

Public Welfare and Related Activities

CHAPTER 245

DEPARTMENT OF HUMAN SERVICES

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245.03 DEPARTMENT OF HUMAN SERVICES ESTABLISHED; COMMISSIONER.

There is created a department of human services. A commissioner of human services shall be appointed by the governor under the provisions of section 15.06. The commissioner shall be selected on the basis of ability and experience in welfare and without regard to political affiliations. The commissioner shall appoint a deputy commissioner.

History: 1953 c 593 s 1; 1965 c 45 s 17; 1969 c 1129 art 8 s 6; 1977 c 305 s 30; 1984 c 654 art 5 s 58

245.031 [Obsolete]

245.0311 TRANSFER OF PERSONNEL.

(a) Notwithstanding any other law to the contrary, the commissioner of human services shall transfer authorized positions between institutions under the commissioner's control in order to properly staff the institutions, taking into account the differences between programs in each institution.

(b) Notwithstanding any other law to the contrary, the commissioner of corrections may transfer authorized positions between institutions under the commissioner's control in order to more properly staff the institutions.

History: 1971 c 961 s 18; 1984 c 654 art 5 s 58; 1986 c 444

245.0312 DESIGNATING SPECIAL UNITS AND REGIONAL CENTERS.

Notwithstanding any provision of law to the contrary, during the biennium, the commissioner of human services, upon the approval of the governor after consulting with the legislative advisory commission, may designate portions of hospitals for the mentally ill under the commissioner's control as special care units for mentally retarded or inebriate persons, or as nursing homes for persons over the age of 65, and may designate portions of the hospitals designated in Minnesota Statutes 1969, section 252.025, subdivision 1, as special care units for mentally ill or inebriate persons, and may plan to develop all hospitals for mentally ill, mentally retarded, or inebriate persons under the commissioner's control as multipurpose regional centers for programs related to all of the said problems.

If approved by the governor, the commissioner may rename the state hospital as a state regional center and appoint the hospital administrator as administrator of the center, in accordance with section 246.0251.

The directors of the separate program units of regional centers shall be responsible directly to the commissioner at the discretion of the commissioner.

History: 1971 c 961 s 19; 1975 c 271 s 6; 1984 c 654 art 5 s 58; 1986 c 444

245.0313 AID TO THE DISABLED; MENTALLY RETARDED.

Notwithstanding any provision of law to the contrary, the cost of care not met by federal funds for any mentally retarded patient eligible for the medical assistance program or the supplemental security income for the aged, blind and disabled program in institutions under the control of the commissioner of human services shall be paid by the state and county in the same proportion as provided in section 256B.19 for division of costs.

History: 1969 c 1136 s 23 subd 2; 1971 c 961 s 20; 1973 c 717 s 10; 1981 c 360 art 2 s 13; 1984 c 654 art 5 s 58

245.032 [Obsolete]

245.033 [Repealed, 1973 c 717 s 33]

245.035 INTERVIEW EXPENSES.

Job applicants for professional, administrative, or highly technical positions recruited by the commissioner of human services may be reimbursed for necessary travel expenses to and from interviews arranged by the commissioner of human services.

History: 1976 c 163 s 42; 1984 c 654 art 5 s 58

245.036 LEASES FOR STATE-OPERATED, COMMUNITY-BASED PROGRAMS.

Notwithstanding section 16B.24, subdivision 6, paragraph (a), or any other law to the contrary, the commissioner of administration may lease land or other premises to provide state-operated, community-based programs authorized by sections 252.50, 253.018, and 253.28 for a term of 20 years or less, with a ten-year option to renew, subject to cancellation upon 30 days' notice by the state for any reason, except rental of other land or premises for the same use. The commissioner of administration may lease land or premises to provide state-operated, community-based programs authorized by sections 252.50, 253.018, and 253.28 for no more than 30 years.

History: 1990 c 568 art 2 s 37

245.04 [Repealed, 1981 c 253 s 48]

245.05 [Repealed, 1981 c 253 s 48]

245.06 [Repealed, 1981 c 253 s 48]

245.07 [Repealed, 1981 c 253 s 48]

245.071 [Repealed, 1969 c 334 s 2]

245.072 DIVISION FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

A division for persons with developmental disabilities is created in the department of human services which shall coordinate those laws administered and enforced by the commissioner of human services relating to mental retardation and related conditions, as defined in section 252.27, subdivision 1, which the commissioner may assign to the division. The division for persons with developmental disabilities shall be under the supervision of a director whose responsibility it shall be to maximize the availability of federal or private money for programs to assist persons with mental retardation or related conditions. The commissioner shall appoint the director who shall serve in the classified service of the state civil service. The commissioner may employ additional personnel with such qualifications and in such numbers as are reasonable and are necessary to carry out the provisions of this section.

History: 1971 c 486 s 1; 1984 c 654 art 5 s 58; 1985 c 21 s 3; 1987 c 44 s 1

245.073 TECHNICAL TRAINING ASSISTANCE TO COMMUNITY-BASED PROGRAMS.

In conjunction with the discharge of persons from regional treatment centers and their admission to state-operated and privately operated community-based programs, the commissioner may provide technical training assistance to the community-based programs. The commissioner may apply for and accept money from any source including reimbursement charges from the community-based programs for reasonable costs of training. Money received must be deposited in the general fund and is appropriated annually to the commissioner of human services for training under this section.

History: 1989 c 282 art 6 s 2

245.08	[Obsolete]
245.09	[Unnecessary]
245.10	[Unnecessary]
245.11	[Unnecessary]
245.12	[Unnecessary]
245.21	[Renumbered 256.451]
245.22	[Renumbered 256.452]
245.23	[Renumbered 256.453]
245.24	[Renumbered 256.454]
245.25	[Renumbered 256.455]
245.26	[Renumbered 256.456]
245.27	[Renumbered 256.457]
245.28	[Renumbered 256.458]
245.29	[Renumbered 256.459]
245.30	[Renumbered 256.461]
245.31	[Renumbered 256.462]
245.32	[Renumbered 256.463]
245.33	[Renumbered 256.464]
245.34	[Renumbered 256.465]
245.35	[Renumbered 256.466]
245.36	[Renumbered 256.467]
245.37	[Renumbered 256.468]
245.38	[Renumbered 256.469]
245.39	[Renumbered 256.471]
245.40	[Renumbered 256.472]
245.41	[Renumbered 256.473]
245.42	[Renumbered 256.474]
245.43	[Renumbered 256.475]
245.46	[Repealed, 1973 c 650 art 21 s 33]

MINNESOTA COMPREHENSIVE 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, 1990, the commissioner shall report to the legislature on all steps taken and recommendations for full implementation of sections 245.461 to 245.486 and on additional resources needed to further implement those sections.

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

- (1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;
- (2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and
- (3) provide necessary support regardless of where persons with mental illness choose to live.

History: 1987 c 403 art 2 s 16; 1989 c 282 art 4 s 1

245.462 DEFINITIONS.

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

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

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

Subd. 4. **Case manager.** "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in 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 ser-

vices to adults with mental illness must complete 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness and must receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of supervised experience is met. Clinical supervision must be documented in the client record.

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

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

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

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

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

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

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

Subd. 8. Day treatment services. "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to an adult in: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, 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. **Local mental health proposal.** "Local mental health proposal" means the proposal developed by the county board, reviewed by the commissioner, and described in section 245.463.

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

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

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

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

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

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

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

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist by the American nurses association;

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

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

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

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

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

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

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

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

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

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

(3) the adult:

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

(ii) indicates a significant impairment in functioning; and

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

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

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

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

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

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

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

History: 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

245.463 PLANNING FOR A MENTAL HEALTH SYSTEM.

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

Subd. 2. Technical assistance. The commissioner shall provide ongoing technical assistance to county boards to develop local mental health proposals as specified in section 245.478, to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of adults with mental illness residing in the county and extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Subd. 3. Report on increase in community-based residential programs. The com-

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

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

History: 1987 c 403 art 2 s 18; 1989 c 282 art 4 s 3,4; art 6 s 3

245.464 COORDINATION OF MENTAL HEALTH SYSTEM.

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

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

- (1) the provision of locally available emergency services;
- (2) the provision of locally available services to all adults with serious and persistent mental illness and all adults with acute mental illness;
- (3) the provision of specialized services regionally available to meet the special needs of all adults with serious and persistent mental illness and all adults with acute mental illness;
- (4) the provision of locally available services to adults with other mental illness; and
- (5) the provision of education and preventive mental health services targeted at high-risk populations.

History: 1987 c 403 art 2 s 19; 1989 c 282 art 4 s 5

245.465 DUTIES OF COUNTY BOARD.

The county board in each county shall use its share of mental health and community social service act funds allocated by the commissioner according to a biennial local mental health service proposal approved by the commissioner. The county board must:

- (1) develop and coordinate a system of affordable and locally available adult mental health services in accordance with sections 245.461 to 245.486;
- (2) provide for case management services to adults with serious and persistent mental illness in accordance with sections 245.462, subdivisions 3 and 4; 245.471; and 245.486;
- (3) provide for screening of adults specified in section 245.476 upon admission to a residential treatment facility or acute care hospital inpatient, or informal admission to a regional treatment center;

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

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

History: 1987 c 403 art 2 s 20; 1988 c 689 art 2 s 74; 1989 c 282 art 4 s 6

245.466 LOCAL SERVICE DELIVERY SYSTEM.

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

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

- (1) education and prevention services in accordance with section 245.468;
- (2) emergency services in accordance with section 245.469;
- (3) outpatient services in accordance with section 245.470;
- (4) community support program services in accordance with section 245.4711;
- (5) residential treatment services in accordance with section 245.472;
- (6) acute care hospital inpatient treatment services in accordance with section 245.473;
- (7) regional treatment center inpatient services in accordance with section 245.474;
- (8) screening in accordance with section 245.476; and
- (9) case management in accordance with sections 245.462, subdivision 3; and 245.4711.

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

- (1) name the commissioner as a third party beneficiary;
- (2) identify monitoring and evaluation procedures not in violation of the Minnesota government data practices act, chapter 13, which are necessary to ensure effective delivery of quality services;
- (3) include a provision that makes payments conditional on compliance by the contractor and all subcontractors with sections 245.461 to 245.486 and all other applicable laws, rules, and standards; and
- (4) require financial controls and auditing procedures.

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

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

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

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

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

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

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

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

History: 1987 c 403 art 2 s 21; 1988 c 689 art 2 s 75-77; 1989 c 282 art 4 s 7-10

245.467 QUALITY OF SERVICES.

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

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

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

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

(4) accessible to all age groups;

(5) delivered in a manner that provides accountability;

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

(7) coordinated with mental health services offered by other providers; and

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

Subd. 2. Diagnostic assessment. All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of outpatient and day treatment services must complete a diagnostic assessment within 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.

History: 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.

History: 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. The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional. The commissioner may waive the requirement that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

- (1) mental health professionals or mental health practitioners are unavailable to provide this service;
- (2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and
- (3) the service provider is not also the provider of fire and public safety emergency services.

Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available for at least telephone consultation within 30 minutes.

History: 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

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). Cli-

ents 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.

History: 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]

History: 1989 c 282 art 4 s 17; 1990 c 568 art 5 s 4-6

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.

History: 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 until July 1, 1991, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

Subd. 3. Transition to community. Residential treatment programs must plan for and assist clients in making a transition from residential treatment facilities to other

community-based services. In coordination with the client's case manager, if any, residential treatment facilities must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the residential treatment facility must notify the client's case manager, so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

History: 1987 c 403 art 2 s 27; 1988 c 689 art 2 s 84; 1989 c 282 art 4 s 18,19

245.473 ACUTE CARE HOSPITAL INPATIENT SERVICES.

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

- (1) stabilize the medical and mental health condition for which admission is required;
- (2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible; and
- (3) facilitate appropriate referrals for follow-up mental health care in the community.

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

History: 1987 c 403 art 2 s 28; 1989 c 282 art 4 s 20

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 treat-

ment 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.

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

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

The screening process and placement decision must be documented in the client's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards specified in clauses (1) to (3).

Subd. 2. Qualifications. Screening for residential and inpatient services must be conducted by a mental health professional. Mental health professionals providing screening for inpatient and residential services must not be financially affiliated with any acute care inpatient hospital, residential treatment facility, or regional treatment center. The commissioner may waive this requirement in sparsely populated areas.

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

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

existing mechanisms may be changed to accomplish the goals of screening as described in subdivision 1.

Subd. 5. Report on preadmission screening. The commissioner shall review the statutory preadmission screening requirements for psychiatric hospitalization, both in the regional treatment centers and other hospitals, to determine if changes in preadmission screening are needed. The commissioner shall deliver a report of the review to the legislature by January 31, 1990.

History: 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.

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

245.478 LOCAL MENTAL HEALTH PROPOSAL.

Subdivision 1. Time period. The first local mental health proposal period is from July 1, 1988, to December 31, 1989. The county board shall submit its first proposal to the commissioner by January 1, 1988. Subsequent proposals must be on the same two-year cycle as community social service plans. If a proposal complies with sections 245.461 to 245.486, it satisfies the requirement of the community social service plan for the mental illness target population as required by section 256E.09. The proposal must be made available upon request to all residents of the county at the same time it is submitted to the commissioner.

Subd. 2. Proposal content. The local adult mental health proposal must include:

(1) the local adult mental health advisory council's or adult mental health subcommittee of an existing advisory council's report on unmet needs of adults and any other needs assessment used by the county board in preparing the local adult mental health proposal;

(2) a description of the local adult mental health advisory council's or the adult mental health subcommittee of an existing advisory council's involvement in preparing the local adult mental health proposal and methods used by the county board to ensure adequate and timely participation of citizens, mental health professionals, and providers in development of the local mental health proposal;

(3) information for the preceding year, including the actual number of clients who received each of the mental health services listed in sections 245.468 to 245.476, and actual expenditures for each mental health service and service waiting lists; and

(4) the following information describing how the county board intends to meet the requirements of sections 245.461 to 245.486 during the proposal period:

(i) specific objectives and outcome goals for each adult mental health service listed in sections 245.461 to 245.486;

(ii) a description of each service provider, including county agencies, contractors, and subcontractors, that is expected to either be the sole provider of one of the adult mental health services described in sections 245.461 to 245.486 or to provide over \$10,000 of adult mental health services per year, including a listing of the professional qualifications of the staff involved in service delivery for the county;

(iii) a description of how the adult mental health services in the county will be unified and coordinated;

(iv) the estimated number of clients who will receive each adult mental health service; and

(v) estimated expenditures for each adult mental health service and revenues for the entire proposal.

Subd. 3. Proposal format. The local adult mental health proposal must be made in a format prescribed by the commissioner.

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

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

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

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

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

Subd. 6. Proposal approval. The commissioner shall review each local mental health proposal within 90 days and work with the county board to make any necessary modifications to comply with sections 245.461 to 245.486. After the commissioner has approved the proposal, the county board is eligible to receive an allocation of mental health and community social service act funds.

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

Subd. 8. Award notice. Upon approval of the county board proposal, the commissioner shall send a notice of approval for funding. The notice must specify any conditions of funding and is binding on the county board. Failure of the county board to comply with the approved proposal and funding conditions may result in withholding or repayment of funds as specified in section 245.483.

Subd. 9. Plan amendment. If the county board finds it necessary to make significant changes in the approved local proposal, it must present the proposed changes to the commissioner for approval at least 30 days before the changes take effect. "Significant changes" means:

(1) the county board proposes to provide a mental health service through a provider other than the provider listed for that service in the approved local proposal;

(2) the county board expects the total annual expenditures for any single mental health service to vary more than ten percent or \$5,000, whichever is greater, from the amount in the approved local proposal;

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

(4) the county board proposes a major change in the specific objectives and outcome goals listed in the approved local proposal.

History: 1987 c 403 art 2 s 33; 1988 c 689 art 2 s 89-91; 1989 c 282 art 4 s 26,27

245.479 COUNTY OF FINANCIAL RESPONSIBILITY.

For purposes of sections 245.461 to 245.486 and 245.487 to 245.4887, the county of financial responsibility is determined under section 256G.02, subdivision 4. Disputes between counties regarding financial responsibility must be resolved by the commissioner in accordance with section 256G.09.

History: 1987 c 403 art 2 s 35; 1988 c 689 art 2 s 92; 1989 c 282 art 4 s 28

245.48 MAINTENANCE OF EFFORT.

Counties must continue to spend for mental health services specified in sections 245.461 to 245.486 and 245.487 to 245.4887, according to generally accepted budgeting and accounting principles, an amount equal to the total expenditures shown in the county's approved 1987 Community Social Services Act plan under "State CSSA, Title XX and County Tax" for services to persons with mental illness plus the comparable figure for Rule 5 facilities under target populations other than mental illness in the approved 1987 CSSA plan.

History: 1987 c 403 art 2 s 34; 1988 c 689 art 2 s 241; 1989 c 282 art 4 s 29

245.481 FEES FOR MENTAL HEALTH SERVICES.

A client or, in the case of a child, the child or the child's parent may be required to pay a fee for mental health services provided under sections 245.461 to 245.486 and 245.487 to 245.4887. The fee must be based on the person's ability to pay according to the fee schedule adopted by the county board. In adopting the fee schedule for mental health services, the county board may adopt the fee schedule provided by the commissioner or adopt a fee schedule recommended by the county board and approved by the commissioner. Agencies or individuals under contract with a county board to provide mental health services under sections 245.461 to 245.486 and 245.487 to 245.4887 must not charge clients whose mental health services are paid wholly or in part from public funds fees which exceed the county board's adopted fee schedule. This section does not apply to regional treatment center fees, which are governed by sections 246.50 to 246.55.

History: 1989 c 282 art 4 s 30

245.482 REPORTING AND EVALUATION.

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

Subd. 2. Fiscal reports. The commissioner shall develop a unified format for quarterly fiscal reports that will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486, 245.487 to 245.4887, and section 256E.08. The county board shall submit a completed fiscal report in the required format no later than 30 days after the end of each quarter.

Subd. 3. Program reports. The commissioner shall develop unified formats for reporting, which will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486, 245.487 to 245.4887, and section 256E.10. The county board shall submit completed program reports in the required format according to the reporting schedule developed by the commissioner.

Subd. 4. Provider reports. The commissioner may develop formats and procedures for direct reporting from providers to the commissioner to include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4887. In particular, the provider reports must include aggregate information by county of residence about mental health services paid for by funding sources other than counties.

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

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

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

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

History: 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

NOTE: Subdivision 1 was also amended by Laws 1989, chapter 89, section 1. The amendment renumbered it to subdivision 2 to read as follows:

"Subd. 2. **Fiscal reports.** The commissioner shall develop a unified format for quarterly fiscal reports that will include information that the commissioner determines necessary to carry out sections 245.461 to 245.486 and section 256E.08."

245.483 TERMINATION OR RETURN OF AN ALLOCATION.

Subdivision 1. Funds not properly used. If the commissioner determines that a county is not meeting the requirements of sections 245.461 to 245.486 and 245.487 to 245.4887, or that funds are not being used according to the approved local proposal, all or part of the mental health and community social service act funds may be terminated upon 30 days notice to the county board. The commissioner may require repayment of any funds not used according to the approved local proposal. If the commissioner receives a written appeal from the county board within the 30-day period, opportunity for a hearing under the Minnesota administrative procedure act, chapter 14, must be provided before the allocation is terminated or is required to be repaid. The 30-day period begins when the county board receives the commissioner's notice by certified mail.

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

Subd. 3. Delayed payments. If the commissioner finds that a county board or its contractors are not in compliance with the approved local proposal or sections 245.461 to 245.486 and 245.487 to 245.4887, the commissioner may delay payment of all or part of the quarterly mental health and community social service act funds until the county board and its contractors meet the requirements. The commissioner shall not delay a payment longer than three months without first issuing a notice under subdivision 2 that all or part of the allocation will be terminated or required to be repaid. After this notice is issued, the commissioner may continue to delay the payment until completion of the hearing in subdivision 2.

Subd. 4. State assumption of responsibility. If the commissioner determines that services required by sections 245.461 to 245.486 and 245.487 to 245.4887 will not be provided by the county board in the manner or to the extent required by sections 245.461 to 245.486 and 245.487 to 245.4887, the commissioner shall contract directly with providers to ensure that clients receive appropriate services. In this case, the commissioner shall use the county's community social service act and mental health funds to the extent necessary to carry out the county's responsibilities under sections 245.461 to 245.486 and 245.487 to 245.4887. The commissioner shall work with the county board to allow for a return of authority and responsibility to the county board as soon as compliance with sections 245.461 to 245.486 and 245.487 to 245.4887 can be assured.

History: 1987 c 403 art 2 s 37; 1989 c 282 art 4 s 32

245.484 RULES.

The commissioner shall adopt permanent rules as necessary to carry out sections 245.461 to 245.486 and Laws 1989, chapter 282, article 4, sections 1 to 53.

History: 1987 c 403 art 2 s 38; 1989 c 282 art 4 s 33

245.485 NO RIGHT OF ACTION.

Sections 245.461 to 245.484 and 245.487 to 245.4887 do not independently establish a right of action on behalf of recipients of services or service providers against a county board or the commissioner. A claim for monetary damages must be brought under section 3.736 or 3.751.

History: 1987 c 403 art 2 s 39; 1989 c 282 art 4 s 34

245.486 LIMITED APPROPRIATIONS.

Nothing in sections 245.461 to 245.485 and 245.487 to 245.4887 shall be construed to require the commissioner or county boards to fund services beyond the limits of legislative appropriations.

History: 1987 c 403 art 2 s 40; 1989 c 282 art 4 s 35

245.4861 PUBLIC/ACADEMIC LIAISON INITIATIVE.

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

Subd. 2. Consultation. The commissioner of human services shall consult with the Minnesota department of health, the regional treatment centers, the post-secondary educational system, mental health professionals, and citizen and advisory groups.

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

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

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

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

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

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

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

History: 1989 c 282 art 4 s 36

CHILDREN'S MENTAL HEALTH ACT

245.487 CITATION; DECLARATION OF POLICY; MISSION.

Subdivision 1. **Citation.** Sections 245.487 to 245.4887 may be cited as the "Minnesota comprehensive children's mental health act."

Subd. 2. **Findings.** The legislature finds there is a need for further development of existing clinical services for emotionally disturbed children and their families and the creation of new services for this population. Although the services specified in sections 245.487 to 245.4887 are mental health services, sections 245.487 to 245.4887 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for continuity of care with other community agencies. At the same time, sections 245.487 to 245.4887 emphasize the importance of developing special mental health expertise in children's mental health services because of the unique needs of this population.

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

Subd. 3. **Mission of children's mental health service system.** As part of the comprehensive children's mental health system established under sections 245.487 to 245.4887, the commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that is consistent with the provision of public social services for children as specified in section 256F.01 and that:

- (1) identifies children who are eligible for mental health services;
- (2) makes preventive services available to all children;
- (3) assures access to a continuum of services that:
 - (i) educate the community about the mental health needs of children;
 - (ii) address the unique physical, emotional, social, and educational needs of children;
 - (iii) are coordinated with the range of social and human services provided to children and their families by the departments of education, human services, health, and corrections;
 - (iv) are appropriate to the developmental needs of children; and
 - (v) are sensitive to cultural differences and special needs;
- (4) includes early screening and prompt intervention to:
 - (i) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and
 - (ii) prevent further deterioration;
- (5) provides mental health services to children and their families in the context in which the children live and go to school;
- (6) addresses the unique problems of paying for mental health services for children, including:
 - (i) access to private insurance coverage; and
 - (ii) public funding;
- (7) includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs; and
- (8) when necessary, assures a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age.

Subd. 4. **Implementation.** (a) The commissioner shall begin implementing sections 245.487 to 245.4887 by February 15, 1990, and shall fully implement sections 245.487 to 245.4887 by January 1, 1992.

(b) Annually until February 15, 1992, the commissioner shall report to the legislature on all steps taken and recommendations for full implementation of sections 245.487 to 245.4887 and on additional resources needed to further implement those sections.

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

History: 1989 c 282 art 4 s 37; 1990 c 568 art 5 s 9,10

245.4871 DEFINITIONS.

Subdivision 1. Definitions. The definitions in this section apply to sections 245.487 to 245.4887.

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

Subd. 3. Case management services. "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with severe emotional disturbance and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include 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. **Local mental health proposal.** "Local mental health proposal" means the proposal developed by the county board, reviewed by the commissioner, and described in section 245.4872.

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

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

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

- (1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and has at least 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances;
- (2) has at least 6,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances;

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

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

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

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

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

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

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

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

Subd. 28. Mental health services. "Mental health services" means at least all of the treatment services and case management activities that are provided to children with emotional disturbances and are described in sections 245.487 to 245.4887.

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

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

Subd. 31. Professional home-based family treatment. "Professional home-based family treatment" means intensive mental health services provided to children (1) who are at risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement because of an emotional disturbance. Services are provided to the child and the child's family primarily in the child's home environment or other location appropriate to the child. Examples of appropriate locations include, but are not limited to, the child's school, day care center, home, and any other living arrangement of the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed to meet the specific mental health needs of the child and the child's family. Services include family and individual therapy and family living skills training and must be coordinated with other service providers.

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

Subd. 33. Service provider. "Service provider" means either a county board or an individual or agency including a regional treatment center under contract with the county board that provides children's mental health services funded under sections 245.487 to 245.4887.

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

History: 1989 c 282 art 4 s 38; 1990 c 568 art 5 s 11,34

245.4872 PLANNING FOR A CHILDREN'S MENTAL HEALTH SYSTEM.

Subdivision 1. Planning effort. Starting on the effective date of sections 245.487 to 245.4887 and ending January 1, 1992, the commissioner and the county agencies shall plan for the development of a unified, accountable, and comprehensive statewide children's mental health system. The system must be planned and developed by stages until it is operating at full capacity.

Subd. 2. Technical assistance. The commissioner shall provide ongoing technical assistance to county boards to develop local mental health proposals, as specified in section 245.4887, to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of children with emotional disturbances residing in the county and the extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

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

History: 1989 c 282 art 4 s 39

245.4873 COORDINATION OF CHILDREN'S MENTAL HEALTH SYSTEM.

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

Subd. 2. State level; coordination. The commissioners or designees of commissioners of the departments of human services, health, education, state planning, and corrections, and a representative of the Minnesota district judges association juvenile committee, in conjunction with the commissioner of commerce or a designee of the commissioner, shall meet at least quarterly 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 245.4887. The commissioner shall review local mental health service proposals developed by county boards as specified in section 245.4872 and provide technical assistance to county boards in developing and maintaining locally available and coordinated children's mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's children's mental health proposals and other information as required by sections 245.487 to 245.4887.

Subd. 6. Priorities. By January 1, 1992, the commissioner shall require that each of the treatment services and management activities described in sections 245.487 to 245.4887 be developed for children with emotional disturbances within available resources based on the following ranked priorities:

- (1) the provision of locally available mental health emergency services;
- (2) the provision of locally available mental health services to all children with severe emotional disturbance;
- (3) the provision of early identification and intervention services to children who are at risk of needing or who need mental health services;
- (4) the provision of specialized mental health services regionally available to meet the special needs of all children with severe emotional disturbance, and all children with emotional disturbances;
- (5) the provision of locally available services to children with emotional disturbances; and
- (6) the provision of education and preventive mental health services.

History: 1989 c 282 art 4 s 40; 1990 c 568 art 5 s 12

245.4874 DUTIES OF COUNTY BOARD.

The county board in each county shall use its share of mental health and community social service act funds allocated by the commissioner according to a biennial local children's mental health service proposal required under section 245.4887, and approved by the commissioner. The county board must:

- (1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;
- (2) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;
- (3) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost effectiveness of their delivery;
- (4) assure that mental health services delivered according to sections 245.487 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;
- (5) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;
- (6) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;
- (7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;
- (8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4887;
- (9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871; and
- (10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age.

History: 1989 c 282 art 4 s 41; 1990 c 568 art 5 s 13

245.4875 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision 1. Development of children's services. The county board in each county is responsible for using all available resources to develop and coordinate a system of

locally available and affordable children's mental health services. The county board may provide some or all of the children's mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward fully implementing sections 245.487 to 245.4887 during the period July 1, 1989, to January 1, 1992. County boards must develop fully each of the treatment services prescribed by sections 245.487 to 245.4887 by January 1, 1992, according to the priorities established in section 245.4873 and the local children's mental health services proposal approved by the commissioner under section 245.4887.

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

- (1) education and prevention services according to section 245.4877;
- (2) early identification and intervention services according to section 245.4878;
- (3) emergency services according to section 245.4879;
- (4) outpatient services according to section 245.488;
- (5) family community support services according to section 245.4881;
- (6) day treatment services according to section 245.4884, 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 245.4887 and all other applicable laws, rules, and standards; and
- (4) require financial controls and auditing procedures.

Subd. 4. Joint county mental health agreements. To efficiently provide the children's mental health services required by sections 245.487 to 245.4887, counties are encouraged to join with one or more county boards to establish a multicounty local children's mental health authority under the joint powers act, section 471.59, the human services board act, sections 402.01 to 402.10, community mental health center provisions, section 245.62, or enter into multicounty mental health agreements. Participating county boards shall establish acceptable ways of apportioning the cost of the services.

Subd. 5. Local children's advisory council. (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health

interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with severe emotional disturbance; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

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

- (1) arrange for input from the local system of care providers regarding coordination of care between the services; and
- (2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2).

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

Subd. 6. Local system of care; coordinating council. The county board shall establish, by January 1, 1990, a council representing all members of the local system of care including mental health services, social services, correctional services, education services, health services, and vocational services. The council shall include a representative of an Indian reservation authority where a reservation exists within the county. When possible, the council must also include a representative of juvenile court or the court responsible for juvenile issues and law enforcement. The members of the coordinating council shall meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. A county may use an existing child-focused interagency task force to fulfill the requirements of this subdivision if the representatives and duties of the existing task force are expanded to include those specified in this subdivision and section 245.4873, subdivision 3.

Subd. 7. Other local authority. The county board may establish procedures and policies that are not contrary to those of the commissioner or sections 245.487 to 245.4887 regarding local children's mental health services and facilities. The county board shall perform other acts necessary to carry out sections 245.487 to 245.4887.

History: 1989 c 282 art 4 s 42; 1990 c 568 art 5 s 14,34

245.4876 QUALITY OF SERVICES.

Subdivision 1. Criteria. Children's mental health services required by sections 245.487 to 245.4887 must be:

- (1) based, when feasible, on research findings;
- (2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;
- (3) delivered in a manner that improves family functioning when clinically appropriate;
- (4) provided in the most appropriate, least restrictive setting available to the county board to meet the child's treatment needs;

- (5) accessible to all age groups of children;
- (6) appropriate to the developmental age of the child being served;
- (7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;
- (8) provided by qualified individuals as required in sections 245.487 to 245.4887;
- (9) coordinated with children's mental health services offered by other providers;
- (10) provided under conditions that protect the rights and dignity of the individuals being served; and
- (11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Subd. 2. Diagnostic assessment. All residential treatment facilities and acute care hospital inpatient treatment 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 245.4887 require each county board, within the limits of available resources, to make the mental health services listed in those sections available to each child residing in the county who needs them, the county board shall not provide any services, either directly or by contract, unless consent to the services is obtained under this subdivision. The case manager assigned to a child with a severe emotional disturbance shall not disclose to any person other than the case manager's immediate supervisor and the mental health professional providing clinical supervision of the case manager information on the child, the child's family, or services provided to the child or the child's family without informed written consent unless required to do so by statute or under the Minnesota government data practices act. Informed written consent must comply with section 13.05, subdivision 4, paragraph (d), and specify the purpose and use for which the case manager may disclose the information.

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

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

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

- (1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; and
- (2) staff who provide treatment services or case management and their clinical supervisors.

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

History: 1989 c 282 art 4 s 43; 1990 c 568 art 5 s 15-17

245.4877 EDUCATION AND PREVENTION SERVICES.

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

- (1) convey information regarding emotional disturbances, mental health needs, and treatment resources to the general public and groups identified as at high risk of developing emotional disturbance under section 245.4872, subdivision 3;
- (2) at least annually, distribute to individuals and agencies identified by the county board and the local children's mental health advisory council information on predictors and symptoms of emotional disturbances, where mental health services are available in the county, and how to access the services;

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

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

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

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

History: 1989 c 282 art 4 s 44

245.4878 EARLY IDENTIFICATION AND INTERVENTION.

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

History: 1989 c 282 art 4 s 45

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. The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional. The commissioner may waive the requirement that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

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

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

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

When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available for at least telephone consultation within 30 minutes.

History: 1989 c 282 art 4 s 46; 1990 c 568 art 5 s 18

245.488 OUTPATIENT SERVICES.

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

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

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

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

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

- (1) meets the professional qualifications contained in sections 245.487 to 245.4887;
- (2) uses a multidisciplinary mental health professional staff including, at a minimum, arrangements for psychiatric consultation, licensed consulting psychologist consultation, and other necessary multidisciplinary mental health professionals;
- (3) develops individual treatment plans; and
- (4) provides initial appointments within three weeks, except in emergencies where there must be immediate access as described in section 245.4879.

History: 1989 c 282 art 4 s 47; 1990 c 568 art 2 s 39

245.4881 CASE MANAGEMENT AND FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. Availability of case management services. (a) By July 1, 1991, 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) 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 fam-

ily 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]

History: 1989 c 282 art 4 s 48; 1990 c 568 art 5 s 19-22,34

245.4882 RESIDENTIAL TREATMENT SERVICES.

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

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

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

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

(4) stabilize crisis admissions; and

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

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

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

History: 1989 c 282 art 4 s 49; 1990 c 568 art 5 s 23

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.

History: 1989 c 282 art 4 s 50; 1990 c 568 art 5 s 24

245.4884 FAMILY COMMUNITY SUPPORT SERVICES.

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

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

- (1) handle basic activities of daily living;
- (2) improve functioning in school settings;
- (3) participate in leisure time or community youth activities;
- (4) set goals and plans;
- (5) reside with the family in the community;
- (6) participate in after-school and summer activities;
- (7) make a smooth transition among mental health services provided to children; and
- (8) make a smooth transition into the adult mental health system as appropriate.

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

Subd. 2. Day treatment services provided. (a) Day treatment services must be part of the family community support services available to each child with severe emotional disturbance residing in the county. A child or the child's parent may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

- (1) provide a structured environment for treatment;
- (2) provide support for residing in the community;
- (3) prevent placements that are more intensive, costly, or restrictive than necessary to meet the child's need;
- (4) coordinate with or be offered in conjunction with the child's education program;
- (5) provide therapy and family intervention for children that are coordinated with education services provided and funded by schools; and

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

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

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

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

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

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

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

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

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

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

Subd. 4. Therapeutic support of foster care. By January 1, 1992, county boards must provide or contract for foster care with therapeutic support as defined in section 245.4871, subdivision 34. Foster families caring for children with severe emotional disturbance must receive training and supportive services, as necessary, at no cost to the foster families within the limits of available resources.

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

History: 1990 c 568 art 5 s 25

245.4885 SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT.

Subdivision 1. Screening required. The county board shall, upon admission, screen all children admitted for treatment of severe emotional disturbance to a residential treatment facility, an acute care hospital, or informally admitted to a regional treatment center if public funds are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment of emotional disturbance or held for emergency care by a regional treatment center under section

253B.05, subdivision 1, screening must occur within five working days of admission. Screening shall determine whether the proposed treatment:

- (1) is necessary;
- (2) is appropriate to the child's individual treatment needs;
- (3) cannot be effectively provided in the child's home; and
- (4) provides a length of stay as short as possible consistent with the individual child's need.

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

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

The screening process and placement decision must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (5).

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. 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.

History: 1989 c 282 art 4 s 51; 1990 c 568 art 5 s 26,27

245.4886 APPEALS.

A child or a child's family, as appropriate, who requests mental health services under sections 245.487 to 245.4887 must be advised of services available and the right to appeal as described in this section at the time of the request and each time the individual family community support plan or individual treatment plan is reviewed. A child whose request for mental health services under sections 245.487 to 245.4887 is denied, not acted upon with reasonable promptness, or whose services are suspended, reduced, or terminated by action or inaction for which the county board is responsible under sections 245.487 to 245.4887 may contest that action or inaction before the state agency according to section 256.045. The commissioner shall monitor the nature and frequency of administrative appeals under this section.

History: 1989 c 282 art 4 s 52

245.4887 CHILDREN'S SECTION OF LOCAL MENTAL HEALTH PROPOSAL.

Subdivision 1. Time period. The county board shall submit its first complete children's section of its local mental health proposal to the commissioner by November 15, 1989. Subsequent proposals must be on the same two-year cycle as community social service plans. If a proposal complies with sections 245.487 to 245.4887, it satisfies the requirement of the community social service plan for the emotionally disturbed target population as required by section 256E.09. The proposal must be made available upon request to all residents of the county at the same time it is submitted to the commissioner.

Subd. 2. Proposal content. The children's section of the local mental health proposal must include:

(1) a report of the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council on unmet needs of children and any other needs assessment used by the county board in preparing the local mental health proposal, including the report of the local coordinating council or local interagency task force specified in section 245.4875, subdivision 6;

(2) a description of the involvement of the local children's mental health advisory council or the children's mental health subcommittee of the existing local mental health advisory council in preparing the local mental health proposal and methods used by the county board to ensure adequate and timely participation of citizens, mental health professionals, and providers in development of the local mental health proposal;

(3) information for the preceding year, including the actual number of children who received each of the mental health services listed in sections 245.487 to 245.4887, and actual expenditures for each mental health service and service waiting lists; and

(4) the following information describing how the county board intends to meet the requirements of sections 245.487 to 245.4887 during the proposal period:

(i) specific objectives and outcome goals for each mental health service listed in sections 245.487 to 245.4887;

(ii) a description of each service provider, including county agencies, contractors, and subcontractors, that is expected to either be the sole provider of one of the mental health services described in sections 245.487 to 245.4887 or to provide over \$10,000 of mental health services per year, including a listing of the professional qualifications of the staff involved in service delivery for the county;

(iii) a description of how the mental health services in the county will be unified and coordinated, including the mechanism established by the county board providing for interagency coordination as specified in section 245.4875, subdivision 6;

(iv) the estimated number of children who will receive each mental health service; and

(v) estimated expenditures for each mental health service and revenues for the entire proposal.

Subd. 3. Proposal format. The children's section of the local mental health proposal must be made in a format prescribed by the commissioner.

Subd. 4. Provider approval. The commissioner's review of the children's section of the local mental health proposal must include a review of the qualifications of each service provider required to be identified in the children's section of the local mental health proposal under subdivision 2. The commissioner may reject a county board's proposal for a particular provider if:

(1) the provider does not meet the professional qualifications contained in sections 245.487 to 245.4887;

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

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

Subd. 5. Service approval. The commissioner's review of the children's section of the local mental health proposal must include a review of the appropriateness of the amounts and types of children's mental health services in the children's section of the local mental health proposal. The commissioner may reject the county board's proposal if the commissioner determines that the amount and types of services proposed are not cost-effective, do not meet the child's needs, or do not comply with sections 245.487 to 245.4887.

Subd. 6. Proposal approval. The commissioner shall review each children's section of the local mental health proposal within 90 days and work with the county board to make any necessary modifications to comply with sections 245.487 to 245.4887. After the commissioner has approved the proposal, the county board is eligible to receive an allocation of mental health and community social service act funds.

Subd. 7. Partial or conditional approval. If the children's section of the local mental health proposal is in substantial compliance, but not in full compliance with sections 245.487 to 245.4887, and necessary modifications cannot be made before the proposal period begins, the commissioner may grant partial or conditional approval and withhold a proportional share of the county board's mental health and community social service act funds until full compliance is achieved.

Subd. 8. Award notice. Upon approval of the county board proposal, the commissioner shall send a notice of approval for funding. The notice must specify any conditions of funding and is binding on the county board. Failure of the county board to comply with the approved proposal and funding conditions may result in withholding or repayment of funds according to section 245.483.

Subd. 9. Plan amendment. If the county board finds it necessary to make significant changes in the approved children's section of the local mental health proposal, it must present the proposed changes to the commissioner for approval at least 30 days before the changes take effect. "Significant changes" means:

(1) the county board proposes to provide a children's mental health service through a provider other than the provider listed for that service in the approved local proposal;

(2) the county board expects the total annual expenditures for any single children's mental health service to vary more than ten percent or \$5,000, whichever is greater, from the amount in the approved local proposal;

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

(4) the county board proposes a major change in the specific objectives and outcome goals listed in the approved local children's mental health proposal.

History: 1989 c 282 art 4 s 53

245.490 REGIONAL TREATMENT CENTERS: MISSION STATEMENT.

The legislature recognizes that regional treatment centers are an integral part of the continuum of care for people with mental illness. The commissioner of human services shall ensure that regional treatment centers:

(1) develop a policy that identifies persons who have a mental illness and are medically appropriate for admission to inpatient care;

(2) provide active treatment;

(3) provide mental health services in accordance with sections 245.461 to 245.486 for people with mental illness. The services must:

(a) enable and assist people to return to community care settings that promote and maintain community integration at the highest possible level of independent functioning; and

(b) meet contemporary professional standards for staffing levels and for quality of program, staffing, and physical environment;

(4) maximize contact with the surrounding community to minimize isolation of patients and further the goal of community reintegration;

(5) protect patients' rights and their access to advocacy services;

(6) encourage appropriate voluntary admission of individuals seeking regional treatment center services; and

(7) are appropriately funded to implement the goals of this section.

The commissioner shall implement the goals and objectives of this section by June 30, 1993. By February 15, 1989, and annually after that until February 15, 1993, the commissioner shall report to the legislature all steps taken toward implementation. The reports shall include recommendations for full implementation of this section and a thorough analysis of any additional resources needed for implementation.

History: 1988 c 464 s 1

245.50 INTERSTATE CONTRACTS FOR MENTAL HEALTH SERVICES.

Subdivision 1. Definitions. For purposes of this section, the following terms have the meanings given them.

(a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

(b) "Agency or facility" means a public or private hospital, mental health center, or other person or organization authorized by a state to provide mental health services.

Subd. 2. Authority. Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board may contract with an agency or facility in a bordering state for mental health services for residents of Minnesota, and a Minnesota mental health agency or facility may contract to provide services to residents of bordering states. A person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be informed of the consequences of receiving services in another state, including the implications of the differences in state laws.

Subd. 3. Exceptions. A contract may not be entered into under this section for services to persons who:

(1) are serving a sentence after conviction of a criminal offense;

(2) are on probation or parole;

(3) are the subject of a presentence investigation;

(4) have been committed involuntarily; or

(5) will be receiving treatment for chemical dependency.

Subd. 4. Contracts. Contracts entered into under this section must, at a minimum:

(1) describe the services to be provided;

(2) establish responsibility for the costs of services;

(3) establish responsibility for the costs of transporting individuals receiving services under this section;

(4) specify the duration of the contract;

(5) specify the means of terminating the contract;

(6) specify the terms and conditions for refusal to admit or retain an individual; and

(7) identify the goals to be accomplished by the placement of an individual under this section.

History: 1985 c 253 s 1

245.51 INTERSTATE COMPACT ON MENTAL HEALTH.

The interstate compact on mental health is hereby enacted into law and entered into by this state with all other states legally joining therein in the form as follows:

INTERSTATE COMPACT ON MENTAL HEALTH

The contracting states solemnly agree that:

ARTICLE I

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action, to the benefit of the patients, their families, and society as a whole. Further, the party states find that the necessity of and desirability for furnishing such care and treatment bears no primary relation to the residence or citizenship of the patient but that, on the contrary, the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this compact and of the party states to provide the necessary legal basis for the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in terms of such welfare.

ARTICLE II

As used in this compact:

(a) "Sending state" shall mean a party state from which a patient is transported pursuant to the provisions of the compact or from which it is contemplated that a patient may be so sent.

(b) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the compact or to which it is contemplated that a patient may be so sent.

(c) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(d) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state, for institutionalization or other care, treatment, or supervision pursuant to the provisions of this compact.

(e) "Aftercare" shall mean care, treatment and services provided a patient, as defined herein, on convalescent status or conditional release.

(f) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community.

(g) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs, but shall not include mental illness as defined herein.

(h) "State" shall mean any state, territory or possession of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

ARTICLE III

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he shall be eligible for care and treatment in an institution in that state irrespective of his residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof, and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this article unless the sending state has given advance notice of its intention to send the patient; furnished all available medical and other pertinent records concerning the patient; given the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient if said authorities so wish; and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that he would be taken if he were a local patient.

(e) Pursuant to this compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at any time and such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

ARTICLE IV

(a) Whenever, pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive aftercare or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state shall have reason to believe that aftercare in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the receiving state to investigate the desirability of affording the patient such aftercare in said receiving state, and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient, and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby, and if the public safety would not be jeopardized thereby, the patient may receive aftercare or supervision in the receiving state.

(c) In supervising, treating, or caring for a patient on aftercare pursuant to the terms of this article, a receiving state shall employ the same standards of visitation, examination, care, and treatment that it employs for similar local patients.

ARTICLE V

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and

without the jurisdiction of the escape in a manner reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately upon the apprehension and identification of any such dangerous or potentially dangerous patient, he shall be detained in the state where found pending disposition in accordance with law.

ARTICLE VI

The duly accredited officers of any state party to this compact, upon the establishment of their authority and the identity of the patient, shall be permitted to transport any patient being moved pursuant to this compact through any and all states party to this compact, without interference.

ARTICLE VII

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of and incidental to the transportation of any patient pursuant to this compact, but any two or more party states may, by making a specific agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of a party state, or between a party state and its subdivisions, as to the payment of costs, or responsibilities therefor.

(d) Nothing in this compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereof may be responsible pursuant to any provision of this compact.

(e) Nothing in this compact shall be construed to invalidate any reciprocal agreement between a party state and a nonparty state relating to institutionalization, care or treatment of the mentally ill or mentally deficient, or any statutory authority pursuant to which such agreements may be made.

ARTICLE VIII

(a) Nothing in this compact shall be construed to abridge, diminish, or in any way impair the rights, duties, and responsibilities of any patient's guardian on his own behalf or in respect of any patient for whom he may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall upon being duly advised of the new appointment, and upon the satisfactory completion of such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances; provided, however, that in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion to relieve a guardian appointed by it or continue his power and responsibility, whichever it shall deem advisable. The court in the receiving state may, in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment.

(b) The term "guardian" as used in paragraph (a) of this article shall include any guardian, trustee, legal committee, conservator, or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

ARTICLE IX

(a) No provision of this compact except Article V shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge, or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible, it shall be the policy of states party to this compact that no patient shall be placed or detained in any prison, jail or lockup, but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

ARTICLE X

(a) Each party state shall appoint a "compact administrator" who, on behalf of his state, shall act as general coordinator of activities under the compact in his state and who shall receive copies of all reports, correspondence, and other documents relating to any patient processed under the compact by his state either in the capacity of sending or receiving state. The compact administrator or his duly designated representative shall be the official with whom other party states shall deal in any matter relating to the compact or any patient processed thereunder.

(b) The compact administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE XI

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis whenever the states concerned shall find that such agreements will improve services, facilities, or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this compact.

ARTICLE XII

This compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

ARTICLE XIII

(a) A state party to this compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing to the governors and compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the compact.

(b) Withdrawal from any agreement permitted by Article VII(b) as to costs or from any supplementary agreement made pursuant to Article XI shall be in accordance with the terms of such agreement.

ARTICLE XIV

This compact shall be liberally construed so as to effectuate the purposes thereof.

The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

History: 1957 c 326 s 1

245.52 COMMISSIONER OF HUMAN SERVICES AS COMPACT ADMINISTRATOR.

The commissioner of human services is hereby designated as "compact administrator." The commissioner shall have the powers and duties specified in the compact, and may, in the name of the state of Minnesota, subject to the approval of the attorney general as to form and legality, enter into such agreements authorized by the compact as the commissioner deems appropriate to effecting the purpose of the compact. The commissioner shall, within the limits of the appropriations for the care of persons with mental illness or mental retardation, authorize such payments as are necessary to discharge any financial obligations imposed upon this state by the compact or any agreement entered into under the compact.

If the patient has no established residence in a Minnesota county, the commissioner shall designate the county of financial responsibility for the purposes of carrying out the provisions of the Interstate Compact on Mental Health as it pertains to patients being transferred to Minnesota. The commissioner shall designate the county which is the residence of the person in Minnesota who initiates the earliest written request for the patient's transfer.

History: 1957 c 326 s 2; 1981 c 98 s 1; 1984 c 654 art 5 s 58; 1985 c 21 s 4; 1986 c 444

245.53 TRANSMITTAL OF COPIES OF ACT.

Duly authenticated copies of sections 245.51 to 245.53 shall, upon its approval, be transmitted by the secretary of state to the governor of each state, the attorney general and the secretary of state of the United States, and the council of state governments.

History: 1957 c 326 s 3

245.61 COUNTY BOARDS MAY MAKE GRANTS FOR LOCAL MENTAL HEALTH PROGRAMS.

County boards are hereby authorized to make grants to public or private agencies to establish and operate local mental health programs to provide the following services: (a) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, alcoholism, and other psychiatric disabilities; (b) informational and educational services to the general public, and lay and professional groups; (c) consultative services to schools, courts and health and welfare agencies, both public and private, including diagnostic evaluation of cases from juvenile courts; (d) outpatient diagnostic and treatment services; (e) rehabilitative services for patients suffering from mental or emotional disorders, mental retardation, alcoholism, and other psychiatric conditions particularly those who have received prior treatment in an inpatient facility; (f) detoxification in alcoholism evaluation and service facilities.

History: 1957 c 392 s 1; 1969 c 1043 s 7; 1973 c 123 art 5 s 7; 1976 c 163 s 43; 1979 c 324 s 13

245.62 COMMUNITY MENTAL HEALTH CENTER.

Subdivision 1. Establishment. Any city, county, town, combination thereof, or private nonprofit corporation may establish a community mental health center.

Subd. 2. Definition. A community mental health center is a private nonprofit corporation or public agency approved under the emergency and permanent rules promulgated by the commissioner pursuant to subdivision 4.

Subd. 3. Clinical supervisor. All community mental health center services shall be provided under the clinical supervision of a licensed consulting psychologist licensed under sections 148.88 to 148.98, or a physician who is board certified or eligible for board certification in psychiatry, and who is licensed under section 147.02.

Subd. 4. Rules. The commissioner shall promulgate emergency and permanent rules to establish standards for the designation of an agency as a community mental health center. These standards shall include, but are not limited to:

(a) provision of mental health services in the prevention, identification, treatment and aftercare of emotional disorders, chronic and acute mental illness, mental retardation and developmental disabilities, and alcohol and drug abuse and dependency, including the services listed in section 245.61 except detoxification services;

(b) establishment of a community mental health center board pursuant to section 245.66; and

(c) approval pursuant to section 245.69, subdivision 2.

History: 1957 c 392 s 2; 1959 c 530 s 1; 1967 c 888 s 1; 1973 c 123 art 5 s 7; 1973 c 583 s 14; 1973 c 773 s 1; 1975 c 69 s 1; 1979 c 324 s 14; 1983 c 312 art 5 s 1; 1984 c 640 s 32; 1989 c 282 art 4 s 54

NOTE: For Yellow Medicine County participation in a mental health services program outside its region, see Laws 1977, Chapter 24.

245.63 ASSISTANCE OR GRANT.

Any city, town, or public or private corporation may apply to a county board for assistance in establishing and funding a mental health services program. No programs shall be eligible for a grant hereunder unless its plan and budget have been approved by the county board or boards.

History: 1957 c 392 s 3; 1973 c 123 art 5 s 7; 1975 c 69 s 2; 1979 c 324 s 15

NOTE: For Yellow Medicine County participation in a mental health services program outside its region, see Laws 1977, Chapter 24.

245.64 [Repealed, 1989 c 282 art 4 s 64]

245.65 [Repealed, 1979 c 324 s 50]

245.651 [Repealed, 1979 c 324 s 50]

245.652 CHEMICAL DEPENDENCY SERVICES FOR REGIONAL TREATMENT CENTERS.

Subdivision 1. Purpose. The regional treatment centers shall provide services designed to end a person's reliance on chemical use or a person's chemical abuse and increase effective and chemical-free functioning. Clinically effective programs must be provided in accordance with section 246.64.

Subd. 2. Services offered. Services provided must include, but are not limited to, the following:

(1) primary and extended residential care, including residential treatment programs of varied duration intended to deal with a person's chemical dependency or chemical abuse problems;

(2) follow-up care to persons discharged from regional treatment center programs;

(3) outpatient treatment programs; and

(4) other treatment services, as appropriate and as provided under contract or shared service agreements.

Subd. 3. **Persons served.** The regional treatment centers shall provide services primarily to adolescent and adult residents of the state.

Subd. 4. **System locations.** Programs shall be located in Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter, and Willmar.

History: 1989 c 282 art 6 s 5

245.66 COMMUNITY MENTAL HEALTH CENTER BOARDS.

Every city, county, town, combination thereof or nonprofit corporation establishing a community mental health center shall establish a community mental health center board. The community mental health center board may include county commissioner representatives from each participating county and shall be representative of the local population, including at least health and human service professions and advocate associations, other fields of employment, and the general public. Each community mental health center board shall be responsible for the governance and performance of its center.

History: 1957 c 392 s 6; 1959 c 303 s 1; 1963 c 796 s 2; 1973 c 123 art 5 s 7; 1975 c 69 s 3; 1975 c 169 s 2; 1979 c 324 s 17; 1981 c 355 s 21; 1983 c 312 art 5 s 2

245.67 [Repealed, 1981 c 355 s 34]

245.68 [Repealed, 1981 c 355 s 34]

245.69 ADDITIONAL DUTIES OF COMMISSIONER.

Subdivision 1. In addition to the powers and duties already conferred by law the commissioner of human services shall:

(a) Promulgate rules prescribing standards for qualification of personnel and quality of professional service and for in-service training and educational leave programs for personnel, governing eligibility for service so that no person will be denied service on the basis of race, color or creed, or inability to pay, providing for establishment, subject to the approval of the commissioner, of fee schedules which shall be based upon ability to pay, and such other rules as the commissioner deems necessary to carry out the purposes of sections 245.61 to 245.69.

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

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

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

Subd. 1a. [Repealed, 1987 c 403 art 2 s 164]

Subd. 2. The commissioner of human services has the authority to approve or disapprove public and private mental health centers and public and private mental health clinics for the purposes of section 62A.152, subdivision 2. For the purposes of this subdivision the commissioner shall promulgate both emergency and permanent rules in accordance with sections 14.001 to 14.69. The rules shall require each applicant to pay a fee to cover costs of processing applications and determining compliance with the rules and this subdivision. The commissioner may contract with any state agency, individual, corporation or association to which the commissioner shall delegate all but final approval and disapproval authority to determine compliance or noncompliance.

(a) Each approved mental health center and each approved mental health clinic shall have a multidisciplinary team of professional staff persons as required by rule. A mental health center or mental health clinic may provide the staffing required by rule by means of written contracts with professional persons or with other health care providers. Any personnel qualifications developed by rule shall be consistent with any personnel standards developed pursuant to chapter 214.

(b) Each approved mental health clinic and each approved mental health center

shall establish a written treatment plan for each outpatient for whom services are reimbursable through insurance or public assistance. The treatment plan shall be developed in accordance with the rules and shall include a patient history, treatment goals, a statement of diagnosis and a treatment strategy. The clinic or center shall provide access to hospital admission as a bed patient as needed by any outpatient. The clinic or center shall ensure ongoing consultation among and availability of all members of the multidisciplinary team.

(c) As part of the required consultation, members of the multidisciplinary team shall meet at least twice monthly to conduct case reviews, peer consultations, treatment plan development and in-depth case discussion. Written minutes of these meetings shall be kept at the clinic or center for three years.

(d) Each approved center or clinic shall establish mechanisms for quality assurance and submit documentation concerning the mechanisms to the commissioner as required by rule, including:

- (1) Continuing education of each professional staff person;
- (2) An ongoing internal utilization and peer review plan and procedures;
- (3) Mechanisms of staff supervision; and
- (4) Procedures for review by the commissioner or a delegate.

(e) The commissioner shall disapprove an applicant, or withdraw approval of a clinic or center, which the commissioner finds does not comply with the requirements of the rules or this subdivision. A clinic or center which is disapproved or whose approval is withdrawn is entitled to a contested case hearing and judicial review pursuant to sections 14.01 to 14.70.

(f) Data on individuals collected by approved clinics and centers, including written minutes of team meetings, is private data on individuals within the welfare system as provided in chapter 13.

(g) Each center or clinic that is approved and in compliance with the commissioner's existing rule on July 1, 1980 is approved for purposes of section 62A.152, subdivision 2, until rules are promulgated to implement this section.

History: 1957 c 392 s 9; 1975 c 122 s 1; 1979 c 324 s 19; 1980 c 506 s 1; 1981 c 311 s 39; 1982 c 424 s 130; 1982 c 545 s 24; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 428 s 1; 1986 c 444; 1987 c 384 art 2 s 1; 1990 c 422 s 10

245.691 [Repealed, 1979 c 324 s 50]

245.692 [Repealed, 1973 c 572 s 18]

245.693 [Repealed, 1973 c 572 s 18]

245.694 [Repealed, 1973 c 572 s 18]

245.695 [Repealed, 1973 c 572 s 18]

245.696 ADDITIONAL DUTIES OF COMMISSIONER.

Subdivision 1. Mental health division. A mental health division is created in the department of human services. The division shall enforce and coordinate the laws administered by the commissioner of human services, relating to mental illness, which the commissioner assigns to the division. The mental health division shall be under the supervision of an assistant commissioner of mental health appointed by the commissioner. The commissioner, working with the assistant commissioner of mental health, shall oversee and coordinate services to people with mental illness in both community programs and regional treatment centers throughout the state.

Subd. 2. Specific duties. In addition to the powers and duties already conferred by law, the commissioner of human services shall:

- (1) review and evaluate local programs and the performance of administrative and mental health personnel and make recommendations to county boards and program administrators;
- (2) provide consultative staff service to communities and advocacy groups to

assist in ascertaining local needs and in planning and establishing community mental health programs;

(3) employ qualified personnel to implement this chapter;

(4) adopt rules for minimum standards in community mental health services as directed by the legislature;

(5) cooperate with the commissioners of health and jobs and training to coordinate services and programs for people with mental illness;

(6) evaluate the needs of people with mental illness as they relate to assistance payments, medical benefits, nursing home care, and other state and federally funded services;

(7) provide data and other information, as requested, to the advisory council on mental health;

(8) develop and maintain a data collection system to provide information on the prevalence of mental illness, the need for specific mental health services and other services needed by people with mental illness, funding sources for those services, and the extent to which state and local areas are meeting the need for services;

(9) apply for grants and develop pilot programs to test and demonstrate new methods of assessing mental health needs and delivering mental health services;

(10) study alternative reimbursement systems and make waiver requests that are deemed necessary by the commissioner;

(11) provide technical assistance to county boards to improve fiscal management and accountability and quality of mental health services, and consult regularly with county boards, public and private mental health agencies, and client advocacy organizations for purposes of implementing this chapter;

(12) promote coordination between the mental health system and other human service systems in the planning, funding, and delivery of services; entering into cooperative agreements with other state and local agencies for that purpose as deemed necessary by the commissioner;

(13) conduct research regarding the relative effectiveness of mental health treatment methods as the commissioner deems appropriate, and for this purpose, enter treatment facilities, observe clients, and review records in a manner consistent with the Minnesota government data practices act, chapter 13; and

(14) enter into contracts and promulgate rules the commissioner deems necessary to carry out the purposes of this chapter.

History: 1987 c 342 s 1; 1988 c 689 art 2 s 94; 1989 c 282 art 4 s 55; 1990 c 568 art 5 s 28

245.697 STATE ADVISORY COUNCIL ON MENTAL HEALTH.

Subdivision 1. Creation. A state advisory council on mental health is created. The council must have 30 members appointed by the governor in accordance with federal requirements. The council must be composed of:

(1) the assistant commissioner of mental health for the department of human services;

(2) a representative of the department of human services responsible for the medical assistance program;

(3) one member of each of the four core mental health professional disciplines (psychiatry, psychology, social work, nursing);

(4) one representative from each of the following advocacy groups: mental health association of Minnesota, Minnesota alliance for the mentally ill, and Minnesota mental health law project;

(5) providers of mental health services;

(6) consumers of mental health services;

(7) family members of persons with mental illnesses;

- (8) legislators;
- (9) social service agency directors;
- (10) county commissioners; and
- (11) other members reflecting a broad range of community interests, as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.

Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. The council does not expire as provided in section 15.059.

Subd. 2. **Duties.** The state advisory council on mental health shall:

- (1) advise the governor, the legislature, and heads of state departments and agencies about policy, programs, and services affecting people with mental illness;
- (2) advise the commissioner of human services on all phases of the development of mental health aspects of the biennial budget;
- (3) advise the governor and the legislature about the development of innovative mechanisms for providing and financing services to people with mental illness;
- (4) encourage state departments and other agencies to conduct needed research in the field of mental health;
- (5) review recommendations of the subcommittee on children's mental health;
- (6) educate the public about mental illness and the needs and potential of people with mental illness;
- (7) review and comment on all grants dealing with mental health and on the development and implementation of state and local mental health plans; and
- (8) coordinate the work of local children's and adult mental health advisory councils and subcommittees.

Subd. 2a. **Subcommittee on children's mental health.** The state advisory council on mental health (the "advisory council") must have a subcommittee on children's mental health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

- (1) the commissioners or designees of the commissioners of the departments of human services, health, education, state planning, finance, and corrections;
- (2) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;
- (3) at least one representative of an advocacy group for children with emotional disturbances;
- (4) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;
- (5) parents of children who have emotional disturbances;
- (6) a present or former consumer of adolescent mental health services;
- (7) educators currently working with emotionally disturbed children;
- (8) people knowledgeable about the needs of emotionally disturbed children of minority races and cultures;
- (9) people experienced in working with emotionally disturbed children who have committed status offenses;
- (10) members of the advisory council;
- (11) one person from the local corrections department and one representative of the Minnesota district judges association juvenile committee; and
- (12) county commissioners and social services agency representatives.

The chair of the advisory council shall appoint subcommittee members described in clauses (3) to (11) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance on the subcommittee. Terms, com-

pensation, removal, and filling of vacancies are governed by subdivision 1, except that terms of subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Subd. 3. Reports. The state advisory council on mental health shall report from time to time on its activities to the governor, the legislature, and the commissioners of health, jobs and training, and human services. It shall file a formal report with the governor not later than October 15 of each even-numbered year so that the information contained in the report, including recommendations, can be included in the governor's budget message to the legislature. It shall also report to the legislature not later than November 15 of each even-numbered year.

History: 1987 c 342 s 2; 1988 c 629 s 45; 1988 c 689 art 2 s 95,96; 1989 c 282 art 4 s 56-58; 1990 c 568 art 5 s 29

CHILDREN'S MENTAL HEALTH SERVICE SYSTEM

245.698 [Repealed, 1989 c 282 art 4 s 64]

245.70 MENTAL HEALTH; FEDERAL AID.

Subdivision 1. Mentally ill. The commissioner of human services is designated the state agency to establish and administer a statewide plan for the care, treatment, diagnosis, or rehabilitation, of the mentally ill which are or may be required as a condition for eligibility for benefits under any federal law and in particular under the Federal Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9. The commissioner of human services is authorized and directed to receive, administer, and expend any funds that may be available under any federal law or from any other source, public or private, for such purposes.

Subd. 2. Mental health block grants. The commissioner of human services is designated the state authority to establish and administer the state plan for the federal mental health funds available under the alcohol, drug abuse, and mental health services block grant, United States Code, Title 42, Sections 300X to 300X-9. The commissioner shall receive and administer the available federal mental health funds.

History: 1965 c 626 s 1; 1982 c 607 s 1; 1984 c 654 art 5 s 58; 1985 c 252 s 1

245.71 CONDITIONS TO FEDERAL AID FOR MENTALLY ILL.

Subdivision 1. The commissioner of human services may comply with all conditions and requirements necessary to receive federal aid or block grants with respect to the establishment, construction, maintenance, equipment or operation, for all the people of this state, of adequate facilities and services as specified in section 245.70.

Subd. 2. The commissioner may establish a state mental health services planning council to advise on matters relating to coordination of mental health services among state agencies, the unmet needs for services, including services for minorities or other underserved groups, and the allocation and adequacy of mental health services within the state. The commissioner may establish special committees within the planning council authority to address the needs of special population groups. Members of a state advisory planning council must be broadly representative of other state agencies involved with mental health, service providers, advocates, consumers, local elected officials, age groups, underserved and minority groups, and geographic areas of the state.

History: 1965 c 626 s 2; 1982 c 607 s 2; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1985 c 252 s 2

245.711 COMPREHENSIVE PROGRAMS; COORDINATION OF LOCAL PROGRAMS.

Subdivision 1. **County duties.** The county board shall coordinate all services for mentally ill individuals conducted by local agencies under contract to the county boards and review all proposed agreements, contracts, grants, plans, and programs in relation to services for mentally ill individuals prepared by any local agencies for funding from any local, state, or federal governmental sources.

Subd. 2. **Grants by counties.** The county boards may make grants for comprehensive programs for prevention, care, and treatment of mentally ill individuals. Grants utilizing money under section 245.713 may be made for the cost of these comprehensive programs and services whether provided directly by county boards, by individuals pursuant to contract, or by other public and private not for profit agencies and organizations. When only state and county money is involved, county boards may make comprehensive program grants to profit or not for profit agencies and organizations. Nothing in this section shall prevent the commissioner from entering into contracts with, and making grants to, other state agencies for the purpose of providing specific services and programs. With approval of the county board, the commissioner may make grants or contracts for research or demonstration projects specific to needs within that county.

History: 1982 c 607 s 3; 1985 c 252 s 3

245.712 COUNTY USE OF FEDERAL BLOCK GRANT FUNDS FOR MENTAL HEALTH SERVICES.

Subdivision 1. **Allowable services.** Funds awarded to the state for mental health services by federal block grants shall be used for grants to counties to directly provide, or contract with qualified community mental health centers for the provision of, the following services:

(a) Services for chronically mentally ill individuals, which include identification of chronically mentally ill individuals and assistance to them in gaining access to essential services through the assignment of case managers;

(b) Identification and assessment of severely mentally disturbed children and adolescents and provision of appropriate services to them;

(c) Identification and assessment of mentally ill elderly individuals and provision of appropriate services to them;

(d) Services for identifiable populations which are currently underserved in the state; and

(e) Coordination of mental health and health care services provided within health care centers including planning, administration, and educational activities.

Subd. 2. **Prohibited services.** Funds allocated to the state for mental health services by the federal block grant may not be used to:

(a) Provide inpatient services;

(b) Make cash payments to intended recipients of health services;

(c) Purchase or improve land, or to purchase, construct or permanently improve any building or other facility, except for minor remodeling, or to purchase major medical equipment;

(d) Satisfy any requirement for expenditure of nonfederal funds as a condition for receiving federal funds; or

(e) Provide financial assistance to any entity other than a public or nonprofit private entity.

History: 1982 c 607 s 4

245.713 FORMULA.

Subdivision 1. [Repealed, 1987 c 403 art 2 s 164]

Subd. 2. **Total funds available; allocation.** Funds granted to the state by the federal government under United States Code, title 42, sections 300X to 300X-9 each federal fiscal year for mental health services must be allocated as follows:

(a) Any amount set aside by the commissioner of human services for American Indian organizations within the state, which funds shall not duplicate any direct federal funding of American Indian organizations and which funds shall be at least 25 percent of the total federal allocation to the state for mental health services; provided that sufficient applications for funding are received by the commissioner which meet the specifications contained in requests for proposals. Money from this source may be used for special committees to advise the commissioner on mental health programs and services for American Indians and other minorities or underserved groups. For purposes of this subdivision, "American Indian organization" means an American Indian tribe or band or an organization providing mental health services that is legally incorporated as a nonprofit organization registered with the secretary of state and governed by a board of directors having at least a majority of American Indian directors.

(b) An amount not to exceed five percent of the federal block grant allocation for mental health services to be retained by the commissioner for administration.

(c) Any amount permitted under federal law which the commissioner approves for demonstration or research projects for severely disturbed children and adolescents, the underserved, special populations or multiply disabled mentally ill persons. The groups to be served, the extent and nature of services to be provided, the amount and duration of any grant awards are to be based on criteria set forth in the Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9, and on state policies and procedures determined necessary by the commissioner. Grant recipients must comply with applicable state and federal requirements and demonstrate fiscal and program management capabilities that will result in provision of quality, cost-effective services.

(d) The amount required under federal law, for federally mandated expenditures.

(e) An amount not to exceed 15 percent of the federal block grant allocation for mental health services to be retained by the commissioner for planning and evaluation.

Subd. 3. [Repealed, 1987 c 403 art 2 s 164]

Subd. 4. **Funds available due to transfer.** Any federal funds available to the commissioner for mental health services prescribed under United States Code, title 42, sections 300X to 300X-9 due to transfer of funds between block grants shall be allocated as prescribed in subdivision 1.

History: 1982 c 607 s 5; 1984 c 654 art 5 s 58; 1985 c 252 s 4; 1987 c 403 art 2 s 41; 1989 c 282 art 4 s 59

245.714 MAINTENANCE OF EFFORT.

Beginning in federal fiscal year 1983, each county shall annually certify to the commissioner that the county has not reduced funds from state, county, and other nonfederal sources which would in the absence of the federal funds made available by United States Code, title 42, sections 300X to 300X-9 have been made available for services to mentally ill persons.

History: 1982 c 607 s 6

245.715 QUALIFICATIONS AS A COMMUNITY MENTAL HEALTH CENTER.

In addition to those agencies that have previously qualified as comprehensive community mental health centers under the provisions of the federal Community Mental Health Centers Act, other public or nonprofit private agencies that are able to demonstrate their capacity to provide the following services as defined by the commissioner may qualify as a community mental health center for the purposes of the federal block grant. The federally required services may be provided by separate agencies. These services include:

(a) Outpatient services, including specialized outpatient services for children, the

elderly, individuals who are chronically mentally ill and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;

- (b) 24-hour a day emergency care services;
- (c) Day treatment or partial hospitalization services;
- (d) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of the admission; and
- (e) Consultation and education services.

Before accepting federal block grant funds for mental health services, counties shall provide the commissioner with all necessary assurances that the qualified community mental health centers which receive these block grant funds meet the minimum service requirements of clauses (a) to (e). At any time at least 30 days prior to the commissioner's allocation of federal funds, any county may notify the commissioner of its decision not to accept the federal funds for qualified community mental health centers.

History: 1982 c 607 s 7

245.716 REPORTS; DATA COLLECTION.

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

Subd. 2. **Social services report.** Beginning in calendar year 1983, each county shall include in the report required by section 256E.10 a part or subpart which addresses the items specified in section 256E.10, subdivision 1, clauses (a) and (b), as they pertain to the use of funds available from the federal government for services of qualified community mental health centers.

Subd. 3. **Social services report.** Beginning in calendar year 1983, each county shall include in the report required by section 256E.10 a part or subpart which addresses the items specified in section 256E.10, subdivision 1, clauses (a) and (b), as they pertain to the use of funds available from the federal government for services of qualified community mental health centers.

History: 1982 c 607 s 8; 1989 c 89 s 2

245.717 WITHHOLDING OF FUNDS.

Beginning in federal fiscal year 1983, the distribution of funds to counties provided in section 245.713 shall be reduced by an amount equal to the federal block grant funds allotted pursuant to section 245.713 in the immediately preceding year which have been spent for some purpose other than qualified community mental health centers. If it is determined that the state is legally liable for any repayment of federal block funds which were not properly used by the counties, the repayment liability shall be assessed against the counties which did not properly use the funds. The commissioner may withhold future block grant funds to those counties until the obligation is met. The commissioner shall not award additional block grant funds to those counties until the commissioner is assured that no future violations will occur.

History: 1982 c 607 s 9; 1986 c 444

245.718 APPEAL.

At least 30 days prior to certifying any reduction in funds pursuant to section 245.717, the commissioner shall notify the county of an intention to certify a reduction. The commissioner shall notify the county of the right to a hearing. If the county requests a hearing within 30 days of notification of intention to reduce funds, the commissioner shall not certify any reduction in funds until a hearing is conducted and a decision rendered in accordance with the provisions of chapter 14 for contested cases.

History: 1982 c 424 s 130; 1982 c 607 s 10

245.72 MS 1980 [Repealed, 1981 c 355 s 34]

245.721 MENTAL ILLNESS INFORMATION MANAGEMENT SYSTEM.

By January 1, 1990, the commissioner of human services shall establish an information management system for collecting data about individuals who suffer from severe and persistent mental illness and who receive publicly funded services for mental illness.

History: 1987 c 403 art 2 s 42

245.73 GRANTS FOR RESIDENTIAL SERVICES FOR ADULTS WITH MENTAL ILLNESS.

Subdivision 1. Commissioner's duty. The commissioner shall establish a statewide program to assist counties in ensuring provision of services to adult mentally ill persons. The commissioner shall make grants to county boards to provide community-based services to mentally ill persons through programs licensed under sections 245A.01 to 245A.16.

Subd. 2. Application; criteria. County boards may submit an application and budget for use of the money in the form specified by the commissioner. The commissioner shall make grants only to counties whose applications and budgets are approved by the commissioner for residential programs for adults with mental illness to meet licensing requirements pursuant to sections 245A.01 to 245A.16. State funds received by a county pursuant to this section shall be used only for direct service costs. Both direct service and other costs, including but not limited to renovation, construction or rent of buildings, purchase or lease of vehicles or equipment as required for licensure as a residential program for adults with mental illness under sections 245A.01 to 245A.16, may be paid out of the matching funds required under subdivision 3. Neither the state funds nor the matching funds shall be used for room and board costs.

Subd. 2a. Special programs. Grants received pursuant to this section may be used to fund innovative programs in residential facilities, related to structured physical fitness programs designed as part of a mental health treatment plan.

Subd. 3. Formula. Grants made pursuant to this section shall finance 75 percent of the county's costs of expanding or providing services for adult mentally ill persons in residential facilities as provided in subdivision 2.

Subd. 4. Rules; reports. The commissioner shall promulgate an emergency and permanent rule to govern grant applications, approval of applications, allocation of grants, and maintenance of service and financial records by grant recipients. The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (17). The commissioner shall require collection of data for compliance, monitoring and evaluation purposes and shall require periodic reports to demonstrate the effectiveness of the services in helping adult mentally ill persons remain and function in their own communities. As a part of the report required by section 245.461, the commissioner shall report to the legislature as to the effectiveness of this program and recommendations regarding continued funding.

History: 1981 c 360 art 2 s 14; 1983 c 164 s 1; 1984 c 640 s 32; 1986 c 349 s 1; 1987 c 384 art 2 s 1; 1989 c 89 s 3; 1989 c 282 art 2 s 55,56; art 4 s 60; 1990 c 568 art 5 s 30

245.74 [Repealed, 1987 c 403 art 2 s 164]

245.75 FEDERAL GRANTS FOR INDIANS.

The commissioner of human services is authorized to enter into contracts with the department of health, education, welfare and the department of interior, bureau of Indian affairs, for the purpose of receiving federal grants for the welfare and relief of Minnesota Indians. Such contract and the plan of distribution of such funds shall be subject to approval of the Minnesota public relief advisory committee.

History: 1965 c 886 s 23; 1984 c 654 art 5 s 58

245.76 [Repealed, 1987 c 403 art 2 s 164]

245.765 REIMBURSEMENT OF COUNTY FOR CERTAIN INDIAN WELFARE COSTS.

Subdivision 1. The commissioner of human services, to the extent that state and federal money is available therefor, shall reimburse any county for all welfare costs expended by the county to any Indian who is an enrolled member of the Red Lake Band of Chippewa Indians and resides upon the Red Lake Indian Reservation. The commissioner may advance payments to a county on an estimated basis subject to audit and adjustment at the end of each state fiscal year. Reimbursements shall be prorated if the state appropriation for this purpose is insufficient to provide full reimbursement.

Subd. 2. The commissioner may promulgate rules for the carrying out of the provisions of subdivision 1, and may negotiate for and accept grants from the United States for the purposes of this section.

History: 1971 c 935 s 1; 1981 c 360 art 1 s 20; 1984 c 654 art 5 s 58; 1986 c 444

245.77 LEGAL SETTLEMENT OF PERSONS RECEIVING ASSISTANCE; ACCEPTANCE OF FEDERAL FUNDS.

In the event federal funds become available to the state for purposes of reimbursing the several local agencies of the state for costs incurred in providing financial relief to poor persons under the liability imposed by Minnesota Statutes 1986, section 256D.18, or for reimbursing the state and counties for categorical aid assistance furnished to persons who are eligible for such assistance only because of the United States Supreme Court decision invalidating state residence requirements, the commissioner of human services is hereby designated the state agent for receipt of such funds. Upon receipt of any federal funds, the commissioner shall in a uniform and equitable manner use such funds to reimburse counties for expenditures made in providing financial relief to poor persons. The commissioner is further authorized to promulgate rules, consistent with the rules and regulations promulgated by the secretary of health, education, and welfare, governing the reimbursement provided for by this provision.

History: 1969 c 910 s 1; 1973 c 380 s 5; 1973 c 650 art 21 s 22; 1976 c 2 s 84; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1989 c 209 art 2 s 27

245.771 SUPERVISION OF FOOD STAMP PROGRAM.

Subdivision 1. **Supervision of program.** The commissioner of human services shall supervise the food stamp program to aid administration of the food stamp program by county welfare boards pursuant to section 393.07, subdivision 10, to promote excellence of administration and program operation, and to ensure compliance with all federal laws and regulations so that all eligible persons are able to participate.

Subd. 2. **Waivers.** The commissioner of human services shall apply to the United States Department of Agriculture for waivers of monthly reporting and retrospective budgeting requirements.

Subd. 3. **Employment and training programs.** The commissioner of human services, in consultation with the commissioner of jobs and training, is authorized to implement and allocate money to food stamp employment and training programs in as many counties as is necessary to meet federal participation requirements and comply with federal laws and regulations. The commissioner of human services may contract with the commissioner of jobs and training to implement and supervise employment and training programs for food stamp recipients that are required by federal regulations.

History: 1986 c 404 s 9; 1988 c 689 art 2 s 98; 1989 c 282 art 5 s 4

245.775 [Repealed, 1Sp1989 c 1 art 16 s 21]

245.78 [Repealed, 1976 c 243 s 15]

PUBLIC WELFARE LICENSING ACT

- 245.781 [Repealed, 1987 c 333 s 20]
 245.782 [Repealed, 1987 c 333 s 20]
 245.783 [Repealed, 1987 c 333 s 20]
 245.79 [Repealed, 1976 c 243 s 15]
 245.791 [Repealed, 1987 c 333 s 20]
 245.792 [Repealed, 1987 c 333 s 20]
 245.80 [Repealed, 1976 c 243 s 1]
 245.801 [Repealed, 1987 c 333 s 20]

245.802 RULES.

Subdivision 1. [Repealed, 1987 c 333 s 20]

Subd. 1a. [Repealed, 1987 c 333 s 20]

Subd. 1b. **Monitoring of facilities.** After June 30, 1989, no residential facility licensed by the commissioner of human services or the commissioner of health, other than facilities specifically licensed for people with mental illness, may have more than four residents with a diagnosis of mental illness. The commissioner of health, with the cooperation of the commissioner of human services, shall monitor licensed boarding care, board and lodging, and supervised living facilities to assure that this requirement is met. By January 1, 1989, the commissioner of health shall recommend to the legislature an appropriate mechanism for enforcing this requirement.

Subd. 2. [Repealed, 1987 c 333 s 20]

Subd. 2a. **Specific review of rules.** The commissioner shall:

(1) provide in rule for various levels of care to address the residential treatment needs of persons with mental illness;

(2) review Category I and II programs established in Minnesota Rules, parts 9520.0500 to 9520.0690 to ensure that the categories of programs provide a continuum of residential service programs for persons with mental illness;

(3) provide in rule for a definition of the term "treatment" as used in relation to persons with mental illness;

(4) adjust funding mechanisms by rule as needed to reflect the requirements established by rule for services being provided;

(5) review and recommend staff educational requirements and staff training as needed; and

(6) review and make changes in rules relating to residential care and service programs for persons with mental illness as the commissioner may determine necessary.

Subd. 3. [Repealed, 1987 c 333 s 20]

Subd. 4. [Repealed, 1987 c 333 s 20]

Subd. 5. **Housing services for persons with mental illness.** The commissioner of human services shall study the housing needs of people with mental illness and shall articulate a continuum of services from residential treatment as the most intensive service through housing programs as the least intensive. The commissioner shall develop recommendations for implementing the continuum of services and shall present the recommendations to the legislature by January 31, 1988.

History: 1976 c 243 s 7; 1977 c 305 s 45; 1980 c 618 s 18; 1981 c 360 art 2 s 15; 1Sp1981 c 4 art 1 s 115; 1982 c 424 s 130; 1984 c 542 s 6; 1984 c 654 art 5 s 58; 1984 c 658 s 2; 1985 c 248 s 70; 1986 c 444; 1987 c 197 s 2-4

NOTE: Subdivision 1a was also amended by Laws 1987, chapter 197, section 1, to read as follows:

"Subd. 1a. **Standards for supportive living residences.** Standards for licensing supportive living residences shall include provisions concerning the referral of adults needing treatment to appropriate programs and the prevention of inappropriate placements in supportive living residences, a maximum bed limit of 40, and provisions discouraging the concentration of supportive living residences in any one region or neighborhood. The commissioner shall develop no licensing standards for supportive living residences until the legislature has met and considered recommendations presented under subdivision 5."

245.803 [Repealed, 1987 c 333 s 20]

245.804 [Repealed, 1987 c 333 s 20]

245.805 [Repealed, 1987 c 333 s 20]

245.81 [Repealed, 1976 c 243 s 15]

245.811 [Repealed, 1987 c 333 s 20]

245.812 [Repealed, 1987 c 333 s 20]

245.813 [Repealed, 1980 c 542 s 2]

245.814 LIABILITY INSURANCE FOR LICENSED PROVIDERS.

Subdivision 1. **Insurance for foster home providers.** The commissioner of human services shall within the appropriation provided purchase and provide insurance to individuals licensed as foster home providers to cover their liability for:

(1) injuries or property damage caused or sustained by persons in foster care in their home; and

(2) actions arising out of alienation of affections sustained by the natural parents of a foster child or natural parents or children of a foster adult.

Subd. 2. **Application of coverage.** Coverage shall apply to all foster homes licensed by the department of human services, licensed by a federally recognized tribal government, or established by the juvenile court and certified by the commissioner of corrections pursuant to section 260.185, subdivision 1, clause (c)(5), to the extent that the liability is not covered by the provisions of the standard homeowner's or automobile insurance policy. The insurance shall not cover property owned by the individual foster home provider, damage caused intentionally by a person over 12 years of age, or property damage arising out of business pursuits or the operation of any vehicle, machinery, or equipment.

Subd. 3. **Compensation provisions.** If the commissioner of human services is unable to obtain insurance through ordinary methods for coverage of foster home providers, the appropriation shall be returned to the general fund and the state shall pay claims subject to the following limitations.

(a) Compensation shall be provided only for injuries, damage, or actions set forth in subdivision 1.

(b) Compensation shall be subject to the conditions and exclusions set forth in subdivision 2.

(c) The state shall provide compensation for bodily injury, property damage, or personal injury resulting from the foster home providers activities as a foster home provider while the foster child or adult is in the care, custody, and control of the foster home provider in an amount not to exceed \$250,000 for each occurrence.

(d) The state shall provide compensation for damage or destruction of property caused or sustained by a foster child or adult in an amount not to exceed \$250 for each occurrence.

(e) The compensation in clauses (c) and (d) is the total obligation for all damages because of each occurrence regardless of the number of claims made in connection with the same occurrence, but compensation applies separately to each foster home. The state shall have no other responsibility to provide compensation for any injury or loss caused or sustained by any foster home provider or foster child or foster adult.

This coverage is extended as a benefit to foster home providers to encourage care of persons who need out-of-home care. Nothing in this section shall be construed to mean that foster home providers are agents or employees of the state nor does the state accept any responsibility for the selection, monitoring, supervision, or control of foster home providers which is exclusively the responsibility of the counties which shall regulate foster home providers in the manner set forth in the rules of the commissioner of human services.

Subd. 4. **Liability insurance; risk pool.** If the commissioner determines that appropriate commercial liability insurance coverage is not available for a licensed foster

home, group home, developmental achievement center, or day care provider, and that coverage available through the joint underwriting authority of the commissioner of commerce or other public entity is not appropriate for the provider or a class of providers, the commissioner of human services and the commissioner of commerce may jointly establish a risk pool to provide coverage for licensed providers out of premiums or fees paid by providers. The commissioners may set limits on coverage, establish premiums or fees, determine the proportionate share of each provider to be collected in a premium or fee based on the provider's claim experience and other factors the commissioners consider appropriate, establish eligibility and application requirements for coverage, and take other action necessary to accomplish the purposes of this subdivision. A human services risk pool fund is created for the purposes of this subdivision. Fees and premiums collected from providers for risk pool coverage are appropriated to the risk pool fund. Interest earned from the investment of money in the fund must be credited to the fund and money in the fund is appropriated to the commissioner of human services to pay administrative costs and covered claims for participating providers. In the event that money in the fund is insufficient to pay outstanding claims and associated administrative costs, the commissioner of human services may assess providers participating in the risk pool amounts sufficient to pay the costs. The commissioner of human services may not assess a provider an amount exceeding one year's premiums collected from that provider.

History: 1977 c 360 s 1; 1980 c 614 s 125; 1984 c 654 art 5 s 58; 1986 c 313 s 10; 1986 c 455 s 61; 1988 c 689 art 2 s 99-101

245.82 [Repealed, 1976 c 243 s 15]

245.821 NOTICE OF ESTABLISHMENT OF FACILITIES FOR TREATMENT, HOUSING OR COUNSELING OF HANDICAPPED PERSONS.

Subdivision 1. Notwithstanding any law to the contrary, no private or public facility for the treatment, housing, or counseling of more than five persons with mental illness, physical disabilities, mental retardation or related conditions, as defined in section 252.27, subdivision 1, chemical dependency, or another form of dependency, nor any correctional facility for more than five persons, shall be established without 30 days written notice to the affected municipality or other political subdivision.

Subd. 2. No state funds shall be made available to or be expended by any state or local agency for facilities or programs enumerated in this section unless and until the provisions of this section have been complied with in full.

History: 1974 c 274 s 3; 1985 c 21 s 5

245.825 USE OF AVERSIVE OR DEPRIVATION PROCEDURES IN FACILITIES SERVING PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Subdivision 1. **Rules governing use of aversive and deprivation procedures.** The commissioner of human services shall by October, 1983, promulgate rules governing the use of aversive and deprivation procedures in all licensed facilities and licensed services serving persons with mental retardation or related conditions, as defined in section 252.27, subdivision 1. No provision of these rules shall encourage or require the use of aversive and deprivation procedures. The rules shall prohibit: (a) the application of certain aversive or deprivation procedures in facilities except as authorized and monitored by the designated regional review committees; (b) the use of aversive or deprivation procedures that restrict the consumers' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (c) the use of faradic shock without a court order. The rule shall further specify that consumers may not be denied ordinary access to legal counsel and next of kin. In addition, the rule may specify other prohibited practices and the specific conditions under which permitted practices are to be carried out. For any persons receiving faradic shock, a plan to reduce and eliminate the use of faradic shock shall be in effect upon implementation of the procedure.

Subd. 2. **Regional review committee.** After the rules have been promulgated the commissioner shall appoint regional review committees to monitor the rules.

History: 1982 c 637 s 1,2; 1984 c 654 art 5 s 58; 1985 c 21 s 6; 1987 c 110 s 1

245.826 USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES IN FACILITIES SERVING EMOTIONALLY DISTURBED CHILDREN.

When amending rules governing facilities serving emotionally disturbed children that are licensed under section 245A.09 and Minnesota Rules, parts 9545.0900 to 9545.1090, and 9545.1400 to 9545.1500, the commissioner of human services shall include provisions governing the use of restrictive techniques and procedures. No provision of these rules may encourage or require the use of restrictive techniques and procedures. The rules must prohibit: (1) the application of certain restrictive techniques or procedures in facilities, except as authorized in the child's case plan and monitored by the county caseworker responsible for the child; (2) the use of restrictive techniques or procedures that restrict the clients' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of corporal punishment. The rule may specify other restrictive techniques and procedures and the specific conditions under which permitted techniques and procedures are to be carried out.

History: 1990 c 542 s 6

245.827 COMMUNITY INITIATIVES FOR CHILDREN.

Subdivision 1. **Program established.** The commissioner of human services shall establish a demonstration program of grants for community initiatives for children. The goal of the program is to enlist the resources of a community to promote the healthy physical, educational, and emotional development of children who are living in poverty. Community initiatives for children accomplish the goal by offering support services that enable a family to provide the child with a nurturing home environment. The commissioner shall award grants to nonprofit organizations based on the criteria in subdivision 3.

Subd. 2. **Definition.** "Community initiatives for children" are programs that promote the healthy development of children by increasing the stability of their home environment. They include support services such as child care, parenting education, respite activities for parents, counseling, recreation, and other services families may need to maintain a nurturing environment for their children. Community initiatives for children must be planned by members of the community who are concerned about the future of children.

Subd. 3. **Criteria.** In order to qualify for a community initiatives for children grant, a nonprofit organization must:

(1) involve members of the community and use community resources in planning and executing all aspects of the program;

(2) provide a central location that is accessible to low-income families and is available for informal as well as scheduled activities during the day and on evenings and weekends;

(3) provide a wide range of services to families living at or below the poverty level including, but not limited to, quality affordable child care and training in parental skills;

(4) demonstrate that the organization is using and coordinating existing resources of the community;

(5) demonstrate that the organization has applied to private foundations for funding;

(6) ensure that services are focused on development of the whole child; and

(7) have a governing structure that includes consumer families and members of the community.

Subd. 4. **Covered expenses.** Grants awarded under this section may be used for the capital costs of establishing or improving a program that meets the criteria listed in subdivision 3. Capital costs include land and building acquisition, planning, site preparation, design fees, rehabilitation, construction, and equipment costs.

History: 1988 c 689 art 2 s 102

- 245.83 [Repealed, 1989 c 282 art 2 s 219]
- 245.84 [Repealed, 1989 c 282 art 2 s 219]
- 245.85 [Repealed, 1989 c 282 art 2 s 219]
- 245.86 [Repealed, 1988 c 689 art 2 s 269]
- 245.87 [Repealed, 1988 c 689 art 2 s 269]
- 245.871 [Repealed, 1989 c 282 art 2 s 219]
- 245.872 [Repealed, 1989 c 282 art 2 s 219]
- 245.873 [Repealed, 1989 c 282 art 2 s 219]

CHILD CARE SERVICES

- 245.88 [Repealed, 1987 c 333 s 20]
- 245.881 [Repealed, 1987 c 333 s 20]
- 245.882 [Repealed, 1987 c 333 s 20]
- 245.883 [Repealed, 1987 c 333 s 20]
- 245.884 [Repealed, 1987 c 333 s 20]
- 245.885 [Repealed, 1987 c 333 s 20]

245.90 COURT AWARDED FUNDS, DISPOSITION.

The commissioner of human services shall notify the house appropriations and senate finance committees of the terms of any contractual arrangement entered into by the commissioner and the attorney general, pursuant to an order of any court of law, which provides for the receipt of funds by the commissioner.

Any funds recovered or received by the commissioner pursuant to an order of any court of law shall be placed in the general fund.

History: 1975 c 434 s 24; 1984 c 654 art 5 s 58

OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION

245.91 DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of sections 245.91 to 245.97, the following terms have the meanings given them.

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state departments of human services and health, and of designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 3. **Client.** "Client" means a person served by an agency, facility, or program, who is receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, that is required to be licensed by the commissioner of human services, and an acute care inpatient facility that provides services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 5. **Regional center.** "Regional center" means a regional center as defined in section 253B.02, subdivision 18.

Subd. 6. **Serious injury.** "Serious injury" means:

- (1) fractures;
- (2) dislocations;
- (3) evidence of internal injuries;
- (4) head injuries with loss of consciousness;
- (5) lacerations involving injuries to tendons or organs, and those for which complications are present;
- (6) extensive second degree or third degree burns, and other burns for which complications are present;
- (7) extensive second degree or third degree frostbite, and others for which complications are present;
- (8) irreversible mobility or avulsion of teeth;
- (9) injuries to the eyeball;
- (10) ingestion of foreign substances and objects that are harmful;
- (11) near drowning;
- (12) heat exhaustion or sunstroke; and
- (13) all other injuries considered serious by a physician.

History: 1987 c 352 s 2; 1988 c 543 s 1-3; 1989 c 282 art 2 s 57

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information about decisions, acts, and other matters of an agency, facility, or program. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

History: 1987 c 352 s 3; 1988 c 543 s 4

245.93 ORGANIZATION OF OFFICE OF OMBUDSMAN.

Subdivision 1. **Staff.** The ombudsman may appoint a deputy and a confidential secretary in the unclassified service and may appoint other employees as authorized by the legislature. The ombudsman and the full-time staff are members of the Minnesota state retirement association.

Subd. 2. **Advocacy.** The function of mental health and mental retardation client advocacy in the department of human services is transferred to the office of ombudsman according to section 15.039. The ombudsman shall maintain at least one client advocate in each regional center.

Subd. 3. **Delegation.** The ombudsman may delegate to members of the staff any authority or duties of the office except the duty of formally making recommendations to an agency or facility or reports to the governor or the legislature.

History: 1987 c 352 s 4

245.94 POWERS OF OMBUDSMAN; REVIEWS AND EVALUATIONS; RECOMMENDATIONS.

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility, or program if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, mental retardation or a related condition, or emotional disturbance.

(f) The ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(g) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(h) The ombudsman may attend department of human services review board and special review board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the department of human services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(i) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services provided to clients with mental retardation or a related condition.

(j) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(k) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Subd. 2. Matters appropriate for review. (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

- (1) may be contrary to law or rule;
- (2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;
- (3) may be mistaken in law or arbitrary in the ascertainment of facts;
- (4) may be unclear or inadequately explained, when reasons should have been revealed;
- (5) may result in abuse or neglect of a person receiving treatment;
- (6) may disregard the rights of a client or other individual served by an agency or facility;

(7) may impede or promote independence, community integration, and productivity for clients; or

(8) may impede or improve the monitoring or evaluation of services provided to clients.

(b) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

Subd. 2a. Mandatory reporting. Within 24 hours after a client suffers death or serious injury, the facility or program director shall notify the ombudsman of the death or serious injury.

Subd. 3. Complaints. The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in section 626.557, subdivision 17, paragraph (c), against a client or other person, who in good faith makes a complaint or assists in an investigation.

Subd. 4. Recommendations to agency. (a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

- (1) consider the matter further;
- (2) modify or cancel its actions;
- (3) alter a rule, order, or internal policy;
- (4) explain more fully the action in question; or
- (5) take other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

History: 1987 c 352 s 5; 1988 c 543 s 5-8; 1989 c 282 art 2 s 58,59; 1989 c 351 s 16; 1990 c 398 s 1

245.95 RECOMMENDATIONS AND REPORTS TO GOVERNOR.

Subdivision 1. Specific reports. The ombudsman may send conclusions and suggestions concerning any matter reviewed to the governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, program, or any person, the ombudsman shall consult with the governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the governor that is adverse to an agency, facility, program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation.

Subd. 2. General reports. In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall at the end of each year report to the governor concerning the exercise of the ombudsman's functions during the preceding year.

History: 1987 c 352 s 6; 1988 c 543 s 9

245.96 CIVIL ACTIONS.

The ombudsman and his designees are not civilly liable for any action taken under sections 245.91 to 245.97 if the action was taken in good faith, was within the scope of the ombudsman's authority, and did not constitute willful or reckless misconduct.

History: 1987 c 352 s 7

245.97 OMBUDSMAN COMMITTEE.

Subdivision 1. Membership. The ombudsman committee consists of 15 members appointed by the governor to three-year terms. Members shall be appointed on the basis of their knowledge of and interest in the health and human services system subject to the ombudsman's authority. In making the appointments, the governor shall try to ensure that the overall membership of the committee adequately reflects the agencies, facilities, and programs within the ombudsman's authority and that members include consumer representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individuals served by an agency, facility, or program; human services and health care professionals, including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

Subd. 2. Compensation; chair. Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The governor shall designate one member of the committee to serve as its chair at the pleasure of the governor.

Subd. 3. Meetings. The committee shall meet at least four times a year at the request of its chair or the ombudsman.

Subd. 4. Duties. The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

Subd. 5. Medical review subcommittee. At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the governor to serve as a medical review subcommittee. Terms of service, vacancies, and compensation are governed by subdivision 2. The governor shall designate one of the members to serve as chair of the subcommittee. The medical review subcommittee may:

(1) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes; and

(5) submit a report regarding the death of a client to the committee, the ombudsman, the client's next-of-kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility.

Subd. 6. Terms, compensation, removal and expiration. The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. The ombudsman committee and the medical review subcommittee expire on June 30, 1993.

History: 1987 c 352 s 8; 1988 c 543 s 10; 1988 c 629 s 46

245.98 COMPULSIVE GAMBLING TREATMENT PROGRAM.

Subdivision 1. Definition. For the purposes of this section, "compulsive gambler" means a person who is chronically and progressively preoccupied with gambling and with the urge to gamble to the extent that the gambling behavior compromises, disrupts, or damages personal, family, or vocational pursuits.

Subd. 2. Program. The commissioner of human services shall establish a program for the treatment of compulsive gamblers. The commissioner may contract with a non-profit entity with expertise regarding the treatment of compulsive gambling to operate

the program. The program may include the establishment of a statewide toll-free number, resource library, public education programs; regional in-service training programs and conferences for health care professionals, educators, treatment providers, employee assistance programs, and criminal justice representatives; and the establishment of certification standards for programs and service providers. The commissioner may enter into agreements with other governmental or nonprofit entities and may employ or contract with consultants to facilitate the provision of these services or the training of individuals to qualify them to provide these services. The program may also include inpatient and outpatient treatment and rehabilitation services and research studies. The research studies must include baseline and prevalence studies for adolescents and adults to identify those at the highest risk. The program must be approved by the commissioner before it is established.

Subd. 3. **Report.** The commissioner must report annually to the legislature by January 15 of each year of the manner in which the program to treat and prevent compulsive gamblers is being implemented.

History: 1989 c 334 art 7 s 1