall collect information about the local system of care and report annually to the commissioner of human services on forms and in the manner provided by the commissioner. The report must include a description of the services provided through each of the service systems represented on the council, the various sources of funding for services and the amounts actually expended, a description of the numbers and characteristics of the children and families served during the previous year, and an estimate of unmet needs. Each service system represented on the council shall provide information to the council as necessary to compile the report.

Subd. 4. **Individual case coordination.** The case manager designated under section 245.4881 is responsible for ongoing coordination with any other person responsible for planning, development, and delivery of social services, education, corrections, health, or vocational services for the individual child. The family community support plan developed by the case manager shall reflect the coordination among the local service system providers.

Subd. 5. **Duties of the commissioner.** The commissioner shall supervise the development and coordination of locally available children's mental health services by the county boards in a manner consistent with sections 245.487 to 245.4888. The commissioner shall review the children's mental health component of the community social services plan developed by county boards as specified in section 245.4872 and provide technical assistance to county boards in developing and maintaining locally available and coordinated children's mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's children's mental health proposals and other information as required by sections 245.487 to 245.4888.

Subd. 6. **Priorities.** By January 1, 1992, the commissioner shall require that each of the treatment services and management activities described in sections 245.487 to 245.4888 be developed for children with emotional disturbances within available resources based on the following ranked priorities. The commissioner shall reassign agency staff and use consultants as necessary to meet this deadline:

(1) the provision of locally available mental health emergency services;

(2) the provision of locally available mental health services to all children with severe emotional disturbance;

(3) the provision of early identification and intervention services to children who are at risk of needing or who need mental health services;

(4) the provision of specialized mental health services regionally available to meet the special needs of all children with severe emotional disturbance, and all children with emotional disturbances;

(5) the provision of locally available services to children with

emotional disturbances; and

(6) the provision of education and preventive mental health services.

HIST: 1989 c 282 art 4 s 40; 1990 c 568 art 5 s 12; 1991 c 94 s 24; 1991 c 292 art 6 s 16,58 subd 1

245.4874 DUTIES OF COUNTY BOARD.

The county board in each county shall use its share of mental health and community social services act funds allocated by the commissioner according to a biennial children's mental health component of the community social services plan required under section 245.4888, and approved by the commissioner. The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4888;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) develop a biennial children's mental health component of the community social services plan required under section 256E.09 which considers the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4888;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4888 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4888;

(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age; and

(13) assure that special mental health consultants are used as

necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage.

HIST: 1989 c 282 art 4 s 41; 1990 c 568 art 5 s 13; 1991 c 94 s 6; 1991 c 292 art 6 s 17,58 subd 1

245.4875 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision 1. **Development of children's services.** The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable children's mental health services. The county board may provide some or all of the children's mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward fully implementing sections 245.487 to 245.4888 during the period July 1, 1989, to January 1, 1992. County boards must develop fully each of the treatment services prescribed by sections 245.487 to 245.4888 by January 1, 1992, according to the priorities established in section 245.4873 and the children's mental health component of the community social services plan approved by the commissioner under section 245.4888.

Subd. 2. **Children's mental health services.** The children's mental health service system developed by each county board must include the following services:

(1) education and prevention services according to section 245.4877;

(2) early identification and intervention services according to section 245.4878;

(3) emergency services according to section 245.4879;

(4) outpatient services according to section 245.488;

(5) family community support services according to section 245.4881;

(6) day treatment services according to section 245.4884, subdivision 2;

(7) residential treatment services according to section 245.4882;

(8) acute care hospital inpatient treatment services according to section 245.4883;

(9) screening according to section 245.4885;

(10) case management according to section 245.4881;

(11) therapeutic support of foster care according to section 245.4884, subdivision 4; and

(12) professional home-based family treatment according to section 245.4884, subdivision 4.

Subd. 3. **Local contracts.** The county board shall review all proposed county agreements, grants, or other contracts related to children's mental health services from any local, state, or federal governmental sources. Contracts with service providers must:

(1) name the commissioner as a third party beneficiary;

(2) identify monitoring and evaluation procedures not in violation of the Minnesota government data practices act, chapter 13, which are necessary to ensure effective delivery of quality services;

(3) include a provision that makes payments conditional on compliance

by the contractor and all subcontractors with sections 245.487 to 245.4888 and all other applicable laws, rules, and standards; and

(4) require financial controls and auditing procedures.

Subd. 4. **Joint county mental health agreements.** To efficiently provide the children's mental health services required by sections 245.487 to 245.4888, counties are encouraged to join with one or more county boards to establish a multicounty local children's mental health authority under the joint powers act, section 471.59, the human services board act, sections 402.01 to 402.10, community mental health center provisions, section 245.62, or enter into multicounty mental health agreements. Participating county boards shall establish acceptable ways of apportioning the cost of the services.

Subd. 5. **Local children's advisory council.** (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with severe emotional disturbance; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with emotional disturbance in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county to be included in the county's biennial children's mental health component of the community social services plan required under section 256E.09, and participate in developing the mental health component of the plan.

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Subd. 6. **Local system of care; coordinating council.** The county board shall establish, by January 1, 1990, a council representing all

members of the local system of care including mental health services,, social services, correctional services, education services, health services, and vocational services. The council shall include a representative of an Indian reservation authority where a reservation exists within the county. When possible, the council must also include a representative of juvenile court or the court responsible for juvenile issues and law enforcement. The members of the coordinating council shall meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. A county may use an existing child-focused interagency task force to fulfill the requirements of this subdivision if the representatives and duties of the existing task force are expanded to include those specified in this subdivision and section 245.4873, subdivision 3.

Subd. 7. **Other local authority.** The county board may establish procedures and policies that are not contrary to those of the commissioner or sections 245.487 to 245.4888 regarding local children's mental health services and facilities. The county board shall perform other acts necessary to carry out sections 245.487 to 245.4888.

HIST: 1989 c 282 art 4 s 42; 1990 c 568 art 5 s 14,34; 1991 c 94 s 7,24; 1991 c 292 art 6 s 58 subd 1

245.4876 QUALITY OF SERVICES.

Subdivision 1. **Criteria.** Children's mental health services required by sections 245.487 to 245.4888 must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;

(3) delivered in a manner that improves family functioning when clinically appropriate;

(4) provided in the most appropriate, least restrictive setting available to the county board to meet the child's treatment needs;

(5) accessible to all age groups of children;

(6) appropriate to the developmental age of the child being served;

(7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;

(8) provided by qualified individuals as required in sections 245.487 to 245.4888;

(9) coordinated with children's mental health services offered by other providers;

(10) provided under conditions that protect the rights and dignity of the individuals being served; and

(11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Subd. 2. **Diagnostic assessment.** All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of outpatient and day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is

necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance or general assistance medical care reimbursement under chapters 256B and 256D.

Subd. 3. **Individual treatment plans.** All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in section 257.071, subdivisions 2 and 4. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.

Subd. 4. **Referral for case management.** Each provider of emergency services, outpatient treatment, community support services, family community support services, day treatment services, screening under section 245.4885, professional home-based family treatment services, residential treatment facilities, acute care hospital inpatient treatment facilities, or regional treatment center services must inform each child with severe emotional disturbance, and the child's parent or legal representative, of the availability and potential benefits to the child of case management. The information shall be provided as specified in subdivision 5. If consent is obtained according to subdivision 5, the provider must refer the child by notifying the county employee designated by the county board to coordinate case management activities of the child's name and address and by informing the child's family of whom to contact to request case management. The provider must document compliance with this subdivision in the child's record. The parent or child may directly request case management even if there has been no referral.

Subd. 5. **Consent for services or for release of information.** (a) Although sections 245.487 to 245.4888 require each county board, within the limits of available resources, to make the mental health services listed in those sections available to each child residing in the county

who needs them, the county board shall not provide any services, either directly or by contract, unless consent to the services is obtained under this subdivision. The case manager assigned to a child with a severe emotional disturbance shall not disclose to any person other than the case manager's immediate supervisor and the mental health professional providing clinical supervision of the case manager information on the child, the child's family, or services provided to the child or the child's family without informed written consent unless required to do so by statute or under the Minnesota government data practices act. Informed written consent must comply with section 13.05, subdivision 4, paragraph (d), and specify the purpose and use for which the case manager may disclose the information.

(b) The consent or authorization must be obtained from the child's parent unless: (1) the parental rights are terminated; or (2) consent is otherwise provided under sections 144.341 to 144.347; 253B.04, subdivision 1; 260.133; 260.135; and 260.191, subdivision 1, the terms of appointment of a court-appointed guardian or conservator, or federal regulations governing chemical dependency services.

Subd. 6. **Information for billing.** Each provider of outpatient treatment, family community support services, day treatment services, emergency services, professional home-based family treatment services, residential treatment, or acute care hospital inpatient treatment must include the name and home address of each child for whom services are included on a bill submitted to a county, if the release of that information under subdivision 5 has been obtained and if the county requests the information. Each provider must try to obtain the consent of the child's family. Each provider must explain to the child's family that the information can only be released with the consent of the child's family and may be used only for purposes of payment and maintaining provider accountability. The provider shall document the attempt in the child's record.

Subd. 7. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of children receiving mental health services and their families are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; and

(2) staff who provide treatment services or case management and their clinical supervisors.

Release of mental health data on individuals submitted under subdivisions 5 and 6, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 5 and 6, results in civil or criminal liability under section 13.08 or 13.09.

HIST: 1989 c 282 art 4 s 43; 1990 c 568 art 5 s 15-17; 1991 c 292 art 6 s 58 subd 1

245.4877 EDUCATION AND PREVENTION SERVICES.

Education and prevention services must be available to all children residing in the county. Education and prevention services must be designed to:

(1) convey information regarding emotional disturbances, mental health needs, and treatment resources to the general public and groups identified as at high risk of developing emotional disturbance under section 245.4872, subdivision 3;

(2) at least annually, distribute to individuals and agencies

identified by the county board and the local children's mental health advisory council information on predictors and symptoms of emotional disturbances, where mental health services are available in the county, and how to access the services;

(3) increase understanding and acceptance of problems associated with emotional disturbances;

(4) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning;

(5) prevent development or deepening of emotional disturbances; and

(6) refer each child with emotional disturbance or the child's family with additional mental health needs to appropriate mental health services.

HIST: 1989 c 282 art 4 s 44

245.4878 EARLY IDENTIFICATION AND INTERVENTION.

By January 1, 1991, early identification and intervention services must be available to meet the needs of all children and their families residing in the county, consistent with section 245.4873. Early identification and intervention services must be designed to identify children who are at risk of needing or who need mental health services. The county board must provide intervention and offer treatment services to each child who is identified as needing mental health services. The county board must offer intervention services to each child who is identified as being at risk of needing mental health services.

HIST: 1989 c 282 art 4 s 45

245.4879 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for enough mental health emergency services within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;

(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;

(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who

receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

HIST: 1989 c 282 art 4 s 46; 1990 c 568 art 5 s 18; 1991 c 312 s 2

245.488 OUTPATIENT SERVICES.

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; or by contract with a licensed mental health professional as defined in section 245.4871, subdivision 27, clauses (1) to (4). A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;
(2) conducting psychological testing;
(3) developing or modifying individual treatment plans;
(4) making referrals and recommending placements as appropriate;
(5) treating the child's mental health needs through therapy; and
(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Subd. 2. **Specific requirements.** The county board shall require that a service provider of outpatient services to children:

(1) meets the professional qualifications contained in sections 245.487 to 245.4888;

(2) uses a multidisciplinary mental health professional staff including, at a minimum, arrangements for psychiatric consultation, licensed consulting psychologist consultation, and other necessary multidisciplinary mental health professionals;

(3) develops individual treatment plans; and

(4) provides initial appointments within three weeks, except in emergencies where there must be immediate access as described in section 245.4879.

HIST: 1989 c 282 art 4 s 47; 1990 c 568 art 2 s 39; 1991 c 292 art 6 s 58 subd 1

245.4881 CASE MANAGEMENT AND FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. **Availability of case management services.** (a) By April 1, 1992, the county board shall provide case management services for each child with severe emotional disturbance who is a resident of the county and the child's family who request or consent to the services. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Except as permitted by law and the commissioner under demonstration projects, case management services provided to children with severe emotional disturbance eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

Subd. 2. **Notification and determination of case management eligibility.** (a) The county board shall notify, as appropriate, the child, child's parent, or child's legal representative of the child's potential eligibility for case management services within five working days after receiving a request from an individual or a referral from a provider under section 245.4876, subdivision 4.

(b) The county board shall send a notification written in plain language of potential eligibility for case management and family community support services. The notification shall identify the designated case management providers and shall contain:

(1) a brief description of case management and family community support services;

(2) the potential benefits of these services;

(3) the identity and current phone number of the county employee designated to coordinate case management activities;

(4) an explanation of how to obtain county assistance in obtaining a diagnostic assessment, if needed; and

(5) an explanation of the appeal process.

The county board shall send the notice, as appropriate, to the child, the child's parent, or the child's legal representative, if any.

(c) The county board must promptly determine whether a child who requests or is referred for case management services meets the criteria of section 245.471 or 245.4871, subdivision 6. If a diagnostic assessment is needed to make the determination, the county board must offer to assist the child and the child's family in obtaining one. The county board shall notify, in writing, the child and the child's representative, if any, of the eligibility determination. If the child is determined to be eligible for case management services, and if the child and the child's family consent to the services, the county board shall refer the child to the case management provider for case management services. If the child is determined not to be eligible or refuses case management services, the county board shall notify the child of the appeal process and shall offer to refer the child to a mental health provider or other appropriate service provider and to assist the child in making an appointment with the provider of the child's choice.

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall complete a written functional assessment according to section 245.4871, subdivision 18. The case manager shall develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The information required under section 245.4886 shall be provided in writing to the child and the child's family. The case manager shall note this provision in the child's record.

Subd. 4. **Individual family community support plan.** (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan every 90 calendar days after it is developed. To the extent appropriate, the child with severe emotional disturbance, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of an individual family community

support plan, the case manager shall assist the child and child's family in accessing the needed services listed in section 245.4884, subdivision 1.

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

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual family community support plan.

Subd. 5. **Coordination between case manager and family community support services.** The county board must establish procedures that ensure ongoing contact and coordination between the case manager and the family community support services as well as other mental health services for each child.

Subd. 6. Repealed, 1990 c 568 art 5 s 35

Subd. 7. Repealed, 1990 c 568 art 5 s 35

Subd. 8. Repealed, 1990 c 568 art 5 s 35

Subd. 9. Repealed, 1990 c 568 art 5 s 35

Subd. 10. Repealed, 1990 c 568 art 5 s 35

HIST: 1989 c 282 art 4 s 48; 1990 c 568 art 5 s 19-22,34; 1991 c 292 art 6 s 18

245.4882 RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with severe emotional disturbance residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be subject to the six-month review process established in section 257.071, subdivisions 2 and 4. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs;

(2) help the child improve family living and social interaction skills;

(3) help the child gain the necessary skills to return to the community;

(4) stabilize crisis admissions; and

(5) work with families throughout the placement to improve the ability of the families to care for children with severe emotional disturbance in the home.

Subd. 2. **Specific requirements.** A provider of residential services to children must be licensed under applicable rules adopted by the commissioner and must be clinically supervised by a mental health professional.

Subd. 3. **Transition to community.** Residential treatment facilities and regional treatment centers serving children must plan for and assist those children and their families in making a transition to less restrictive community-based services. Residential treatment facilities must also arrange for appropriate follow-up care in the community. Before a child is discharged, the residential treatment facility or regional treatment center shall provide notification to the child's case

manager, if any, so that the case manager can monitor and coordinate the transition and make timely arrangements for the child's appropriate follow-up care in the community.

Subd. 4. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for residential treatment services are based on the clinical needs of the child. The county board shall ensure that each entity under contract to provide residential treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts shall specify specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. The county board shall ensure that, at least ten days prior to discharge, the operator of the residential treatment facility shall provide written notification of the discharge to the child's parent or caretaker, the local education agency in which the child is enrolled, and the receiving education agency to which the child will be transferred upon discharge. When the child has an individual education plan, the notice shall include a copy of the individual education plan. All contracts for the provision of residential services must include provisions guaranteeing clients the right to appeal under section 245.4887 and to be advised of their appeal rights.

Subd. 5. **Specialized residential treatment services.** The commissioner of human services shall establish or contract for specialized residential treatment services for children. The services shall be designed for children with emotional disturbance who exhibit violent or destructive behavior and for whom local treatment services are not feasible due to the small number of children statewide who need the services and the specialized nature of the services required. The services shall be located in community settings. If no appropriate services are available in Minnesota or within the geographical area in which the residents of the county normally do business, the commissioner is responsible for 50 percent of the nonfederal costs of out-of-state treatment of children for whom no appropriate resources are available in Minnesota. Counties are eligible to receive enhanced state funding under this section only if they have established juvenile screening teams under section 260.151, subdivision 3.

HIST: 1989 c 282 art 4 s 49; 1990 c 568 art 5 s 23; 1991 c 292 art 6 s 19,20,58 subd 1 NOTE: Subdivision 5, as added by Laws 1991, chapter 292, article 6, section 20, is effective July 1, 1993. See Laws 1991, chapter 292, article 6, section 61, subdivision 2.

245.4883 ACUTE CARE HOSPITAL INPATIENT SERVICES.

Subdivision 1. **Availability of acute care hospital inpatient services.** County boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for children with severe emotional disturbances residing in the county needing this level of care. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible;

(3) facilitate appropriate referrals for follow-up mental health care in the community;

(4) work with families to improve the ability of the families to care for those children with severe emotional disturbances at home; and

(5) assist families and children in the transition from inpatient services to community-based services or home setting, and provide notification to the child's case manager, if any, so that the case manager can monitor the transition and make timely arrangements for the child's appropriate follow-up care in the community.

Subd. 2. **Specific requirements.** Providers of acute care hospital inpatient services for children must meet applicable standards established by the commissioners of health and human services.

Subd. 3. **Admission, continued stay, and discharge criteria.** No later than January 1, 1992, the county board shall ensure that placement decisions for acute care hospital inpatient treatment services are based on the clinical needs of the child and, if appropriate, the child's family. The county board shall ensure that each entity under contract with the county to provide acute care hospital treatment services has admission, continued stay, discharge criteria and discharge planning criteria as part of the contract. Contracts should specify the specific responsibilities between the county and service providers to ensure comprehensive planning and continuity of care between needed services according to data privacy requirements. All contracts for the provision of acute care hospital inpatient treatment services must include provisions guaranteeing clients the right to appeal under section 245.4887 and to be advised of their appeal rights.

HIST: 1989 c 282 art 4 s 50; 1990 c 568 art 5 s 24; 1991 c 292 art 6 s 21

245.4884 FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. **Availability of family community support services.** By July 1, 1991, county boards must provide or contract for sufficient family community support services within the county to meet the needs of each child with severe emotional disturbance who resides in the county and the child's family. Children or their parents may be required to pay a fee in accordance with section 245.481.

Family community support services must be designed to improve the ability of children with severe emotional disturbance to:

(1) manage basic activities of daily living;

(2) function appropriately in home, school, and community settings;

(3) participate in leisure time or community youth activities;

(4) set goals and plans;

(5) reside with the family in the community;

(6) participate in after-school and summer activities;

(7) make a smooth transition among mental health and education services provided to children; and

(8) make a smooth transition into the adult mental health system as appropriate.

In addition, family community support services must be designed to improve overall family functioning if clinically appropriate to the child's needs, and to reduce the need for and use of placements more intensive, costly, or restrictive both in the number of admissions and lengths of stay than indicated by the child's diagnostic assessment.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be part of the family community support services available to each child with severe emotional disturbance residing in the county. A child or the child's parent may be required to pay a fee according to section

245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placements that are more intensive, costly, or restrictive than necessary to meet the child's need;

(4) coordinate with or be offered in conjunction with the child's education program;

(5) provide therapy and family intervention for children that are coordinated with education services provided and funded by schools; and

(6) operate during all 12 months of the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) alternative services exist through the county's family community support services for each child who would otherwise need day treatment services; and

(2) county demographics and geography make the provision of day treatment services cost ineffective and unfeasible.

Subd. 3. **Professional home-based family treatment provided.** (a) By January 1, 1991, county boards must provide or contract for sufficient professional home-based family treatment within the county to meet the needs of each child with severe emotional disturbance who is at risk of out-of-home placement due to the child's emotional disturbance or who is returning to the home from out-of-home placement. The child or the child's parent may be required to pay a fee according to section 245.481. The county board shall require that all service providers of professional home-based family treatment set fee schedules approved by the county board that are based on the child's or family's ability to pay. The professional home-based family treatment must be designed to assist each child with severe emotional disturbance who is at risk of or who is returning from out-of-home placement and the child's family to:

(1) improve overall family functioning in all areas of life;

(2) treat the child's symptoms of emotional disturbance that contribute to a risk of out-of-home placement;

(3) provide a positive change in the emotional, behavioral, and mental well-being of children and their families; and

(4) reduce risk of out-of-home placement for the identified child with severe emotional disturbance and other siblings or successfully reunify and reintegrate into the family a child returning from out-of-home placement due to emotional disturbance.

(b) Professional home-based family treatment must be provided by a team consisting of a mental health professional and others who are skilled in the delivery of mental health services to children and families in conjunction with other human service providers. The professional home-based family treatment team must maintain flexible hours of service availability and must provide or arrange for crisis services for each family, 24 hours a day, seven days a week. Case loads for each professional home-based family treatment team must be small enough to permit the delivery of intensive services and to meet the needs of the family. Professional home-based family treatment providers shall coordinate services and service needs with case managers assigned to children and their families. The treatment team must develop an individual treatment plan that identifies the specific treatment objectives for both the child and the family.

Subd. 4. **Therapeutic support of foster care.** By January 1, 1992, county boards must provide or contract for foster care with therapeutic

support as defined in section 245.4871, subdivision 34. Foster families caring for children with severe emotional disturbance must receive training and supportive services, as necessary, at no cost to the foster families within the limits of available resources.

Subd. 5. **Benefits assistance.** The county board must offer help to a child with severe emotional disturbance and the child's family in applying for federal benefits, including supplemental security income, medical assistance, and Medicare.

HIST: 1990 c 568 art 5 s 25; 1991 c 292 art 6 s 22

245.4885 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subdivision 1. **Screening required.** The county board shall, prior to admission, except in the case of emergency admission, screen all children referred for treatment of severe emotional disturbance to a residential treatment facility or informally admitted to a regional treatment center if public funds are used to pay for the services. The county board shall also screen all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within three working days of admission. Screening shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's need.

Screening shall include both a diagnostic assessment and a functional assessment which evaluates family, school, and community living situations. If a diagnostic assessment or functional assessment has been completed by a mental health professional within 180 days, a new diagnostic or functional assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the screening process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the screening process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

Screening shall be in compliance with section 256F.07 or 257.071, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.

The screening process, and placement decision, and recommendations for mental health services must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been

established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

Subd. 2. **Qualifications.** No later than July 1, 1991, screening of children for residential and inpatient services must be conducted by a mental health professional. Where appropriate and available, special mental health consultants must participate in the screening. Mental health professionals providing screening for inpatient and residential services must not be financially affiliated with any acute care inpatient hospital, residential treatment facility, or regional treatment center. The commissioner may waive this requirement for mental health professional participation after July 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service; and

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional.

Subd. 3. **Individual placement agreement.** The county board shall enter into an individual placement agreement with a provider of residential treatment services to a child eligible for county-paid services under this section. The agreement must specify the payment rate and terms and conditions of county payment for the placement.

Subd. 4. **Task force on residential and inpatient treatment services for children.** The commissioner of human services shall appoint a task force on residential and inpatient treatment services for children that includes representatives from each of the mental health professional categories defined in section 245.4871, subdivision 27, the Minnesota mental health association, the Minnesota alliance for the mentally ill, the children's mental health initiative, the Minnesota mental health law project, the Minnesota district judges association juvenile committee, department of human services staff, the department of education, local community-based corrections, the department of corrections, the ombudsman for mental health and mental retardation, residential treatment facilities for children, inpatient hospital facilities for children, and counties. The task force shall examine and evaluate existing and available mechanisms that have as their purpose determination of and review of appropriate admission and need for continued care for all children with emotional disturbances who are admitted to residential treatment facilities or acute care hospital inpatient treatment. These mechanisms shall include at least the following: precommitment screening, preplacement screening for children, licensure and reimbursement rules, county monitoring, technical assistance, hospital preadmission certification, and hospital retrospective reviews. The task force shall report to the legislature by February 15, 1990, on how existing mechanisms may be changed to accomplish the goals of screening as described in section 245.4885, subdivision 1.

Subd. 5. **Summary data collection.** The county board shall annually collect summary information on the number of children screened, the age and racial or ethnic background of the children, the presenting problem, and the screening recommendations. The county shall include information on the degree to which these recommendations are followed and the reasons for not following recommendations. Summary data shall be available to the public and shall be used by the county board and local

MANDATE REFORM BILL

Laws of Minnesota 1991, Chapter 94

(To receive a copy of the *Mandate Reform Bill* call Neil Doughty, Department of Human Services (612) 296 2113)

In the summer of 1990, the Department of Human Services (DHS) conducted a study of all social services mandates. The study resulted in the development of two major documents: the Report on Social Services Mandates and the Social Services Mandates Catalog. In response to the findings in the Social Services Mandates Report, DHS developed the Mandate Reform Bill. The bill took effect on August 1, 1991 and is referred to below as the *Mandate Reform Act (1991).*

The *Mandate Reform Act* is designed to:

A. Facilitate the consolidation of Mental Health and Community Social Services Act (CSSA) planning in the following ways:

- **-change the mental health plan or proposal to a component of the CSSA plan;**
- -eliminate the separate planning requirements for mental health programs; and,
- -standardize the timelines for submittal and approval of the plan components and Rule 14 grants.

B. Simplify the CSSA plan by reducing the number of required elements in the plan and clarifying the approval process

C. Provide feedback to the legislature through the biennial social services plan on difficult aspects of social services administrative requirements, social services requirements that are inadequately funded, and unmet needs of specific counties.

D. Provide the commissioner with the authority to review social services administrative rules and adopt amendments to reduce administrative costs and complexity.

E. Provide the commissioner with the authority to establish demonstration projects designed to test planning and service models that are less complex and costly to administer. For the purposes of these demonstration projects, the commissioner is

allowed to waive administrative rule requirements.

F. Provide counties that are in financial difficulty with a means to limit services if the county can show that they have made reasonable efforts to comply with administrative rules and have developed an amended CSSA plan.

Mandate Reform Act Update

The Department of Human Services established a Mandate Reform Implementation Team to advise the commissioner on issues related to the implementation of the *Mandate Reform Act* . Work groups to assist in analyzing issues and developing proposals have been convened. Additional county, state and staff from other agencies and organizations have been participating in the following work groups:

- Demonstration Projects
- Fiscal Limitations
- Rule Streamlining
- Plan Integration
- Legislative Development
- Outcome Measures

Demonstration Projects. The *Mandate Reform Act* authorizes the commissioner to establish demonstration projects to test alternatives to existing state requirements. Three basic types of demonstration projects are:

1. Projects to demonstrate methods of social services planning.
2. Projects to demonstrate alternative methods of delivering services to persons with developmental disabilities and persons with mental illness.
3. Projects to demonstrate alternatives to existing administrative requirements that maintain or enhance services but reduce the administrative cost and complexity of the programs.

Because the *Mandate Reform Act* combines some aspects of the county mental health proposal with the CSSA plan and Rule 14 grant application, some technical changes have been made in the wording of *The Comprehensive Mental Health Act.*

REPORT ON MANDATES REFORM PROPOSALS

AUGUST 20, 1992

Proposals for projects to date - 34

Number of counties proposing projects - 27

PROGRESS TO DATE

Projects approved - 3

Project is in planning phase with DHS - 5

Project can be accomplished by county without rule waivers - 5

Resulted in new mental health legislation for demonstration projects - 2

Department is requesting changes in federal waiver to accomplish - 1

Anticipated DHS rule change (Rule 79) will meet need - 1

Project can be accomplished with provider licensing variances - 3

Counties will probably do a "Managed Care" Demo - 1

Project not needed due to legislation being passed addressing the need - 1

Not possible due to federal regulations - 7

Not possible due to licensing regulations - 2

Project not related to county mandates - 3

Waiting for county to follow-up - 1

EXECUTIVE DIRECTOR
Jeremy Lane

MINNESOTA MENTAL HEALTH LAW PROJECT

DEPUTY DIRECTOR
Luther A. Granquist

MINNESOTA DISABILITY LAW CENTER

430 FIRST AVENUE NORTH, SUITE 300
MINNEAPOLIS, MN 55401-1780
(612) 332-1441 • TDD (612) 332-4668
Toll Free 1-800-292-4150

MINNESOTA ADVANCE PSYCHIATRIC DIRECTIVE

Notice:

This is an important legal document. Before signing this document, you should know these important facts:

A. Purpose and Power of This Document.

If you are a person with a mental illness diagnosis, this document has been designed as a way for you to express your consent or refusal to neuroleptic medications and/or electroshock therapy in the event that you are admitted or committed to a mental health treatment facility and considered incompetent to make an informed decision at that time.

This declaration form may also be used to designate and authorize another person, a "proxy", to make decisions regarding neuroleptic or electroconvulsive therapy or other forms of mental health treatment in the event that you are not competent to do so yourself. You may authorize this proxy decision-maker to make all decisions regarding intrusive and other mental health treatment that are consistent with your expressed wishes or only to make those decisions regarding mental health treatment that are not addressed in this document. Your proxy may be a family member, friend or any adult individual who you believe understands your wishes and preferences regarding your mental health treatment and care. You should be sure that the named proxy is willing and able to serve in that capacity should he or she ever be required to do so.

You may also indicate or "nominate" in this document the person you would want to serve as your guardian or conservator in the event that a petition for appointment of guardian or conservator is ever filed in the future. Powers of guardianship or conservatorship can be far broader than those of the proxy decision-maker set forth in this form and usually include both health care and mental health treatment decision-making. You should seek legal advice regarding the powers and duties of a guardian or conservator if you have any questions regarding the effect of this nomination.

This form is <u>not</u> intended for persons who have never been given a mental illness diagnosis. This form is also <u>not</u> intended as the place for you to declare your wishes regarding health care in the event of a terminal illness, to designate proxy decision-making for those purposes or to indicate your wishes regarding the use of life-sustaining treatment. The form and instructions for expressing those wishes are provided for in the Minnesota Living Will Act, Minnesota Statutes section 145B.01.

Designation of a durable power of attorney and temporary transfer of parental powers in the event of future incapacity are also authorized by statute but are not provided

for in this form. All documents which indicate your wishes in the event of any future incapacity should be attached to one another and delivered to your family, doctor, treatment provider and any other affected individuals.

B. Competency to Decide.

Minnesota courts have indicated that your competence to refuse or consent to neuroleptic medications (and presumably to other forms of intrusive treatment) requires that you acknowledge your mental illness, display sufficient knowledge about the medication which you are accepting or refusing (the risks and benefits) and its effect on the mental disorder, and that any refusal not be based upon delusional belief--including the belief that one is not mentally ill. It is therefore advisable for you to acknowledge the mental illness in this document, to state your understanding of the risks and benefits of any intrusive treatment which you refuse or consent to in this document, and to briefly explain the rational reason for your consent or refusal. You may also indicate in this document the circumstances under which you want your choices to be implemented and your preferences regarding treatment location or facility.

C. Applications and Limitations.

The declarations made in this document or the appointment of a proxy decision-maker will apply only if and while you:

1. are admitted (voluntarily) or committed to a treatment facility; and

2. are not capable of making informed refusal or consent.

The declarations in this document become effective as soon as they are delivered to the physician or treatment provider who will be expected to carry them out. This document should become part of your medical record. The law requires that the choices declared in this document be complied with to the fullest extent possible unless: a) they are inconsistent with reasonable medical practice; b) the treatment requested is not available; or c) they are contradicted by other applicable laws. A physician or provider who is unwilling to comply with this document at any time for any of the above reasons must tell you so promptly.

If you have been committed as a patient under Minnesota Statutes section 253B, the physician or provider may subject you to intrusive treatment in a manner contrary to your wishes only upon order of the committing court. In the event that a hearing on the issue of forced administration of neuroleptics or ECT would take place, the choices that you have expressed in this document and your competence to make informed decisions at the time you signed this document should be considered by the court. If you have not been committed and are a voluntary patient, the physician or provider may subject you to intrusive treatments in a manner contrary to the wishes expressed in this document only following a commitment and issuance of a court order authorizing the treatment.

A treatment provider is prohibited by law from requiring you to make a declaration consenting to intrusive treatment as a condition of receiving services.

D. Revocation.

Any or all of the declarations contained in this document may be revoked at any time and in any manner by you if you are competent at the time of revocation. The revocation is effective when you communicate it to the attending physician or other provider. This document will remain valid and in effect until and unless you amend it or revoke it. Review this document periodically to make sure that it continues to reflect your wishes.

E. Statutory Authority.

This declaration of instructions regarding intrusive mental health treatment is authorized under Minnesota Statutes section 253B.03, Subd. 6D. If there is anything in this document that you do not understand, you should ask for professional legal help to have it explained to you before completing and signing the document.

#####

Advance Directives Regarding Mental Health Treatment and Care; Designation of Proxy Decision-maker and Nomination of Guardian or Conservator

TO MY FAMILY, DOCTORS, TREATMENT PROVIDERS, AND ALL THOSE CONCERNED WITH MY MENTAL HEALTH CARE:

I, _____, being an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed if I am admitted or committed to a mental health treatment facility and it is determined that I lack the competence to refuse or consent to intrusive mental health treatment. For purposes of this document, "intrusive mental health treatment" means electroshock therapy and neuroleptic medication. I have read the information contained in the Notice section of this document and I understand the nature and significance of the declarations that I am making.

I am aware that I have a mental illness that has been diagnosed as _____

_____.

I. Regarding Neuroleptic Medications:

If I am admitted or committed to a treatment facility and it is determined that I am not legally competent to consent to or refuse intrusive mental health treatment, my wishes regarding neuroleptic medications are as follows:

(Instruction: Choose section A or B or C and complete that section. Filling out section D is optional.)

A. I consent to the administration of _____

medication(s): (Circle and fill in 1 or 2 or 3.)

1. in such dosage(s) as the attending psychiatrist deems appropriate.

2. in such dosages as Dr. _____ deems appropriate.

address _____

_____

telephone _____

3. in the following dosage(s) _____

_____.

B. I do not consent to the administration of any neuroleptic medication. My understanding of the risks and benefits of neuroleptic medications is: _____

_____

_____

_____

_____.

Therefore, my reasons for refusing all neuroleptic medications are: _____

_____

_____.

C. I particularly do not want the following medication(s) administered to me:

_____

_____.

My understanding of the risks and benefits of these specific medications is: _____

_____

_____.

My reasons for refusing these specific medications are: _____

_____

_____.

D. Other instructions and preferences regarding the administration of neuroleptic medications: _____

_____

_____

_____.

II. Regarding Electroconvulsive Therapy (Shock Treatment):

If I am admitted or committed to a treatment facility and it is determined that I am not legally competent to consent to or refuse intrusive mental health treatment at that time, my wishes regarding electroconvulsive therapy are as follows:

(Instruction: Choose either section A or B and complete that section. Filling in section C is optional.)

A. I consent to the administration of electroconvulsive therapy.

1. with the number of treatments to be determined by my attending psychiatrist.

2. with the number of treatments to be determined by Dr. _____

_____.

address _____

_____

telephone _____

3. for the following number of treatments only: _____

_____.

B. I do not consent to the administration of electroconvulsive therapy. This refusal is based on my understanding of the following risks and benefits of electroconvulsive (shock) therapy: _____

_____

_____

_____.

Therefore, my reasons for refusing electroconvulsive therapy are: _____

_____

_____.

C. Other instructions and preferences regarding the administration of electroconvulsive therapy: _____

_____

_____

_____.

III. Designation of Proxy Decision-maker:

In the event that I am admitted or committed to a mental health treatment facility and am considered incompetent to make informed decisions regarding my mental health treatment and care. I designate the following person(s) to act on my behalf consistent with any instructions I have set forth in this document and otherwise communicated to him or her. Unless I have granted additional authority to my proxy elsewhere, my proxy has power and authority to make decisions regarding my mental health care and treatment only.

Name _____

Address _____

Phone Numbers _____

Relationship (if any): _____

If the person I have named above refuses or is unable or unavailable to act on my behalf, or if I revoke that person's authority to act as my proxy, I authorize the following person to act as my proxy:

Name _____

Address _____

Phone numbers _____

Relationship _____

Instructions to my proxy not contained elsewhere in this document: _____

_____

_____

_____.

I understand that I have the right to revoke the appointment of the person(s) named above to act on my behalf at any time by communicating that decision to the proxy or to my mental health care provider.

IV. Nomination of Guardian or Conservator:

If there is a petition for the appointment of a guardian or conservator for me, I nominate the following individual to serve in that capacity pursuant to the authority given to me under Minnesota Statute section 525.544:

Name _____

Address _____

Phone Numbers _____

Relationship (if any): _____

I ask that this individual be given authority to make such mental health care and medical decisions regarding my person as may be permitted under applicable Minnesota law.

V. Other Direction to Treatment Provider or Physician:

A. Person(s) to contact in the event of my hospitalization:

Name	Phone
_____	_____
_____	_____
_____	_____

B. Other wishes regarding medical or psychiatric treatment, care and other issues:

_____

_____

_____

VI. Other Documents:

A. I have/have not (circle one) completed a Delegation of Parental Powers document regarding temporary placement and care of my child(ren) to be applicable in the event that I am hospitalized or otherwise temporarily unable to provide care for him/her/them. That delegation of powers, as authorized by Minnesota Statutes sections 524.5 - 505, is/is not (circle one) contained in a separate document.

B. I have/have not (circle one) designated a durable power of attorney. That designation as authorized by Minnesota Statute section 523.07 is/is not (circle one) contained in a separate document.

#####

(Sign and date here in the presence of two adult witnesses, neither of whom is your proxy or nominee for guardianship.)

Date _____ Declarant _____

I certify that the declarant voluntarily signed this declaration in my presence and that it is my belief that the declarant fully understands the nature and significance of the declarations made here.

Witness _____ Address _____

_____

_____

Witness _____ Address _____

_____

_____

(Reminder: Keep the signed original of this document with your personal papers. Give signed copies to your doctors, family, proxy and the facility which is likely to be the site of any future mental health treatment or care.)

This form has been developed and distributed by the Minnesota Mental Health Law Project. Permission to reproduce this form for non-profit purposes is granted. By providing this form to you, MMHLP is not giving specific legal advice or agreeing to represent you in any matter related to the wishes you may express in this document. Because the Advance Psychiatric Directive is a relatively new statutory right, it is not possible to guarantee how some of its provisions will be interpreted by physicians, treatment providers or the courts.

MMHLP 1/92C

LOCAL RESOURCES

Many of the numbers below are listed in your telephone book under the name of your county. Emergency numbers are often listed in a special section of the telephone book. Some of the numbers can be found under "mental health." Names of your county commissioners and state legislators are often run periodically in your local newspaper.

YOUR COUNTY: _____

24 Hour Crisis Line Number: _____

- **Is the crisis line available to all persons in county (toll-free)?**

- **How is the public informed that your crisis line is available?**

CHAIR, MENTAL HEALTH ADVISORY COUNCIL:

_____

Telephone: _____

DIRECTOR OF SOCIAL SERVICES:

_____

Telephone: _____

DIRECTOR OF MENTAL HEALTH UNIT:

_____

Telephone: _____

DIRECTOR OF COMMUNITY SUPPORT PROGRAM:

_____

Telephone: _____

Names and telephone numbers of county commissioners:

_____

_____

_____

_____

_____

Name and telephone number of county commissioner who serves your area:

_____

Name and address of your state senator and your state representative(s).

_____

Does your county have a drop-in center? If so list address and telephone:

_____

Does your county have a chapter of the Mental Health Association? If so, write below the name of the chair and his/her telephone number.

_____

Does your county have an affiliate chapter of the Alliance for the Mentally Ill? Write below the name of the Chair and his/her telephone number.

_____

THE FUNDING OF MENTAL HEALTH SERVICES AT THE COUNTY LEVEL

This information is designed to show you how to go about getting the services you want for the people you love or yourself. Getting those services requires an understanding of how service programs are arrived at in the first place. Like everything else, it is a question of money. And money decisions are made through the budget process. Understanding the budget is your ticket to getting the programs you want.

You may already know one or more of the elected members of your county commission or board, the people who make the decisions about which services are provided and how. That means you know they are human and perfectly approachable. You are also probably well acquainted with some of the people who work in the agencies that provide the services. You know those people are human too.

And even if you don't know anyone personally, you elected those governing representatives and they should be pursuing their public's best interest--YOUR interests.

Most counties are bound by the Freedom of Information Act. The Act gives you the right to see many governmental records and papers. You won't be asking a big favor of anyone by requesting local records. You have a RIGHT to see them. You can learn a lot about how your county works and what its priorities have been in the past by examining how it has spent YOUR money over the years.

Minnesota's Mental Health System

Under the *Comprehensive Adult Mental Health Act*, first passed in 1987 and later amended, counties, as local mental health authorities, are responsible for providing a comprehensive array of mental health services. Almost all funds for mental health services flow through the counties, with the exception of Medical Assistance (MA) and Medicare which are paid directly to providers. (MA is partly federal and partly state funded and Medicare is 100 percent federally funded.)

Public monies fund a large proportion of costs for persons with serious and persistent mental illness. Funding for a full array of services for all persons with serious and persistent mental illness is inadequate. Although concern is often expressed about the low level of public funding for mental health services, the **complexity and rigidity of different funding programs for mental health services is also a problem.** How the funding is made available is as important as the amount. A variety of separate funding streams for distinct services is a source of frustration for counties, service providers, and consumers of services and their families. Because of these distinct funding streams, some advocates believe, it is sometimes necessary to fit the client to the available program, rather than designing the program to fit the needs of the client. Some believe that a single consolidated fund, perhaps even including the RTC funding, should be available to counties to design creative, individualized programs for clients and to make the best use of available funds. This is the basis of the model for Dane County, Wisconsin and has been promoted in the legislature in Minnesota. Some of the new demonstration projects, encouraged under the *Mandate Reform Act (1991)* and promoted in individual counties are moving in this direction.

With tight federal, state and county budgets, not only in recent past, but for the foreseeable future, making use of "other sources" of funding has been encouraged at the county level. "Other"--more often than not--means a level of government other than the one setting the policy.

You might want to look at the pie chart on page 8A of the **Appendices** section of this workbook. This diagram shows the breakdown of funding sources for adult mental health services. The chart for children's mental health services is found on page 10A. These charts may make the complicated system of funding clearer as you read about the county budget process.

Mental Health Dollars Have Remained Constant

Privately funded mental health services are usually paid by insurers or HMO's, although people also pay out of their own pockets when benefits run out.

Over the last seven years, the total state and federal block grants for social services for all populations have remained

practically unchanged. There has been no allowance for inflation. By contrast, total county tax funding for social services has increased from $152 million in 1985 to $267 million in 1990. That works out to an overall increase in county funds of 45 percent over six years for <u>all social services.</u>

Since complete reporting systems have not been in place to track the mental health portion of social service funds for either children or adults, it is impossible to come up with precise proportions of the county social service budget spent on mental health. Estimates were made in 1987 that about 20 percent of county funds, or $50 million was for adult and children's mental health services.

County plan data for 1990 indicates that on the average counties are budgeting approximately 24 percent or about $89 million of their total county social service funds for adult and children's mental health services.

The *Comprehensive Adult Mental Health Act (1989)* requires maintenance of effort from counties. This means that the county must continue to spend for mental health services an amount equal to the total expenditures for services to persons with mental illness in the county's 1987 Community Social Services Act plan. This requirement applies **only to county funds**. It means that counties receiving new state or federal categorical funds for existing county services must redirect their county funds towards expanded mental health services.

Funding sources for different services mandate different combinations of state and county dollars. What follows is a brief description of the major Department of Human Services funding streams for mental health services. Refer to the pie chart to get an idea of total state spending.

<u>County Funding Sources</u>

See **Appendices** page 5A of this workbook for a chart showing the current funding flow for the Department of Human Services.

Rule 12 grants fund treatment and program services at community residential facilities licensed under Rule 36. (Use your glossary in the workbook to review rule numbers.) Counties must

provide a match of 25 percent. This match can come from non-county sources.

Rule 14 grants fund community support services for persons with serious and persistent mental illness and case management for persons who are not eligible for Medical Assistance. Counties must provide a match of ten percent. The match can come from non county sources.

Federal Mental Health Block Grant funds are targeted to serve special adult populations, including Native Americans and the elderly. No local match is required for Native American projects. Most of the other projects are funded on a three year demonstration basis with the expectation that other funding sources must be secured to pay for an increasing share of the project each year.

State Special Project funds for adults include money in fiscal year 1991 for the Anoka Alternatives Project. This project provides 100 per cent state funding for community services for people being discharged from Anoka Regional Treatment Center. State Special Project funds are also being used in fiscal year 1991 in combination with Rule 14 funds for housing support services demonstration projects. The housing support projects include a ten percent county matching requirement.

Special projects in fiscal year 1992 include funding for self-help support groups and self-help employability projects. These projects are funded with state funds matched with federal dollars. Other demonstration projects are described on page 55 of the **Mental Health Act** tab.

Community Social Services Act (CSSA) funds consist of monies from the Federal Social Services Act (formerly Title XX), state CSSA funds and county tax funds. State CSSA funds are based on a per capita formula by county. These are "generic" social service funds for all disabilities and all age groups. In 1990 counties planned to spend about 14 percent or $52 million of these funds for adult mental health services. These funds are the most flexible available to the counties and are used when other funds are inadequate to meet client needs. They are often referred to as "County Tax/CSSA/Title XX Funds" or more simply "county funds."

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 and General Assistance. People with mental illness are estimated at approximately twenty percent 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 depend on the client's individual eligibility. State law used to require that counties pay fifteen percent of the non-federal share of MSA and twenty five per cent of GA. The county share was eliminated by the state legislature after January 1991

Regional Treatment Centers (RTC's) are funded directly by the state legislature through a separate appropriation. State law requires counties to pay ten percent of the cost for non-MA eligible adults. (MA pays only for persons under 18 and over 65 who are at RTC's.)

Medical Assistance (MA and General Assistance Medical Care (GAMC) cover inpatient services, outpatient services, day treatment and case management services. Reimbursement is limited and eligible services are carefully regulated for both MA and GAMC. MA is 53 percent federal funding and is subject to federal requirements. GAMC is totally state funded for low-income people who do not qualify for MA. A number of persons with mental illness who would otherwise be eligible for MA lose their eligibility because they live in IMDs--rule 36 or other treatment facilities which offer treatment 1991, counties were required to pay ten percent of the non-federal share of MA and GAMC. The County share has now been eliminated.

Social Security Disability Income (SSDI) monthly payments to persons with disabilities who have worked a certain time in the past. This is a social security program and is funded by federal dollars. Monthly payments vary according to the length of time worked and the level of employment. SSDI recipients ordinarily qualify for Medicare or Medicaid.

Supplemental Security Income (SSI) monthly payments for persons with demonstrated disabilities which prevent productive work. In 1991 individuals received $442 a month. Most SSI recipients qualify

for Medical Assistance. As with SSDI this is a federally funded program. It does not effect the overall flow of county dollars, but indirectly influences the expenditure of county funds.

Budget Formats Used by Counties

It will help you understand the system used by your county if you know **what kind** of budget your county uses. The three most commonly used formats are:

The Line Item Budget

- by far the most common. It breaks down expenses by categories such as personnel services (salaries), contractual services, supplies, etc., and generally states the number of positions authorized. It is the easiest format to monitor and review (e.g., are sufficient positions authorized; is enough money allocated to fund those position; is too much allocated for rent, supplies or materials?) It may be difficult to figure out which of these budget items refers to mental health services.

Example:		
	Personnel Services	$80,000
	Contractual Services	$14,500
	Supplies & Materials	
	Rent	5,000
	Travel	500
	Total	$100,000

The Program Budget

- less common. Presents expenses by programs or service component without breaking down specific amounts (for example: salaries, travel). A program budget allows maximum management flexibility; administrators can decide the degree to which to contract out services, whether to invest in new recruitment materials or to hire more staff. It minimizes accountability to the community. It includes neither operational strategies, as does the line item format, nor performance indicators, as does the performance budget format (see below).

Example:	Job training placement	$55,000
	Work with business sponsors	$20,000
	Training	4,500
	Administrative Overhead	20,000
	Total	$100,000

The Performance Budget

- also less common. Based on measurable indicators, with dollars linked to units of service such as the number of job training sponsors found or clients placed. This appears to be straightforward and accountable, but there is rarely a direct relationship between dollars appropriated and the units of service.

Example:	Job training placed (# clients placed: 20 cost per placement: $2,750	$55,000
	Work with business sponsors (# sponsors counseled: 16 cost per sponsor: $1,250	$20,000
	All other	25,000
	Total	$100,000

There are several ways to influence the budget making process. The local advisory council is the one body that advises the county board on expenditures that are made in the mental health area. To really impact the system, LAC members need to become familiar with the budget process as well as how funds are allocated for programs and services for persons with serious mental illness.

As an individual, or as a member of an lac you can express your concern to the commissioners and staff. Suggest questions that might be addressed to an agency that concerns you. If you can participate in public hearings, DO! Find out all you can about the hearing: how much time you will have, what kind of presentation is appropriate, where they will be held. Follow those guidelines carefully. Invite other people

who are have a personal interest in local programs for persons with mental illness to attend the hearings. There is always strength in numbers. Remember, the county board is covered by the **Open Meeting Law**. Budget meetings in committee as well as the full board meetings are open to the public.

DOING YOUR HOMEWORK

- Become acquainted with your county's budget. (See page 47-48 September Training in this workbook.

- Find out <u>where</u> the money for the budget for your county comes from (see earlier text). A lot of it is local revenue, sales taxes, property taxes, or bonds floated by the city. Some of it may be from the state or federal governments and may have strings attached, that is, it may be predesignated and not up for grabs in the general budgetary appropriations. See if your county is doing all it can to access Community Development Block Grants or special project grants from the Department of Human Services. These funds may be available for special projects.

- If you need information, go straight to the county courthouse. See if there is an information office that can provide you with literature about the county and how it functions. There may be a public relations office that can help you. Get copies of any any pertinent booklets or pamphlets they may have on hand. If they are out of the ones you need, ask that they reorder them for you.

-Don't be shy about asking for information, <u>**but do be polite, and thank people for helping you.**</u>

Information that will help you understand the budgeting of mental health dollars:

- what services exist in your county for people who suffer from mental illness.
- what agencies provide the services that interest you.
- who runs those agencies.
- where to go to talk with the person in charge of those agencies.
- how the agencies are funded.

When you are gathering information for your own use, get copies of the materials people tell you about: budgets, last year's minutes for budget hearings, personnel lists, calendars, publication of revenue sources, anything that you may want to consult later.

Try to keep records of phone conversations, appointments, letters, even trips to the county courthouse. This will help you keep track of your progress and might come in handy if you aren't sure just where you got some bit of information.

Again, be assertive and nice. You have a right to obtain all of this information and to participate in the budget process. Your efforts will be much more successful and less frustrating if you are courteous in your requests. Don't shrink back at the first sign of an obstacle, just stick to your (nice) guns.

Sources:

1991 Mental Health Report to the Legislature
Department of Human Services, Mental Health Division

1992 Mental Health Report to the Legislature
Department of Human Services, Mental Health Division

Serving Minnesota's Mentally Ill
League of Women Voters of Minnesota

Background Briefing #4: How Mental Health Services are Funded in Minnesota
State Advisory Council on Mental Health

How to Get Services for People Who Are Mentally Ill. Making Use of the Budgetary Process.
National Alliance For The Mentally Ill

Glossary of Terms--County Budgets.

Budget Justifications: The reasons given in the narrative portion of the executive budget for proposed increases or decreases in the funding for particular programs.

Budget Requests: The petitions for funding for specific programs or items made by individual departments or agencies.

Capital Budget: The plan for expenditure of public funds for property acquisition, construction and improvements to public facilities.

Coalition: A group organized around a specific issue on which they hope to see some action. Often, a coalition consists of very diverse groups who come together only on one issue, creating a strong front and conveying the idea that the issue is so important that the groups involved are willing and able to overcome (or ignore) other differences.

Community Development Block Grants: Federal funds made available to towns and counties for expenditure on special programs or projects.

Cost Benefits: The financial or budgetary advantages of a particular plan or project.

Executive Budget: The budget proposed by the executive branch (mayor, for example) of the government. The chief executive gathers requests from departments and agencies and puts them together in one budget proposal.

Fiscal Year: The twelve-month period during which a particular budget is in affect. Dates vary: January 1 - December 31 is common, as is July 1 - June 30. The Federal Fiscal Year is October 1 - September 30.

Freedom of Information Act: A law that details the kinds of information kept by the government to which the public is guaranteed access. The act may detail exact procedures for gaining access to the information. Usually all budget and accounting information is covered by the act.

Line Item Budget: A budget organized by the type of item for which expenses are actually incurred, e.g., salaries, supplies, etc.

Local Revenues: Funds gathered through local, county, or state property, sales, income, or other taxes, fees, etc.

Operating Budget: The plan for expenditure of public funds for such basic costs as salaries, supplies, travel, rent of office space, etc. for the regular
services provided by the government.

Operational Strategies: The plans and schedules developed for how a particular program will operate through the fiscal year.

Performance Budget: A budget organized by services, but based on specific, measurable performances or service goals. The number of dollars spent is determined by the units of a particular service that are provided.

Performance Indicators: The points by which a program may be measured for its effectiveness. The number of service units provided is the indicator, and determines the amount of money that should be spent.

Program Budget: A budget that breaks down expenses by programs or service components, without specifying amounts to be spent on salaries, supplies, etc. within each program.

Reprogramming: Changes made in the budget after the enactment of the budget by the legislative body and after the start of the fiscal year. Also supplies, etc. within each program.

Revenue Projections: Estimates of what the available revenues for the upcoming fiscal year will be. Projections may be based on predictions of local economic conditions affecting tax sources, anticipated inflation, fixed costs, and overall expenditures.

TABLE 14

MENTAL HEALTH PLAN MAINTENANCE OF EFFORT

COUNTY		1987 CSSA PLAN MAINTENANCE OF EFFORT**	1990 MH PLAN CSSA/TXX/CTY TAX EXPENDITURES	PERCENT INCREASE
AITKIN	*	$145,150	$157,231	8%
ANOKA		$1,910,376	$2,657,363	39%
BECKER		$344,200	$441,172	28%
BELTRAMI		$370,850	$397,350	7%
BENTON		$311,101	$494,329	59%
BIG STONE		$90,692	$101,179	12%
BLUE EARTH		$637,089	$712,735	12%
BROWN		$306,120	$498,527	63%
CARLTON		$307,684	$340,264	11%
CARVER		$581,777	$791,134	36%
CASS		$165,800	$335,543	102%
CHIPPEWA		$248,269	$339,541	37%
CHISAGO		$219,956	$383,799	74%
CLAY		$486,290	$752,477	55%
CLEARWATER		$92,083	$124,122	35%
COOK		$29,882	$115,289	286%
COTTONWOOD		$171,588	$294,942	72%
CROW WING	*	$300,982	$1,012,903	237%
DAKOTA		$2,470,163	$3,110,153	26%
DODGE		$130,242	$188,508	45%
DOUGLAS		$142,263	$269,500	89%
FILLMORE		$155,306	$213,681	38%
FMW		$523,361	$706,921	35%
FREEBORN		$573,100	$652,681	14%
GOODHUE		$469,143	$883,276	88%
GRANT		$61,210	$89,020	45%
HENNEPIN		$20,611,220	$34,011,422	65%
HOUSTON		$169,019	$225,065	33%
HUBBARD		$110,000	$209,424	90%
ISANTI		$235,326	$486,653	107%
ITASCA		$452,122	$576,334	27%
JACKSON		$119,651	$119,651	0%
KANABEC		$80,370	$211,927	164%
KANDIYOHI		$955,586	$1,082,413	13%
KITTSON		$54,741	$54,741	0%
KOOCHICHING		$313,930	$514,094	64%
LAC QUI PARLE		$73,681	$84,343	14%
LAKE		$118,106	$118,210	0%
LAKE OF WOODS		$28,194	$32,160	14%
LE SUEUR		$187,231	$292,382	56%
MCLEOD		$205,155	$458,875	124%
MAHNOMEN		$50,470	$82,517	63%
MARSHALL		$111,801	$173,198	55%
MEEKER		$226,436	$303,729	34%
MILLE LACS		$180,636	$303,500	68%
MORRISON		$330,870	$360,842	9%
MOWER		$839,601	$839,601	0%
NICOLLET		$270,258	$521,791	93%
NOBLES		$370,063	$391,687	6%
NORMAN		$141,567	$144,415	2%
OLMSTED		$1,262,603	$1,262,603	0%
OTTER TAIL		$323,496	$792,903	145%
PENNINGTON		$136,221	$203,683	50%
PINE		$342,013	$342,013	0%
PIPESTONE		$106,565	$175,138	64%
POLK		$492,700	$701,223	42%
POPE		$107,400	$127,700	19%
RAMSEY	*	$7,235,139	$11,160,242	54%
RED LAKE		$27,084	$37,424	38%
REDWOOD		$248,757	$318,664	28%
REGION VIII		$632,938	$691,587	9%
RENVILLE		$383,000	$402,418	5%
RICE		$420,294	$592,195	41%
ROCK		$105,750	$115,556	9%
ROSEAU		$74,150	$86,215	16%
SAINT LOUIS		$2,611,000	$4,156,205	59%
SCOTT		$447,501	$626,390	40%
SHERBURNE		$384,545	$761,016	98%
SIBLEY	*	$187,400	$188,711	1%
STEARNS		$900,796	$1,410,953	57%
STEELE		$388,035	$499,393	29%
STEVENS		$59,409	$126,133	112%
SWIFT		$213,100	$273,513	28%
TODD		$171,987	$306,026	78%
TRAVERSE		$77,940	$77,940	0%
WABASHA		$207,910	$212,467	2%
WADENA		$83,470	$85,500	2%
WASECA		$176,476	$223,830	27%
WASHINGTON		$1,312,863	$2,874,143	119%
WILKIN		$139,064	$171,685	23%
WINONA		$323,702	$768,164	137%
WRIGHT		$495,276	$930,168	88%
YELLOW MEDICINE		$145,845	$272,260	87%
TOTAL		$57,705,140	$88,636,675	54%

NOTE: ** This column shows the amount counties budgeted for mental health services in their 1987 CSSA Plans. This figure shows county discretionary funds only, excluding state and federal dedicated funds

* Indicates that the Children's Mental Health Plan has not been approved as of February 6, 1991.

MANDATE REFORM BILL

Laws of Minnesota 1991, Chapter 94

(To receive a copy of the *Mandate Reform Bill* call Neil Doughty, Department of Human Services (612) 296 2113)

In the summer of 1990, the Department of Human Services (DHS) conducted a study of all social services mandates. The study resulted in the development of two major documents: the Report on Social Services Mandates and the Social Services Mandates Catalog. In response to the findings in the Social Services Mandates Report, DHS developed the Mandate Reform Bill. The bill took effect on August 1, 1991 and is referred to below as the *Mandate Reform Act (1991).*

The *Mandate Reform Act* is designed to:

A. Facilitate the consolidation of Mental Health and Community Social Services Act (CSSA) planning in the following ways:

- **change the mental health plan or proposal to a component of the CSSA plan;**
- eliminate the separate planning requirements for mental health programs; and,
- standardize the timelines for submittal and approval of the plan components and Rule 14 grants.

B. Simplify the CSSA plan by reducing the number of required elements in the plan and clarifying the approval process

C. Provide feedback to the legislature through the biennial social services plan on difficult aspects of social services administrative requirements, social services requirements that are inadequately funded, and unmet needs of specific counties.

D. Provide the commissioner with the authority to review social services administrative rules and adopt amendments to reduce administrative costs and complexity.

E. Provide the commissioner with the authority to establish demonstration projects designed to test planning and service models that are less complex and costly to administer. For the purposes of these demonstration projects, the commissioner is

allowed to waive administrative rule requirements.

F. Provide counties that are in financial difficulty with a means to limit services if the county can show that they have made reasonable efforts to comply with administrative rules and have developed an amended CSSA plan.

Mandate Reform Act Update

The Department of Human Services established a Mandate Reform Implementation Team to advise the commissioner on issues related to the implementation of the *Mandate Reform Act* . Work groups to assist in analyzing issues and developing proposals have been convened. Additional county, state and staff from other agencies and organizations have been participating in the following work groups:

- Demonstration Projects
- Fiscal Limitations
- Rule Streamlining
- Plan Integration
- Legislative Development
- Outcome Measures

Demonstration Projects. The *Mandate Reform Act* authorizes the commissioner to establish demonstration projects to test alternatives to existing state requirements. Three basic types of demonstration projects are:

1. Projects to demonstrate methods of social services planning.
2. Projects to demonstrate alternative methods of delivering services to persons with developmental disabilities and persons with mental illness.
3. Projects to demonstrate alternatives to existing administrative requirements that maintain or enhance services but reduce the administrative cost and complexity of the programs.

Because the *Mandate Reform Act* combines some aspects of the county mental health proposal with the CSSA plan and Rule 14 grant application, some technical changes have been made in the wording of *The Comprehensive Mental Health Act.*

REPORT ON MANDATES REFORM PROPOSALS

AUGUST 20, 1992

Proposals for projects to date - 34

Number of counties proposing projects - 27

PROGRESS TO DATE

Projects approved - 3

Project is in planning phase with DHS - 5

Project can be accomplished by county without rule waivers - 5

Resulted in new mental health legislation for demonstration projects - 2

Department is requesting changes in federal waiver to accomplish - 1

Anticipated DHS rule change (Rule 79) will meet need - 1

Project can be accomplished with provider licensing variances - 3

Counties will probably do a "Managed Care" Demo - 1

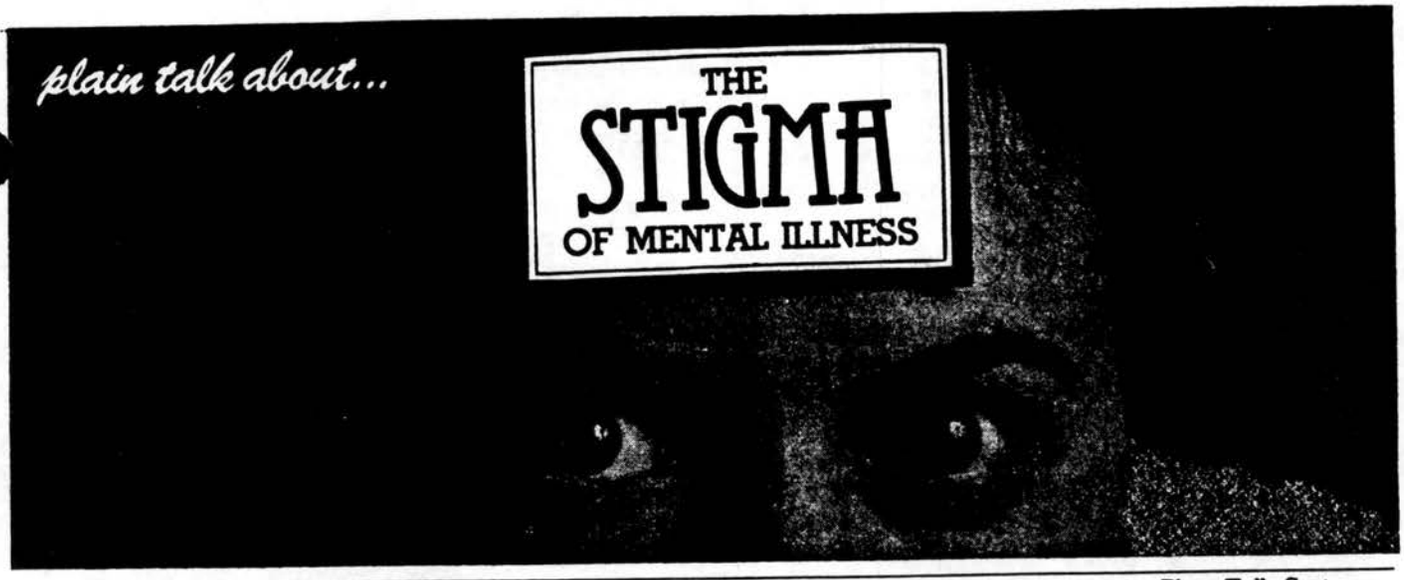
Project not needed due to legislation being passed addressing the need - 1

Not possible due to federal regulations - 7

Not possible due to licensing regulations - 2

Project not related to county mandates - 3

Waiting for county to follow-up - 1



National Institute of Mental Health *Office of Scientific Information* Plain Talk Series

COMBATING THE STIGMA OF MENTAL ILLNESS

Among people who have been treated for mental illness, what is the biggest problem they face when trying to resume life in the community?

Most will say it is simply their inability to be accepted by other people. They have difficulty finding friends, housing, and work. They feel the sting of discrimination in almost everything they attempt. Many times they feel old friends are uncomfortable in their presence. They feel cut off from society.

They are the victims of the stigma that still surrounds mental illness. Numerous scientific studies have shown that stigma, often overt, is directed toward former mental patients by society. It becomes their most debilitating handicap.

Since 1980, the National Institute of Mental Health has been a leader in a nationwide attempt to remove the stigma associated with mental illness through an effort to encourage employers to hire people who have come through such illness and who are now able and eager to work. It has been proven that the dignity of work provides stability and meaning to these people as much as to those who have never experienced mental illness.

By forming a partnership with the private sector, the Institute has inaugurated an information program for employers that is paying dividends. Employers have learned that former mental patients, including the chronically mentally ill, comprise a valuable labor pool for American business.

But, employer knowledge and acceptance are not enough. The problems of stigma are everywhere. They affect all of us. We have found, also, that as the general public learns more about the devastating problems caused by stigma, even greater understanding and help will follow.

One in five families in the United States knows the devastating impact of mental illness. But its effects are far-reaching as family, friends, and co-workers suffer by the changes inflicted on *them* by another's mental illness.

Thirty percent of the population will suffer from cancer during their lifetimes, while 15 percent will be touched by mental illness. However, victims who have suffered both mental illness and cancer report that the mental illness caused them the greater pain.

In truth—the obstacles faced by recovering mental patients following treatment for their illness are often as difficult to overcome as was the illness.

Here, the question must be asked, "What is mental illness?" To begin with, mental illness is not a homogeneous entity which a general discussion of mental illness seems to imply. However, included under the rubric of mental illness are symptoms and problems that affect many persons but which may not be evident in others. These symptoms may not seriously—or even markedly—impair personal or social functioning. On the other hand, there are persons who may suffer from more serious, obvious, and incapacitating degrees of illness. These latter persons may well require hospitalization and intensive care and treatment.

Since the passage of the National Mental Health Act by Congress in 1946, care and treatment of mentally ill people has improved dramatically, assisted immeasurably by improvement in the use of psychoactive drugs (such as tranquilizers) and the development and use of other new therapies.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • Alcohol, Drug Abuse, and Mental Health Administration
5600 Fishers Lane, Rockville, MD 20857

Improving Treatment

Today, research has unraveled many of the mysteries about the origins of mental illness. It has revealed that many mental illnesses are actually caused by biochemical imbalances, as is the case with many physical illnesses.

The mentally ill should not be blamed for their condition any more than diabetics should be blamed for having diabetes. Uncovering many of the biochemical imbalances has led to treatments restoring the needed chemical balances, just as insulin controls the balances for diabetes. As long as a diabetic person takes the proper dosage of insulin, that person can live a normal life. It is much the same with mental illness. As long as the victim follows prescribed treatments, that person, too, can lead as normal a life as possible.

As care has been upgraded, so, too, have the settings in which treatment is given. For many decades, the usual responses to the mentally ill were to hide them away at home or to relegate them to asylums. As the number of admissions increased, care in the asylum became mostly custodial.

Problems of Deinstitutionalization

The populations of public mental hospitals grew until, about 30 years ago, more than 550,000 were housed in State and county facilities. Since then, deinstitutionalization—the process of releasing mental patients to communities—has lowered the number to fewer than 150,000.

At first, deinstitutionalization was hailed as a momentous advance by those who advocated treatment and services in community-based facilities—community mental health centers, halfway houses, psychosocial rehabilitation programs, and the like.

However, practice outpaced practicality; where the mentally ill were once caged as animals, chained to walls, mistreated, and even beaten, new understanding of mental illness has given many of them freedom. But the price of that freedom has often been aimless wandering through the streets, without homes or jobs. And, in too many instances, Americans who have had the misfortune to suffer mental illness—even those who approach a societal definition of normal—daily face an unsympathetic, unfair, and hostile society.

Historical physical abuse or neglect has been replaced by a less visible but no less damaging psychic cruelty.

Generally, in these enlightened days, we do not physically remove from our midst those we do not wish to have around; and we no longer send them to a far-away asylum. Instead, we isolate them socially, a much more artful though equally debilitating form of ostracism. A paradox now exists. In a time of vastly increased medical sophistication, which virtually guarantees greater numbers of restored mental patients, discrimination against them continues. Although we as a society have come far in the way we respond to those with mental illness, there is still a great distance to go.

For example, research studies have found that most Americans think the two worst things that can happen to a person are leprosy and insanity. In American society, ex-convicts stand higher on the ladder of acceptance than former mental patients. Asked to rank 21 categories of disability, from the least offensive to the most, respondents placed mental illness at the bottom of the list.

Attitude Changes

Public attitudes toward the mentally ill have changed in the past few decades, but the changes appear to be minimal. A 1979 study updating an earlier attitudes survey found "no noteworthy changes in attitudes toward the mentally ill 23 years later."

People continue to discriminate against the mentally ill, although it may be less socially acceptable to admit it openly. Discrimination crosses all boundaries of society and exists among people of all ages, socioeconomic levels, intelligence, education, and places. Nearly everyone, it seems, regards victims of mental disorders as "fundamentally tainted and degraded."

Even more astounding, mental patients sometimes face rejection from professionals who are paid to treat and help them. A key finding of a 1980 forum on stigma was that many health-care professionals harbor unconscious, unstated negative feelings about their mental patients. A 1980 survey found some psychiatric nurses showed prejudice toward their patients. Other studies have shown that it is not unusual for some staff members in psychiatric facilities to abuse their patients physically.

In this respect, the media—in the interests of fairness and in recognition of their power to influence public opinion—have a responsibility to provide a broader perspective on the mentally ill. A leading scientific investigator in this area has commented, "That the mass media can condition a subtle set of attitudes which influences the behavior of society toward those who have been hospitalized for mental disorder is unequivocal."

The media usually reflect the beliefs of the public. Thus, it follows that when a majority of Americans are convinced that there are benefits in helping to change beliefs about mental illness, these beliefs will be positively altered. And the media must be convinced that at least some of the credit for helping change beliefs would accrue to them.

Possibility of Change

A summary of several studies indicates important areas where change is likely: in increased positive images of mental patients, in decreased fear ratings of them, in decreased fear of becoming insane, and (by patients themselves) in increased self-confidence. This likelihood is borne out by university-based studies which show that negative and stigmatizing images of mental patients can be altered.

For example, a Minnesota mental health education program informs the public in a straightforward way of the struggles of real people with emotional problems. Early indications are that awareness of such people's experiences and perceptions results in increased resistance to negative mass media images of current and former mental patients.

There are other encouraging signs of greater public understanding and acceptance of mental illness. Women, for example, have been found to be far more accepting of mental patients than are men. Recent Canadian and U.S. studies have shown positive acceptance of community mental health residential facilities, even in situations where residents have been labeled "mentally disordered offenders."

A survey by the National Restaurant Association, the first ever to investigate employment of the mentally restored in a single industry, produced solid evidence of the value of former mental patients to employers. The most outstanding result of the survey concerned work performance. More than 75 percent of employers who had hired mentally restored people rated them "as good as or better" than their co-workers in motivation, quality of work, attendance, job punctuality, and job tenure.

Fellow employees were described as cooperative and helpful toward their mentally restored coworkers, supporting the findings of another study of a shift toward understanding and acceptance when mental patients are given a chance to fill normal roles in work and other activities.

Thus, as impressive as the gains in treatment of mental illness have been over the past few decades, they are not enough. It is also necessary to alter society's perceptions of mental illnesses and the mentally ill. People must understand that mental illnesses are real, that they are common, and that no one is beyond help. It is important to spread the message that, thanks to research, effective treatments are now available to help most mentally ill people lead satisfying and productive lives at home, at work, and in the community. These treatments are continually being improved through ongoing research. There is now more hope than ever for people who are mentally ill, and there should be more acceptance of these individuals by society at large. Only when they can take their place among us as valued employees, tenants, and friends will their struggle against mental illness be won.

This booklet was produced by the National Institute of Mental Health (NIMH), the U.S. Government agency that supports and conducts research to improve the diagnosis, treatment, and prevention of mental illness. NIMH-supported studies alleviate suffering and bring hope to people who have a mental disorder, to those who are at risk of developing one, and to their families, friends, and coworkers. Thus, mental health research benefits millions of Americans and reduces the burden that mental disorders impose on society as a whole. NIMH is part of the Alcohol, Drug Abuse, and Mental Health Administration, a component of the U.S. Department of Health and Human Services.

Lewis L. Judd, M.D.
Director
National Institute of Mental Health

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What is behind the stigma directed at mental patients? Some researchers think the term stigma is itself the problem. Too strong a word to be useful in describing the full range of reactions toward the mentally ill, they believe, it discourages objective thinking about the problem it encompasses. That is, they believe simply talking about stigma may cause it.

Other investigators suggest that behavior, not a label, is what evokes negative response. For example, relatively well-adjusted and well-educated people who develop a psychiatric disorder but recover are unlikely, in this view, to suffer extensively from the problems of the stigma. It is the more or less permanently disabled persons who tend to be the objects of fear and avoidance.

Fears of Dangerousness

One of the reasons for this view, perhaps, is that people fear the mentally ill because they are thought to be unpredictable. But the truth is that the behavior of former mental patients is, on nearly every occasion, no different from the rest of society.

Thus, it should be said clearly: The vast majority of mentally ill persons are not dangerous. Here as elsewhere it is unfair to stigmatize the many for the acts of the few. The unfairness is apparent when danger from former mental patients is compared with the danger from drunk drivers. Some of the most predictably and demonstrably dangerous persons in our society are drunk drivers who account for about half of all fatal automobile accidents (about the same number as all criminal homicides each year), but Americans demonstrate a truly astonishing tolerance for this group of dangerous persons.

Then compare this to the record of former mental patients. Fewer than 2 percent of them pose any kind of danger to society. The reality is that persons who have been through emotional disturbances are typically anxious, passive, and fearful.

But the myth of dangerousness is perpetuated through a lack of knowledge by most members of the public. The belief that mentally ill persons are to be feared has been described in the research literature as a "core belief of the American public." Further, a recent California survey found only 17 percent of respondents agreed with the statement that mental patients are not dangerous.

The facts belie these beliefs. There has been an increase in the arrest rates of former mental patients over the past 29 years, but this increase pertains to former patients who had arrest records *prior* to being hospitalized.

Though there have also been a few studies showing *higher* rates of violent crimes by mentally ill persons, those who do not have prior arrest records have post-discharge arrest rates *equal to or lower* than those of the general population.

Why then the continuing public perception of them as dangerous individuals to be feared and shunned?

Role of the Media

Many observers fix a large share of the blame on the communications media. Newspapers in particular stress a history of mental disorder when they find it in the backgrounds of people who commit crimes of violence. Television news programs also sustain this view with their sensationalization of crimes where former mental patients are involved.

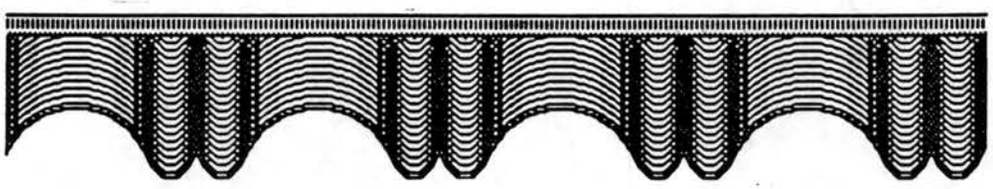
In television dramas, mentally ill persons are often portrayed as violent or victims of violence. Such stereotyping illustrates one of the many uses of mental illness by television producers or directors—to excite fear in the audience. One critic has pointed out that, on television, mental illness is synonymous with danger. Although that idea cannot be supported by known facts, it lends authenticity to the myth.

The following material is taken from an "Anti-Stigma Kit" that was distributed by the Department of Human Services to local mental health advisory councils. If you want to see the entire kit, which includes 2 videos on mental illness, ask the chair of your lac or the director of social services in your county.

The "Anti-Stigma Kit" was the result of a concerted effort by a number of people. The acknowledgement is included as the last page in this section.

The testimony of Jane Mastro-Sadovsky was not a part of the kit, but has been included here with the remarks by two other consumers about stigma and mental illness.

Ms. Mastro-Sadovsky had just been appointed Executive Director of the Alliance for the Mentally Ill-Minnesota.



For Mental Illness In America: A Series of Public Hearings

Jane Mastro-Sadovsky

My name is Jane Mastro, I am 42 years old, an accomplished business person, and I am afflicted with a brain disease which manifests as Bi-Polar Affective Disorder, more commonly known as manic depression.

In many ways it is a miracle that I am here before you today. Just 4-1/2 years ago I was without hope, and having consulted a "right to die" organization, I took what was guaranteed to be, a lethal dose of barbituates. I awoke 5 days later from a deep coma, on a respirator, in a public hospital. My overriding emotion was anger, tempered by despair, that my attempt to end a darkness and pain which had engulfed me for the previous 5 years, had failed.

But let me take you back to 1981 to share a bit of my life prior to the onset of this terribly disabling, and many times deadly illness. At 32 years of age, I was one of the 4 principles in a successful, international consulting firm, catering to the petrochemical industry. I spent most of my time working with clients on the East Coast in Asia, or the Middle East. I had decided to strike out on my own after working in domestic and international marketing and planning with Union Carbide, GE, Celanese and Atlantic Richfield.

I felt so fortunate to be joining 3 individuals who were as talented as I was, and equally as thrilled with the adventure of owning our own business. I didn't believe it could get much better for me. We were working with exciting individuals and companies, I had a loving husband, a large supportive family, a wonderful circle of friends, a gracious home outside of Philadelphia, and a cozy beach house on the Jersey shore. I was in a position that most people can only dream of. I looked forward to each day, even those with their share of problems--for even the problem-solving held excitement for us. Life was good, rich and fun. I was happy!

For no apparent reason, a troubling, and deepening darkness, an almost suffocating heaviness entered my life. Over a 6 - 7 week period, this feeling intensified, and an overwhelming sense of hopelessness became familiar. It was the beginning of a nightmare that was to last for 5 years.

As I briefly outline my experience with this illness, I wish to highlight the key problems in our society from a patient's perspective, even one with the initial advantages of being wealthy, white and well- educated. These problems include diagnosis, isolation, impoverishment, physical vulnerability and stigma. And these problems are shared by all of those afflicted. These problems observe no boundaries. We are all vulnerable, all at risk. Brain diseases do not discriminate; cures and medications to control them are essential.

After weeks of feeling awful and unable to work, I carted myself first to an internist. He recommended an ophthalmologist because of my complaint of a "greyness" that had engulfed me. The physicians concluded that I was healthy, and passed me on to psychologist who, in turn, passed me on to a well-known Philadelphia psychiatrist. She concluded that I was "stressed," and after months of psychotherapy, rendered a diagnosis of "post-traumatic stress syndrome." In spite of the endless hours of therapy, we couldn't seem to identify the source of the trauma.

During the first 18 months of my illness, only one antidepressant was administered, and I inappropriately received an antipsychotic agent. I was terrified. I became more and more ill. My life, my work and close to $200,000 slipped away. I sold one home, my husband left, my business partners were perplexed and angry, and with the exception of my grandmother, my family denied my illness. They insisted that I was having "low days." In fact, by that time, I'd had 550 "low days." I was unable to concentrate, sleep, read, write, or laugh: I was in the most intense, unrelenting pain imaginable.

After 18 months of illness, I received a new diagnosis: Major Depressive Episode. I sold my beach house. My health insurance had run out, and my ex-husband's insurance would end shortly. I began to sell my possessions.

During the following 19 months, I lived with a series of friends, and for a short period of time, in a group home that was crowded, filthy and unsafe. The upside was that I found a physician who began methodical trials of medications. He fought for my life with far more energy that I myself had. During much of this time, I was suicidal, barely functional, and I experienced commitment proceedings for the first time. I also experienced the terror of assault by a forensic patient: I had never been so vulnerable or so frightened.

I received no flowers or "get well" cards until I had some minor surgery. After having been hospitalized repeatedly for 3 years (in far worse pain than the surgery ever caused), I was being viewed as worthy of concern and compassion. The entire situation struck me as sad and pitiful.

I had just about given up, when one medication worked! I was stunned. Up until that moment, I truly hadn't believed that depression was a disease, or that I wasn't in some way responsible. For the next 6 months, I enjoyed all the things I had missed for the previous 3 years. I felt alive and hopeful, in spite of all the losses and pain. I took the advice of the young physician who had fought for my life so diligently, and moved to St. Louis where he told me that I could get state-of-the-art care at a clinic at Washington University in St. Louis.

Six months after my move, the medication I had been taking was withdrawn from the market by the company producing it. I petitioned the company to allow me to continue using the medication, despite its dangerous and potentially lethal side effects, but my request was denied; in spite of the fact that I waived them of any liability.

All I could do was hope was that it had cured me, but 1 month after I discontinued its use, the darkness returned. I was forced to stop working once again, and was reduced to living on my disability income of $686/month and food stamps. I was despondent and exhausted, and set about planning my death. On the day I chose to die, I felt calmed and resolved, I had given up. I had been through countless drug trials, ECT, and various forms of psychotherapy, only to have the one medication that enabled me to live again, be taken away! I knew that this severe depression would kill me more quickly than the side effects of this new medication.

As I shared with you earlier, I survived my attempt at suicide, and through the efforts of a young resident physician who had been monitoring me, I was transferred to a large private teaching hospital. I spent the next 9 months in and out of the hospital, as other medications and ECT were once again unsuccessfully tried. Although I had given up, the clinicians around me had not.

Ten months after my suicide attempt, the depression lifted spontaneously - not completely, but slowly and steadily. At this point, I set about the task of rebuilding my life. It took 3 years and over 300 resumes to find a challenging job. Society is not very forgiving to those who have experienced psychiatric illness. If you have any doubt that this could happen to you or a loved one, simply examine your insurance policy and ask if any but the wealthiest can endure the extraordinary financial costs of severe mental illness. If this appalling situation is to end, we must work together to build coalitions to effect change, to find cures, and to educate the public and private sectors to ensure that psychiatric illnesses are viewed with compassion and understanding.

I sit here today as one of the fortunate ones who has survived a severe psychiatric illness. For 5 long years, all the joy in my life had been silenced, and although I have been free from this horrific disease for over 4 years, my battle against ignorance and stigma will continue.

I thank you for inviting me to share my story at this hearing today.

Testimony given by Jane Mastro-Sadovsky at the Federal Interdepartmental Task Force on Homelessness and Severe Mental Illness, Chicago, Hyatt Regency Hotel, September 5, 1991.

Thoughts on the Stigma of Mental Illness

On My Own
by Nadine Phillips

Finding a place in the world where you feel accepted and you fit in, can be difficult for anyone. Finding that place in the world when you have a mental illness often feels impossible.

I'm learning to cope with my mental illness, however I run into a lot of obstacles. People in the community believe in myths and fears about persons with mental illnesses. They fear for safety of themselves and their children. They fear if a treatment center is located near them, property values will decrease and that residents there will be dangerous. Even some of my friends are not accepting me anymore. It is as though they think I am a different person than I once was. A few friends cross the street to avoid talking with me, pretending they don't see me.

To me, my mental illness is just like any other kind of illness. I didn't choose to have it. I struggle with it sometimes having bad days and a lot of good days. I'm recovering and I need all the support I can get, but I often feel branded as "crazy." It feels like I've become a "label" that doesn't feel, think and care. I know I'm still the same person I was. My mental illness has affected me, by slowing me down in the things I want to accomplish, but I'm still doing them. I have many talents and abilities. They haven't disappeared because of my illness. I get frustrated that I can't always accomplish what I want to, at a faster pace, but I have to accept that, being a part of my illness and then go on. That's just what I am doing and with success. After getting my G.E.D, I continued on in college and maintained a 3.8 grade point average, while becoming well known as a public speaker on mental health issues and finding success in fashion design. I'm in therapy and working hard in my recovery.

I guess when it comes right down to the bottom line, people are afraid because they don't understand and haven't had the education available to help them know what a mental illness means. It's easy to believe in the myths and fears when even the media portrays persons with mental illnesses in a negative light. There are a lot of people like me, who have a mental illness and are living and working the community. Maybe it's time we all learn to cope, recover and grow together. The stigmas of mental illness exist because of the lack of knowledge and understanding--not because they are true.

Thoughts on the Stigma of Mental Illness

Stigma-A Journey
By Susan Talbott Carey

I always thought of life as a journey with some moments of light and some of darkness. Some persons who have mental illness have substantially more times of darkness.

Stigma is a source of that darkness and contributes to the perpetuating of ideas in the community which contribute to discrimination and feelings of shame. Can anyone ever escape it?

For me, the patterns that stigma made in my life changed and lessened when I became involved in an advocacy organization about eight years ago, after I had struggled with mental illness for 17 years. I learned that some very sensitive people, both consumers and non-consumers, were working to reform the mental health system, a system that I thought would destroy my life. I was elected president of that organization's chapter in my county. The years have passed and I have become more and more involved as the opportunities have come to speak out.

I consider that involvement to have been crucial to my recovery and to being free of institutionalization for seven years.

The work to be done creates its own light and erases darkness. We have made a beginning in creating a new system. Some important remnants of the old system are still with us. Parts of the cruelty that stigma breeds is still here. But services are being created and are innovative. More people are speaking out.

There is much to be done. Speeches to be given, lobbying to do, people to talk to, and organizations to form. Fear will bind stigma to us if we let it thrive. The stigma must be fought as fiercely as the mental illness. They can hold power over us and our loved ones. To paraphrase the poet Tennyson, it is not too late to seek "a newer world."

Attitude Exploration Exercise:
Examining your Attitudes about Mental Illness

The following questions were designed to provoke thought and to raise awareness about the stigma surrounding mental illness and the people who have a mental illness.

Understanding mental illness

Do people with a mental illness have a right to refuse mental health treatment?

Do you know the difference between mental illness and mental retardation?

Do most people who are homeless also have a mental illness?

Understanding the rights of persons with mental illness

Do you believe that a person who has had a mental health problem should avoid overly stressful situations?

Do you believe that people with a mental illness should be allowed to raise children?

Do you believe the statement "Once a person has a mental illness, he or she will always have a mental illness?"

Should people who have a mental illness be given responsibility?

Are people with a mental illness accountable for their actions?

If an acquaintance had been hospitalized for depression, would you send a card or call? How about if that person had a heart attack?

Understanding mental illness in the community

Should our government increase spending for mental health research?

Should our government increase spending for mental health programs?

Would you object to a person with mental illness living next door to you?

Would you object to a community-based treatment program moving into your neighborhood?

Do you think a Regional Treatment Center is an appropriate option for most people with a mental illness?

Does mental illness strike people with lower socio-economic status more often?

Would you hire someone who has a mental illness?

Understand mental illness
EVERY MIND MATTERS

Would you work with someone who has a mental illness? Or do you know that you may in fact already work with someone with a mental illness, but because of the stigma, he or she does not talk about it?

If the news media reported that an elected official suffers from a mental illness, do you think it is correct for the media to question that official about his/her illness?

Have you ever written a letter of complaint to a store that advertises "Crazy Days" or "Moonlight Madness" or to a television network that incorrectly portrays a person with a mental illness?

Are you comfortable when a newscaster explains that the person who went on a shooting spree had a history of mental health problems, or does it anger you?

Understanding the stigma of mental illness

Did you know that approximately 20% of Americans have mental health problems?

When you hear a friend make a comment about a "crazy person," do you speak up?

Do you correct misinformation about assumptions of people with a mental illness or mental illnesses in general?

If you have a mental illness would (are) you able to tell others?

Do you recognize the fact that many people who have had (or currently have) a mental illness are productive citizens working as doctors, lawyers, teachers, truck drivers, and every other walk of life?

Did you know that Patty Duke, Winston Churchill, Virginia Woolf and Abraham Lincoln have (had) lived with mental illness?

Do you ever comment "he is driving me crazy" or "that is nuts?"

Do you see people with a mental illness as having a personal weakness?

Would you conceal the fact that you or a friend had experienced a mental illness at some point in your or his/her life?

Learning to respond to someone with a mental illness

Do you have a clear understanding about what mental illness is?

Do you know some of the warning signs or symptoms of mental illness?

Would you know what to do if a friend came to you needing help because he or she had a mental illness?

Do you know what to do in a mental health emergency (suicide attempt, psychotic behavior, danger to self or others)?

Information prepared by the Mental Health Association of Minnesota.

Tips for Consumers by Consumers

Believe in yourself.
You have the same abilities and talents as you did before your illness. They haven't left because you have an illness, even if you think they have. It's easy to get caught up in your illness and believe you can't make it on your own.

Set-up and use a support network.
Talk to people you feel you can trust and who accept you. Although you may feel alone, you're not! There are people who care, understand and are willing to listen. Include people who are not in the mental health system as well as those who are.

Let people close to you know what your cues are.
If you're having a hard time, sometimes it's easy to cover that up. For example: when I have a hard time I try to make sure I look and dress perfectly. It helps me to feel better about myself but can give the opposite message to my friends. So let people know what some of the things are that you do when you're having a hard time. By doing this, even if you can't always ask for the support you need, others have a better chance to offer it.

Recognize that it is not easy.
It's hard to live in a community so don't let frustration get the best of you. Often, people believe we can't do anything but we can! Find something, such as a volunteer job or a talent like painting, writing, sewing, etc., and schedule time to let your self expression work for you. There are lots of places that will appreciate your efforts.

If you are on medications take them.
Sometimes the side effects can be really uncomfortable--talk to your doctor if you're having trouble.

Get to know your community.
It helps when living in a high-rise or apartment setting to try and be helpful and let neighbors know you. Respect your own confidentiality--having a mental illness is not something to be ashamed of, but tell only those people you want to know. Once people know you as their neighbor, they'll be more receptive to hearing about your illness.

Remember that it is not a failure to occasionally need to be hospitalized.
Problems don't go away just because you're ready to live independently and sometimes the hospital can be a safe, supportive environment when things get tough and you can't make it on your own--keep the faith, it will get better again.

Give yourself positive strokes
Though it's not always easy to see them, you deserve positives! Acknowledge all the positive things you do and have accomplished, and keep going.

Thanks to Nadine Phillips for these helpful tips for consumers living in the community

Involving Community Leaders and Groups in your Mental Illness Awareness Project

An overview of community organization steps

Start by setting a goal and choosing target audience.

Involve community leaders and important representatives of your target audience in the planning process of a program or event, in order to meet your goal.

Some examples of activities to raise awareness include: speaker's bureaus, briefing sessions with legislators and local officials, media coverage via public service announcements, feature stories, and media events, and a variety of other techniques as broad as your imagination.

Some examples of community leaders include: *clergy*; *school personnel,* county personnel such as *social workers and public health nurses*; *community education directors*; *hospitals*; *health professionals*; *political leaders*; *media representatives*; *service clubs*, who may be interested in taking on your cause as a specific project; *cultural community leaders*, and *community members* with a connection with mental illness.

Assign tasks to committee members, with a timeline for action. Accountability is important if you want to get things accomplished. Work as a team.

Foster a sense of enthusiasm. If you are not excited about your issue, your target audiences will not be interested and will not participate in your effort.

Stay committed to your efforts for the long-term. People may not give an immediate response, but important seeds may be planted for their future reference.

An illustration of successful community organization in action

Meetings of the Mower County Mental Health Advisory Council were held to discuss the D/ART depression awareness program. Tasks were assigned and timeline determined for depression awareness events.

A kick-off event was planned to raise awareness and promote upcoming programs for Mental Health Month.

The media was contacted, including two TV station, 4 radio stations, and several newspapers, and interviews were scheduled on depression topic.

Presentations on depression were planned for various organizations.

The two-day kick-off event included seminars at a hospital for staff and the general public, a senior center, local high schools, and a church.

The Mental Health Month three-day event included presentations for all county staff, employee assistance program staff, high schools, hospitals, rehabilitation centers, and service clubs.

Keys to Success:
A Checklist for Community Organizers

When following the five stages of community organization, there are some important things to keep in mind, regardless of which stage you are in or which specific step you are on.

Use these keys to success as a quick checklist as you begin or maintain mental health education and/or anti-stigma activities in your community.

Keep it simple

It is the simplest activities that are often the most easily implemented, most recognized by your target audiences, and most successful

Be enthusiastic and persistent

Enthusiasm is contagious so communicate your enthusiasm at all stages of development of your activity. When your project suffers setbacks and your enthusiasm wanes (as is typical in any long-term process), persist.

Recognize that you cannot do it alone

To be successful, your project requires multiple perspectives, input, and involvement. Don't burn yourself out by trying to manage tough issues on your own.

Believe in the process

Successful community organization requires careful planning and a step-by-step process of implementation

Find a specific hook for your community

There must be something about your community, whether it is something inherent to your community or timely in relation to a current issue or event, that will provide a foundation for your campaign and will capture the attention of the citizens in your area

Know your community's uniqueness

Develop your project focus, based on your community attitudes and values. Then you can adapt relevant materials from within or outside of this kit to best meet the needs of your community

adapted from information presented by Lee Kingsbury, Minnesota Department of Health, at the Minnesota Heart Health Program Dissemination Conference, June 1989

Creating Successful Community Coalitions

As you prepare to work together with others in your community to plan mental illness awareness activities, you are likely to encounter the challenges of managing a group of diverse people with different strategies for how goals should be accomplished. Though your group may disagree on specifics, it is imperative that the group establish a mutually agreeable goal, and encourage active involvement and good communication

According to A Practical Guide to Creating and Managing Community Coalitions by Daniel Merenda, the following characteristics are important to effective collaboration:

A common, unified, and highly-focused purpose
This occurs when participants agree on a purpose and focus on specific objectives. Without this, it is difficult to get things accomplished or measure if goals were met.

Active involvement of members
Make sure your goals and objectives are developed with the input of the majority of members. This assures that your activity will reflect the group's identified concerns. It also establishes commitment to the cause.

Clearly defined operating procedures and roles
In order to function effectively, all participating members must understand the ground rules of the group and its expectations of them.

Involvement of key community leaders from the beginning
Your coalition will benefit from the support and influence of community leaders, whether formal or informal. These leaders bring to your group contacts, notoriety, credibility, visibility, and access to decision makers and media sources.

A common vocabulary for effective communication
Clear, effective communication should be a priority, flowing freely between members and toward target audiences. Information is a source of power for your coalition, whether you obtain or share the information.

Atmosphere of collaboration and shared leadership
By sharing the responsibility (and the burden) for organizing and maintaining the coalition, both the group and its individual members are strengthened.

Good time management
Time is the most precious resource of each of your members. Be careful to keep meetings and activities focused and well-organized.

Evaluation of efforts
Monitor your progress in meeting your group's established goals and alter activities if goals aren't being adequately met. It is also important to make your progress known, demonstrating that your coalition is responsible and accountable.

Assignment of staff for optimal effectiveness
Whether paid, loaned, or volunteered; whether part- or full-time, it is important that someone is giving regular attention to your project.

Community Responsiveness to Mental Illness: What Physicians and Health Care Organizations Can Do

The physician is a recognized community leader in the area of health care and therefore often the first professional sought for assistance in dealing with mental health concerns or crises. Therefore, internal medicine, family practice, pediatric or other primary care doctors play an important role in the prevention, identification, early intervention, and referral of persons with mental health problems.

In addition, hospitals, clinics, and other health care organizations are important sites for the promotion of mental health and the provision of information about mental illness. *The following are some of the ways that primary care physicians and health care organizations can open the door to health and to help for persons and families experiencing mental health crises or mental illness:*

Ways to promote mental health and mental illness awareness in your practice or institution

Utilize your waiting area with information on maintaining good health and on accessing support services. Offer magazines, books, and articles health and mental health topics, as well as pamphlets, posters, and other available materials. Display your local emergency services phone number for mental health crisis in your waiting area

Provide or post information about mental illness for Mental Health Month in May or Mental Illness Awareness Week in October. Include information about mental illness or about support groups in a hospital or clinic newsletter.

Include questions regarding emotional and behavioral functioning in initial health assessments and health histories.

Promote information regarding stress management classes, parenting support groups, and other kinds of self-help groups and programs to meet mental health needs.

When treating any medical problem, recognize the linkages between the patient's body and mind, including the psychological impact of many physical illnesses or diseases.

Encourage medical schools in your state to expand training and educational activities in psychiatric disorders, with the goal of increasing knowledge and skills of medical students and residents in mental health-oriented areas.

Explore your own attitudes regarding mental health and mental illness and how those attitudes are reflected in your practice.

Provide information about careers in the mental health field for high school and college career programs.

Become aware of how different cultures, such as Southeast Asian or Native American cultures, view and are affected by mental illness.

Identification, early intervention, and referral of patients with mental health needs

Respond to patient's and parent's mental health concerns, by being an empathetic and non-judgmental listener.

Through patient health assessments, further explore patient or family concerns related to emotional, behavioral, psychological, or social functioning. If warranted, refer patients for further assessments or services by appropriate mental health professionals or to specialists for ongoing care.

Follow-up with the referred patient to determine assessment results and patient follow-through for further services. As a health professional, you are in an important educational and advocacy role in helping to assure that the individual or family obtains the services they need.

Become aware of community support services or refer patients to social service agencies who can help them identify needed services.

Provide hospital- or clinic-based crisis and needs assessment services to help in the identification, early intervention, and referral of persons in need.

Read Minnesota's Comprehensive Mental Health Act. Work with your local county social service agency to refer and coordinate the care of persons with mental illness. Learn about Minnesota's mandated mental health services and work with case managers and other mental health providers in client care.

Community Responsiveness to Mental Illness: What Employers and Business Organizations Can Do

Worksites are greatly impacted, both in productivity and bottom line terms, by unhealthy employees. Mental health costs are among the fastest rising in health care and American businesses are paying for an ever-increasing portion of those costs. One of the ways that employers can recognize the wide-spread impact of mental health problems and mental illness in the community, and manage health care costs, is through health awareness and educational activities at the worksite.

Employers can play an important role in improving or maintaining worker's health, and in educating employees about health-related issues. Employers can promote information about personal mental health, be responsive to employees' mental health needs, and encourage awareness and understanding of mental illness at the worksite and in the community.

The following are some examples of ways that employers and their business organizations can be responsive to mental illness in the community:

Promoting information about personal mental health

Use a variety of communication channels, such as newsletters, posters, and pamphlets to educate employees about maintaining mental health.

Offer educational programs and events for employees and their families on mental health topics.

Examine and alter stress-producing policies and styles in the workplace, particularly ones that perpetuate negative communication patterns and unrealistic performance expectations.

Allow for flexible work schedule policies, child care support programs, participative decision-making, and other programs and policies that help employees manage stress and increase work satisfaction.

Becoming responsive to employees' mental health needs

Provide employee assistance programs that enable employees to receive early intervention and referral in managing mental health problems.

Train supervisors how to recognize problem behavior in work performance, and how to refer employees to employee assistance programs.

Orient employees on how to use the employee assistance program and other employee support services.

Help employees make a smooth transition back to work after a health-related leave.

Offer insurance benefits that include coverage for mental health care. Enhance those benefits with good managed care programs, that help ensure quality and appropriate care for mental health.

Encouraging understanding of mental illness at the worksite and in the community

Educate employees about disabilities, including mental illness, to increase employee awareness and sensitivity to individual differences in the workplace.

Sponsor community projects that assist people with special needs in your area.

Sponsor workers in transitional or supported employment programs, and hire qualified disabled persons, including persons with mental illness, for available jobs in the workplace.

Sponsor school curriculum that promotes mental health for children, and community programs that provide mental health services for young people.

Provide information about careers in the mental health field for high school and college career programs and other business/education partnerships.

Incorporate mental health information into professional development programs for professional organizations. Hold discussions on movies or books that deal with mental illness in sensitive or in stigmatizing ways. Or invite a speaker from a mental health center to discuss depression, stress management, or other mental health topics.

Provide presentations on employee mental health and employee assistance issues, at breakfast meetings and seminars sponsored through chambers of commerce and professional organizations. Include information on mental health and mental illness as a topic in conferences for human resource professionals or employee health benefits workers.

Community Responsiveness to Mental Illness: What Churches and Service Organizations Can Do

In every community, every neighborhood, every church in that neighborhood and every service organization in the community, you can find people whose lives have been touched by mental illness. Some may have a colleague who has experienced a personal crisis resulting in the need for mental health counseling. Others may have a friend who suffers from bouts of anxiety. And some may cope daily with the serious and persistent mental illness of a family member.

Regardless of the type or severity, mental illness is prevalent. And people whose lives are touched personally, directly or indirectly, by mental illness need support and understanding, as they are particularly prone to isolation and the effects of misperceptions.

Churches, synagogues, and other places of gathering are a natural place for education, outreach, caring, and non-judgmental support. *The following is a list of ideas for churches, synagogues, and other service organizations in the community, to help improve community awareness and understanding for people and families affected by mental illness.*

Ideas for members and parishioners

Reach out to families who are coping with the serious and persistent mental illness of a family member or an emotionally disturbed child. Offer your support and understanding.

Respond to mental illness in the same ways you respond to physical illness of a parishioner. This may include hospital visits, cards, prayers, and well-wishes.

Recognize instances of stigma in your church or community. Report any abuses you see of people with mental illness, and speak out when you see persons forgotten or underserved, when you see parents being blamed for their child's emotional disturbance, or when you hear the media misinform the public.

Do more than be nice. Be a friend to a parishioner who is isolated by a mental illness. Invite him or her to church functions or lunch after church services.

Examine your own attitudes about mental illness. Mental illness is not a personal weakness or the result of sinful behavior, but a biochemical condition affecting the brain. Avoid labeling people by their illness. Recognize them as people first.

Volunteer to assist people with mental illness. Provide driving, friendly visiting, needed clothing and personal items, or just a helping and supportive hand.

Include in your personal thoughts, hope for the future for people with mental illness and their families, and for greater understanding for members of the community.

Read Minnesota's Comprehensive Adult and Children's Mental Health Acts. Learn about mental health services that each county is mandated to provide.

Understand mental illness
EVERY MIND MATTERS

Ideas for pastors, ministers, rabbis, and other religious leaders

Reach out, through pastoral care, to families who are coping with the serious and persistent mental illness of a family member.

Learn more about how the mental health system works in your community or state. Identify community resources in the area for more information and referral.

Respond to mental illness in the same ways you respond to physical illness of a parishioner. This may include hospital visits, cards, prayers, and well-wishes.

In sermons, speak about the reality of differences between the various church or temple members. Acknowledge that the church is there for all different types of families, educational and income levels, and disability groups.

Participate in special community programs, such as "Mental Illness Awareness Sundays", programs for pastors held by local hospitals and mental health centers.

Examine your own feelings and attitudes regarding mental illness.

Ideas for church groups and service organizations

Offer factual information about mental illness, denouncing the many myths and misperceptions of mental illness. Encourage members to educate themselves on what mental illness is and what it is not.

Reach out, through support groups and programs, to families who are coping with the serious and persistent mental illness of a family member.

Donate building space for a community mental health program or activity.

Sponsor a program to benefit people with mental illness or those who are homeless.

Sponsor a program about a community mental health topic. Invite a speaker from the Mental Health Association, Alliance for the Mentally Ill, the County Mental Health Advisory Council, or the local community mental health center to speak. Invite parishioners or the general public to attend.

Provide or post information about mental illness. Include information about mental illness or about support groups in a newsletter.

Examine policies and programs that encourage participation by church members who are disabled, including people disabled by mental illness.

Hold cooperative mental illness awareness programs with other churches and synagogues in your community. Focus on the topic of mental illness in sermons, presentations by affected families or recovering persons, educational or support programs, fundraisers, or commemorations for people who had a mental illness.

Support efforts at the community or government level to raise awareness, provide research funding, or promote legislation concerning people with mental illness.

Some of the ideas listed came from the National Alliance for the Mentally Ill, the Alliance for the Mentally Ill-Minnesota, and Reverend Arthur Dale of the St. Louis County Mental Health Advisory Council.

Community Responsiveness to Mental Illness: What Schools, Colleges, and Community Education Can Do

Schools are institutions of learning. Whether addressing young children, college students, or adult learners, schools provide opportunities for increasing knowledge and expanding experience.

One of the opportunities and responsibilities that rests with schools is the promotion of accurate information about mental health, as well as specialized services for people who are affected by mental health problems. These problems exist in every community and in every school.

Students young and old have something to learn and experience regarding the value of their own mental well-being and the prevalence of mental illness in their community. Schools can make information about mental health and mental illness available through educational curriculum, self-improvement classes, or information/referral or counseling services. *The list below includes just a few of the ways that school, colleges, and community education programs can be responsive to mental illness in their communities:*

Pro-active approaches for promoting mental health and mental illness information

Begin promoting information, in early grades, about mental health and well-being, in the same way that information is provided regarding physical health.

Include self-esteem and relationship enhancement activities as a part of other units in elementary and secondary curriculum. Emphasize the importance of acceptance of self, expression of feelings, and connections with others, as these critical elements of mental health and well-being are major skills needed throughout life.

Provide mental illness information in high school or college psychology or sociology classes, including information about stigma and exploration of attitudes about persons with mental illness.

Provide or post information about mental illness for Mental Health Month in May or Mental Illness Awareness Week in October. Include information about mental illness or about support groups in a school newsletter.

Offer self-improvement classes, such as stress management and communication, through community education or extension to promote mental wellness and awareness of personal and community mental health issues.

As part of curriculum on mental illness, give high school or college students an assignment to identify examples of negative stereotypes of mental illness. Discuss common attitudes about mental illness by the public, how people with mental illness are not fully accepted in the community, or how the news and entertainment media often promote misinformation about mental illness. Encourage students to speak out when they see examples of stigma, misinformation, or discrimination.

Publish the emergency services number for mental health crises in school directories.

School-based methods for problem identification and mental health intervention

Stay informed about normal child development so you can recognize symptoms that are out of the norm. Be aware of mental health disorders and mental illnesses that may affect child or adult students. Learn about community resources that serve children, adults, and families affecting by mental illness.

Determine the extent and type of students at risk for mental health-related problems, such as family crises, low self-esteem, poor performance, and behavioral problems in the classroom. Involve teachers, administrators, school nurses, counselors, and health educators, and parents and students in using this data to determine the prevention and intervention programs needed.

Provide student assistance programs, using school nurses, counselors, and community resources, to respond to students in crisis or need.

Offer support groups and peer and adult "mentors" for at-risk students.

Educate families about the range of prevention and intervention services being provided by the school.

Intervene early to ensure that the student can receive the needed evaluation, educational, social, and health care services, as soon as possible. Work with your local county social service agency to refer and coordinate services.

Involve parents, teachers, counselors, and administrators, as well as medical and community resources, in working together toward establishing plans for accommodating the special needs of students who have emotional disturbances. A partnership, which focuses on the needs of the student, will ensure the most appropriate plan.

Involve community workers from ethnic communities, such as Southeast Asian, Native American , or Hispanic communities, in the planning of mental health education programs and particularly in the identification and intervention of all children with mental health needs.

If the student must leave school for health care or treatment, provide a designated counselor or teacher to follow-up in order to prepare for working with the health care team as soon as the student is ready to return to school.

Upon return to school, provide supplemental school and community support services to help the student make the best transition possible back to the school environment.

Recognize that healthy children, who have a parent or guardian with a mental illness, may also have need for individual support and community support services.

Read Minnesota's Comprehensive Mental Health Act. Learn about Minnesota's mandated mental health services.

Community Responsiveness to Mental Illness: What Community Organizations Can Do

Mental illness is a community issue. Mental illness impacts the lives of so many. It affects the lives of one in five persons and one in four families. It affects our co-workers, our friends, our neighbors, and even our own families. Children, adolescents, adults, and elderly people in our communities are affected by mental illness. So are people at every income and educational level.

In order to deal with mental illness as a community, law enforcement, social service agencies, media, health, school, business, and church and other community organizations, must all work together for greater understanding of mental illness, and acceptance of mentally ill persons. We must accept differences and diversity throughout the community and reach out to others in need. As a community, we cannot close our doors, our minds, or our hearts, to people whose lives are impacted by mental illness.

The following are some additional ways that people can work together to recognize and respond to mental illness as a community. (Specific information for physicians and health organizations, for schools, for businesses, and for churches, is also available for more ideas for community responsiveness.)

Ways that law enforcement agencies, courts, and corrections agencies can be responsive

Provide education for the police, including information to aid in understanding mental illness and specific ways to respond to incidents involving a person with mental illness.

Educate police, courts, and corrections agencies about resources for social and health care services. Educate them about the Minnesota Mental Health Act and each county's mandated mental health services. Work with local mental health providers to coordinate services.

Educate the public about the insanity defense, and when and how it is used. Irresponsible information promotes the misperception of a link between mental illness and violence. (In actuality, persons with mental illness are less likely to commit acts of violence than the general public, and are more likely to be victims of violence.)

Involve police and courts in supporting youth diversion activities and community education programs that help children and adolescents make healthy choices.

Ways that social service and public health agencies can be responsive

Sponsor educational programs for service, civic, educational, or church groups regarding mental health. Utilize educational resources and help answer questions about mental illness and the stigma and misperceptions around it.

Speak out as an organization when you hear negative or inaccurate stereotypes about mental illness being promoted by individuals, groups, or the media.

Understand mental illness
EVERY MIND MATTERS

Encourage volunteerism or internships in your agency. Involve volunteers or interns in a project to enhance community awareness of mental illness. Involve consumers of mental health services as volunteers as well.

Provide support and advocacy programs for parents of children with mental health problems, in addition to your other social service programs.

Act as a resource to the schools to provide accurate information regarding mental health and mental illness, mental health and social services, or careers in the human service field.

Advocate for more integration and coordination of services between social service, public health, and mental health programs.

Recognize mental illness in any disability awareness programs your agency sponsors or supports.

Promote general information regarding mental health through a variety of communication channels at your office, including pamphlets, posters, or newsletters.

Ways that libraries can be responsive

Display books and materials on mental health and mental illness for Mental Health Month in May or Mental Illness Awareness Week in October.

List the emergency services numbers for mental health crises on bulletin boards.

Write book reviews of fiction and other works dealing with the topic of mental illness and include them in your newsletters and other communications. Address the accuracy of the information on mental illness and whether it takes a sensitive or stigmatizing view of mental illness.

Sponsor workshops at the library about mental illness and the needs of people with mental illness.

Encourage and welcome use of the library by residents from community -based treatment programs.

Do an in-service for library staff on mental illness and Minnesota's Adult and Children's Comprehensive Mental Health Act.

Community Responsiveness to Mental Illness: What Families Can Do

Mental, emotional, and behavioral disorders cut across all income, educational, and ethnic groups. They can be found in two-parent families, single parent families, and birth, adoptive, or foster families. Yet despite the diversity of families affected by mental illness, they have much in common. These families share the problems of isolation, inconsistency and lack of coordinated services, and staggering health care costs. They share the need for accurate information, therapeutic, educational, social, and recreational resources, and support and advocacy services, to help them and their affected family member cope with the impact of mental illness.

Despite these challenges and needs, families have strengths. And it is with these strengths that they can help their family member, support each other, and attempt to improve the system of mental health services. *The following list shows ways that families can work together with others in the community toward an improved awareness of the needs of, and the services for, their loved ones with mental illness:*

Ways that families can promote mental health and well-being at home

Listen to your children's concerns. Family communication is an important part of family health. When parents take an active interest in their children's behavior, they can provide the guidance and support children need to maintain a healthy lifestyle.

Encourage children and family members to express feelings at home. Expression of feelings are an important part of mental health and well-being.

Give children and other family members the message that you value them for who they are, as well as for their contributions to the family. Remind them that they are capable and lovable.

Help promote family member's self-confidence and uniqueness. Praise and encourage them. Acknowledge that mistakes are simply a learning experience. And most importantly, model your appreciation of your own self-worth.

Recognize times of change and crisis as a source of stress in the family. Talk about the situation and identify ways that family members can support one another.

Recognize the important role that you, as a parent or family member, play in the healthy development of children in the family.

Ways that families can address mental health needs within the family

Assess changes in the mood, affect, or behavior of a family member. If the changes become more serious or persist, seek help by contacting a mental health professional.

Recognize the common phases that a family goes through when one family member becomes ill to increase your own self-awareness and awareness of your family. Typically, the family may become more isolated, both from extended family and

friends and from the community-at-large. They may also begin to seek support and self-help from individual, groups, and books, and gather information to educate themselves about the illness. Finally, the family may look for individual and group advocacy to help themselves and the affected family member cope. These stages may repeat themselves, not necessarily sequentially. As a result of dealing with these various stages, a family may also experience times of effective coping.

Learn about Minnesota's Comprehensive Adult and Children's Mental Health Acts and the mental health services mandated in each county in the state.

Do not be afraid to ask for help. Many families keep family problems within the home for fear of being stigmatized, but it is nearly impossible for families to become empowered without outside support and advocacy.

If you are a parent of a child or adult, assist your child but set limits.

If your family member is hospitalized or placed in a community-based treatment program, stay in touch with their case manager or primary treatment professional. Ask questions if you don't understand the treatment plan.

Accept and acknowledge that your family member has an illness. Learn all you can about ways to help.

Take care of yourself. Utilize a variety of support systems and techniques: attend support groups, exercise, participate in community, religious, or social activities that help you in coping.

Recognize the important role that you, as a parent or family member, play in recognizing the onset of problems and supporting the affected individual through the treatment and ongoing care process.

<u>Ways that families can promote mental illness awareness outside their homes</u>

Involve extended family members in helping to support and understand the family member with mental illness. Let them know that with proper treatment, people can recover from mental illness.

Speak out against misperceptions and discrimination against people with mental illness. Dispel myths and educate the uninformed with facts.

Get involved with advocacy and support organizations. They can provide needed information, reassurance, and the opportunity to channel frustrations about public misunderstanding into productive efforts at raising public awareness. The collective wisdom and experience of family members of people with mental illness can provide a powerful force for advocacy and support.

Recognize the important role you, as a parent or family member, play in helping the attitude change process in the community. Share information and resources with others to improve public awareness and attitudes about mental illness. Serve as a resource to other families who share your intimate understanding of mental illness.

Some of the suggestions came from the Dakota County Mental Health Resources for Individuals and Families, The Federation of Families for Children's Mental Health, and the Education and Partnership Project of the Children's Mental Health Initiative.

Community Responsiveness to Mental Illness: How to Involve Community Officials and Legislators

One of the most important ways to promote awareness of mental illness and issues that affect people with mental illness is by capturing the attention and interest of public officials.

While it may appear challenging to gain the attention of these groups, given their busy agendas and competing influences, establishing a connection with state legislators and county officials involves many of the same elements as the connections made with other community leaders and groups: via personal contact and a mix of communications techniques. *The following is a list of tips for educating community officials and addressing legislative issues:*

Get to know more about your legislators or community officials: Identify what causes they support, their voting records, on what committees they serve, etc.

Establish personal contact. Visit your legislator's office. Make phone calls. Personalize all communications and letters.

Learn about Minnesota's Adult and Children's Comprehensive Mental Health Acts, and the service provision requirements of local social service agencies.

Prepare facts sheets and other brief informational materials. Capture attention with interesting graphics or bold messages. Hand deliver information.

Establish contact appropriate legislative aides to share information and encourage them to bring information to legislators.

Be visible at public hearings, council meetings, and other community forums. Involve authoritative experts to testify at hearings, with concise but compelling information to make a point. Be specific with what is needed and how legislators or other officials can help make that happen.

Invite officials to your group's meetings or special events. Ask them to educate you about related issues that impact persons with disabilities.

Demonstrate impact of action or inaction, using two groups as an illustration.

Involve a legislator in spearheading your cause. Involve key committee chairs, in addition to your own legislator, county commissioner, etc.

Mobilize members throughout your group for action, commitment, and advocacy.

Establish relationships with related organizations to build numbers and influence.

Gather information about the issues before your state legislator and the bills he or she may be authoring. With this information, you can present your views, concerns, and issues to the legislator in the more concise manner. *(See the numbers on the back of this page to learn how to contact your state legislators and about the bills they are involved in.)*

Tracking state legislation can be easy once you have the information you need.*

Generally, ideas of proposals are drafted into *bills*, introduced by a House and Senate author, and assigned a *file number*. Knowing a file number is important because, with the volume of bills legislators must handle each year, the file number quickly becomes the code word for specific legislative proposals.

You can track a specific proposal, a particular bill, or can check to see what bills your state Senator or Representative is authoring. You can also request information on how the bill is progressing through the legislative process.

To find out who your state Senator or Representative is, call:

Senate:	612-296-0504
Representative	612-296-2146

To find out what bills a Senator or Representative is authoring, call:

Senate:	612-296-2887
Representative:	612-296-6646

To receive a copy of a bill at no charge, call:

Senate:	612-296-2344
Representative:	612-296-2343

To find out about Committee schedules and agendas, call:

Senate:	612-296-8088
Representative:	612-296-9283

(Note: the messages on these recordings change daily, and sometimes more frequently as the session nears adjournment.)

* Information obtained from the Minnesota Department of Human Services, Mental Health Division

Making Your Pitch To The News Media

Selling a local reporter on a story is easier than you might think. Newspapers gobble up material at an amazing rate. Editors and reporters who often lack time to beat the bushes for ideas nearly always welcome timely, meaty stories - especially if they have a strong "people" angle.

Mental health advocates can get their message out by tuning into the needs of the news media, critically analyzing their areas of expertise for story ideas, and pitching those ideas to the right reporter or editor. *Here are some tips for working with the news media:*

Working with newspaper reporters and editors:

Identify an individual in your community who is knowledgeable about mental health issues, such as the county social services' mental health contact person or other mental health professional. Call upon that resource person for media and public information activities in your area.

Call the newspaper and introduce yourself and organization to the reporter who covers mental health issues or the city editor who controls what stories are written.

When you meet, identify the individual who can be considered as a resource person on mental health issues. Ask what kind of stories their newspaper is interested in covering. Provide a brief overview of current local and national issues, and perhaps whet their appetites with story ideas.

Before suggesting an idea, ask yourself: Is it newsworthy? Does it provide timely information that a broad cross-section of readers will find useful and interesting? If something happened today, it's timely. If it's expected to happen tomorrow, it's even more timely. If it happened last week, it's probably not timely. Judgments about whether something is newsworthy can also vary with people, so if one reporter bypasses an idea, you might try another reporter or an editor.

If there's an issue you'd like to see written about, it has a better chance of making the paper if there's a "news hook." A news hook helps make the case for an otherwise timeless story to go in the paper now. For example, Mental Health Month could provide a news hook for many issues.

Don't give up if you get a cool response to one idea. News value is relative - it changes every day depending on what's going on in the world. What makes the front page one day might not get in the paper, yet the next day, might be news.

Watch for national and state-wide stories that have local angles. It's probably one of your best bets for getting coverage. If there's a national story on community services for people with mental illness for example, you could suggest a follow-up story on what is being done locally.

Reporters often try to quickly "localize" stories from news wire services such as the Associated Press by asking hometown experts for their opinions. Provide reporters with a list of names and numbers of mental health professionals and reliable, clear-thinking advocates who are willing to be quoted on particular topics.

Look for success stories among the programs you're involved with the people they serve. Stories probably will focus on an individual's personal accomplishments, but they'll likely also include information on the program itself, the broader issues involved, and what is needed in the future.

Keep an eye out for background stories. If the county board is considering a particular issue, suggest a preview story to the media. Provide background information and identify resources.

Watch the bylines - the names of reporters that appear at the top of stories. If no one regularly handles mental health issues as part of their beat, watch for reporters who do a particularly good job presenting complicated subjects. When you have a good story idea, pitch it to them.

Be reliable. Think through what you're trying to accomplish and why. Promote a half-baked idea once and you may find it difficult to sell a good idea the next time. You'll be valued, if reporters can depend on you to provide useful information.

Mental health issues are important, but be sure you have reliable data when dealing with the news media. Strong, unsupported opinions can ruin your reputation in the newsroom.

If there's a speech or other event you want covered, let the editor know one to two weeks in advance. Any longer warning, and it could get lost in the shuffle. Any less lead time and there may be no one available to cover the event.

If you convey information through a phone call, follow it up by sending the information in writing to the person you spoke with.

The more legwork you're willing to do, the better your chances of getting a story in the paper. Make it easy on the reporter or editor. Supply names of people and numbers of people they can contact. Provide background information on the subject. Offer to track down other information.

Don't forget the editorial writers. Often these people need ideas for opinions and you can be among their best sources of information. Find out who writes their newspaper's editorials, meet with that person, and be prepared with well-rounded arguments to support your case.

Most editorial pages provide space for reader commentaries, usually lengthier, more formal version of a letter to the editor. Ask the editorial writer for guidelines on what kind of material is accepted and how you go about getting something in.

If you want to pass on a story idea or some information to the newspaper but don't want to be quoted, be sure the reporter knows that at the start of the conversation.

Working with Radio and Television Reporters

The same basic rules for working with newspapers apply to radio and television journalists. There are additional opportunities, though, for getting coverage.

Local radio stations usually have talk shows that deal with current issues in the news or of general interest. Meet with the program director to find out how a spokesperson for your group can be included. Choose a mental health resource person who states your group's position articulately, who can answer questions on other related areas, and who has a good radio voice.

Radio stations that take editorial positions must provide time for opposing viewpoints. Call the news director to respond to an editorial, and watch for opportunities for guest commentaries.

Many local television stations also have public affairs programs, most often in a talk show format. Call the program director to find out more about how to get an issue on the air.

For news coverage of an event, call the stations' assignment desk the morning the event takes place. Recap the information they'll need; time, place, etc. When reporters aren't available, often on weekends, cameras may be sent to get pictures that are described from the press release.

Local public access stations provide a better chance for getting air time, although your audience will be smaller than with commercial stations. Contact the cable access station in your city for specific information on what they offer. Ask about electronic bulletin boards for announcements.

Story Ideas about Mental Health Issues to Pitch to the Media

"Day in the life" stories.

This is a good way to chronicle what it's like to be a person with mental illness who in a community-based program, as one example. It provides an excellent opportunity for good photographs. The concept can also be adapted to other individuals, including mental health professionals who have particularly interesting or challenging careers.

Parents of children with mental illness

What are the special challenges? What support services are available in our community and what is needed?

Mental illness and the homeless

This is a timely topic that has received a lot of national attention. Are there any efforts being made to reach out? How serious is the situation here?

Community-based treatment

This is one of the major trends in the treatment of mental illness. Explain what this community is doing, putting it in the broader context of what is being done nationwide.

The stigma of mental illness

This story could explain what it's like to live with stigma by talking to people who are mentally ill, as well as their family members and the professionals who treat them. A good candidate for an in-depth Sunday story.

Going back to the community after hospitalization

Finding a job, a place to live and adequate support services are all major challenges. Each is a key issue that could be a separate story but would also work well linked to one person's experience.

Finding treatment close to home

Are there people in your community having difficulty because they cannot find treatment nearby? What are the options?

Depression

Depression among the elderly is beginning to get more recognition from researchers. Suicide rates in that age group are also being noted. Also of interest may be depression among teens and children, or what people do to cope when faced with chronic depression.

Care-giver burnout

What are the challenges of caring for someone who is mentally ill? Are there support groups available that can help?

Minnesota's Adults and Children's Comprehensive Mental Health Act

Explain the acts and the services mandated by them

Housing

Identify the need for safe and affordable housing for persons with mental illness, and the financial and support services needed to ensure a successful living situation

Holiday depression, or the holiday "blues."

This is a sure-fire story at Christmas. It's a good way to get information out from local professionals on how to deal with the holidays and other every day stresses of life.

Treating people with more than one problem

If someone is mentally ill and is chemically dependent, for example, what are the challenges of treating that person? Are new approaches needed?

Crime and mental illness

Next time there's a crime committed by someone who is mentally ill, consider doing sidebars of follow-up stories on 1) how the mental health system responded, or 2) Data on how people with mental illness are no more dangerous than the general population.

Mental illness and child neglect

What role does mental illness play when a child is neglected, particularly in cases involving single, teen-age mothers and the death of their infants.

Features on mental health advocates

How did they become involved? Most have personal stories about mental illness to share. Features can also focus on the problems that support and advocacy groups are geared to and how they help members cope.

Families and mental illness

How does mental illness affect families? How do they handle feelings of guilt and shame? How does society in general treat them?

A newspaper column on mental health issues

A mental health advocacy group or professional may be willing to supply regular columns about current issues.

How to Write a Press Release

Press releases are one of the main ways to get information to reporters, editors and news directors. When you're writing your release, remember that newsrooms get flooded with paper every day. *Here are some ways to help make sure your news doesn't get overlooked.*

Follow an easy-to-use format. Leave about one third of the first page blank for editing marks. Allow generous margins.

Double space and use standard punctuation. DON'T USE ALL CAPS. It irritates typists and can lead to misspellings.

Provide a contact person. Put the name of that person on the top of the page, indicate what organization that person is with, and list a daytime phone number where they can be reached.

Keep it clean. The less editing that needs to be done, the more likely the information is to get in the paper or on the air.

Be conscious of style. Make it sound like other news stories you've read. Summarize the most important information in the first paragraph and list the details in the body of the story.

Don't write chronologically. Instead start with the most current information and list the background.

Be precise. Include times, dates and addresses of upcoming events and names and phone numbers of key people involved.

Stick to the facts. Avoid information or quotes that don't tell readers anything useful. Don't use quotes from your organization's president saying: "I'd like to thank everyone who worked to make this program a success." It's guaranteed to be cut, and if there are too many to clean up, the whole release may be tossed out.

Think like a reporter. Be sure to answer all of the basic reporting questions: who, what, when, where, why and how.

Do their homework. Include separate background information that may be helpful.

More information about writing press releases is featured on the back-side of this page, including tips on structuring the release. Note that it is written in standard press release format.

Information prepared by the Department of Human Services Communications Office

Understand mental illness

EVERY MIND MATTERS

Press Release Format

Contact: Jane Smith, Director
Any County Mental Health Advisory Board
(000) 123-4567

Terri Gunderson, Public Information Officer
Minnesota Department of Human Services
(612) 296-0000

HEADLINES SHOULD BE COMPLETE SENTENCES

The first paragraph should contain the most important, timely information: What is going to happen, when, where and what for or why.

"The second paragraph often includes a quote from the leader of the organization, an expert, or a well-known person," said John Doe, President of the AnyCounty Mental Health Association.

The third paragraph gives more detail on the issue discussed or on the event being publicized.

Also remember to include phone or address for more information about the issue or your organization.

Keep in mind that when editors are short of space or time, they use only the information that fits -- starting from the top of your press release. So leave least important information for last.

Double check spelling of all names and places. Be accurate. Use only one side of the paper. It is also helpful to double space the press release for easy reading.

End the press release with a little "30" with a dash on either side. That's an old-fashioned code still taught in journalism school signalling that what follows is not part of the press release.

- 30 -

Sample Scripts And Key Areas To Discuss in Interviews or Presentations on Mental Illness

The following are many of the basic questions that you may get when you are on an interview. These answers are to be used as guidelines and can help you in preparing for interviews or presentations.

General Information on Mental Health and Mental Illness

What is Mental Illness? What Is Mental Health?

This may be a time when you will be most challenged by your audience. Many people may have in their mind stereotypes about mental illness, perpetuated by the news media and the entertainment world. Tread carefully when trying to describe either of these definitions. The following comments may be used or may just be something to ponder!

Mental illness is a term that we are not really able to describe. Almost daily new discoveries are being made about mental illness and treatments. In diagnosing a mental illness, professionals often refer to the Diagnostic and Statistical Manual of Mental Disorders Third Edition (DSM-III). Many mental illnesses are caused by a chemical imbalance in the brain. There are medications that alleviate some of the symptoms of mental illness. Some people use talk therapy to deal with their mental illness; and some use a combination of both.

Mental illness is not a result of personal failure or moral weakness. People with a mental illness often suffer because they are made to feel they are somehow to blame for their illness. However, we do not blame a person who has diabetes, heart disease or the flu. It is important to emphasize that the person is not to blame.

Mental health often refers to adherence to acceptable norms of a society. This may challenge some people's beliefs in the accepted American culture. In our multi-cultural society we must learn to be tolerant of those who are different from ourselves or our neighbors. However, if an individual displays behavior that is dangerous to self or others or is disruptive to family relations, job performance, physical well-being or everyday functioning such as sleep patterns or eating patterns, it is time to seek help from a mental health professional.

Mental health is something all of us want for ourselves, whether we know it by name or not. When we speak of happiness, peace of mind, enjoyment or satisfaction we are usually talking about mental health. Mental health has to do with everybody's everyday life. It means the overall way that people get along - in their families, at school, on the job, at play, with their associates and in their community. There is no line that neatly divides the mentally healthy from the unhealthy. There are many different degrees of mental health. No one characteristic by itself can be taken as evidence of good mental health nor can the lack of any one as evidence of mental illness. And nobody has all of the traits of good mental health all of the time.

Who Is Affected By Mental Illness?

All Americans are affected in some way. Mental illness knows no boundaries. Mental illness does not discriminate on basis of age, race, gender, or socio-economic conditions. Children as young as four years old have been diagnosed as having depression. Individuals with mental illness and families and friends of someone with a mental illness suffer greatly because of lack of understanding or because of the stigma of mental illness. Job discrimination, insurance discrimination, housing discrimination, or lost educational opportunities impact on the daily lives of those in our society who suffer the most are understood the least.

According to the National Institute of Mental Health, twenty percent of Americans will have a mental illness at some point in their lives.

Today, 10 million Americans have some form of depression.
12 million have a phobia.
1.5 million have schizophrenia.
Nearly 2.5 million have an obsessive compulsive disorder.
1.5 million have a panic disorder.

General Information on Treatment of Mental Illness

There are "traditional" types of mental health services:

One treatment is medication therapy. Specific drugs are prescribed to alleviate symptoms of the mental illness.

The second treatment is talk therapy. This relies upon a mental health professional working with the client to understand the reasons for the feelings or actions of the mental illness and how to control these.

Mental health professionals often depend upon a combination of both types of therapies to address a person's mental illness.

There are also many alternative mental health treatments. These include mega-vitamin therapy, dietary restrictions, bio-energetics and several others.

It is important to not say one type is the only way to treat a mental illness. One specific type of treatment may have worked in your personal experience, but it may not work for another person.

Sample Scripts And Key Areas (continued)

Stigma and Misunderstanding

What Is A Stigma?

Stigma is the unfair generalization of a group of people based upon false or exaggerated circumstances.

Stigma does not allow people to see others as individuals. People with a mental illness often become identified only by their mental illness, and it is often assumed that their every action is dictated by their mental illness. The majority of people with a mental illness are living and working and struggling to carry on normal lives. Their mental illness interferes with everyday life, but it does not run their lives.

Stigma closes doors on opportunities for people with a mental illness in the work place, on where to live, with educational opportunities, on having a "normal" life.

Why Are These People Let Out On The Streets?

People with a mental illness have a right to the least restrictive and most appropriate treatment available. Individuals have a right to choose to live where they want. State law mandates that each county provide a full range of community based services for people with a mental illness. This law should provide for increased community based treatment. In mental health treatment it is important to allow people to live in the most normalized setting as possible. This encourages learning social skills and independent living skills. It is in the best interest of the person with mental illness, his/her families and the community as a whole to live in the community.

However, there are some people with a mental illness who either do not have access to the appropriate services, or cannot pay for the services, or refuse the services that are offered. These issues demonstrate a lack of adequate and/or appropriate funding for appropriate services.

Are People With A Mental Illness Dangerous?

Research has shown that people with a mental illness are no more likely to commit crimes than the general population. People with a mental illness are very often victims of crimes. The entertainment media and the news media often distort perceptions of people with a mental illness.

A person with a mental illness may, at times, portray unusual behavior. This may make people around him/her uncomfortable. It is human nature to not trust a situation that you are not familiar with. Do not misjudge action for more than it is.

What About Homeless People?

There seems to be no agreement on the number of people who are homeless and who have a mental illness. Estimated vary from as few as one third to over two thirds of the homeless people have a mental illness.

Getting and Giving Help

Where Can A Person Go For Help?

There are many alternatives that a person can turn to for referrals.

Your county's Social Services Department or Community Mental Health Center
Each county in Minnesota has an identified number for mental health crisis.
Your own physician or health clinic
Check the yellow pages under:
Mental Health Services
Psychiatrists
Psychologists
Social Service Agencies

For general information on mental health

Mental Health Association of Minnesota	612-331-6840
Toll Free	1-800-862-1799
TDD	612-331-1630
Greater Duluth area (	218 726-0793
Alliance for the Mentally Ill	612-645-2498
Schizophrenia Association of Minnesota	612-922-6916
MN Depressive & Manic Depressive Association	612-333-0219

What Can I Do To Help?

Gain a better understanding of mental illnesses and people with mental illness.

Volunteer at a local mental health program.

Avoid terms which are derogatory to people with a mental illness.

Speak out when you hear others use negative, inaccurate comments about mental illness.

Challenge the media when they report one-sided stories.

Complain to advertisers who sponsor gimmicks that laugh at a person's illness.

Encourage your service, civic, social, educational, or church group to become better educated.

Be open; be available. If someone you know has a mental illness, acknowledge it. Send flowers or a card or visit. Remember a mental illness is an illness. You would not think twice about sending something to someone you know who has pneumonia. Treat a person with mental illness with the same respect.

Information prepared by the Mental Health Association of Minnesota.

Tips for Interviews or Presentations on Mental Illness

Tips for interviews or presentations

Look upon all interviews with the media or presentations to community groups as excellent opportunities to reach large groups of people that we may not be able to otherwise reach.

Be prepared to tell your own story. As a mental health consumer, family member or professional, tell what you know about mental illness.

Do your research. Know the message you want to leave with your audience.

If you have resources to refer to, have the correct address and phone numbers. Write them down!

If you have read a particularly helpful book, tell your audience. People want to learn; they just don't know where to start.

If you don't know an answer, say so. Offer suggestions of where to find answers.

Speak slowly and clearly.

Be prepared for some leading questions. Many people have strong misconceptions about people with a mental illness. Do not respond with anger. Rehearse your responses.

Avoid using stereotyping terms - refer to "people with a mental illness" not "the mentally ill!"

Don't let one person dominate the conversation. Validate concerns, then move on.

Wear appropriate clothing. Checks and stripes or flashy jewelry will detract from your message. Dress simply, attractively, and comfortably.

Use your most positive self-talk before the event or interviews. The right frame of mind will enable you to respond effectively to the questions.

Information prepared by the Mental Health Association of Minnesota

More Ideas for Mental Illness Awareness

Creating Mental Illness Awareness in Business

Contact your local chamber of commerce. Educate them about the prevalence of mental illness and the effect on the business community. Encourage their support in organizing a breakfast meeting for local businesses to discuss mental health issues of interest to business: win-win opportunities for business and disabled workers, prevention, early intervention, and rehabilitation for workers with emotional problems or mental illness, ways that business can support the needs of persons with mental illness in the community, etc. Provide them with materials to support employee education about mental health and mental illness at their workplaces. Ask for their support in planning other public awareness activities.

Creating Mental Illness Awareness in Education

Contact your local school district. Educate them about the prevalence of children with emotional disturbance. Encourage their support in planning a workshop for teachers on recognizing and supporting children with special emotional needs in the classroom. Or suggest a mental illness awareness program for students during Mental Illness Awareness Week or Mental Health Month. Provide them with resources, and tools that they can use to implement mental illness education programs. Ask for their support in planning other community awareness activities.

Creating Mental Illness Awareness in Health and Human Service Professionals

Contact professional associations for various professions in your community, such as doctors, nurses, social workers, emergency workers, etc. Educate them on the prevalence of mental illness. Remind them of the likelihood of their being the first professional that a family or individual approaches for care for mental health concerns. Offer to provide a symposium about mental illness. Ask for their support, sponsoring an ad in a local publication or other activities.

Creating Mental Illness Awareness in Churches

Contact your local council of churches. Educate them about the prevalence of mental illness and encourage them to make mental illness awareness a priority in church worship, activities, and education. Suggest a "Mental Illness Awareness Sunday" to educate and support families community-wide. Provide them with materials to support a community-wide or single church effort, including the videotapes within this kit. Ask for their support in providing volunteers to offer support to persons with mental illness living in the community.

Creating Mental Illness Awareness in the Media

Contact your local media, advertising, or public relations organizations. Educate them about the prevalence of mental illness and ask their help in creating greater public awareness about mental health and mental illness. Suggest a series of reports on mental illness. Offer story ideas and interview subjects. Ask for their support in planning creative campaigns in your community.

How Minnesota Communities are Organizing to Promote Awareness and Acceptance of Mental Illness

Across Minnesota, consumers, families, providers, and advocates are organizing to improve understanding of mental illness and its impact on individuals and families in their community. Representing local mental health advisory councils, Alliance for the Mentally Ill (AMI) or the Mental Health Association (MHA) chapters, county agencies, and other committed service organizations, these groups are making the public aware of mental illness issues and concerns. *The following are some examples of the many innovative ways that Minnesota communities are organizing to promote mental illness awareness:*

Anoka County established a *Mental Health Consortium.* They have developed a resource directory for providers, policy makers, consumers, families, and allied health professionals in the county.

Two Carver County newspapers ran a story featuring information about the local AMI chapter and its efforts to help families cope with mental illness. In addition to *interviewing an AMI member about myths about mental illness*, the papers ran a *sidebar presenting facts about mental illness.*

The Dakota County AMI chapter has held fundraisers, including *a style show and raffle drawing, a garage sale, a quilt raffle, inventory night at a local department store, and a community theater benefit.* Through ticket sales, publicity, and donation efforts, members have educated merchants, media, neighbors, and community leaders.

In order to establish relationships and make connections with community leaders, Dakota County Advisory Council members serve on a number of boards and committees, including *mental health center board, residential facility board, church board, and American Legion event committees.*

An important part of any community awareness activity is educating public officials. The Dakota County Advisory Council *keeps their County Board of Commissioners informed about mental illness* while the Dakota County AMI stays *visible at public hearings* to present priorities.

Presentations to local churches, service clubs, and other community organizations help keep mental health and mental illness visible to the community and improve community understanding. Dakota County AMI members participated in a *"Breakfast with the Experts"* for county employees.

The Dakota County AMI received a *proclamation from the county board, declaring May as Mental Health Month.* They kicked it off with an *ice cream social.* They also sponsored a local residential facility for *community night at a sporting event.*

The Duluth Area AMI sponsored a *series of free community seminars through their Community Education program* entitled "Mental Illness/Mental Wellness." The presentations included a video, followed by a panel discussion by a professional, consumer, and family member.

The Goodhue County AMI chapter *distributed information* to *key city and county officials.*

The Grant and Ottertail County Advisory Council, in conjunction with the Lakeland Mental Health Center, have *provided church and service groups with mental health information.*

The Hennepin County Mental Health Advisory Council has been active in *media watch activities, including opinion/editorial letters* to a major newspaper, in response to offensive stories or ads.

In addition, Hennepin County Social Services has coordinated *mental health roundtables, bringing together county officials in areas of recreation, law enforcement, housing, education, etc. to address mainstreaming issues and provide ideas for adapting programs* for citizens with mental illness.

Understand mental illness

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The Hennepin County MHA chapter created a *videotape,"Bridge to Understanding" to increase understanding about residential treatment facilities* for persons with mental illness.

Isanti County Advisory Council *trained law enforcement about mental illness*, and provided a resource guide.

In Kandiyohi County, MHA members have presented *information through "sandwich boards."*

The Koochiching County Advisory Council educates the community, via a *newspaper column.*

The Mental Health Association of Minnesota's *D/ART program has presented information on depression to schools, churches, libraries, and media* in communities across Minnesota. In addition, local chapters hold community awareness activities for Mental Health Month each May.

The Children's Mental Health Initiative has *organized parents of children with emotional disabilities* for identification of needs and organization of support and advocacy networks. In addition, the Children's Mental Health Subcommittee of the State Advisory Council advises on service needs and promotes understanding of the mental health needs of children and families.

Mower County's local advisory council has distributed *information to churches.*

In Ramsey County, the local Advisory Council has held *presentations on mental illness and stigma, and broadcast them on cable TV.* These presentations focus on the strengths and capabilities of people with mental illness.

The Refugee Mental Health Program of the Community University Health Care Center in Minneapolis has *interfaced with leadership of the Hmong community* to create awareness of refugee mental health needs.

Rice County coordinated a variety of public information activities, including *media coverage* concerning depression in elderly people, presentations on *mental illness and the church community*, and educational *programs for therapists and for families.*

In Rochester, local AMI members *contacted members of the Appropriations Sub-Committee of Congress* to urge their approval of a $500 million dollar budget for mental illness research.

The Range Mental Health Center in St. Louis County, has utilized the area's *community education, park and recreation, and vocational institutes to promote information about mental illness.*

The St. Louis County Mental Health Advisory Council has held *"Mental Illness Awareness Sundays" at local churches to promote information and understanding* about mental illness. Pastors give workshops to clergy, and consumers and families share their stories.

The 26th Street Project, a community-based program of the Mental Health Association of Minnesota, has held an *"art fair" and display of the original poetry and art work, created and sold by consumers.* Focusing on their creative abilities, the program helped raise awareness of the abilities of "disabled" people.

In Washington County, AMI members held a *meeting with area legislators* to discuss issues which affect people with mental illness. In addition, local Advisory Council members have maintained visibility at county fairs and health fairs.

Contributors to list include Jean Brown -Dakota County Mental Health Advisory Council Chair, Chuck Krueger-Alliance for the Mentally Ill of Minnesota, Bruce Weinstock-DHS-Mental Health Division Local Advisory Council Liaison, and other local advisory council chairs, consumers, providers, and advocates across Minnesota

Understanding the Fair Housing Amendment Act of 1988: What it means for people with mental illness

The Fair Housing Amendments Act of 1988

In 1968, Congress enacted Title VIII of the Civil Rights Act of 1968, popularly called the Fair Housing Act, to end racial discrimination in housing. Twenty years later, Congress amended the law to extend fair housing to persons with disabilities, including mental disabilities. It is now unlawful to discriminate against persons for desired housing on the basis of their race, color, national origin, sex, *as well as* handicap. Discrimination includes a variety of unlawful activities, such as coercion, intimidation, threats, interference, steering, blockbusting, limiting accessibility, or falsely representing a dwelling.

Purpose of the Act

The Fair Housing Amendments Act is a pronouncement of a national commitment to end the unnecessary exclusion of persons with handicaps from mainstream America. Thus, the views of hostile or uncomfortable neighbors, landlords, or legislators can no longer control the housing choices of people with mental illness.

Key Definitions

"Handicap" is defined with respect to a person's 1) physical or mental impairment which substantially limits one or more of such person's major life activities, 2) a record of having such an impairment, and/or 3) being regarded as having such an impairment.

"Steering" refers to practices designed to discourage or direct a person who is seeking housing in a particular community.

"Blockbusting" refers to any effort to induce or attempt to induce a person, for profit, to sell or rent a dwelling.

Discriminatory housing practices has been expanded to include coercion, intimidation, threats, or interference with any individual in the exercise or enjoyment of any right granted or protected by these fair housing amendments.

Description of Discriminatory Housing Practices

Whenever possible, Congress simply amended the Fair Housing Act to include "handicap" in the list of prohibited reasons for engaging in a particular housing activity. Thus discrimination in printed advertisements, representations of availability of housing, and blockbusting activities is unlawful.

In addition, Congress expanded upon the original provisions of the Fair Housing Act with additional disability specific provisions. These include:

It is unlawful to discriminate in the sale or rental, or to otherwise make unavailable or deny a dwelling to any buyer or renter because of a handicap

of (1) the buyer or renter, (2) a person residing in or intending to reside in the dwelling, or (3) any person associated with the buyer or renter.

It is unlawful to discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection with such dwelling, because of a handicap of (1) that person, (2) a person residing in or intending to reside in that dwelling, or (3) any person associated with that person

It is unlawful to refuse to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling. Therefore, handicapped tenants cannot be barred individual access to recreation facilities, parking, cleaning services, use of premises, and any other benefits and privileges made available to other tenants, residents, and owners. As an example, recreational activities must be held in an accessible space, though it is not necessary to hire a special recreation or social service worker to provide services for the tenant.

It is unlawful for state and local health, safety, land-use and zoning regulations to exclude or restrict people with disabilities from living in group homes or other community-based residential treatment programs. Therefore, negative attitudes, prejudices, or fears on the part of neighbors cannot keep a program out of a neighborhood, nor be used to restrict the housing options of people with mental illness.

Another statute assures that extending civil rights protections to all people with disabilities will not limit property owners' rights to maintain a safe property. Therefore, a dwelling does not need to be made available to an individual whose tenancy would constitute a direct threat to the health or safety of other tenants or of property.

The Act also limits the questions that a property owner may ask of a prospective tenant to those asked of all applicants. The owner may ask an individual questions asked of other tenants that relate directly to tenancy, such as rental history, but may not ask if the prospective tenant has a disability or ask for information regarding medical history. The only exception is that a property owner may ask whether an individual is a current illegal abuser or addict of a controlled substance.

In addition, the Act establishes standards for accessibility and adaptability for new multi-family construction, such as accessible space in common use areas, doorways designed for passage, and adaptive design throughout the dwelling, in kitchens, bathrooms, and appliances or outlets.

<u>How to handle violations</u>

Complaints are to be submitted in writing to the Department of Housing and Urban Development in Washington, or the regional HUD office or a local agency (State Department of Human Rights). Complaints must contain the name and address of the aggrieved person, the name and address of the respondent, description and address of the dwelling, and a concise statement of pertinent dates and facts.

from the Mental Health Law Project

What To Do If You Are A Victim of Housing Discrimination

What is Illegal Housing Discrimination?

Under the Minnesota Human Rights Act, and the Fair Housing Amendments Act, illegal discrimination in housing occurs if:

Owners or agents refuse to sell or rent, advertise, or use applications which express discrimination or include terms which discriminate on the basis of race, color, creed, religion, national origin, sex, marital status, disability, public assistance status, and in most situations familial status.

Financial institutions or lenders refuse financial assistance, or use applications which limit or discriminate on the basis of race, color, creed, religion, national origin, sex, marital status, disability, public assistance status, and in most situations familial status.

What can you do if you believe you are victim of housing discrimination?

The Department of Human Rights advises that any person who experiences discrimination as defined by the Human Rights Act may file a discrimination charge, through the following process:

The party who is alleging discrimination may call for information or file a discrimination charge with:

Minnesota Department of Human Rights
500 Bremer Tower
7th Place and Minnesota Street
St. Paul, MN 55101
612-296-5663 / Toll Free 1-800-652-9747 / TTY 612-296-1283

The Department will conduct an investigation into the charge in an attempt to uncover evidence to support the allegation.

If the findings support the charge, the department issues a determination of probable cause, and becomes an advocate for the charging party.

If the findings indicate that there was not enough information or material to support the allegation, and thus no probable cause is determined, the charging party may appeal the decision.

Attempts at settlement are made throughout the process. When attempts fail, the case is referred to a special assistant attorney general who prepares the department's position for a public hearing. The hearing involves the review of all evidence and facts by the administrative law judge who then issues an order. The order of the administrative law judge may then be appealed to the Court of Appeals and then to the Minnesota Supreme Court.

from the Minnesota Department of Human Rights

Resources for Mental Illness and Housing

Educational Materials on Housing and Mental Illness

Dr. Paul Carling on Housing
A 74 minute video by a nationally recognized expert on housing talks about the housing needs of persons with mental illness and strategies for meeting those needs (available from the Alliance for the Mentally Ill/Minnesota, 612-645-2948)

A variety of additional materials and articles about mental illness and housing are available from the Minnesota Department of Human Services-Mental Health Division. For more information, call 612-296-2307.

Additional information on mental illness and housing is available from the Center for Community Change through Housing and Support, University of Vermont, 802-656-0000

General housing information can be obtained from the Minnesota Office of the United States Department of Housing and Urban Development. For more information, call 612-370-3000

Housing Resources and Services

A number of HUD programs are provided by local housing authorities, whose jurisdiction is in either your city or county. *For more information, contact:*

- *United States Housing and Urban Development, 612-370-3000*
- *Minnesota Housing and Finance Agency, 612-296-7608*
- *Your City or County's Housing and Redevelopment Authority, listed in your phone book's government listings under your county or city*

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Housing in Minnesota:
Opportunities for Persons with Mental Illness

Housing in Minnesota: The Governor's Commission on Affordable Housing (1)

In response to concerns about the provision of decent and affordable housing in Minnesota, Governor Perpich appointed a Commission on Affordable Housing for the 1990's. Three factors have resulted in the need for state action on housing: 1) decreases in federal support for housing, 2) changes in Minnesota demographics, increasing the need for low income housing, and 3) more pronounced housing needs of special populations including people with mental illness, people with physical disabilities, families, and homeless people.

The Commission adopted principles to guide the development of recommendations:

1) All Minnesotans have the right to decent, affordable housing.
2) The state should first assist those most in need of help and who are most at risk of suffering from a lack of decent and affordable housing.
3) The state must recognize the needs of both renters and homeowners.
4) Communities in all parts of Minnesota must be helped with new programs, as needs differ and local communities can best determine their own needs.
5) Long-term affordability should be an objective of all activity.

As a result of the Commission, the Governor appropriated $2.75 million dollars for low-income housing, of which a portion is designated for use by people with mental illness. Such housing is coordinated with the provision of support services.

Housing in Minnesota: Department of Human Services Pilot Projects (2)

The Minnesota Department of Human Services, Mental Health Division, funds a number of qualified pilot projects for housing support services for persons with severe and persistent mental illness. Pilot projects are located in Blue Earth, Carver, Clay, Hennepin, Itasca, Kandiyohi, Olmstead, Ottertail, Ramsey, and St. Louis Counties.

These projects provide an array of housing support services for people with mental illness when they are discharged from treatment facilities, and for those already living in the community. They also help people obtain and maintain long-term housing, and maximize their dignity, so that they can develop their lives and skills in the most appropriate housing available.

Types of projects in operation include those that provide assistance with *locating and maintaining housing of choice*; *independent living skills, social and recreational activities, and the use of community resources*; 24-hour per day *response mechanism in case of emergency*; *additional support services*, such as personal care, transportation, money management, housekeeping, etc.; and *applying for government assistance* and benefit programs, particularly housing assistance.

These projects are in accordance with the Division's mission statement:

All people with mental illness should live in decent, stable, affordable housing, in settings that maximize community integration and opportunities for acceptance. People should actively participate in the selection of their housing from those living

environments available to the general public. Necessary support services should be available regardless of where people choose to live.

Housing in Minnesota: Other programs available for persons with mental illness (2) (3)

The Mental Health Division is the administrative agent for the Stewart B. McKinney Block Grant for Mental Health Services for Homeless People. The grant is federally administered by the Alcohol, Drug Abuse, and Mental Health Administration and the United States Department of Health and Human Services. The Minnesota Department of Human Services distributes money to local programs to provide outreach, mental health services, referrals, case management, supportive services, and housing services to homeless persons with mental illness. The following counties have funded projects: Anoka, Blue Earth, Clay, Hennepin, Polk, Ramsey, St. Louis (in Duluth and in the Range area) Counties.

In addition, the United States Department of Housing and Urban Development (HUD) has several housing programs that can provide low-rent housing for disabled persons, including those persons with mental illness. These programs include low-rent public housing (owned and managed by the Public Housing Authorities), Section 8 certificates and vouchers (administered by a local Public Housing Authority) Section 202 Housing (owned and managed by private non-profit organizations), and other programs.

Housing in Minnesota: Consumer attitudes about housing (2)

A survey of hospital staff and client perceptions about post-hospital placement found that *65% of clients were most satisfied with independent living settings*, while 53% were satisfied with Rule 36 program settings and 47% with living with relatives. Staff on the other hand had different perceptions: most were satisfied with client placements in Rule 36 facilities, but were less favorable of client's living with relatives or independently. (Office of the Legislative Auditor, 1989)

The *percentage of Minnesotans with mental illness indicating they were living where they wished to be living was the highest (72%) for those living independently*, while only 30% of persons living in residential treatment settings indicated that they were living where they wanted. (Ernst and Whinney, 1988)

A consumer survey conducted at the University of Vermont (Tanzman and Yoe, 1989) found that *the majority of consumers (70%) preferred subsidized rental housing*. This reflects both their preference and their income level, which is typically far below that which would permit them to rent or buy on the open market.

In a meeting between the Minnesota Department of Human Services and consumers to identify the most pressing needs in the area of residential services, *consumers requested more options beyond Rule 36 facilities, which are highly structured and offer little privacy, and complete independence. They further requested the availability of additional support services*, ranging from someone to chat with to crisis assistance, transportation services, and independent living skills training. In addition, they urged that *skills training be offered by consumers, to help build confidence among those providing services, and in turn to build a network of knowledgeable, involved consumers.*

1 *from Recommendations from the Governor's Commission on Affordable Housing for the 1990's, 1989*
2 *from the Minnesota Department of Human Services, Mental Health Division*
3 *from the Minnesota Office of the United States Department of Housing and Urban Development*

Minnesota's Comprehensive Mental Health Act

In 1987, the Minnesota Legislature passed the Minnesota Comprehensive Mental Health Act, ensuring a unified, accountable, and comprehensive mental health service system that recognizes the rights of people with mental illness, promotes the independence and safety of people with mental illness, reduces the chronicity of mental illness, and provides quality services to stabilize, support, and improve the functioning of people with mental illness.

The Act mandates that housing services be provided as part of a comprehensive mental health services system:

> *All people with mental illness should live in decent, stable, affordable housing, in settings that maximize community integration and opportunities for acceptance. People should actively participate in the selection of their housing from those living environments available to the general public. Necessary support services should be available regardless of where people choose to live.*

The Act also mandates the availability of community support services.

> "County boards must *provide or contract for sufficient community support services* within the county to meet the needs of adults with serious and persistent mental illness residing in the county."
>
> "The community support program must be designed *to improve the ability* of adults with serious and persistent mental illness; *to work in a regular or supported work environment, to handle basic activities of daily living, to participate in leisure time activities, to set goals and plans, to obtain and maintain appropriate living arrangements, to reduce use of more intensive, costly, or restrictive placements both in number of admissions and lengths of stay as determined by client need.*"

Proposed rule language further defines the community support program component for housing:

> "The county board shall *develop, identify and monitor community living arrangements services* for adults The services shall:
>
> - assist the adult *to obtain and maintain a living arrangement that is least restrictive and most appropriate* to the adult's needs, including if needed, referrals to housing services such as the Minnesota Housing Finance Agency, local housing authorities, subsidized housing programs, realtors, or private apartment rental services;
>
> - *include periodic visits to the adult's living arrangement* to ensure that the adult's health and safety are being maintained;
>
> - *not include the direct provision of, subsidization of, or payment for home care, homemaker services, or shelter*, except as provided under crisis assistance placements. "

Mental Illness and Employment:
A Research Review

Employers often express concerns regarding hiring persons with histories of mental illness: concerns regarding reliability, unpredictability, and the impact on co-workers and business clients are common.

Numerous studies have explored mental illness and employment. *The following is a review of some of those studies:*

Performance of employees with mental illness

Two studies of a majority of organizations that hired workers with mental disabilities found that few of them had a formal policy of hiring such workers, but that in most cases those *employers rated the worker's performance as favorable.* (Burden, 1975)

Research of the 2,745 employees with physical and mental disabilities at DuPont indicates that their *job performance is equivalent to that of their non-impaired co-workers in safety, job duties, and attendance.* (DuPont Company, 1982)

A comparative study of employees with mental illness showed that such employees are *indistinguishable from randomly selected employees in job performance, human relations, and overall rating.* (Howard, 1975)

A survey of 48 employers of persons with a history of mental illness revealed that most employers rated the employees as *comparable to their other workers.* Those who rated them as inferior workers cited difficulties with working alone, remembering job responsibilities, and problem solving. *Those who rated them as superior workers noted eagerness, cooperativeness, thoroughness, reliability, conscientiousness, dependability, and openness to advice.* (Margolin, 1961)

Attitudes of employers about employees with mental illness

When a group of *52 employers was asked to consider the possibility of hiring persons with a current or past mental illness, more than 75 percent responded positively.* Their attitudes were further tested when a vocational counselor attempted placements of 33 prospective employees with these employers. Out of 59 attempts with this pool of workers, nineteen employees were placed. Nine others landed jobs on their own. (Landy and Griffith, 1958)

Employer's attitudes, toward status of workers with a history of mental illness or psychiatric hospitalization, were examined. Analysis of the data showed that *job tenure is shorter among workers of employers with unfavorable attitudes, while job tenure is not affected when employers are unaware* of having persons with mental illness in their employ. (Whatley, 1963)

In an overview of employer reluctance to hire persons with histories of psychiatric problems, the most prominent reasons were fear arising from lack of knowledge and the unusual nature of psychiatric problems. (Hall, 1966)

Returning To Work:
Ideas for Employers Helping Employees Make the Transition Back to Work

As an employer, you know that every employee sometimes experiences stress, anxiety, or even depression. Some employees are able to cope more easily than others. Some can manage stress on their own, with support from family, friends, or people at work. Others may benefit from a formal support services, such as a referral to the employee assistance program or other counseling in the community.

But some employees may experience feelings so severe that traditional methods of coping are not adequate. Some may become incapacitated to the point that they are temporarily unable to work, possibly requiring hospitalization before they can return to work.

You can play an important role in helping to make the transition back to work a smooth one for both the worker and the workplace. *The following are some tips for employers interested in helping their employees who, because of a mental health problem or mental illness, have been temporarily absent from work.*

Be sensitive
Recognize that treatment of a mental illness is a process, just as treatment from a physical health problem or illness takes some time.

Be patient
Provide the employee with an opportunity to "walk before running" on the job. This allows the employee a chance to acclimate to the work environment, and helps ensure a more complete recovery. Soon the employee will return to previous, even improved, levels of functioning over pre-illness work performance.

Be positive, but realistic, in setting return to work goals
Assume that the returning employee can return to his/her former position, but if the employee indicates that he/she is not yet ready to return to that position, work with the employee to find a somewhat less demanding task or modify the job to accommodate the employee. Then, establish some step-by-step goals for returning to the former position. This will help ensure a smoother transition.

Be supportive
If possible, assign an understanding supervisor to the employee. Encourage co-workers to take a role in welcoming the employee back to work. Such support at work can help eliminate feelings of isolation on the part of the employee.

Be respectful of privacy
As the employer, you may be aware of the details regarding the employee's absence. This is confidential information and should be respected as such. If the employee elects to share an explanation for his absence, that may foster added support from a co-worker who experienced a similar situation in his/her own life or in the family. But it is up to the employee how much or how little information, if any, he/she wishes to make public.

Special thanks to consumer John Wills for generating the ideas used in this information sheet

Returning to Work:
Ideas for Employees Making the Transition Back to Work

Every employee sometimes experiences stress, anxiety, or even depression. Some employees are able to cope more easily than others. Some can manage stress on their own, with support from family, friends, or people at work. Others may benefit from a formal support services, such as counseling through the employee assistance program or other program in the community.

But some employees may experience feelings so severe that traditional methods of coping are not adequate. Some may become incapacitated to the point that they are temporarily unable to work, possibly requiring hospitalization before they can return to work.

If you have experienced a temporary leave of absence due to a mental health problem or mental illness and are now looking at returning to work, you play an important role in helping to make the transition back to work a smooth one for both you and your employer. *The following tips are for employees who, because of a mental health problem or mental illness, have been temporarily absent from work, and are now making the transition back to the workplace.*

Be patient
Accept the fact that it may take you some time to prove to yourself, as well as your co-workers and your employer, that you can manage your job.

Be realistic
Upon returning to work, you may find that you cannot return immediately to your old position. Instead, you may need to take a different, less stressful, position for a short time period. This may occur for a variety of reasons:

- You may decide that you are not ready to return to your old position.
- Your employer may want to see how you handle the work situation in general, before you return to your former position.
- Your position may have been filled in your absence.

Be flexible and willing to accept a change in your position, even your job status, when you first return. Work with your employer to set realistic goals for a smooth transition back to your former position. Trust that your employer wants you to succeed, but you must learn to "walk before you run" on the job again.

Be positive
Believe that your employer and your co-workers want to help. They are interested in making your transition back to work a smooth and successful one.

Be aware
Not all your fellow workers may be supportive. Some may be insensitive or unsympathetic. Give them time. Many will become more understanding over time, especially when they see you respecting yourself and taking pride in your ability to return to work. And remember that one in four families have experienced mental illness, so chances are that most people already know or will know someone close to them who has a mental illness.

Understand mental illness
EVERY MIND MATTERS

Be yourself
There is no need to explain your illness in great detail to anyone. When necessary, explain, in general terms, that you were ill and simply indicate that you received help and now you are much better and able to work again.

Your fellow employees will react to you, based on how you react to them. Be yourself; not apologetic, not defensive, just yourself.

Be proud
Each day, you are taking another step in the process of overcoming a major illness. Take pride in your determination. Though you may feel frustrated that your illness may mean a temporary set back in your work career, your eventual success on the job, and proving to yourself and your employer that you are fully recovered is worth it!

And if you are looking for a new job, be determined
Looking for a new job, may be more difficult because of your mental illness. Be determined, however, because with effort you will find the right job and the right employer for you.

Be honest in interviews and on job applications when asked if you have ever been treated for a mental illness. However, you do not need to provide other details or information concerning your mental illness history.

When you are on a job interview, you are selling yourself. Therefore, emphasize your skills, qualifications, and achievements. Prospective employers are interested in the benefits to them and to their company if they hire you.

Special thanks to consumer John Wills for generating the ideas used in this information sheet

Strategies for Successful Job Placement: How Employers, Counselors, and Employees Can Work Together

What employers can do to enhance work experiences for employees with mental illness

Work closely with a vocational counselor, or community support program, to provide details about job expectations. This will help match an employee to the employer's needs.

Be confident about working with disabled persons. Studies show that mentally disabled workers are typically indistinguishable from other employees, and in many cases demonstrate strengths over their co-workers in the areas of conscientiousness and dependability.

Note that you cannot exclude categories of people from consideration for a job. For example, specifying a desire to recruit a physically disabled person is unethical. Instead, identify a desire to access the job applicant pool from a vocational rehabilitation firm or community support program, and they will provide you with information regarding all qualified candidates.

Upon interviewing a prospective employee, remember that information regarding mental health history is confidential information and should be respected as such.

Once an acceptable match is made, work with the program counselor to determine an appropriate training schedule and transition to the job. If possible, assign an understanding supervisor or sensitive co-workers to work with the employee, to aid in the success of the work experience.

What vocational rehabilitation counselors, community support programs, and case managers can do to enhance their client's work experiences *

Know your clients and your employers well, including your client's skills and tolerances, your employer's needs and values, the skills and tolerances of each particular job, and the consequences of poor placement in relation to the client, the employer, and the job.

Prepare presentations regarding particular job candidates. Be clear and concise with employers. Avoid psychological jargon.

Obtain detailed work histories on all clients. Gather as much detailed information as possible, including positive aspects of the work experience for both the employer and the employee, as well as overall work assessment.

Take the time to complete an asset and skill review for clients who have been out of work for a long time, in order to identify the qualifications that the client can bring to a job. This information will enable both counselor and client to best "sell" the client's skills to a prospective employer, rather than relying on descriptive psychiatric symptoms.

Build up the client's confidence, in order to improve their motivation and momentum in job seeking. This can be accomplished through job skills groups, peer support groups, or regular contacts and pep talks.

Examine your own attitudes regarding the client's skills and abilities. Fears of client failure will sabotage counselor's ability to convince an employer to hire a client. A belief that people can and do progress, and that everyone has some job skills, is critical to the counseling role.

Be open-minded and do not simply screen out people for certain jobs before they have a chance to compete for that job. If someone has skills reasonably similar to the expectations of a job, refer him/her for an interview. The interview is a forum for the client to get information and feedback.

Recognize that "stressful jobs" are in the "eye of the beholder." While an employer might indicate that a job is stressful, do not assume that it is not appropriate for someone with a mental illness.

When sharing information about a client's disability with a prospective employer, stress the positive aspects of the person's past, with primary emphasis on current functioning. Describe clients in terms of their qualifications for the job, not in terms of their disabilities.

Maintain communication with clients once they have been placed in a job. Recognize the reality of the client's losses (agency support, financial support, etc.) in addition to the more obvious gains (status, income, and independence). Therefore, it is important to plan for ongoing follow-up with the client, including brief meetings (off the client's work-time) or phone calls.

What employees can do to enhance their job search and work experiences

Provide your vocational counselor or case manager with any information regarding your skills and your work history. Regardless if you have been out of the job market for a long time or have never had a job, you have skills and abilities that can contribute to many jobs.

If you do not know your skills, actively participate in an asset and skill review provided by your counselor or case manager. This provides important information about your abilities. Focus on these abilities, rather than on fears and limitations, as you proceed with vocational planning.

Job seeking can be frustrating for anyone. You put yourself on the line each time you go out to a job interview, so take care of yourself and accept support. Look upon each job interview as a opportunity to improve your interpersonal skills and to get information and feedback. Focus on positive aspects of your performance in the interview, even if you were not accepted for a job.

Don't rule out a job just because you do not fulfill all the expectations listed for a job. Focus on the qualifications that you do have for the job. Be open-minded and confident about your abilities.

Participate in job skills groups, peer support groups, or other pep talks from counselors and peers. Your confidence in yourself will fuel your motivation and give you momentum in job seeking.

Accept the fact that it may take you some time to prove to yourself that you are able to work. Take pride in your determination along the way.

Be honest in interviews and on job applications, when asked if you have ever been treated for a mental illness. You need not provide other information concerning your mental illness history.

Once on the job, assume that your employer is interested in making your work experience a smooth and successful one. Set goals with your employer, and work to achieve those goals.

Recognize that all your fellow workers may not be supportive. Many will become more understanding over time, especially when they see you taking pride in your yourself and your work.

Maintain communication with your counselor or case manager after you have been placed in a job. This is an important time for acknowledgement of your progress.

Recognize that the excitement and challenge of a job is both a gain and a loss. While you benefit from improved status, income, and support, it is common to feel anxious as you give up agency support, financial support, and vocational support. Accept the normality of these feelings, but emphasize the gains of your new found job status.

**adapted with permission, from "Job Placement Techniques for Counselors Working with Persons with Psychiatric Disabilities", by Joseph Marrone*

Mental Illness and Employment: Alleviating Employers' Concerns

There has been increasing interest and effort in the availability of employment opportunities for persons with mental illness. Although many of Minnesota's employers are providing employment opportunities, many persons with mental illness face unemployment due to a reluctance by employers to hire them. This reluctance typically is the result of misperceptions about mental illness. Concerns expressed by employers frequently include the stigma associated with mental illness and the resulting concerns of workers and clients, reliability and attendance of workers with mental illness, and fear of saying or doing the wrong thing with a employee with mental illness.

One of the ways to counteract stigma is to provide accurate information and educational materials that increase employers' awareness and understanding of mental illness. Another way is through effective job placement, matching job candidates with the right job and employer.

The following addresses some of the common questions and concerns raised by employers, in regard to hiring persons with mental illness:

Can I rely on persons who have been treated for mental illness to be good and reliable workers?

When placed in appropriate job situations, persons with mental illness are as effective in their work as other workers. When there is additional support provided, either through a supported employment program, community support programs, or other kinds of vocational rehabilitation, employer/worker relationships are even more successful.

Employers' experiences show that workers with a mental disability are equal to other workers in terms of job performance. In some cases, these workers have demonstrated superior motivation, attendance, and punctuality. This may be because these workers show a great loyalty to persons and companies that assist them in leading a normal life.

However, it is important that employers have realistic expectations. All situations are not successful. In some cases, as with all employees, the employee will demonstrate an ability to meet performance expectations or even to perform at above average levels. In other cases, again as with all employees, individuals with mental illness may not be ready or able to handle the job demands. In other words, people with a history of mental illness present the same risks as any other employee. Like other employees, they must be able to show qualifications for a particular job in order to be hired, and must be able to meet the expectations of the job in order to be retained The important thing is that persons who have a mental illness deserve, like all persons, the chance to succeed and the chance to fail in a job. When additional support is needed to maintain employment, it is essential that employers work with the employee and available support programs to enhance the possibility of successful employment.

What kind of jobs are people with mental illness suited for?

Like all job-seekers, an individual's potential depends on personal talents, experiences, and motivation. Many people who have recovered from mental illness have held positions of high regard and responsibility, such as Abraham Lincoln, Vincent Van Gogh, and Virginia Wolff. An employer who hires persons with mental illness provides them with the opportunity to achieve

independence and full potential, and provides a benefit to society through the enhancement of individual creativity and productivity.

Will people with mental illness negatively affect my productivity, turnover and health and disability insurance rates?

As discussed above, the key to successful job placement and stability is a good match between the worker's talents and abilities and the job itself. A person with mental illness presents the same opportunity and risk for productive work as any other employee.

But expectations should be realistic. Loss of time from the job by any worker can pose a problem. A person with mental illness may possibly relapse and require short-term treatment. Flexibility in scheduling and work hours will help all workers, including workers with occasional personal needs. Flexibility at work helps improve morale for all workers, as they continue to meet the performance and productivity expectations of their jobs.

As far as increased insurance rates, insurance companies do not track disabled employees. It is the business of the employer to make employment decisions, not the business of the insurance company. Employers interested in containing their health care costs and insurance premiums in general can do so by having employee assistance programs, safety programs and policies, and health promotion activities to enhance the health of all employees.

How will other workers feel about having persons with mental illness at the workplace? Will they be safe working with a person with mental illness?

Lack of accurate information fuels fears about persons with mental illness and their ability to adapt into situations. Most employers and workers are surprised to learn that they cannot distinguish persons with mental illness from other workers. Mental illness is quite prevalent in our society. One in four families is affected.

Unfortunately, movies and television often portray persons with mental illness as violent and unpredictable. This promotes a negative and inaccurate stereotype of mental illness.

In reality, persons with mental illness are no more likely to commit criminal acts than persons without mental illness. In a study of people who had been treated for mental illness, only one tenth of one percent were arrested for violent crimes. In each of those few cases, all had a criminal record before their treatment for mental illness. In other words, a person who has been treated for mental illness and does not have a previous criminal record is considered to be less likely to be arrested than the average citizen. In addition, because mental illness often makes people more passive, persons with mental illness are more likely to be victims, not perpetrators, of aggressive acts.

Unpredictability is another myth of mental illness. Experts state that most relapses into acute episodes of mental illness develop gradually, not instantly or even unpredictably. Physicians, family and friends, supervisors, and individuals themselves can help recognize some early warning signs and assist in seeking care before symptoms progress.

What To Do If You Are A Victim of Employment Discrimination

What is Employment Discrimination?

Employment Discrimination or unfair employment practice, occurs when an employer, employment agency, or labor organization denies employment to (whether not hiring, firing, or discriminating against) an individual on the basis of *race, color, creed, religion, national origin, sex, marital status, and status with regard to age, public assistance, or disability*.

Disability refers to any condition or characteristic that makes a person disabled. A disabled person refers to anyone who has a *physical or medical impairment which materially limits one or more major life activities*, who has a record of such impairment, or who is regarded as having such an impairment.

What is within the rights of the employer?

An employer can look for information which will determine whether a person can *safely and efficiently perform* the duties of the position for which he or she applies. This may include requiring a physical examination, provided (1) that an offer of employment has been made on the condition that the person meets the physical or mental requirements of the job, (2) that the physical examination only tests for essential job-related abilities, and (3) that the examination is required of all persons conditionally offered employment for the same position.

An employer can also *administer pre-employment tests*, provided (1) that the tests measure only essential job-related abilities, (2) that the tests are required of all applicants for the same position, and (3) that the tests accurately measure the applicant's aptitude, achievement level, or whatever factors they purport to measure.

An employer may also, with the employee's consent, *obtain additional medical information* for the purpose of establishing an employee health record.

What can you do if you believe you are victim of employment discrimination?

The Department of Human Rights advises that any person who experiences discrimination as defined by the Human Rights Act may file a discrimination charge, by calling:

Minnesota Department of Human Rights
500 Bremer Tower
7th Place and Minnesota Street
St. Paul, MN 55101
612-296-5663 / Toll Free 1-800-652-9747 / TTY 612-296-1283

The Department conducts an investigation into the charge to uncover evidence to support the allegation.

If the findings support the charge, the department issues a determination of probable cause, and becomes an advocate for the charging party. Action is then taken to stop the discriminatory act and to provide relief for the person who has suffered the discrimination.

In an employment discrimination case, relief may include (1) the hiring, reinstatement or upgrading of a person, (2) the admission or restoration to membership in a labor organization, and (3) the admission to or participation in an apprenticeship training program, on-the-job training program, or other retraining program. Relief could also include (1) compensatory damages, (2) punitive damages, and (3) damages for mental pain and suffering. Violators of the law will be assessed a civil penalty payable to the State of Minnesota.

Any person who files a charge of discrimination, testifies, assists, or participates in any way in an investigation, hearing, or any other proceeding conducted by the Minnesota Department of Human Rights, is protected by law against any reprisal by person, employer, labor organization, or employment agency.

from the Minnesota Department of Human Rights

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Understand mental illness
EVERY MIND MATTERS

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LWVMN Education Fund, 550 Rice Street, Suite 201, St. Paul, MN 55103 1/89

MENTAL HEALTH POSITION STATEMENT

Position: LWVMN supports a comprehensive and coordinated system of programs and services for mentally ill adults and emotionally disturbed children and adolescents (hereafter referred to as "persons with mental illness"). Priority should be given to persons with acute and/or serious and persistent mental illness. Minnesota public policy and funding should sustain an array of community based services which are available and accessible to persons with mental illness. Administration of that policy should provide clients with appropriate and adequate services.

-LWVMN supports adequate and consistent funding for services for persons with mental illness. Public funding should be flexible, following the client's needs, yet accountable to the public.

-LWVMN supports a range of appropriate housing options for persons with mental illness.

-LWVMN supports a commitment process which ensures prompt and appropriate treatment for persons with mental illness while protecting their civil rights. The commitment process should enable the commitment of persons so gravely disabled by mental illnees that they cannot meet their basic human needs.

-LWVMN supports a coordinated system of quality assurance (including standards, mechanisms to monitor and the ability to take corrective action) for programs and services for persons with mental illness with an emphasis on evaluating outcomes and consumer response.

-LWVMN supports continuing state financial responsibility for improved intensive treatment programs and adequate living conditions for persons currently served in regional treatment centers.

Approved by the LWVMN Board of Directors, January 10, 1989

MENTAL ILLNESS IN MINNESOTA, PHASE I FINAL REPORT

"Mental Illness in Minnesota," a two-year study by the League of Women Voters of Minnesota, 1987-89, examined the mental health system in Minnesota with particular emphasis on the availability and quality of community services. The project reviewed current programs and policies, promoted statewide education about mental illness and the mental health system, and trained volunteers to further monitor community programs for those with mental illness.

The project began with adoption of the study at the June 1987 LWVMN state convention. In August 1987 a committee of metro and Greater Minnesota League members formed to scope out the education and monitoring portions of the study. Because services for those with mental illness are often administered at the county level, the committee determined that educational efforts should be directed to county commissioners as well as to local League members. A pre- and post-survey of levels of awareness of mental health services was taken by local Leagues of their county commissioners. Nine serialized fact sheets were published and distributed to all local League members, 489 county commissioners, 87 chairs of county Mental Health Advisory Councils, human services and advocacy organizations, churches, public libraries, etc. The fact sheets explored mental illnesses, the 1987 legislation, funding, continuum of services, housing and employment, commitment laws, children and adolescents, quality assurance and unresolved issues.

Local Leagues studied these fact sheets in conjunction with local meetings featuring consumers, commissioners, social service directors and others who described and debated community and county mental health services and programs. Several Leagues used videotapes and printed materials from the Alliance for the Mentally Ill and the Minnesota Mental Health Association. Twenty-one Leagues in twelve metro and Greater Minnesota counties interviewed county staff, commissioners, providers and consumers to formulate an initial profile of mental health services in those counties.

In April 1988 a 46-page publication "Serving Minnesota's Mentally Ill: An Introduction" was published and distributed at the April 19th public forum, "Creating Quality in Services for the Mentally Ill". That forum offered 215 participants the opportunity to hear Allyson Ashley, Department of Human Services Mental Health Commissioner, Norma Schleppegrell, chair of the State Mental Health Advisory Board, Tish Halloran, Hennepin County Social Services director and other providers and consumers discuss quality control in mental health services and facilities. In the fall of 1988, 78% of all local Leagues, representing 2,069 members, participated in the consensus (membership agreement) process, translating much of their previous year's study of mental health issues into LWVMN positions.

The LWVMN committee members with Barbara Flanigan as writer and editor, researched and wrote a comprehensive 100-page publication "Monitoring Mental Health Services at the County Level: A Workbook," published in March 1989. As part of their own education, the committee sponsored a series of public forums and field trips, including lobbyist Louise Brown and Wisconsin parent-advocate Bev Young, and trips to Anoka and St. Peter Regional Treatment Centers.

The second year of the project was originally planned to offer hands-on monitoring workshops, training volunteers to assess the quantity and quality of local mental health services and facilities. However, LWVMN was subcontracted by the Humphrey Institute to write curriculum for 12 workshops on mental health policy and implementation which the Institute offered statewide April-June 1989. Included in the workshop materials for the almost 1,000 participants were the two League publications, the Introduction (April '88) and the workbook (March '89). Following the Humphrey workshops the LWVMN committee continued with its plans to offer four regional monitoring workshops in the fall of 1989. Those workshops, in Minneapolis, Duluth, Alexandria and Rochester, enabled about 200 participants to learn how to use the monitoring workbook and to organize a local program of assessing and evaluating county mental health services and facilities. (A detailed report on the monitoring workshops will be available in May, 1990.)

Because learning how to monitor just barely opens the door to actual monitoring, LWVMN applied for and received a significant grant from the McKnight Foundation to continue "Phase II" of the mental illness study. This two-year project will assist specific Leagues in counties representing a variety of socio-economic and geographic characteristics to actively monitor and document their mental health community support programs and policies.

Phase II speaks eloquently to the lessons of Phase I: that issues surrounding mental illness are complex, and changes are slow. During the consensus process in the fall of 1988 League members, after a full year of study, wrestled with the difficult questions of voluntary vs. involuntary commitment, client- or service-oriented funding, diagnosis and treatment of emotionally disturbed children and adolescents, etc. Our post-survey of county commissioners showed that the fact sheets and, no doubt, the intervening political debate, had raised their awareness somewhat but not dramatically. Real change will come slowly and incrementally. And that is the intention of Phase II of the LWVMN project: to assist local Leagues and other interested organizations within a community to work one-on-one with county commissioners, staff and providers to assure real and lasting improvements for people with mental illness.

League's study, publications, public forums and cooperation with other organizations concerned with mental health services have placed LWVMN at the forefront of the Minnesota movement toward improved services. The League has assisted the Department of Human Services in reviewing county mental health plans. In 1988, the Alliance for the Mentally Ill gave LWV their Special Recognition Award for "... dedicated efforts and outstanding achievments in helping to bring a better quality of life to those affected by mental illness." The Minnesota Psychiatric Society awarded LWVMN their 1989 Public Service Award for the publications and educational efforts 1987-89. And, perhaps most important, letters from consumers have come to the state office, expressing their appreciation for League's willingness to promote to a wider audience a better understanding of issues surrounding mental illness.

League of Women Voters of Minnesota Education Fund
550 Rice Street, St. Paul, MN 55103

Mental Illness in Minnesota
Project budget

Publications	Budgeted	Actual
Volunteer resource committee		
10 meetings, travel for 8 nonmetro, 13 met mems, materials and supplies, conferences, research pubs, task forces participation, mailings	$2,867.50	$1,372.44
Printing		
Fact Sheets		
12 fact sheets, printing, mailing, distribution to cty commissioners, legislators, organizations, local Leagues, 4500 copies	4,808.00	3,208.48
Publication (compile edited fact sheets, plus LL info)		
printing 30 pp booklet with cover, distribution, mailing, 4500 copies	5,195.00	10,164.78
Monitoring guidebook		
printing, distribution, 1500 copies	2,916.00	11,160.35
Publicity		
news releases, announcements, notices, phone calls, mtgs with editorial boards	300.00	64.89
Personnel		
Staff director, development/PR director, secretarial, clerical, bookkeeping, editorial	4,707.00	6,574.29
Office costs	250.00	938.50
Administrative reimbursement	$3,156.52	4,658.96
Total publications expense	$24,200.02	$ 38,142.69

Outreach		
Assistance to local Leagues, fall contacts with policy makers, mental health providers mailings etc	$ 389.00	201.79
Committee expense		
mileage	250.00	992.51
Monitoring training		
mileage for trainers, participants, facilities, publicity,	1,609.00	3,001.62
Structure for maintaining contacts for on-going monitoring and education, calls, mailings, visits	300.00	501.73
Announcement of findings of monitoring*	703.00	-0-
Personnel		
Staff director, development/PR,Secretarial, Clerical, bookkeeping	1,635.00	3,220.17
Administrative reimbursement	732.90	2,369.70
Total outreach expense	$6,351.80	$10,287.52

*at end of Phase II

Mental Illness in Minnesota project budget (page 2)

Public Meeting

Expenses		Budgeted	Actual
Facility rental costs		$ 300	-0-
Speakers, panelists		580	177.20
Committee expenses			
mileage, materials, mailings		282	-0-
Materials, supplies			
program, nametags, agenda, meal tickets, evaluation forms		108	143.07
Video Production			
Production expenses, editing, cassette duplicating		250	
Publication			
to be distributed to all attendees (paid for under publications) for 215 @ $4 =		-0-	(860.00)
Publicity, postage			
flyers,postage, news releases, PSAs		1,015	1,421.28
Staff director and support staff time		900	721.60
Administrative reimbursement		514	596.85
Total		$3,950	3,059.95
Income			
Registration fees			
50 LWV members at $10	$500		
30 non-members at $15	$450	$ 950	957.50
Mental Illness project income from grants & contributions*		$34,501.82	$30,040.00
Total Mental Illness project income, other than contributions - publication sales		$ 950.00	16,854.82
Total income		$33,551.82	$48,262.32
Total Expense			
Pubs	$38,142.69		
Outreach	10,287.52		
Focus	3,059.95		
			$51,490.16
Difference (expense over income)			$ 3,727.84

*This publication Was made possible by a major gift from the McKnight Foundation.

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MENTAL HEALTH MONITORING II

COMMUNITY SUPPORT PROGRAMS/CASE MANAGEMENT IN COUNTIES

BACKGROUND AND PROJECT DESCRIPTION

Historically, discussions of services to persons with serious and persistent mental illness in the community usually focused on clinical services. Increasingly, however, interest centers on the creation of a system of social supports which can often reduce the number of hospitalizations or the length of hospital stays. The failure to provide adequate community support services in many parts of the nation is one of the reasons why people report that "deinstitutionalization has failed." A number of specific programs have been initiated by counties and are now mandated by the state to provide a strong support network. Most important are CSP programs and case management services for persons with serious and persistent mental illness. Vocational services provided by the Division of Rehabilitative Services of the Department of Jobs and Training are also a key in any support network. In addition, the Mental Health Division has also recently established several other programs, administered by counties, which provide support. CSP services are relatively new in many Minnesota counties. Until the passage of the Minnesota Comprehensive Mental Health Act in 1987 forty of Minnesota's 87 counties provided no CSP services.

CSP Programs

CSP programs are intended to provide a wide range of support services for persons with serious mental illness in the community. Under Minnesota law CSP services include: client outreach, medication monitoring, assistance in independent living skills, development of employability and work-related opportunites, crisis assistance, psychosocial rehabilitation, help in applying for government benefits and housing support services. CSP services, particularly psychosocial rehabilitation, emphasize clients wellness, rather than their illness. CSP programs are funded by Rule 14 state funds (90 percent) with a ten percent county match. CSP services are often provided by a contracting agency, sometimes a mental health center, rather than directly by the county.

DRS (Division of Rehabilitation Services of MN Jobs and Training)

DRS and CSP programs overlap to some extent. DRS, funded with federal and state monies, is charged with aiding persons with disabilities, including psychiatric disabilities, in training and finding employment. Services are time-limited and outcome oriented.

Case Management

Case management, as currently defined by Minnesota law and regulations, is based on the "broker" model emphasizing the linking of clients to services, rather than on helping with

independent living skills. Case management is available to all persons with serious and persistent mental illness who request it (up to available county resources). It is financed by a combination of Medical Assistance, Rule 14 and county and/or CSSA funds. Case management is regarded as the "glue which holds the system together."

PROJECT DESCRIPTION

Each local project will use questionnaires and focus groups to assess the range and quality of community support and case management services for persons with serious and persistent mental illness.

Questions will investigate the following issues:

CSP Service

--The breadth of community support services--the number of services provided and the frequency of services.

--The percentage of the estimated population with serious and persistent mental illness reached by CSP services.

--Strengths of CSP services as stated by staff, agencies and consumers.

--The degree to which client preferences govern CSP programs.

--Consumer hiring in CSP programs.

--Obstacles to providing more complete CSP services.

Case Management

--The number of case managers in the county and the ratio of case managers to clients.

--The number of times clients are seen by case managers per month.

--Strengths of the case management system.

--Obstacles to the delivery of case management services.

Vocational Services

--the availability of vocational help to persons with serious and persistent mental illness.

--the number of supported employment programs (slots) in the county.

--the number of persons with serious and persistent mental illness

who have been placed in training and jobs.

Where relevant, questionnaires will also look at coordination between traditional CSP programs and case management and such programs as Anoka Alternatives, IMD and OBRA which serve selected groups of clients.

MENTAL HEALTH MONITORING II

COMMUNITY SUPPORT PROGRAMS/CASE MANAGEMENT IN COUNTIES

GRANT APPLICATION

Local League_____

Counties Involved_____

Applications should be received in the LWVMN office by June 30, 1992.

* * * * * *

Each local project will

1. Recruit local volunteers.

2. Contact county officials, CSP providers and consumers as needed.

3. Return completed questionnaires/checklists to the state project director in at timely fashion.

4. Return a final report form to the state project director.

5. Prepare a written report in narrative form of local findings to be presented and distributed locally.

6. Keep track of all expenses using project funds and report to the LWVMNEF on the spending of all funds.

The state project will:

1. Prepare all questionnaires and checklists, sample letters and press releases.

2. Provide training to volunteer monitors.

3. Offer technical assistance to local projets as needed.

4. Prepare a statewide report incorporating local data.

PROPOSED BUDGET

(Note: A total of $3000 will be allocated among all local projects.)

This budget need not be watertight. It is possible to transfer

sums among categories during the course of the project.

It is also possible for volunteers and the coordinator to donate stipends and expenses back to the local league.

Amount requested_____

Budget

Payment to local league		_____
Local coordinator's stipend		_____
Coordinator/volunteer expenses		_____
mileage (@ .15 a mile)	_____	
child care	_____	
phone calls	_____	
Project expenses		_____
copying	_____	
typing	_____	
postage	_____	
final reporting	_____	
other	_____	
TOTAL		_____

* * * * * * *

We understand the monitoring project and agree to implement it in our county.

Signature_____

Office_____

Questions: call Barbara Flanigan (612) 374-2892 or Sally Sawyer at the LWVMN office (612) 224-5445.