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DEPARTMENT OF PUBLIC WELFARE
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OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
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Jan. 27, 1981

To:

From: Arthur E. Noot
Commissioner

Subject: Rule 14 Evaluation Report

Attached is the Department of Public Welfare's evaluation report regarding the $2,000,000 pilot program for chronically mentally ill persons in the community (Rule 14). The report has been prepared as required by Minnesota Statutes 256E.12, Subd. 3.

If you have questions regarding any of the details in this report, please contact John Zakelj, DPW Mental Health Bureau, 612-296-4426.

Evaluation Report Regarding $2 Million Pilot Program for Chronically Mentally Ill Persons (Rule 14)

January 26, 1981

Minnesota Department of Public Welfare

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List of Tables (attached to report)

Executive Summary

On June 5, 1979, the Governor signed a bill appropriating $2,000,000 for grants to counties for pilot projects designed to help chronically mentally ill persons to remain and function in their own communities. The authorizing legislation required the Commissioner of Public Welfare to promulgate a rule to govern the grant application process. This rule is known as Rule 14. (Section I.)*

The first services funded under Rule 14 started March 3, 1980. Most projects had later starting dates, due to the work required to plan for and develop these new services and sometimes due to factors beyond the control of the department and the projects. By September 30, 1980, 21 projects provided an average of three (3) months of services to each of 681 clients. An additional large number of persons received brief services such as information and referral, public workshops, etc. (Sections I, III, VI).

Of the 35 counties applying for these funds (including some counties applying jointly), all received a grant. However, a number of the counties did not receive their full request; total requests exceeded the appropriation by $352,799. Fifty-two counties chose not to apply for these funds. (Section I, Table I).

As a result of individual county decisions, a wide variety of services were provided within the limits and priorities set by the authorizing legislation and by Rule 14. All of the services are either new services or an expansion of existing services. (Section III, Table II).

A good cross-section of Minnesot[illegible] population was served; an exception is the fact that racial minorities appear to be underserved, especially Black and Hispanic persons. Within the limits of funds available, the Department will be continuing special efforts which have already been started to ensure mental health services for American Indians, and will attempt to begin similar efforts for Black and Hispanic persons. (Section III, Table III).

Additional data regarding client characteristics show this to be a very dependent population, functioning at a very limited level at the time of their intake into the programs. A majority were on public assistance, were unemployed and had previously been hospitalized for psychiatric conditions. This is as expected and is an indication that the projects are indeed serving the intended target population. (Section III, Table III).

In the judgment of mental health professionals, three (3) months of average service time is not enough to show significant changes in the functioning level of chronically mentally ill persons. Therefore it is stressed that the effectiveness data included with the report is very preliminary and should show a clearer picture after a longer period of service. (Section IV).

* This notation after each paragraph indicates where to look in the full report for further detail.

The preliminary data on hospitalization rates before and after intake into Rule 14 programs show that utilization of state hospitals for these clients is down 68%; utilization of other in-patient psychiatric facilities is down 36%. (Section IV, Table VI).

As expected for such a short time period of service, other significant, measurable changes are not yet evident for most project clients. (Section IV, Table VII).

Although there are some indications that the above reductions in hospitalization may represent considerable savings, it is extremely difficult to measure the cost effectiveness of hospital vs. community care. This is due to a number of complicating variables, including the fact that there is a tremendous variety in the type, duration and amount of publicly supported services received by chronically mentally ill persons in the community. (Section VIII).

One aspect of "effectiveness" is the qualitative difference to the client of being able to be in the community, as opposed to being in an institution. Although it is too early to measure changes in levels of functioning for Rule 14 clients, the preliminary hospitalization data do indicate, subject to qualifications, that project clients are remaining in the community to a much greater degree than they did before. (Section IV, Table VI).

Based on various indicators the projects appear to be coordinated well with county social service/mental health programs. (Section V, Table VIII).

It is the Department's recommendation to continue these projects under a separate appropriation for another biennium. After the next biennium, these funds could be included with county CSSA block grants; by then, the projects should have established a sufficient track record to compete effectively with other county priorities, at least for the 35 counties now receiving Rule 14 funds. For the 52 counties which have not applied for funds, it may be necessary to provide opportunities for special assistance beyond the next biennium. (Section X).

I. Introduction:

On June 5, 1979, Governor Quie signed the Community Social Services Act (CSSA), which included an appropriation of $2 million for "grants to counties to establish, operate, or contract with private providers to provide services designed to help chronically mentally ill persons remain and function in their own communities." (M.S. 256E.12, Subd. 1). The same legislation required the Commissioner of Public Welfare to promulgate a rule governing the grant application process. That rule came to be designated as Rule 14 (12 MCAR 2.014).

Soon after the CSSA was signed, the Commissioner of Public Welfare appointed an advisory committee to provide the Department with county commissioner, private provider and public provider advice regarding the implementation of the CSSA. A subcommittee of that advisory committee and Department staff completed a draft of Rule 14 in September, 1979. During October, 1979, the Department provided all counties and potential providers with the opportunity to review this draft. On November 19, 1979, the proposed temporary rule was officially published in the State Register for public comment. On December 27, 1979, all procedures required under the Administrative Procedures Act for temporary rules had been completed and the new Rule 14 went into effect.

Rule 14 includes definitions of chronic mental illness and of services eligible for state funding; it sets forth priorities for grant allocations and outlines the minimum standards required for grant applications and budgets; it limits the use of grant funds to program/direct service expenditures only, allowing no state funding for capital expenditures or rent; it limits the amount of administrative expenses which can be paid with state funds; and it requires appropriate program and financial records.

On December 31, 1979, the Department completed an informational bulletin, describing the application process and providing each county with copies of the final rule and the application forms. Since a number of counties were interested, but not yet ready to apply for a grant at that time, two grant review cycles were set, with slightly more than one-half of the funds reserved for the second cycle of applications. The deadline for the first cycle of applications was January 31, 1980; the second cycle of applications were due April 18, 1980.

The Department established a rigorous application review process to insure that the requirements of the authorizing legislation and rule were carried out, and to insure that projected costs were reasonable and appropriate. To assist it in this process, the Department established a grant review committee, including representatives from the Mental Health Advocates Coalition and the Mental Health Association of Minnesota.

For the first cycle, 12 applications were received, representing a total request of $345,466 for three metro* counties, plus $794,914 for 16 outstate counties (a number of counties submitted joint applications). After completing the review process, the Department awarded the first grants on March 3, 1980, totaling $335,879 for the metro counties and $532,095 for

* Throughout this report, the term "metro county" is intended to refer to any of the seven counties surrounding Minneapolis and St. Paul, i.e. Hennepin, Ramsey, Anoka, Dakota, Carver, Scott, Washington.

the out-state counties. A number of requests were cut back to comply with the Rule 14 limits regarding eligible expenditures; some were negotiated to a lower level because the proposed costs were unacceptable, in the judgment of the review committee. Two applications were postponed to the second cycle because it was determined that significant improvements and clarifications were needed before the project plans could be approvable for state funding.

For the second cycle, 19 applications were received by April 18, 1980, representing a total request of $877,610 from four metro counties and $561,286 from 22 out-state counties. This included the two applications postponed from the first cycle (one of those two applications was a joint application from eight (8) out-state counties). Again, as was the case with the first cycle, a number of requests had to be cut back. A significant factor was the fact that there simply were not enough funds available to meet all requests. On June 9, 1980, the second cycle of awards was sent to counties, totaling $664,121 for the metro counties and $467,905 for out-state counties. Combining both cycles, $1 million was awarded to the metro counties and $1 million to the out-state counties.

See Table I for details on amounts requested and awarded per county and per project. Note the large variety of projects; although Rule 14 did set priorities as to types of services to be funded, each county had a great deal of latitude in deciding exactly what kinds of services it needed and wanted to provide.

For both cycles (including an adjustment for the two applications submitted twice), the total requests were $2,352,799, or $352,799 over the total dollars available. Considering the need for services for the chronically mentally ill (see Section IX of this report), it is surprising that more counties did not request a considerably higher amount. A major explanation for this is the current reluctance on the part of counties to take on any new programs. A number of counties which contacted state staff expressed concerns about being able to fund their required local share, even though this was only 10 percent; an even greater number expressed concern that advocate groups would expect the county to pick up the full cost of a project after state funds ran out. In some cases, the practical aspects of the time and effort required to define the need, plan the services, and find a provider proved to be more than the county could do by April 18, 1980, the deadline set for the second cycle of applications.

As it turned out, even a number of the counties which did submit applications and received grants had considerable delays in getting their services started. These difficulties varied across the state (Section VI provides a more detailed description); the net result was that, as of September 30, 1980, four projects were just beginning to serve their first clients; another nine projects had not yet begun their services.

As can be seen above and in Section VI, a great deal of work is required on the part of a large number of people to initiate a new program of services. In the case of this program, some of the resulting delays have been longer than expected. Upon reviewing the process in detail, it can be seen that the

delays were necessary and sometimes beyond the Department's and the project's control. Cutting corners along the way (e.g., not being as careful in promulgating the rule or doing a less rigorous review of the applications) would have resulted in considerable reduction in the quality and effectiveiveness of services to be provided.

By September 30, 1980, twenty-one projects did provide an average of three months of services to each of 681 clients. Further detail regarding these services and the persons served is provided in Section III.

II. The Rule 14 Reporting System:

The authorizing legislation included the following:

> The Commissioner shall require collection of data and periodic reports as the Commissioner deems necessary to demonstrate the effectiveness of the services in helping chronically mentally ill persons remain and function in their own communities. The Commissioner shall report to the Legislature no later than January 15, 1981 on the effectiveness of the experimental program and his recommendations regarding making this program an integral part of the social development programs administered by counties. (M.S. 256E.12, Subd. 3).

During April, 1980, the Department developed reporting requirements in two parts: The first part defined the data each project had to collect and report; the second part consisted of guidelines for a narrative report in which each county could describe its progress in achieving objectives, explain problems, etc. Taken together, this two-part report would enable the Department to monitor projects and to provide the information necessary for the report to the Legislature. The first reporting period was designated as covering the period from the grant award to September 30, 1980, with reports due to the state by November 1, 1980. This timetable was necessary to allow: one month for each project to complete its report; one and one-half months for Department staff to review each report and contact projects for any necessary correction of errors and clarifications; and one and one-half months for Department staff to write this summary report and obtain the necessary reviews and approvals within the Department before submitting it to the Legislature.

Even though this appropriation is separate from the CSSA block grants, every effort was taken to insure that the Rule 14 reporting system would be as compatible as possible with the larger CSSA reporting system. However, this was limited by the fact that the CSSA reporting requirements were not final at the time the Rule 14 requirements had to be issued. Rule 14 projects have been notified that some minor changes may be necessary in Rule 14 reporting for 1981 to be fully compatible with final CSSA reporting requirements.

For the Rule 14 reports due November 1, 1980, the Department received excellent cooperation from the participating counties. All counties submitted relatively complete reports, including progress reports from those counties which had not yet started providing service as of September 30, 1980. As can be expected with any reporting system of this size, there were some situations where certain counties did not understand certain reporting requirements and submitted some information in a manner which was not compatible with the rest of the state. In addition, the Department requested in November (on a voluntary basis) a small, but important, amount of additional information which had not been included with the original reporting requirements. All of these corrections, clarifications and additions were taken care of through communication between Department and project staff during November and December, 1980. The experience gained through this process will be used to improve future reporting requirements.

In the Department's judgment, the reports from the Rule 14 projects provide a reasonably complete, reliable and accurate description of the services provided and persons served through September 30, 1980.

III. Description of Persons Served and Services Provided:

These sample case histories are presented because they may help in understanding the people and services behind the statistics presented later:

The first case history is from a St. Louis County day treatment program in Duluth:

A is a middle-aged homemaker who was referred to the S.T.A.R. program after hospitalization in a local psychiatric unit. Upon entering the program, A appeared quiet and anxious. Although she was willing to carry on conversations initiated by others, she had difficulty verbalizing her thoughts in a coherent fashion. A's anxiety level was so high initially that she was unable to participate in the program for the entire day. Her attendance was also erratic. In the past five months, A has become actively involved in the program components, particularly those classes and activities which have helped her learn about feelings and how to deal with them. Encouragement and support from staff and members have contributed to A's emotional growth. She has demonstrated much progress during her relatively short involvement in the S.T.A.R. program and is now a willing and active participant in all phases of the program. Her attendance is now much more regular and she remains at club for the entire day. A has recently been willing to try new behaviors involving risk-taking and these behaviors have effected some positive changes in her personal life. A has not been rehospitalized at all since she began attending the S.T.A.R. program. Overall, A is now a more relaxed, cheerful and involved person who delights in the things she is learning at the S.T.A.R. program and who is eager to make even further change.

The second is from an Olmsted County socialization/drop-in center in Rochester (the county contracts with a private provider, Thomas House, Inc., to operate a program called Circle Center):

David is a 30 year old divorced man who was referred to Circle Center by his county social worker just prior to his discharge from Rochester State Hospital in June of 1980. In the five years before being referred to Circle Center, David had spent most of his time in an isolated and non-productive existence;

either in a rented room or as a patient at Rochester State Hospital. During those last five years he spent two to six months each year being treated in a state psychiatric hospital. Since the onset of his illness he has withdrawn socially, been unable to secure and maintain employment, and did not participate in any of the traditional community based recreation opportunities available.

At the time of his referral to Circle Center, David became involved with the Center's Community Adjustment Group and has since been a regular group member. He has slowly begun to participate in the Center's planned educational programming, to drop into the center frequently for other activites, and is slowly developing a small circle of friends.

David is presently seeking gainful employment and has not been hospitalized during the time he has been a member of Circle Center. These last seven months represent his longest period of non-hospitalization during the past five years. He is well accepted by other members of Circle Center and his level of self-esteem has increased significantly. The fact that he is happier and better adjusted is apparent to all who know him.

We have been pleased with the progress David has made and the support system he has developed through the Circle Center program. It is our hope that because of the changes he has made David will once again be a productive member of society in the near future.

The last sample case history was submitted directly from a client at the Anoka County pre-vocational training program (the county contracts with the local sheltered workshop, called Rise, Inc.):

I would like to tell you about some of the emotional problems I have had. In 1969 I was very depressed, I wouldn't do anything around the house and I cried all the time. My brother put me in Anoka State Hospital for three months. When I got out I got a job at Goodwill and an apartment by myself. I started getting real paranoid and hearing voices and quit my job. I tried to study astronomy to find out where the voices came from. I started yelling at them and I blamed the apartments I was living in for the voices, so I moved every three months. I got so involved with voices, I would do everything they told me to do. Then I started going back to my childhood and acting like a child or an infant. In 1976 I was admitted to Anoka State Hospital to try to bring me back to reality. After a year had passed I was released still kind of believing in things that weren't real. I was sent to a very nice foster home and my foster parents really helped me alot. I heared about the Rise Rule 14 program from my social worker in July, 1980 and thought I'd give it a try. I thought I'd never see the day when I would work with the handicapped; I always thought I was normal and everybody else was wrong. At first, I thought everyone looked and acted a little strange, but I soon found out I had just as many problems. From this program I have learned so much about life and myself. I have learned that work is necessary to survive and that working with the right people like at Rise, all my personal problems can be worked out. I now would like to work until I'm 110 years old, if the good Lord lets me live that long. I love work and feel my life is more complete.

A total of 681 clients had received service by September 30, 1980. Another 236 persons who were not officially clients of these projects received "short" services, such as information and referral. In addition, an unspecified number in the communities received services such as primary

prevention/education, which included public talks and workshops by project staff to inform the public about the project and about chronic mental illness.

Table II shows the statewide total dollars spent per service provided, through September 30, 1980. It is inappropriate to match these figures with statistics on persons served, since a large part of the costs shown are actually costs in starting up the particular services, e.g., recruitment of staff, initial preparation of staff, establishment of record systems, etc. Table II does present, in terms of the CSSA services list, a picture as to the distribution of the resources according to type of service.

One of the requirements set forth in Rule 14 was that only new or expanded services would be funded. None of the $2 million appropriation was to be used to replace existing funding. The application review process insured that the requirements were met. Of the 30 projects funded, 24 projects are completely new services; four are expansion of existing services; two are a combination of new and expansion of existing services.

In Table II, some of the project costs may seem particularly low. In a number of cases, this is due to the fact that the project is an expansion of an existing service; only the cost of the expansion is shown, not including the cost of the existing service.

Rule 14 set priorities as to the types of services to be funded: "Funds will be awarded for new or expanded services...which emphasize crisis management, independent living skills training and case management...; day treatment, crisis homes and drop-in centers are examples of services which may be funded under this rule." Comparing this statement to the actual services funded, one finds that most of the services funded do match the priority services listed in the rule. One which may not be immediately evident is drop-in centers; under the CSSA service terminology used in Table II, this appears under the category "social/recreational".

Table III describes the 681 persons served in terms of their characteristics at intake. The first three characteristics (age, sex and race) are compared to census statistics relating to Minnesota's total population.

Age: Children generally are not considered as being "chronically mentally ill persons" and therefore the statistics appropriately show very few persons served under the age of 18. The 25-44 age group does appear in a much larger percentage than their population in the state as a whole. This may be due to the fact that a number of projects are focusing on this age group because they expect that progress can be more easily shown with this group and the benefits will be longer lasting. In addition, there are some indications that chronically mentally ill persons in this age group experience more crises and difficulties in living than similar persons in other age groups; therefore the larger number of persons served in the 25-44 age group may be because that age group experiences a greater need for service.

Sex: Women make up a larger majority (55.2 percent) in the client population than they do in the state's population as a whole (51%). It is interesting that a number of studies presented in national journals have found similar percentages in mental health programs generally. A number of hypotheses have been offered as to the reasons for this; however, there are still disagreements among professionals as to why this occurs.

Race: Note that the percentage of American Indians in the client population exceeds the statewide census percentage. This may be partially due to special efforts which the Department and other groups have undertaken during the last year regarding Indian mental health programs. This does not necessarily mean that Indians are now adequately served. A number of areas in the state with high population of Indians still show no Indians served in their projects.

Racial minorities have a generally higher incidence of both poverty and mental illness. Some mental illness problems are known to be a result of poverty conditions. On this basis, the projects appear to be particularly underserving Black and Hispanic persons and may still be underserving Indians. Special efforts are needed to improve mental health services for these persons, including special outreach efforts and development of culturally appropriate treatment programs. Within the limits of funds available, the Department will continue the special efforts which have been started for American Indians and will attempt to begin similar efforts for Black and Hispanic persons.

A review of client characteristics under "primary source of income", and "employment status" shows that, at intake, most of these persons were functioning at a very dependent, restrictive level. Most were receiving some type of public assistance and were unemployed. This is as expected for chronically mentally ill persons.

The statistics on living arrangement indicate that most clients are living alone or with their families. The second largest number live in semi-independent living facilities, which include board and lodging and boarding care facilities. These statistics are difficult to interpret. Research by Department staff and by an advisory task force on residential care for the mentally ill has shown that community-based residential care for the mentally ill is very inadequate and often not available at all for those who need it. Therefore, the statistics on living arrangement are probably not so much an indicator of the client's level of functioning as they are an indicator of the type and amount of residential care available.

Table III. a., regarding previous hospitalizations, gives an indication as to the severity of the illness involved and the substantial costs which hospitals have already incurred in attempting to care for these persons. During the year before Rule 14 services started, the project clients experienced an estimated total of 19,406 days in state hospitals and 8,080 days in other inpatient psychiatric facilities. At an average state hospital rate of $65.20 for Fiscal Year 1980, and an average rate of $150.73 for other inpatient psychiatric facilities (based on amounts charged to Medical Assistance during December, 1979 to February, 1980), that represents a pre-Rule 14 hospitalization cost of about $2.5 million per year (for the 681 persons who had begun receiving Rule 14 services by September 30, 1980). (See Sections IV and VIII for further discussion regarding hospitalization).

The data regarding hospitalizations occurring more than one year before intake is probably understated, particularly for elderly persons. (This data is in Table III.a, listed as "time hospitalized before 1979".) Generally, projects were not able to obtain data regarding hospitalizations occurring more than five to ten years ago. The projects did serve 104 persons over age 60. Many of these persons had been residing in nursing homes many years and data regarding past hospitalization was not available.

Table IV presents statistics regarding numbers and types of staff employed and/or budgeted by Rule 14 projects. As can be expected from the variety of services provided, the staff cover a broad range of disciplines and academic backgrounds. The format for the reporting of staff statistics was developed by the Department of Public Welfare, federally funded Mental Health Manpower Project, which will be using this data to evaluate statewide mental health staffing needs.

Table V shows the distribution of clients by county of residence and by service location (whether inside or outside the county of residence). It is significant that, by September 30, 1980, 56 counties had no clients served at all, and only 20 counties received services within their own county. This is partly due to the fact that, by September 30, 1980, services had not yet started for some counties receiving project funding. More importantly, the grant program was a voluntary program. Although every county applying for funds did receive funding, 52 counties chose not to apply for funds.

IV. Preliminary Results on Effectiveness in Assisting Clients to Remain and Function in Their Own Communities:

It is important to stress the preliminary nature of the effectiveness information. When the Department originally proposed to include effectiveness-related items in the reporting requirements for the report covering the period through September 30, 1980, many mental health professionals questioned the value of this effort, since the average client would only have received about three months of service by September 30, 1980. Many professionals feel that, for chronically mentally ill persons, one to two years of service is usually required to show significant, measurable improvement in client functioning.

Nevertheless, the Department did choose to require reporting on four effectiveness-related items through September 30, 1980. These items were: hospitalization, client's primary source of income, employment status and living arrangement. This section presents those statistics for projects which started serving clients before September 15, 1980: This represents a total of 17 projects, serving 641 persons, with an average of 3.5 months of service per person.

Table VI presents the actual days Rule 14 clients were hospitalized for psychiatric conditions during the year before intake, and then during the period after intake, up to September 30, 1980. Since the length of the period after intake varies for each client and for each project, Department staff have worked with project staff to estimate, for each project, the average time since intake. This figure was then used to "annualize" the data on actual hospitalization days after intake, i.e., to estimate how many days of hospitalization would occur if the utilization continued at the same rate for a full year.

Table VI indicates that the Rule 14 clients are using the state hospitals 68 percent less than they did last year; and they are using other inpatient psychiatric facilities 36 percent less. This is a much greater reduction than had been expected.

Table VI also shows two special situations which a number of professionals feel should be treated separately in any evaluation of hospital utilization. The first is the situation where a project begins providing day-time services to clients who are still in a state hospital. The decision to serve such clients insures that the project will show considerable hospital utilization after intake. In such a case, data showing hospitalization after intake would not indicate any worsening of the client's condition; rather, it would merely reflect the fact that the person was in the hospital to begin with.

The other special situation involves cases where the project provides major case management services and a person is referred to the project with a clear need for assistance in hospitalization. For some persons, hospitalization is the best treatment, but the person may be extremely anxious and reluctant about being hospitalized; some projects do serve such clients and provide them with counseling and similar assistance to ease the hospitalization process. Hospitalization for these persons definitely should not be viewed as a negative reflection on the project.

If adjustments are made to exclude these special situations, Table VI shows that the rate of hospitalization after intake then drops even lower for state hospital utilization (a reduction of 77 percent), but remains at a reduction of 36% for other inpatient psychiatric facilities.

The data on hospitalizations after intake include any hospitalizations which may have occurred after a person was discharged from the project, up until September 30, 1980. In such cases, the projects kept track of such hospitalizations by contacting the local hospitals or the client's social worker (at the county social services office) or, in a few cases, by contacting the client directly.

It is estimated that the hospitalization data may be subject to an error margin of about 10 percent up or down. This is due to the following factors:

1. In a few cases, the data was based on the client's recollection, rather than on official reports from the hospitals;

2. Some hospitals count days of hospitalization differently, e.g., when a person is sent home for a weekend visit, some hospitals count those days, others do not;*

3. In some cases, the data was known to be approximate when it was obtained and estimates had to be made by either project staff or state staff to estimate a specific number of days.

In addition to the above factors limiting the accuracy of the hospitalization data, it is important to be aware of the following qualifications in interpreting the hospital data:

* This was not due to any lack of cooperation on the part of the hospitals. In the future, the Department will include clearer instructions with the Rule 14 requirements to ensure a more standardized count of hospital days.

1. The reductions in hospitalization may be due to factors other than the provision of Rule 14 services. e.g., other community services, family support, etc.

2. For persons who were hospitalized shortly before intake, the short period since intake could be the person's "normal" period between hospitalizations.

Department staff did make every effort to approach the hospitalization data from other viewpoints in order to address qualifications such as those just described. A major effort was made to obtain data regarding total hospitalizations per county, both in state hospitals and in other inpatient psychiatric facilities. Such data could have compared total hospital utilization for project counties versus nonproject counties, and total utilization before versus after project beginning. Unfortunately, this effort was not successful within the time that was available. Even if these data had been obtained, it is possible that the total number of clients served by the Rule 14 projects is not yet large enough to make a significant impact on county-wide hospital utilization rates. In the future, the Department will continue to pursue this effort.

In addition to the hospitalization data, projects also reported on changes in client's primary source of income, employment status and living arrangement for clients who were released from the active caseload (discharged) by September 30, 1980. In the future, projects will report regularly on changes in these characteristics for all clients; but, for this short period, these changes were expected to be so minimal that the reporting was limited to cases closed by the end of the reporting period. If changes in these client characteristics did occur, the closed cases were expected to be the most likely group to show such changes.

It is important here to first note the statistics regarding the types of case closing, on Table VII. Only 19 persons (16.4% of the cases closed) were judged to have completed the program with no further service needed. The rest of the cases closed were situations where appropriate further services were not available (14.7%); the client discontinued participation in the program against staff advise (28.4%), or the client was referred on for more appropriate services elsewhere (37.9%).

As expected, no significant changes in source of income, employment status, or living arrangement occurred for these persons from intake to discharge. In fact, fully 94.8 percent showed no change in primary source of income, 94.8 percent showed no change in employment status and 75.2 percent showed no change in living arrangement. This no-change data supports the statements made earlier regarding the need for more time to show these types of changes.

For many chronically mentally ill persons, a case closing may never be a realistic goal. Without these services, many of these persons may have spent their entire lives in institutions. With the services, these persons may still continue to experience serious difficulties throughout their lives, due to their illness; but, in the latter case, they will hopefully learn better ways of coping with the problems caused by the illness and be able to lead at least somewhat normal lives in their communities.

One aspect of "effectiveness" is the qualitative difference to the client of being able to be in the community, as opposed to being in an institution. Mental health advocates take the position that it is desirable for a person to be able to lead as normal a life as possible. The Legislature recognized this philosophy by specifying in the authorizing legislation that the purpose of this special grant program is "to help chronically mentally ill persons remain and function in their own communities." Although it is too early to measure changes in the level of functioning for Rule 14 clients, the preliminary hospitalization data do indicate, subject to qualifications, that project clients are remaining in the community to a much greater degree than they did before.

In addition to the statewide statistics, projects were also required to report the results of any locally designed effectiveness evaluations. In their reports, most projects stated that it was simply too early to report. Even though many of the projects are voluntarily using various scales to measure client progress in social skills, work skills, self-confidence, and other measures, most stated that their measurement systems were not sensitive enough to measure significant changes occurring in such a short time period.

V. Coordination of Project Services with Community Social Services:

As required by the authorizing legislation, only county boards are eligible to apply for and receive Rule 14 funds. The county board can decide to have the service provided by an existing county agency or contract with an outside provider. Out of the total of 30 projects funded, counties decided to have the services provided:

1. Directly by the county social services/mental health agency or department—eight projects;

2. By a nonprofit community mental health center—10 projects;

3. By a private nonprofit provider—10 projects;

4. By a combination of a mental health center and a private nonprofit provider—one project;

5. By a combination of direct county provision, plus a mental health center, plus a private provider—one project.

In most cases where the county board has chosen to contract with an outside provider, the county social service agency is the official administrator and monitor of the contract for the county board. This insures an administrative structure conducive to good coordination between the Rule 14 project and the county social services agency, resulting in cooperative planning and provision of services.

Evidence that this coordination is in fact occurring can be seen in Table VIII. The statistics on source of referral indicate that most persons were referred from either county social services agencies or community mental health centers, both of which are now under CSSA. The statistics on concurrent social services indicate that 263 persons, or 61 percent (of the persons served by the 19 projects which submitted usable reports on this item) were receiving some type of social services. The fact that this percentage was not higher is probably due to the fact that appropriate social services often simply have not been available for chronically mentally ill persons.

For Rule 14 clients who did receive other social services concurrent with the Rule 14 services, Table VIII indicates that the service received most often was case management. This was particularly true in situations where the client received services such as day treatment from the Rule 14 project and case management services from the county social services agency. This means that the county social worker retained primary responsibility for the client, determined which services were appropriate for the client and arranged for the client to receive those services; the Rule 14 project functioned as a resource for the county social worker to use for the client.

Narrative reports from the individual projects provide evidence of close cooperation between the project and county social service agencies through methods such as joint staff meetings, regular inter-agency reports, etc.

One potential concern regarding the establishment of a special grant program apart from the CSSA block grants is that the special services might not be coordinated with the services provided under the block grant. To date, the evidence does not support this concern.

VI. Counties' Progress in Meeting Approved Grant Objectives:

A required part of the report from each project was a narrative describing the project's progress on objectives approved in the grant application. This method has the effect of evaluating projects on the basis of standards developed specifically for each project, rather than the statewide measures referred to in Section IV of this report.

Most projects had some objectives which were stated in terms of behavioral and skill changes to be achieved by and for the clients; but in the projects' judgment at the time the report was prepared, it was still too early to expect measurable results. In addition, many projects had "process" objectives which spelled out steps that the project would accomplish in the process of helping client meet their objectives. For example, a typical objective was "to begin providing day treatment services to X-clients by July 1, 1980."

For most projects, progress on accomplishing grant objectives appears to be good and on schedule. However, as can be expected with any new project, there were some start-up difficulties. Most of these difficulties were anticipated when the projects were planned; however, in some cases, factors beyond the projects' control resulted in greater delays than expected. The difficulties included:

1. Problems in finding and hiring appropriate staff; as an example, the Hennepin County Nursing Home Consultation Project reported that after 10 days of advertising one position for a senior clinical psychologist and another position for an associate physician, no applications were received; the project report mentions that a negative consideration for potential applicants was the fact that the project was only assured of funding through June 30, 1981.

2. Delays in meeting county Civil Service procedures for hiring staff; to go back to the example of the Hennepin County Nursing Home Consultation Project, for the staff that were hired, approximately 60 days were needed to meet the Civil Service procedures, including developing and obtaining Hennepin County Personnel Department approval for position descriptions, posting the position for a minimum of 10 days, screening of applicants by the Hennepin County Personnel Department,

conducting oral examinations for eligible applicants and finally, having project staff interview the applicants.

3. Inappropriateness of referrals from existing agencies to Rule 14 projects: Since many of the projects provide services which are very different from what their local areas have had in the past, it is taking referring agencies some time to understand the nature of the new services offered and the type of client most likely to benefit.

4. In a number of cases where physical facilities for the project involved more than office space, there were difficulties in finding appropriate facilities, especially since no state funds were allowed to be used for rent or capital expenditures: Facilities had to be obtained at low prices since they had to be paid for out of very limited local dollars.

5. For the few instances where the Rule 14 project involved starting a new residential facility, difficulties were experienced in meeting local zoning regulations; a project in Minneapolis had a building and was almost ready to start, but could not obtain the approval needed from neighbors to obtain city zoning approval; in St. Paul, a project was similarly close to starting, but then the City Council changed the zoning ordinances to disallow the project in that part of the city; both projects had to start over in looking for a suitable facility.

6. For two projects which have included crisis homes as part of their project plan, there have been difficulties in finding families which would be willing to allow use of their homes as crisis homes; even after extensive advertising, the few families which applied by September 30, 1980 were judged to be inappropriate for the projects.

7. Three rural counties reported problems in arranging for reasonable cost for transportation, including difficulties in finding drivers willing to work with chronically mentally ill persons; after some delay, these problems were resolved.

It is unfortunate that some of the above difficulties appear to be related to continued negative attitudes towards mentally ill persons on the part of some persons in the community. The Department will continue to support public education and other efforts to address this problem.

VII. Potential for Other Sources of Funding:

A review of the income and expenditures reports submitted by each project shows that, as of September 30, 1980 (as expected), projects had not received any significant income other than the budgeted 10 percent county share (usually local tax dollars) and the 90 percent state grant. A number of projects are doing what they can to obtain third-party funding from insurance policies, Medical Assistance and other sources. However, most of these clients do not have insurance which would pay for these types of services; for those clients who are on Public Assistance, programs such as Medical Assistance, partially due to state interpretation of federal regulations, do not pay for most of the types of services these projects offer.

In their narrative reports, projects were required to report on potential future sources of funding. Most projects stated that, without a continued legislative appropriation, the services will have to be cut drastically or eliminated. Many projects said they hoped to obtain at least some third-party funding and client fees. In the absence of continued state funding, most projects would request county boards for CSSA funding; however, since these projects still have such a relatively short track record, they might not fare well in the CSSA priority setting process for many county boards.

VIII. Cost Effectiveness:

Although the authorizing legislation required data only on program effectiveness, cost effectiveness is also of great interest to the Legislature, the Department, and to county boards.

Section I of this report describes the development of Rule 14 and the application review process. From the beginning, every effort was made to limit costs to the essential minimum required to provide services. Some costs, such as rent, were determined as being not appropriate for state funding at all. With local funding being very limited, this required many projects to expend extra effort to obtain the lowest cost facilities available in their area. Some costs, such as administrative expenses, were state fundable only up to certain limits. As a result, a number of counties used the existing staff to handle administrative duties. In addition to the statewide limits regarding the use of state funds, a review committee consisting of Department staff and volunteers from the advocacy groups used their extensive experience with mental health programs to negotiate with individual projects to reduce costs which the committee judged to be not appropriate under this grant program or not essential for the project success.

There are some very difficult considerations which enter into any judgments regarding the cost effectiveness of these programs:

1. Each project is individually designed by and for the applicant county; the types of services vary widely depending on the perceived needs of each county.

2. Although some services offered by different projects sound similar, e.g., social/recreational services, there are considerable differences within each type of service offered: For example, the Carlton County project provides one day per week of social/recreational services and arranges for transportation from a large surrounding area; the Olmsted County project provides social/recreational services six days per week, but does not provide transportation since most of the clients reside in the city of Rochester.

3. As mentioned in Section V, many of the clients are concurrently receiving social services other than the project's services; a valid cost effectiveness analysis would have to differentiate between effects resulting from project services and effects resulting from other services.

Although considerations such as these may make truly valid cost effectiveness analysis almost impossible, the Department will attempt to do more in the area of cost effectiveness analysis in the future. One task will be the development of unit costs for project services. A joint county-state CSSA evaluation committee has now recommended some basic methods for defining and developing unit costs for social services. Rule 14 projects will be expected to report unit costs, using those standard methods.

Another task will be the continuation of reporting and analysis of the hospitalization data referred to in Section IV. If the hospitalization data described in Section IV are accurate and valid, and if the post-Rule 14 rate of hospitalization continues at the same level for a full year, there would be a reduction this year of 12,660 days of state hospital utilization and 2,718 days of other inpatient facility utilization. At a per diem rate of $65.20 for state hospitals and an average of $150.73 for other inpatient facilities (based on billings to Medical Assistance during December, 1979 to February, 1980) that represents a total reduction in hospitalization costs of about 1.2 million per year. This does not include the additional clients starting Rule 14 services after September 30, 1980.

However, comparing such "savings" to costs for maintaining a client in the community can become very complicated. As mentioned in the qualifications above, many clients in the community received services other than Rule 14 services; many also received income maintenance payments, which they may or may not receive while they are hospitalized. On the other hand, as shown in the data described in Section III, a number of the current Rule 14 clients already have jobs in the community and more are learning to hold down jobs and not be dependent on income maintenance payments. All of these variables need to be addressed in any comparison of hospital savings versus community costs.

IX. Need for Additional Services:

Fifty-two counties chose not to apply for funding under this appropriation and presumably are not providing these types of services for their chronically mentally ill persons. Thirteen (13) counties which did apply for and receive funding are sending their clients considerable distances to services located in other counties. And many of the counties which do have project services indicate that a number of their clients still have unmet service needs (See Table IX). Whereas a continuum representing a broad range of services is needed, funding and other constraints have limited most of the current projects to providing only a few services within that continuum. In addition, seven of the projects reported that, as of September 30, 1980, they had a total of 114 persons on waiting lists because the projects were already serving as many clients as their current level of funds would allow.

The above should not be interpreted as advocating a full continuum of services within each county. For certain specialized services, the only feasible method of service provision is through multi-county projects. The need is for all counties to have reasonable access to a full continuum of services.

Judith Turner of the National Institute of Mental Health quotes three different sources which indicate a .75 percent incidence of chronic mental illness in the U.S. adult population. Applying this percent to Minnesota indicates that there may be a total of 30,000 chronically mentally ill persons in Minnesota. If that figure is accurate, probably a large percentage of that 30,000 are not being served and could benefit from the type of services offered by the Rule 14 projects.

X. Recommendations:

The Department's recommendation is that the legislation authorizing a separate appropriation for these projects should be continued for another biennium.

As shown in Section V above, the current projects are well coordinated with social services programs offered by counties. For all practical purposes, this program is now an "integral part of the social development programs administered by counties". It does not appear that integrating this appropriation with the CSSA block grants would, at this time, have any additional positive effect as far as coordination is concerned.

After the next biennium, these funds could be included in CSSA block grants, at least for the 35 counties now receiving a Rule 14 grant. However, other considerations may be necessary for the 52 counties which have not yet applied for, nor received, any of these funds. Unless these 52 counties become included in this grant program during the coming biennium, they could find themselves in the position of needing services, maybe being ready to develop the services two years from now, but not having any special state support to do that.

Most of the Department's requested amount for continuation of this appropriation is to continue the current projects at the same level, plus inflation. The current appropriation is basically paying for about one year's services, from about July 1, 1980 to June 30, 1981. Therefore, a considerably larger amount is needed to cover two years and allow for inflation. A part of the request is for new projects and expansion of existing projects. It is clear in Section IX above that there is definitely a need for much more additional services. However, it is recognized that it is unrealistic to expect any more additional funds than what has been requested.

The main reason for the Department's recommendation to continue this as a separate appropriation is that, although the projects have shown some hopeful signs for excellent progress and effectiveness, they simply have not had enough time yet to show whether or not they really are effective.

Table I
List of Rule 14 Projects

Counties Metro Area	Project	Amount Requested	Amount Awarded	Total Dollars Expended by 9/30/80 (incl. state and local)
Anoka	Pre-Vocational Training and Social Service Program	$ 112,099	$ 104,400	$ 22,234
Dakota	Emergency and Crisis Home Program	143,395	110,000	29,427
Hennepin	Community Based Residential Treatment Facility*	152,500	66,653	0
	Community Based Work, Screening and Training Program	48,700	48,700	0
	Pre-Vocational Work Assessment Program	42,000	42,000	2,169
	Crisis Homes	100,000	100,000	0
	Community Based Residential Treatment Facility (Wellspring)	199,400	193,354	87,767
	Mental Health Services in Nursing Homes	75,000	75,000	20,147
Ramsey	Safe House	188,140	101,592	0
	Adult Foster Home Finding, Orientation, Training and Support Services	17,100	17,100	3,465
	Fairweather Lodge	31,573	31,573	0
	Boarding Home Staff Training (Central Manor)	42,103	42,103	0
	Transitional Competitive Employment (Goodwill)	56,658	53,117	13,942
Washington	Crisis/Short Term Treatment Foster Home	14,408	14,408	3,467
Metro Sub-Total		$1,223,076	$1,000,000	182,618
Out-State Area				
Beltrami	Community Support Services	119,712	105,000	19,626
Blue Earth	Day Treatment, Drop-in Center, Consultation and Training	46,958	46,958	0
Carlton	Socialization/Day Program	22,500	22,500	8,286
Cass	Community Support Services	69,986	48,109	23,478
Goodhue	Community Support Services	56,400	56,400	0
Kandiyohi (Includes 7 neighboring counties)	Day Treatment and Pre-Vocational Work Adjustment Training	118,390	107,134	22,188
Lake	Socialization/Day Program	22,500	22,500	8,286
Morrison	Community Support and Case Management Services	62,054	50,000	4,986
Mower	Day Treatment, Basic Skills Training and Sheltered Work	72,695	72,695	10,521
Nobles (Includes 4 neighboring counties)	Day Treatment, Case Management and Crisis Management	86,472	84,472	805
				and local)
Olmsted	Social/Recreational Drop-in Center	$ 43,823	$ 43,823	$ 13,713
Polk (Includes Norman and Mahnomen)	Vocational Rehab. Services/Case Management/Independent Living Skill Training	90,163	90,163	41,203
St. Louis	Range - Community Support Services	148,455	110,067	52,970
	Human Development Center - Community Support Services	119,369	89,933	28,505
Sherburne	Aftercare and Follow-up Services	27,733	27,733	691
Winona (Includes Houston and Wabasha)	Community Support and Transitional Residential Care	22,513	22,513	1,748
Out-State Sub-Total		1,129,723	1,000,000	237,006
State Total		$2,352,799	$2,000,000	$ 419,624

*This was later revised to Board and Care Consultation Project.

Table II - Actual Expenditures through 9/30/80 per Service Category (Including Rule 14 State Money and Local Match.).

Number of Reports 23	Total Expenditures	% of Total
A. Services Provided to Persons for Whom a Case File was Not Opened.		
Case Management	$ 998.60	0.2%
Consultation	12,426.00	3.0
Emergency Service	153.80	—
Foster Home Recruitment	3,510.40	0.8
Health Deinstitutionalization	153.80	--
Information and Referral	8,762.68	2.1
Primary Prevention Education	1,971.00	0.5
Social and Recreational	904.00	0.2
Therapy	307.60	0.1
Sub-Total	29,187.88	6.9%
B. Service Provided to Persons for whom a Case File was Opened.		
Case Management	$ 34,900.89	8.3%
Consultation	9,459.00	2.3
Crisis Home	25,043.00	6.0
Day Treatment	89,532.71	21.4
Emergency Service	922.80	0.2
Employability	62,133.40	14.8
Health Deinstitutionalization	2,153.20	0.5
Housing	922.80	0.2
Information and Referral	20,822.00	5.0
Medication Supervision	1,133.00	0.3
Primary Prevention/Education	9,635.28	2.3
Residential Long Term Treatment	87,767.00	20.9
Residential Short Term Treatment	3,467.00	0.8
Semi-Independent Living	3,050.00	0.7
Sheltered Employment	733.60	0.2
Social and Recreational	26,400.09	6.3
Therapy	10,207.20	2.4
Transportation	2,153.20	0.5
Sub-Total	$ 390,436.17	93.1
Totals A and B	$ 419,624.05	100.0%

Table III - Client Characteristics at Intake

21 reports used.

	# of Persons	% of Total	Statewide Census Population Percent
A. Age			
0-17	4	0.6%	31.5%
18-24	130	19.1	12.8
25-44	291	42.7	25.5
45-60	152	22.3	15.1
60+	104	15.3	15.1
Total	681	100.0%	100.0%
B. Sex			
Male	305	44.8%	49.0%
Female	376	55.2	51.0
Total	681	100.0%	100.0%
C. Race			
White	662	97.2%	97.6%
Black	4	0.6	0.9
American Indian	14	2.1	0.6
Hispanic	1	0.1	0.6
Oriental	--	--	0.2
Other	--	--	0.1
Total	681	100.0%	100.0%
D. Clients Primary Source of Income			
Client's Job	87	12.8%	
Family or Friends Support	91	13.4	
Supplemental Security Income	91	13.4	
Supplemental Security Income and Minnesota Supplemental Aid	121	17.8	
General Assistance	145	21.2	
Social Security	71	10.4	
Other	75	11.0	
Total	681	100.0%	
E. Employment at Intake			
Less than 32 hours	39	5.7%	
More than 32 hours	76	11.2	
Sheltered	47	6.9	
Homemaker	93	13.7	
Student Full-Time	11	1.6	
Unemployed	415	60.9	
Total	681	100.0%	
F. Living Arrangement at Intake			
Alone or with Family	391	57.3%	
Semi-independent	119	17.5	
Halfway House or Group Home	53	7.8	
Nursing Home	42	6.2	
Residential Treatment	39	5.7	
State Hospital	29	4.3	
Other	8	1.2	
Total	681	100.0%	

Table III a. - Previous Hospitalization of Project Clients

21 reports used.

	# of Persons	% of Total
Previous Hospitalization of Project Clients		
A. Days hospitalized within 1 year before intake.		
1. Number of Clients in State Hospitals		
0 days	495	72.7%
1-60 days	96	14.1
61-120 days	31	4.6
121-180 days	20	2.9
181-240 days	9	1.3
241-300 days	3	0.4
301-365 days	27	4.0
Total	681	100.0%
Total Days	19,406	
2. Number of Clients who were in Other In-patient Psychiatric Facilities		
0 days	512	75.2%
1-60 days	136	20.0
61-120 days	22	3.2
121-180 days	7	1.0
181-240 days	2	0.3
241-300 days	--	--
301-365 days	2	0.3
Total	681	100.0%
Total Days	8,080	
3. Unduplicated # of Persons Hospitalized within 1 year before intake.		
State Hospital and Other In-patient Combined	305	44.8%
Not hospitalized within 1 year before intake	376	55.2
Total	681	100.0%
B. Total time hospitalized before 1979.		
1. Clients in State Hospitals		
0 days	308	45.2%
1-120 Days	107	15.7
121-365 days	44	6.5
1-2 years	47	6.9
Over 2 Years	175	25.7
Total	681	100.0%
2. Number of Clients who were in Other In-patient Psychiatric Facilities		
0 days	491	72.0%
1-120 days	142	20.9
121-365 days	29	4.3
1-2 Years	10	1.5
Over 2 Years	9	1.3
Total	681	100.0%
3. Unduplicated # of Persons Hospitalized before 1979.		
State Hospital and Other In-patient Combined	479	70.3%
Not hospitalized before 1979	202	29.7
Total	681	100.0%

Table IV - Staff paid for whith Rule 14 funds as of 9/30/80

Usable Reports 30	Number of staff		Total Hrs. Per week		Budgeted, unfilled
	Full-time	Part-time	Full-time	Part-time	positions (in FTE's)
A. Psychiatric Nurses					
1. Master's	3	3	120	38	5.00
2. Bachelor's	1	1	40	20	--
B. Social Workers					
1. Master's	4	3	160	52	3.00
2. Bachelor's	7	3	280	14	5.00
C. Psychologists					
1. Ph.D.	--	3	--	3	.40
2. Maters's	2	1	80	3	1.00
3. Bachelor's	3	1	120	--	.40
D. Psychiatrists	--	2	--	34	1.44
E. Other Master's Level Staff	3	9	120	109.4	1.00
F. Other Bachelor's Level Staff	13	10	520	130	7.00
G. Associate of Arts Level Staff	6	4	240	79	--
H. Other Direct Service Staff	7	2	280	14	4.20
I. Other Support Staff	2	24	80	244	3.15
Total	51	66	2,040	740.4	31.59

Table V - Rule 14 Clients by County of Residence

County	In*	Out**	County	In*	Out**
Aitkin	--	--	Marshall	--	--
Anoka	6	2	Martin	--	--
Becker	--	--	Meeker	--	1
Beltrami	27	--	Mille Lacs	--	--
Benton	--	--	Morrison	11	--
Big Stone	--	--	Mower	10	1
Blue Earth	8	--	Murray	--	--
Brown	--	--	Nicollet	--	--
Carlton	31	--	Nobles	4	--
Carver	--	--	Norman	5	--
Cass	20	--	Olmsted	98	--
Chippewa	--	--	Otter Tail	--	--
Chisago	--	--	Pennington	--	1
Clay	--	--	Pine	--	--
Clearwater	--	--	Pipestone	--	1
Cook	--	--	Polk	42	--
Cottonwood	--	--	Pope	--	--
Crow Wing	--	--	Ramsey	24	6
Dakota	13	1	Red Lake	--	--
Dodge	--	--	Redwood	--	1
Douglas	--	--	Renville	--	--
Faribault	--	--	Rice	--	1
Fillmore	--	--	Rock	--	--
Freeborn	--	--	Roseau	--	--
Goodhue	--	2	St. Louis	245	--
Grant	--	--	Scott	--	--
Hennepin	55	1	Sherburne	--	--
Houston	--	1	Sibley	--	--
Hubbard	--	--	Stearns	--	1
Isanti	--	--	Steele	--	2
Itasca	--	1	Stevens	--	--
Jackson	--	--	Swift	--	--
Kanabec	--	--	Todd	--	--
Kandiyohi	4	--	Traverse	--	--
Kittson	--	--	Wabasha	--	--
Koochiching	--	--	Wadena	--	--
Lac Qui Parle	--	--	Waseca	--	--
Lake	9	--	Washington	4	--
Lake of the Woods	--	--	Watonwan	--	--
Le Sueur	--	--	Wilkin	--	--
Lincoln	--	--	Winona	34	--
Lyon	--	--	Wright	--	--
McLeod	--	--	Yellow Medicine	--	--
Mahnomen	8	--	Total	658	23

* "In" refers to the number of clients receiving Rule 14 services within their county of residence, e.g. 6 Anoka County residents were served in Anoka County.

**"Out" refers to the number of clients receiving Rule 14 services outside their county of residents, e.g. 2 Anoka County residents were served outside of Anoka County.

Table VI - Comparative Hospitalization Data Before and After Intake for Rule 14 Clients

Usable Reports 17*	Actual Days Hospitalized Within 1 Year Before Intake	Actual Days Hospitalized After Intake, To 9/30/80	Annualized Days Of Hospitalization After Intake**	Annualized Reduction In Hospitalization	
				Days	Percent
A. Total Days in State Hospitals	18,533	1,398	5,873	12,660	68%
Less: Days for Persons who were in Hospitals at Intake	755	138	526		
Less: Days for Persons for whom Hospitalization was the Treatment Plan at Intake	227	315	1,292		
Net Total in State Hospitals	17,551	945	4,055	13,496	77%
B. Total Days in Other In-patient Psychiatric Facilities	7,630	1,849	4,912	2,718	36%
Less: Days for Persons who were in Hospitals at Intake	51	14	37		
Less: Days for Persons for whom Hospitalization was the Treatment Plan at Intake	131	22	88		
Net Total in Other Psychiatric Facilities	7,448	1,813	4,787	2,661	36%
C. Total Days A & B	26,163	3,247	10,785	15,378	59%
Less: Days for Persons who were in Hospitals at Intake	806	152	563		
Less: Days for Persons for whom Hospitalization was the Treatment Plan at Intake	358	337	1,380		
Net Total Days A & B	24,999	2,758	8,842	16,157	65%

* This table includes all Rule 14 projects beginning service before 9/15/80. This includes 17 projects serving a total of 641 clients. Of those 641 clients, 293 had been in State Hospitals or in other in-patient facilites within one year before intake to Rule 14.

**Annualized days after intake were calculated by determining the average amount of time for clients for each project from intake to 9/30/80. The proportion between that average and a full year was then used to multiply the actual days after intake into an annualized figure. The resulting data is estimated to be subject to an error margin of 10%.

Table VII - Client Characteristics at Case Closing

Usable Reports 21

	Total		Less Persons At Projects without Usable Report for Part B.	Net Total	
	Persons	Percent		Persons	Percent
A. Clients Disposition at Case Closing					
1. Rule 14 services completed, no further services needed.	19	16.4%	11	8	10.5%
2. Rule 14 services completed, appropriate further service not available.	17	14.7	8	9	11.8
3. Client discontinued participation against staff advise.	33	28.4	8	25	32.9
4. Client died.	3	2.6	--	3	4.0
5. Unduplicated Count of Clients referred on for other services. (detail below)	44	37.9	13	31	40.8
Total - unduplicated count of clients	116	100.0%	40	76	100.0%
5a. List of services to which clients were referred.					
Case Management	8	18.2%	1	7	22.6%
Consultation	1	2.3	--	1	3.2
Crisis Home	1	2.3	--	1	3.2
Day Treatment	2	4.5	--	2	6.5
Employability	1	2.3	--	1	3.2
Hospital	3	6.8	2	1	3.2
Residential Short Term Visit	1	2.3	--	1	3.2
Sheltered Employment	2	4.5	--	2	6.5
Social and Recreational	11	25.0	--	11	35.5
Therapy	12	27.2	10	2	6.5
Transitional Halfway House	1	2.3	--	1	3.2
Transportation	1	2.3	--	1	3.2
Total Clients Referred	44	100.0%	13	31	100.0%

Table VII - Client Characteristics at Case Closing
(Continued)

Usable Reports 17

B. Changes in Client Status From Intake to Case Closing	# of Persons	% of Total
1. Change in Clients Source of Income:		
No change	72	94.8%
General Assistance to Clients Job	1	1.3
General Assistance to Family Support	1	1.3
Clients Job to Family Support	1	1.3
Clients Job to General Assistance	1	1.3
Total	76	100.0%
2. Change in Clients Employment Status:		
No Change	72	94.8%
Unemployed to Sheltered employment	2	2.6
Unemployed to Full-Time Student	1	1.3
Employed less than 32 hours to more than 32 hours	1	1.3
Total	76	100.0%
3. Change in Clients Living Arrangement:		
No Change	57	75.2%
Halfway House to Parent	1	1.3
Group Home to Semi-Independent Living	1	1.3
Parent to Independent Living	1	1.3
Semi-Independent Living to VA Hospital	1	1.3
Semi-Independent Living to Outside Catchment Area	2	2.6
Alone to Halfway House	3	3.9
Alone to Family	2	2.6
Alone to Semi-Independent Living	4	5.3
Semi-Independent Living to State Hospital	2	2.6
State Hospital to Semi-Indpendent Living	1	1.3
Semi-Independent Living to Family	1	1.3
Total	76	100.0%

Table VIII

21 usable reports.

Source of Referral	# of Persons	% of Total
Self, Family	60	8.8%
County Social Service Agency	252	37.0
Mental Health Center	100	14.7
Law Enformcement, Courts	11	1.6
Community Health Agencies, Physicians	60	8.8
Private Practitioners	12	1.8
Chemical Dependency Treatment	2	0.3
State Hospitals	28	4.1
Other Inpatient	35	5.1
Other Residential	77	11.3
Other	44	6.5
Total	681	100.0%

19 usable reports.

Concurrent Social Services at Intake		
1. Not Receiving	170	39.3%
2. Receiving	263	60.7%
Detail on # of clients receiving concurrent services:		
Case Management	144	21.1%
Consultation	16	2.3
Crisis Home	--	--
Day Treatment	15	2.2
Emergency Service	58	8.5
Employability	12	1.8
Foster Care	1	0.1
Group Home	2	0.3
Health Deinstitutionalization	16	2.3
Housing	5	0.7
Information and Referral	32	4.7
Medications Supervision	132	19.4
Mental Health Nursing Home	4	0.6
Minnesota Services for the Blind	1	0.1
Other	5	0.7
Primary Prevention Education	28	4.1
Protection	1	0.1
Psych. Unit General Hospital	2	0.3
Residential Long Term	6	0.9
Residential Short Term	5	0.7
Semi-Independent Living	92	13.5
Sheltered Employment	22	3.2
Social and Recreational	7	1.0
Therapy	47	6.9
Transitional Halfway House	--	--
Transportation	10	1.5

Table IX - Unmet Service Needs

A. Rule 14 Clients who in the judgement of project staff or of the clients themselves, need and would use other human services if available, as of 9/30/80.

Usable Reports 19	# of Persons
Case Management	2
Consultation	1
Crisis Home	15
Day Treatment	8
Employability	151
Financial Services	104
Foster Care	19
Group Home	19
Health Deinstitutionalization	106
Housing	119
Medications Supervision	46
Mental Health Nursing Home	28
Primary Prevention Education	12
Residential Long Term	25
Residential Short Term	5
Semi-Independent Living	18
Sheltered Employment	42
Social and Recreational	26
Therapy	48
Transitional Halfway House	50
Transportation	31

B. Number of eligible applicants on a waiting list for Rule 14 services because of insufficient program capacity as of 9/30/80 114