STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR §2.036)

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION AND BACKGROUND

Deinstitutionalization History/Statistics

The need in Minnesota for licensure of facilities for adult mentally ill persons relates directly to a national trend to rely less on large institutions and more on community programs to provide care and treatment for mentally ill adults. This trend, often called "deinstitutionalization", has created a need for an expanded system of outpatient services and residential programs. A number of factors have contributed to this movement, both nationwide and on the local level.

President Kennedy's national initiative in 1963, to move half of the nation's state mental hospital populations to community treatment programs, was a step in the right direction. Admittances to state hospitals dropped steadily and dramatically, from over one half million in the 1950's to 191,000 in 1970; a 67% nationwide decrease.

However, although the hospital populations had decreased substantially, the number of persons still needing mental health services did not. Despite Kennedy's initiative, as of 1970, fewer than half of the needed community-based mental health centers were developed and few states adequately addressed the need for a system of residential treatment programs. What began as a humanitarian effort had evolved into a tragedy for many, due to the thousands of mentally ill persons who were forced to reside in substandard facilities which offered little or no mental health care and treatment.

Minnesota's policies regarding the state's mentally ill population underwent a major change six years prior to President Kennedy's national initiative. In 1957, the passage of community mental health program legislation by the Minnesota Legislature underscored a shift in Minnesota from the treatment approach which was generally regarded as "warehousing" patients in state institutions to one providing alternative community-based care and treatment.

State hospital daily census figures clearly indicate the effects of this shift toward deinstitutionalization. In 1962, the mentally ill population of Minnesota's state mental institutions numbered 8,709. By January, 1980, this figure had dropped to 1,530; less than 20% of the 1962 total.

However, these census figures represent only a portion of Minnesota's mentally ill population needing residential programs. Current estimates place the total number of chronically mentally ill persons in Minnesota between 18,000 and 22,000 residing in 300 to 350 facilities. Additionally, another 10,000 to 20,000 are living independently. Of these totals, approximately 9,400 have mental health needs appropriate for placement in Rule 36 licensed facilities. A statewide estimate by the Department of

Public Welfare indicates only one of every ten mentally ill persons requiring a supervised living situation is residing in a licensed residential program. In 1980, there were only 472 residents in seven Rule 36 licensed facilities. Two state hospitals accounted for 318 of this total.

The average length of hospitalization at state institutions is less than five months. Calculations using the June 1980 per diem, of $74.05, produce a total for four months of $9,009. This figure approximates the cost of 12 months' treatment in a community-based halfway house. Admittedly, residential programs may not be appropriate for all persons currently receiving treatment in state hospitals. For these patients, Rule 36 licensure of mental health units in the state's institutions will strengthen standards for quality mental health treatment and care. However, the existence of mental health programs in residential facilities could shorten hospital stays and eliminate unnecessary admittance to state hospitals.

The 1968 revision of the Hospitalization and Commitment Act, codified at Minn. Stat., Chapt. 253A, also contributed to the shift in emphasis from hospital treatment to community programs. Changes in the act made involuntary hospitalization less common, therefore increasing the need for community-based alternatives.

A number of significant court decisions have also contributed substantially to changes in the mental health system. These cases, including Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), Wyatt v. Stickney, 325 F. Supp. 781 (N.D., Ala. 1971), Wyatt v. Aderhold, 503 F.2d 1305 (5th Cir. 1974), and the recent consent decree in Vickerman, et al. v. Peterson, et al., Civ. 4-78-153, D. Minn. (1980), have increased support for the principles of "least restrictive alternative" in choosing appropriate mental health treatment, and the "right to treatment", as well as choosing the concept of community-based treatment.

An additional development contributing to this shift from hospital to community has been the discovery and widespread use of psychiatric medications. In many instances, introduction of these drugs has eliminated the need for long-term hospital care.

Another issue central to the current emphasis on residential programs rather than hospitals, is cost. The Department of Public Welfare evaluation of the Sharing Life in the Community (SLIC) program indicates a 47.4% decrease in psychiatric costs of the SLIC program. Psychiatric costs for the non-SLIC clients experienced a 6.6% increase for that same period. (SLIC is a community-based treatment program located in South St. Paul serving Dakota, Ramsey and Washington counties.) (A copy of the evaluation referred to above will be offered as a part of the record, and will be available for inspection.)

Current Status

The Public Welfare Licensing Act 245.812 grants authority to the Commissioner of Public Welfare to establish rules governing licensure of all residential facilities housing five or more mentally ill adults. Although Rule 36 was first promulgated in September, 1974, and implementation began in January, 1976, only seven of approximately 150 existing facilities are

currently licensed. This figure poses a dramatic comparison to the 72 residential programs for chemically dependent persons and 258 programs for the mentally retarded that are currently licensed. The reasons for this contrast are explained below.

The dilemma faced by the State of Minnesota in attempting to implement Rule 36 has been multi-faceted. In the past, the rule has been viewed by facility operators as unrealistic because of the additional cost for staff and physical rehabilitation and the lack of stable public funding sources to reimburse expenses. Traditional sources of income for mentally ill persons, e.g., Minnesota Supplemental Aid and General Assistance (Minn. Stat. Ch. 256D), and Supplemental Security Income (Title XVI of the Social Security Act), cover room and board costs but cannot be used by a facility to pay for treatment staff and mental health program costs. The Medical Assistance program (Title XIX of the Social Security Act) which covers medical costs incurred by mentally ill persons, does not cover services for institutionalized mentally ill as it does for some other institutionalized disability groups. Title XIX regulations prohibit Medical Assistance reimbursement to persons residing in "institutions for mental diseases", defined, in part, by Department of Health and Human Services guidelines as any facility where mentally ill residents comprise more than 50% of the resident population. According to Department of Health and Human Services practice, this definition includes state institutions and community-based residential facilities for mentally ill persons.

In addition to the dilemma posed by a lack of funds, other problems have stymied implementation of Rule 36. One problem involved interpretation of the rule itself. The initial interpretation of Rule 36 and response from facility operators was that the rule appeared to specify only one level of programming. Operators thought they were to be held accountable for the same standard of treatment for all residents even though the level of disability and services needed varied widely from resident to resident. In addition, utilization of funding sources became an issue for facilities serving more independent residents, ones who were capable of receiving services in the community.

In May of 1980, public and private concern about the many problems inherent in the existing Rule 36 resulted in the initiation of a revision process. A task force was established under the direction of the Department of Public Welfare's Mental Health Program Division including representation from numerous agencies, organization, consumer group and professionals. (A copy of the list of task force members will be introduced as a part of the hearing record, and will be available for inspection.) The goal of the task force was to produce an enforceable rule with major programmatic changes and a realistic funding recommendation. Though the Rule 36 revision process represented a composite of views from various areas of expertise, the resulting product represents a unified philisophical and practical view that persons disabled by chronic mental illness are entitled to a full continuum of mental health services designed to meet a broad spectrum of treatment needs.

Minimum standards designed to ensure quality of service and accountability are imperative to a system of residential programs. Flexibility, however, is an important aspect of this design in that it allows for the variety of mental health needs. The revised Rule 36 effectively incorporates this flexibility within parameters of minimum standards.

Authority for DPW Rule 36

The following is an explanation of each statutory section which provides authority for the promulgation of Rule 36, either directly or indirectly as specified.

1. Minn. Stat. §246.01 establishes the Commissioner of Public Welfare as the state agency, as defined by the Social Security Act of the United States and the laws of Minnesota, for all purposes relating to mental health and mental hygiene, including the administration of the state hospitals.

2. Minn. Stat. §246.013 directs the Commissioner, in performance of the duties imposed upon him by the laws of Minnesota, to bring to the measure prescribed by Section 246.012, the care and treatment of the mentally ill as speedily as is possible, and to, thereafter, subject to the authority of the legislature with respect to appropriations, maintain said standards in the care and treatment of the mentally ill. The minimal measure of service is defined by Minn. Stat. §§246.012; 246.013; and 246.014, paragraphs (2), (7), (9) and (10).

3. Minn. Stat. §245.61-.70 establishes the authority of county boards to make grants for local mental health programs, allows any city, town or public or private corporation to apply to a county board for assistance in establishing and funding mental health services programs, requires that plans and budgets shall be approved by the county board or boards, and authorizes periodic review of budgets and expenditures. It also establishes additional duties of the Commissioner relating to these mental health services programs: prescribing standards for qualification of personnel, quality of professional service, and in-service training, requires review and evaluation of the programs, requires mental health clinics to establish written treatment plans, establish mechanisms for continuing education, and establishes Minn. Stat. §§15.1611 - 15.1699 as the criteria regarding data privacy. Although Minn. Stat. §§245.61-.69 expressly relates to local mental health programs, it does establish responsibility, authority, intent and mechanisms for allocation of funds and provisions of service to adult mentally ill persons that is reflected in the proposed revised Rule 36. Specifically, Minn. Stat. §245.69 authorizes the Commissioner to promulgate rules prescribing standards for qualification of personnel and quality of professional services and any other rules and regulations the Commissioner deems necessary to carry out the purposes of Minn. Stat. §245.61-.69.

4. Minn. Stat. §245.70 designates the Commissioner and the Minnesota Department of Public Welfare as the state agency to establish and administer a statewide plan for the construction, equipment, maintenance, and operation of any facilities for the care, treatment, diagnosis or rehabilitation of the mentally ill, which are or may be required as a condition for benefits under any federal law. Additionally, this section gives the Commissioner authority to receive, administer and expend funds from any source, for the mentally ill.

5. Minn. Stat. §245.781-.812, Public Welfare Licensing Act, establishes the authority of the Commissioner to regulate by means of licensure, day care and residential facilities, services and agencies, including those serving the mentally ill and emotionally disturbed and providing day treatment and day services.

a. Specifically, Minn. Stat. §245.783, Subd. 1, prescribes how an applicant shall apply. The Commissioner is responsible under Subd. 2 for processing applications, and under Subd. 3 for conducting a study of the applicant.

b. Minn. Stat. §245.801, Subd. 3 gives the Commissioner authority to suspend, revoke or make probationary a license if the operator fails to comply with applicable laws or rules and regulations of the Commissioner.

c. Minn. Stat. §245.802 authorizes the Commissioner to develop and promulgate rules for the operation and maintenance of day care and residential facilities and agencies, and granting, suspending, revoking and making licenses probationary.

d. Minn. Stat. §254.804 provides that the Commissioner shall study and evaluate operators and applicants for a license.

6. Minn. Stat. §256E.02 of the Community Social Services Act, codified at Minn. Stat. Ch. 256E, states, "It is the purpose of the 'community social services act' to establish a system of planning for and providing community social services administered by the boards of county commissioners of each county under the supervision of the commissioner of public welfare." Minn. Stat. §256E.06 states the duties of the Commissioner are to include supervision of the community social services administered by the counties through standard setting, technical assistance and evaluation of the community social services programs. Rule 36 is an attempt in part to ensure that adequate and effective services are provided to adult mentally ill persons.

7. In conformance with Minn. Stat. §256E.01-.11, the Department, through the Rule 36 licensure process, will assist the counties in establishing a network of community support services that will assist disabled persons in maintaining themselves in community settings and will actively seek federal and state funds for this purpose.

8. A recent statutory amendment which provides support for this rule can be found in Laws of 1981, ch. 360, §14, Subd. 1, which requires the commissioner to establish a statewide program to assist counties in ensuring provision of services to adult mentally ill persons and to make grants to county boards to provide community-based services to mentally ill persons through facilities licensed under Minn. Stat. §245.781-.813.

9. Public Law 96-63, Title III, which requires the state to describe procedures which will eliminate inappropriate placement in institutions of persons with mental illness problems, and to assist counties in developing necessary alternatives;

10. Several non-statutory bases can also be identified as supporting promulgation of this rule, including Minnesota's participation in the U.S. Public Health Services Act (Section 314g), the federal Manpower Development Project; and the federal Community Support Project. The latter is an effort designed to develop a model aftercare system for ex-mental patients. All of these acknowledge the need for residential treatment facilities that provide at least a minimum level of program for adult mentally ill persons. Without an adequate residential component, these efforts cannot be successful, nor can the objectives of the rule be met without these components of the continuum.

More specifically, a clear statement of intent and support can be found in the Minnesota Legislature's appropriation of two million dollars in 1979 to fund nonresidential services for adult mentally ill persons and requirement that the Department develop and promulgate a rule to govern administration of the grants. That mechanism is commonly known as Rule 14 and is regarded as the nonresidential counterpart to the residential component, Rule 36. The 1981 session of the Minnesota Legislature then refunded Rule 14 with a two year appropriation of 5 million dollars.

Lastly, the 1981 Minnesota Legislature also appropriated 4.9 million dollars specifically to fund the services required by proposed Rule 36. The legislature understood that revisions would be proposed through the public hearing process and that the revised rule, once promulgated, would ensure at least a minimum standard of a revised Rule 36.

11. Lastly, the Department of Public Welfare intends to apply the standards set by Rule 36 to residential programs within the state hospitals. This encourages uniform treatment of all persons in residential facilities, including state hospital-based programs. In effect, this prevents a double standard.

Statement of Purpose

Rule 36 establishes a commonly understood and acceptable philosophical, legal and programmatic base for the provision of the required services to adult mentally ill persons. It is acknowledged that the rule sets forth minimum standards, that the adult mentally ill are entitled to protection of their human rights and that services must be provided in relation to individual needs. These purposes are consistent with current social policy as found in statute as well as commonly held views of appropriate treatment practice.

The following gives a statement of need and reasonableness for each section of Rule 36. The outline format used parallels that of the rule itself.

A. Applicability

1. This section is necessary in order to ensure that providers of care and treatment to adult mentally ill persons clearly understand who is or is not required to meet provisions of this rule. Further, it acknowledges the historical concern expressed by providers that the original Rule 36 allowed only one level of programming. They thought they were to be held accountable for the same standard or kind of care and treatment for all residents even though the level of disability and services needed varied greatly from resident to resident. This also created problems in utilization of funding sources, particularly for those facilities serving a more independent group of residents. Therefore, this rule establishes two categories of programs, one reflecting the need for intensive, essentially in-house care and treatment, the other for a more semi-independent living model where many services and activities are provided by external community resources. While the rule sets certain standards applicable to both categories, the differences are reflected in staff-to-resident ratios, types of staff, the manner in which services are provided, and the per diem rates that were developed. Further, commonly used descriptive language is included to clarify the types of programs that meet the statutory definitions.

It is necessary to clarify for personnel of state hospitals, adult foster homes and safehouses, that they come under the provisions of this rule only if they have five or more residents in their program. In particular, many adult foster care homes and safehouses have four or less residents, so the number of adult mentally ill residents, rather than the language used to describe the facility, becomes the determining factor.

2. This section simply states clearly the types of programs that are exempted from licensure under 12 MCAR §2.036. The exemption for private hospitals is found in Minn. Stat. §245.791(5). The decision to exempt nursing homes reflects the need to set a priority for use of the limited monies available to fund Rule 36 programs. Several cost control measures were enacted in the 1981 session of the Minnesota Legislature. This exemption also controls costs by limiting Rule 36 licensure for the time being, to non-nursing home residential programs. From a cost control standpoint, the exemption becomes particularly important in view of the current Title XIX eligibility criteria which state that persons residing in an institution for mental diseases are not eligible for Medical Assistance.

B. Definitions

This section is designed to establish common usage of language, particularly that of "mental illness", to clarify those words or phrases that may have several interpretations, or those that need exact definitions in order to be consistent with statutory language.

1. Applicant. The statutory bases for this definition are found in Minn. Stat. §245.782, Subds. 4 and 6.

2. Case management services. This is the commonly used and agreed upon definition used in the mental health and social service field.

3. and 4. Categories of program. As indicated previously, a major problem in implementing existing Rule 36 was the assumption that all programs had to offer the same combination and intensity of services. The creation of two categories reflects the fact that there are at least two distinct categories of clientele, and a need for corresponding categories of programs.

5. Commissioner. Based on Minn. Stat. §245.782, Subd. 8.

6. Community representative. This is the commonly accepted definition with the standard exemption relating to persons having any formal relationship with the type of program being offered.

7. Crisis services. This is common usage in the human service delivery system.

8. Department. This classifies the entity of state government, as distinguished from that of the Health Department or Fire Marshal, which is responsible for enforcement of the program licensure requirement. "Department" is used as an abbreviation for Department of Public Welfare throughout the rule.

9. Full-time. This reflects the prevailing work week of staff in residential programs.

10. Independent living services. This is common usage in the field and is especially relevant to the rule since a major objective of the care and treatment provided is for the residents to progress to a higher level of independence. By definition, Category II facilities provide either a "transitional semi-independent or a supervised group supportive living arrangement".

11. Individual program plan. Although there is some disagreement within the field as to the specific components of an IPP, this definition has the majority support of practitioners and Task Force members. This plan uses a process model which requires continuing review and modification, and which requires designation of staff responsibility in implementation of the plan. Further, it reflects a current, although controversial expectation that the resident be involved in his or her treatment plan as a matter of sound mental health practice. This creates a sense of ownership and shared responsibility for the resident and avoids the client assuming a dependent role that providers are so often accused of encouraging. Lastly, it provides the basis for a valid evaluation mechanism.

12. License. This clarifies the use of the term as specific to program rules.

13. Mental health counselor. This definition, along with 15. and 17. is needed to provide a common meaning to the terms as used in the rule. This definition is common usage in the field, including the requirement that the person work under the supervision of a therapist or program director. In combination with the therapist and mental health worker, the counselor provides a continuum of skill levels to address the mental health needs of residents. This job position is specifically distinguishable from that of the mental health therapist and worker by training and experience.

14. Mental health residential program. This definition reflects the totality of components that must be offered by a facility in order to be licensed under this rule. The phrase "combination of" is the key language since it emphasizes the need to develop a treatment plan tailored to the needs of each resident which in turn increases the potential effectiveness of the program. In essence, this definition is accepted in the field as reflecting sound treatment practice, yet allowing for some program flexibility within each facility.

15. Mental health therapist. The same rationale is used for this definition as is used for mental health counselor, with the commonly accepted distinction that, by virtue of training and experience, the therapist can function independently and without supervision.

16. Mental health therapy. This definition is necessary to clarify that the rule is not intended to require a specific model of therapy. It allows providers to adopt a therapeutic regimen best suited to its philosophy and resident needs, but still provides that any regimen adopted must be effective.

17. Mental health worker. The same rationale is used here as for mental health counselor and therapist.

18. Mentally ill person. This is the commonly accepted definition in the field. This baseline is essential from both an intake, program and individual treatment plan standpoint since these facilities hold themselves out as providing care and treatment to persons with functional mental illness (non-organic) as opposed to senility or problems created by brain damage. Further, the mental illness must be primary, rather than secondary, to chemical dependency or mental retardation. Lastly, since most of the persons having organic brain syndrome reside in nursing homes, it was necessary in order to be consistent with the decision to exempt nursing homes from licensure, to exclude organic mental illness from the definition applicable to this rule. The cost represented by inclusion simply would be prohibitive as explained in Section A.2.

19. Motivation and remotivation services. This term is common usage in the field. It is necessary to include it in the rule both for clarity and as a means of emphasizing the focus of the residential facilities.

20. Program director. This is standard administrative language used in the field to distinguish these responsibilities from those of other staff required by the rule.

21. Provisional license. This definition is necessary to distinguish it from that of license. It specifies the circumstances under which it can be issued so as to protect the health, rights and safety of residents.

22. Recreation and leisure time services. This definition casts recreation and leisure time in a therapeutic context rather than the all-too-common practice of keeping residents busy to fill time. Recreation and use of leisure time is a major mental health issue in our society. Therefore, it is only reasonable to address it here, particularly to establish its purpose.

23. Restraint. This section is designed specifically for purposes of this rule and has support of both providers and consumers involved in the care and treatment of adult mentally ill persons. In non-Rule 36 facilities providing services to a different clientele, it may not be acceptable.

24. Seclusion. The rationale used here is essentially the same as that for restraint. It is intended to set a base line limiting criteria rather than to be in any way permissive.

25. Socialization services. This is common language used in the field which reflects both the kind of functional emphasis programs must have and the fact that a variety of terms can be used to describe services that are not necessarily completely discrete.

26. Social services. This constitutes a generic definition of many of the methods, activities and processes that need to be in place in an effective program. Again, although it is not necessarily discrete, it does recognize an important body of knowledge and skill commonly known as Social Work.

27. Support group services. This is commonly used language in the field, yet is necessary to include both for purposes of clarity and to emphasize that a facility must have formally available a group process for sharing feelings, experiences and constructive feedback.

28. Vocational services. This definition, although commonly used in the field, is included here to emphasize not only the objective of residents moving toward working in a competitive job setting, but also the validity of preparing them for a quasi-competitive job situation. This gradual movement toward a more independent living and job status is consistent with the continuum this rule represents.

C. Licensing process

This section of Rule 36 implements Minnesota Statutes governing licensure. Its intent is to ensure a comprehensive protection of the individual served.

1. License required. The need for a current and valid license is established in Minn. Stat. §245.783, Subd. 1, and is required as ongoing protection of the individual served.

2. Information furnished. This section ensures that the applicant shall receive the necessary and correct forms, as well as information for understanding the licensing process. This requirement is in compliance with Minn. Stat. §245.783, Subd. 1.

3. Application. This reiterates the need for compliance with Minn. Stat. §245.783, Subd. 1. This section also ensures that the health and safety of the resident is protected, as well as the community. It brings the rule into compliance with Minn. Stat. §§245.783 and 245.812 which require other regulatory agencies to report to the Commissioner regarding compliance with fire, safety, building, and health codes. It is also in compliance with the cooperative agreement established April 18, 1973 between the Department of Public Welfare and the Department of Health. The agreement specifies that the Health Department is responsible for the establishment of health and safety standards for residential facilities, and that the Department of Welfare will establish program standards specific to mentally ill residents.

4. Decision. Minn. Stat. 245.783 requires the Commissioner to conduct a study of the applicant. This section spells out the steps of the study. It is meant to ensure a decision based on first-hand knowledge of the facility and its residents, as well as on formal applications.

5. Fee. The establishment of a fee not to exceed $150.00 is authorized by Minn. Stat. §245.811. This fee is established to cover the actual costs of the Department in processing the license.

6. Renewals. Application for renewal is required 30 days prior to expiration. This is the minimum amount of time necessary to enable the licensing division to process the application.

D. License changes; report. Licensure is not a one-time obligation but a means of ensuring quality of continued care. Therefore, a specific program is licensed for a definite period of time based on its ability to provide the minimum standard of care and treatment required by the rule. Since each of the factors mentioned in this section could have an impact on the quality of care provided, and since the Commissioner has responsibility for ensuring a standard of care prescribed by the rule, it is not only reasonable, but consistent with Minn. Stat. §245.783, Subds. 5 and 6 to include these provisions.

E. Program policy and procedures manual. This requirement is based on sound management practice, establishes a baseline for accountability and provides the Department's licensing staff with a central source for review and analysis.

F. Statement of purpose and policies. An organization must have a written purpose and reason for existence if it is to be held accountable to maintain minimum standards, and to survive and be effective. That purpose is defined in its philosophy. The means of accomplishing that purpose are defined in operational policies and goals. This section of the rule requires that the program offered is defined in an attempt to keep its services focused. This requirement helps the program develop its purpose rather than trying to become all things to all persons. And, it helps consumers choose an appropriate program for their client. Because of the diversity of needs of the mentally ill, there must also be varied programs available.

G. Program organization and administration.

1. Advisory committee. Support for this requirement is found both in the Mental Health Act, Minn. Stat. §245.68(j) and common practice in the field. Most agencies and many residential facilities have advisory committees and find them both workable and useful. The quorum includes a resident representative who speaks on behalf of all the residents. This ensures resident input into the program. The quorum also includes a community representative, who speaks on behalf of the community in which the facility is located, and the facility administrator. Access to committees is an essential step in the grievance process for residents and ensures them an opportunity to be heard. Grievance procedures are required by Supervised Living Facility review. Minutes are kept as a means of review for licensure.

2. Governing body. This section ensures accountability of and accessibility to the governing body. A board is ultimately accountable, not the program director or administrator. Authority for policy development is commonly placed at this level in organizations. The Department must have this structure for any effective negotiation regarding the license to occur.

3. Designated authority. This requirement is necessary and reasonable to ensure both accountability and immediacy of response to issues involving the operation of the facility and/or resident concerns.

H. Required documentation and reports.

1. Insurance coverage. Programs will vary in services offered and types of residents served. Therefore, the amount of insurance coverage is left to the operator. The rule specifies it must be in an amount sufficient to protect the interests of residents and staff. Documentation of coverage will allow a check and balance system at the time of licensure and renewal.

2. Bonding. This requirement is intended to protect against residents having to be moved or receiving less than a minimum standard of care when a facility suffers an economic loss due to mishandling of monies by its employees. Further, it serves as a safeguard against the state or local government having to appropriate or allocate additional monies, close a facility or transfer residents in situations in which money has been mishandled.

3. Financial information. Sufficient funding is essential for the program to operate. Guarantees of sufficient funding protect both the resident and the taxpayer.

4. Maintenance. This requirement is meant to ensure that facilities will be maintained at the level mandated by Minn. Stat. §246.014 so that the physical environment is comfortable and attractive. It is also consistent with the health and safety standards of the Department of Health. The purpose of this inclusion is to prevent facilities being housed in older buildings without the means or resources to ensure upkeep.

5. Nondiscrimination policy. This section ensures that no persons shall be discriminated against in the provision of treatment. It is in keeping with the Civil Rights Act of 1964, and is consistent with Minn. Stat. §245.69.

6. Accident reports. It is current practice in both the public and private hospital systems and Rule 34 to document policies and procedures regarding accidents and missing persons. This practice serves as a protection for both the provider and the resident.

7. Annual comprehensive report. Annual reports are a means of guaranteeing a complete assessment of the program by management and is a means of increasing accountability. It is also a readily accessible means of review by the Commissioner for licensure, the advisory committee, and the public.

8. Program evaluation.

a. through d. The rights of patients defined in Minn. Stat. §253A.17 include the right to an individualized treatment plan describing problems in behavioral terms with goals and objectives which are measurable and time-limited. In order to assure that the resident is receiving the kind of care and treatment needed; that knowledgable decisions are made regarding appropriateness of current placement, movement to a less restrictive/ higher level of independent living situation, or even admission/ readmission to a hospital if necessary; it is reasonable to require facilities to provide this type of data. In short, they must demonstrate the effectiveness of their programs. And, in addition to justification in terms of residents, this kind of data assists policymakers and administrators in deciding the most appropriate use of limited funds by providing a baseline for cost comparison, as well as cost effectiveness analysis. Lastly, it provides answers to taxpayers' questions about the expenditure of public funds.

e. Support for program evaluation is found in Minn. Stat. §256E.10 and is required in relation to this rule by Laws of 1981, ch. 360, §14, Subd. 4. Although the legislature, in making its appropriation, did not specify the exact form the Commissioner must use, it clearly required him to report back as to the effectiveness of the program. Since the primary method for collecting data regarding social services has already been developed and is being used by the counties, it is reasonable to adopt that system rather than create a new one.

I. Personnel policies and procedures.

The purpose of this section is to define the basic structure of minimum requirements for personnel policies for licensed facilities. These policies are necesary to clarify staff responsibility, ensure the protection of employee rights and promote the effective management of residential mental health programs. Minn. Stat. §245.69 gives the Commissioner authority to set program standards that guarantee professional care by qualified personnel.

1. General requirements. Issuance of personnel policies to each incoming employee will serve to clarify the conditions of employment. It is necessary to insure employment safeguards for women and minorities pursuant to the following:

a. The United States Constitution;

b. The Civil Rights Acts of 1866 and 1871;

c. The Equal Pay Act of 1963;

d. The Civil Rights Act of 1964 (as amended by the Equal Employment Opportunity Act of 1972);

e. The Age Discrimination in Employment Act of 1967;

f. Several Executive Orders (11246, 11345 and 11478); and

g. Case law.

Current literature on Industrial and Personnel Psychology reiterates and supports these safeguards. "...Americans today would agree that unfair discrimination is ethically and legally improper, and that government and private employers alike should strive to promote equal employment opportunity for all."[1]

2. Job description. The development of job descriptions is justified by program inspection provisions in Minn. Stat. §245.804, Subd. 2.

3. Job evaluation. The development of job evaluation criteria is also justified by Minn. Stat. §245.804, Subd. 2. Staff growth and development plans will encourage employees to gain knowledge and skills necessary to attain goals and objectives of the program. This will benefit the treatment program by providing an influx of new and innovative ideas.

A policy defining procedures for resident input to staff evaluations promotes an open process allowing residents to express both positive and negative opinions about their mental health program and the staff providing the services. Resident responses will provide valuable information about the effectiveness of the program and could alert management and inspection personnel to problems and abuses.

4. Conditions of employment. Personnel guidelines dealing with benefits, hours of work, promotions and dismissal policies will enable programs to be administered in a consistent and effective manner.

Working in the field of mental health treatment is an emotionally intense experience. Many lay, as well as professional caregivers, experience what is commonly called "burn out". Policies addressed to this issue will assist program administrators in providing for mental health needs of the staff, as well as of the residents.

5. and 6. Organizational chart and grievance procedure. These two sections ensure that employees are given the right to bring grievances to their employer. Knowledge of the organizational hierarchy, as well as proper grievance procedures and community resources will allow employees to submit complaints through acceptable channels.

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[1] Contemporary Issues in Applied Psychology and Personnel Management, Chapter 2 "The Law and Personnel Management".

7. Personnel data. In exercising his powers to license, renew, suspend, revoke or grant provisional licenses under Minn. Stat. §245.804, Subd. 1, the Commissioner is required to study and evaluate operators and applicants for a license. Minn. Stat. §245.804, Subd. 2, requires the operator or applicant to cooperate with an evaluation or inspection by providing access to its facilities, records and staff, including references and other information about the character and qualifications of the personnel of the facility. This access is essential if the Department is to make a determination as to whether or not the personnel meet the requirements set forth in this rule.

8. Staff orientation. Minn. Stat. §245.69 state that it is the duty of the Commissioner to set standards for personnel qualifications, as well as quality of professional service and in-service training. This section defines these minimum training standards and outlines implementation through staff orientation and annual staff development plans.

Section 8. is also supported, although more indirectly, by Minn. Stat. §256E.10 (CSSA). Performance criteria and program objectives are to be used in the county evaluation of mental health services. The standards in this section of the rule reflect and clarify these criteria and objectives.

Written guidelines for staff orientation are necessary to ensure a uniform understanding of job performance expectations. Orientation materials and presentations will clarify responsibilities of each staff position and familiarize employees with the program's treatment philosophy. A common understanding of program goals and objectives will enhance efforts to create a team approach to mental health treatment. Residents will benefit most from programs offering such consistency and clear treatment objectives.

9. Staff training. Training opportunities encourage staff to stay abreast of current treatment developments and bring innovative ideas into the program. In-service and out-service training sessions can also be effective means for resolving personnel and treatment dilemmas or training deficits.

Knowledge acquired in the listed areas will assist staff in dealing with the myriad of problems they will be confronted with in their jobs. As many of the topic areas (a-i) usually are not covered in formal educational programs, it is imperative that mental health facilities provide adequate training on-the-job or through community resources. This section is supported by Minn. Stat. §245.813 by ensuring the well-being and safety of residents, Minn. Stat. §245.61(b) authorizing county boards to make grants to mental health programs for informational and educational services, and Minn. Stat. §245.69(a) conferring on the Commissioner the power to promulgate rules and standards for quality of professional service and in-service training and educational leave programs for program personnel.

J. Personnel files.

1. Central training file. This section provides for documentation of compliance with I.8. and 9.

2. Individual files. This section is authorized by Minn. Stat. §245.804, Subd. 2, and is found in all program rules. Sections c., d., e. and f. document compliance with all standards and requirements contained in Section I.

K. Admission, discharge and transfer policies. This ensures clarity of preadmission criteria, a multidisciplinary approach to the resident's treatment and follow-up care. The intent of Section K. is to prevent "dumping" the resident after treatment into the community with no further provisions for help. "Dumping" results in misuse of funds and resources and to aid in the neglect of a vulnerable adult.

L. Program Services. The combination of services to be provided within Category I will vary from program to program because of the differing needs of residents and the acknowledged fact that an adequate system of care and treatment must have a variety of models available. No two residents are exactly alike and therefore no two programs should be exactly alike. Linking residents to appropriate community services and resources will be the primary goal of staff in these programs. Many of the program services (a,b,d,f,g,h,i) are explicitly required by Minn. Stat. §246.014. The implicit requirement is contained in Minn. Stat. §246.014, Subd. 2, which mandates that staff must be adequately trained to provide the most modern medical, psychiatric and social care.

M. Policies and procedures guaranteeing resident rights.

1. Explanation of rights. Minnesota has a Patient's Bill of Rights in statutory form, Minn. Stat. §144.651. Using the statute as a baseline, the rights of residents are further amplified in the rule, and a requirement made that residents be informed of their rights. Further, since rights also have responsibilities, it is reasonable to make residents aware what is expected of them.

2. Grievance procedure. It is standard policy within the state hospital system and common practice in some residential facilities to develop, post, and implement grievance procedures in relation to resident rights. In addition, all state hospitals in Minnesota have a formal patient advocate system which included the posting of a patient rights handbook, giving one to each resident and explaining its contents. This patient advocate and rights sytem has worked well. This requirement in the rule is consistent with this well established practice in the hospitals and some community facilities.

Further, it is standard practice in business, based on sound management principles and/or union contracts, to provide this kind of information and assistance to employees. Government, likewise, has a variety of mechanisms that offer assistance to employees in developing and processing grievances. From a purely humanitarian standpoint, no less should be afforded the adult mentally ill residents of these facilities.

3. Resident council. The resident council assures resident input into the program designed to help them. It is in keeping with numerous research studies documenting the positive correlation of self-determination with increased client independence and health.[2]

4. Personal funds policy. Policies governing supervision of resident's funds are required in order to protect the resident and his/her money from mismanagement, loss, and misuse.

5. Resident compensation. Historically, residents of state hospitals were often required to perform labor that was not designed or required as part of standard housekeeping responsibilities, nor necessarily as having any therapeutic value or relationship to an individualized treatment plan. This practice served as a means of keeping costs down. Although abuse of resident labor is not widespread today, this standard is intended as a reasonable way to protect against exploitation of residents, and acknowledges there are tasks that legitimately can be required as a normal share of housekeeping needs.

Further support for the standard can be found in Minnesota's hospital system where a patient pay and wage reduction plan is required, based on the Handicapped Worker Regulations of the Fair Labor Standards Act, 29 C.F.R. §529 (1977), Minn. Stat. §177.28, Subd. 5; and the current Joint Commission on Accreditation of Hospitals' Standards. Many of the adult mentally ill persons who now reside in community-based residential facilities would be in state hospitals were it not for Minnesota's emphasis on deinstitutionalization. These persons need the protection of this provision wherever they reside.

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[2]Martin, Patricia Yancey and Segal, Brian -- "Bureaucracy, Size, and Staff Expectations for Client Independency in Halfway Houses", Journal of Health and Social Behavior 1977, Vol. 18 (Dec.): pp. 376-390.

"Wilder et al. (1968) note, for example, the undesirable client outcomes associated with staff utilization of a nurturant approach to client management in halfway houses for former mental patients. The nurturant approach, which defines clients as sick, dependent, and basically helpless, requires that staff assume most of the responsibility for the residents which, the authors claim, foster client dependency on the halfway house and staff.

In contrast, Wilder et al. (1968) document the greater effectiveness of the high expectations approach which defines the client as 'healthy' and entails the requirement that residents assume primary responsibility for themselves. In anticipation of the skills and behaviors needed upon discharge, this approach emphasizes client self-responsibility and self-sufficiency. Similar research by Ellsworth et al. (1971), Kish et al. (1971) and Gove and Lubach (1969) supports this position. They find that requiring residents to assume responsibility for themselves and to make decisions regarding the management of the treatment setting is associated with greater client success in terms of a shorter length of stay inside and a longer one outside of the facility." p. 379

6. Physician appointments. This is consistent with the well-established principle of a resident's right to choose his or her vendor particularly covering medical care. All facilities have arrangements for emergency medical care. None have in-house full time physicians. Precedent for ensuring resident choice of vendor is found in Minn. Stat. §253A.17, Subd. 6, which states that "...the patient's personal physician ... shall be permitted to visit the patient at all reasonable times..."

7. Photographs of residents. This section simply ensures that residents retain control over the taking and use of their photograph. It is based on the Minnesota Govern-ment Data Practices Act. Specifically, Minn. Stat. §15.163, Subd. 4, states, "Private or confidential data on an individual shall not be collected, stored, used or disseminated by political subdivisions, statewide systems or state agencies for any purposes other than those stated to the individual".

8. Telephone use. The requirement is based on standard practice found in most mental illness residential facilities and all chemical dependency treatment facilities. It acknowledges that some residents need a period of initial adjustment, free from interference and harassment. Or, they may need time to accept the fact of being in a residential facility, to concentrate on understanding why they are there, or to develop a commitment to the program. These needs exist, therefore access is limited. Since it constitutes a restriction of a right, it is reasonable to limit the use of the policy and require documentation. The requirement also suggests that overall management of a facility may require establishing reasonable hours for general access to phones and length of time for calls.

9. Mail. There is ample basis for this requirement which acknowledges each resident's civil right to privacy and freedom to express and receive ideas. Paragraph (17) of the Patients Bill of Rights, Minn. Stat. §144.651, states that "every resident may associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated and documented by his physician in the medical record". This requirement also acknowledges that there can be circumstances of a therapeutic nature that justify not allowing mail to be received or sent, or warranting censorship. As a protection against infringement on this right, the burden for establishing cause rests with the facility and must be documented in the individual treatment plan.

10. Restraints. For purposes of this rule, it is intended to acknowledge that restraint or seclusion of a resident may sometimes be necessary for safety reasons, yet to clearly define both the circumstances under which it is permissable and the forms it may take. Most importantly, the section is intended to limit, rather than encourage, to be restrictive, rather than permissive. It is viewed very simply as one means of ensuring the protection of resident's rights without prohibiting the use of medications where appropriate for treatment programs.

N. Residents Records

1. Individual program plan development. The standard practice in state and community facilities; whether they are private or public, whether they serve the mentally ill, chemically dependent or mentally retarded, and

no matter what the age of the residents; is to require an individualized treatment plan. Support for the requirement is found in case law (the Wyatt Decrees in 1971 and 1974 address this issue: see page 2 of Statement of Need), and is expressly required by Minn. Stat. §253A.17, Subd. 9, for those persons hospitalized as mentally ill. In addition, it clearly relates to the rationale for section A.8.e. of the rule relating to evaluation. Further, and more specifically, since the mentally ill person has often been helped by agencies, professionals, and family systems, a total picture of treatment must be obtained from all involved persons. This is in keeping with the multidisciplinary approach to care and helps to ensure that the treatment plan is comprehensive. This is consistent with accepted practices of psychiatric treatment attested to by professionals from many disciplines. And, since the resident obviously will be affected by the treatment, it is important to document the extent of participation in order to show the residents agreement or disagreement, and to serve as a written basis for tracking the resident's response and progress.

2. Plan contents. The individual program plan is based on a holistic approach and conforms to Minn. Stat. §253A.17, Subd. 9. And, since the stated objective of Rule 36 facilities is to enable the resident to progress to a more independent, less restrictive living situation, it is reasonable to require the plan to focus on an individual's strengths, wellness and ability factors, rather than just illness or problems.

3. Progress report. Quarterly progress reports are again mandated in Minn. Stat. §253A.17, Subd. 9, and are reasonable to include in Rule 36 residences primarily because a resident's treatment needs never remain constant. Progress must be evaluated and adjustments made in the treatment plan when indicated. The only way to ensure that residents don't get lost, forgotten or locked into a static plan is to require the quarterly progress reports. Further, they encourage the resident's participation, which promotes resident involvement and responsibility in getting well and encourages growth and independence. Copies of the report are given to the resident and are sent to the referring agencies and departments as a means of allowing a check system to ensure quality of care, appropriate use of money, and continued financial support of the resident.

4. Discharge or transfer summary. A discharge and aftercare plan is required for the purpose of ensuring continuity of care and maintenance of health and wellness. It also ensures accountability and ongoing responsibility. As such, it protects both the resident and the taxpayer and is in keeping with Minn. Stat. §626.557 protecting vulnerable adults.

5. Accidents and missing persons. Documentation of policies and procedures regarding accidents and missing persons is consistent with current practice in the public and private hospital systems and Rule 34, and serves as a protection for both the provider and the resident.

6. Release of information. In conformance with the Government Data Practices Act, no information will be given out without written permission of the person concerned.

O. Living unit requirements.

1. Structure. Minn. Stat. §245.802 authorizes the Commissioner of Public Welfare to promulgate rules and regulations to set standards for the operation and maintenance of residential facilities. The living unit is one important component in the operation of a residential treatment facility.

Mentally ill persons often enter the mental health system as young adults never having had the opportunity to learn skills necessary for independent living. A common characteristic of chronic mental illness which is probably exacerbated by institutional care is a general inability to cope with activity stresses of daily living outside a mental health facility.

This section of the rule sets minimum standards for a treatment setting most closely resembling normal apartments (within obvious financial and structural limitations of group living). A "home-like" environment will allow residents to learn the skills, such as grocery shopping, cooking and housekeeping, money management, and personal hygiene, that are necessary for a more independent life style.

2. Ratios. It is the primary purpose of this section to limit unit size to encourage leisure-time activities and create a home-like atmosphere for residents. A larger ratio of residents per living room/lounge area was allowed for existing programs where structural limitations and high reconstruction costs would make a lower ratio unattainable. Enforcement of a lower ratio would result in many large existing programs being out of compliance with Rule 36 standards. The resulting nonlicensure would make these programs subject to penalties defined in Min. Stat. §245.803. As a result, hundreds of mentally ill residents could be displaced from their homes.

3. Program space. Services should be provided in settings most appropriate to the residents' needs. This section of the rule provides for access to household appliances (e.g., kitchen and laundry), group recreation space, and rooms suitable for individual, as well as group counseling and training sessions. These provisions may be necessary to implement residents' individualized program or treatment plans.

4. Gender of residents. Separation of men and women by units may be structurally impossible in many facilities and to some would reflect an institutional setting rather than a more real life atmosphere. Additionally, various program objectives may contraindicate separation. Each facility will be responsible for determining appropriate room assignments with consideration given to societal norms as well as individual residents' right to privacy.

5. Privacy. Privacy in group living is often difficult to obtain. This section recognizes the residents' rights to privacy and for formal, as well as informal activities.

6. Storage space. Although many residents have a limited amount of clothing and personal property, it is essential for both privacy and security reasons to provide this space and capability. It is also valid,

from a safety, therapeutic and management of space standpoint to allow a facility to exclude certain kinds of personal property, yet require that the exclusion be defined and documented when invoked.

P. Additional requirements specific to Category I programs.

1. Capacity. Capacity was determined in keeping with the concept of normalization which was reformulated by Wolfensberger (1972) as "utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible".[3] Forty was allowed as the maximum number for already existing facilities or treatment units within existing facilities for four basic reasons. First it recognizes the fact that a number of facilities already exist that are at or near this figure; second, that several of the larger facilities that grossly exceed forty can be reorganized programmatically to meet this standard; third, while these facilities already exist, there simply isn't enough money available to rebuild or renovate to bring them down in capacity to the ideal of twenty-five that is being required for new facilities; fourth, on the assumption that an existing facility can meet program requirements of this rule and relevant health and life/safety standards, allowing a phase-in period to reduce size was viewed as a lesser evil than the reinstitutionalization which would result from the closure of these facilities.

Twenty-five was chosen by the task force as the maximum for new facilities in keeping with the principle of normalization and the realities of cost factors but also allowing for the benefits of large numbers. Current research has shown that residents in larger homes engaged in more social behavior than those in smaller homes. Larger homes were defined in this research study as those having 18 - 20 persons.[4]

2. Department of health licensing standards. A requirement for a SLF license or boarding care license was retained from the existing rule to ensure protection of the health and safety of the residents and because discussions and negotiations with the Department of Health indicated that waivers will be granted to mental health residential facilities that would allow more home-like atmosphere and promotion of independent living skills.

3. Intake information. Since Category I facilities will be providing services to adult mentally ill persons needing intensive care and treatment, the fact that the demand is greater than beds available and precautions need to be taken to place persons in the least restrictive alternative, as well as control costs, this type of intake information is required to help ensure that the person referred is appropriate for the facility, meets the criteria for admission, and shows the potential to benefit from the services offered. The intent is to offset misdiagnoses and deliberate lack of information for the purpose of gaining admission.

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[3]Wolfensberger, W. The Principle of Normalization in Human Services. Toronto National Institute on MR 1972.

[4]Landesman-Dwyer, Sharon U Sacket, Gene P. "Relationship of Size to Resident and Staff Behavior in Small Community Residences" AJMD, Vol 85, July 1980, No. 1: pp. 6-17.

4. Program director. The reasoning for qualifications of various staff was based on two factors: 1) concern for the best possible care for the residents,[5] as well as 2) the practical reality of recruiting persons in the rural areas of the state. Therefore, a program director would ideally have a master's degree in the behavioral sciences with experiences in working with the mentally ill. Where this is not feasible, and where there are candidates well qualified because of experience, a bachelor's degree plus experience also qualifies. Experience working with the mentally ill is considered essential by mental health professionals for managing a program for the mentally ill.

Expecting one year of experience in administration or supervision before becoming a director is in keeping with accepted practice of management policies.

5. Administrator. Since there are facilities that will have a person functioning as administrator who will not also be the program director, it is necessary and reasonable to expect that minimum qualifications be established. However, rather than spelling them out in detail, experience has shown that it is sufficient to allow the governing board to decide the qualifications since it will act in its own best interests and thus ensure effective administration of the facility.

6. Mental health therapist. Requiring that the mental health therapists be trained beyond having a bachelor's degree in the provision of treatment is in keeping with Minn. Stat. §§246.014, with the recommendations of the President's Commission on Mental Health,[6] with the quality assurance provisions of the professional organizations (American Nursing Association, National Association of Social Workers, American Psychiatric Association), as well as with the Wyatt Decree.

7. and 8. Mental health counselor and mental health worker. These requirements are in keeping with accepted psychiatric personnel policies, and with the President's Commission on Mental Health.[7]

9.a. and b. Staffing ratios. The staffing ratios are based on a combination of existing ratios used by facilities currently meeting the recommended standard and compromise amongst Task Force members where strong arguments were forwarded for both higher and lower ratios. The ratios designated are for those programs dealing with high functioning mentally ill persons and are not meant to suggest that all programs are to be limited to this number.

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[5]"Relationship of Size to Resident and Staff Behavior in Small Community Residences", Landesman-Dwyer, Sharon and Sackett, Gene P., American Journal of Mental Deficiency, July, 1980, Vol. 85 #1: pp. 6-17. "Baker et al. concluded from a national survey of community residential alternatives that the quality of staff is the most important determinant of success in residential programming."

[6]Report to the President from the President's Commission on Mental Health, Vol. I, 1978, Washington, D.C.: pp 35-41, 67-69.

[7]Ibid

The minimum numbers were used to offset the need for hiring staff where they would not be needed --and thus creating an overly expensive system of reimbursement. In a continuum of care, there must be programs operating to help the more disturbed and more chronic population of persons, as well as the higher functioning persons. The former will, by necessity, demand higher staff-to-resident ratios.[8]

c. An inservice training coordinator is required to ensure that the mandated staff training programs are provided.

Q. Additional requirements specific to Category II programs.

1. Capacity. This section grants special status to existing large facilities where, for structural and cost reasons, an immediate decrease in facility size and resident population is not possible. Ideally, programs should not exceed a 25 bed capacity. (See below.) As it would be impossible for most larger existing facilities to immediately comply with this standard, a maximum living unit size, within each facility, will be enforced. This will allow large facilities now providing housing for mentally ill adults to comply with Minn. Stat. §245.783. Noncompliance resulting in non-licensure would force displacement of hundreds of mentally ill residents and/or penalties on the facilities pursuant to Minn. Stat. §245.803. Limited unit size will enhance program efforts to simulate home-like atmosphere and encourage increased resident/staff interaction.

The three year grace period represented a compromise between the two extremes of immediate compliance and no change. The grace period allows a realistic implementation schedule but requires eventual compliance. This is reasonable since the funding proposal to the legislature and the preliminary funding rule authorized expenditure of monies for renovation/ physical upgrading purposes to bring a facility into conformance with requirements of the rule. If funding had been limited strictly to direct service costs, the rule would not include this requirement. Further, the authorizing legislation, Laws of 1981, Ch. 360, §16, Subd. 7 amended Minn. Stat. §245.812, 1980, by adding a subdivision that grants facilities established on or before July 1, 1980 until July 1, 1984 to come into compliance with the provisons of Minn. Stat. §245.812.

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[8]Martin and Segal, p.p. 378 and 381-382. "...a higher staff/client ratio is consistently reported to be positively associated with desirable staff and/or client outcomes (e.g., staff attitudes, behaviors, client discharge rates; see Cohen & Streuning, 1965; Moos, 1972a; Holland, 1973)." p. 378

"...Holland (1973) contends that a higher staff/client ratio is indicative of the fact that staff are able to spend more time with clients and thereby enhance their chances for rehabilitation (and/or release). Research by Becker (1969) and by Linn (1970) supports this interpretation. Both find that clients who spend a greater proportion of time with staff are observed to be released more quickly and to remain in the community longer. Becker (1969) claims that the staff/client ratio is a proxy measure for quality of service rendered by staff. Where the staff/client ratio is higher, therefore, we expect staff members to demand more from the organization's clients." pp 381-382

Since renovation/physical upgrading monies will be available, it was then determined by members of the Task Force, Department fiscal management personnel, providers and county staff, that three years was a reasonable length and a necessary interval for all parties. Plans need to be drawn, requests made to counties and then to the state for funding, and actual structural changes made and inspected. Hennepin County, for example, currently has established a minimum processing period of eighteen months. Several facilities are already in the process of architectural studies.

The effective date of July 1, 1980 was set for two reasons, the first being simply to recognize the current existence of a large number of facilities and to create a fixed point in time for management purposes. The second, and most important reason was to formalize the unanimous position (of the Department, providers, advocates, the Governor's office and legislature) that first priority must be given to ensuring the health and life/safety of current residents, as well as the minimum programmatic requirements of the rule. Although the need for new beds is well documented, given the tight economy, the decision was made to focus on existing facilities this biennium. This decision is reflected by Laws of 1981, Ch. 360, §14, Subd. 2 which reads: "the commissioner shall give first priority to residential facilities for adult mentally ill persons operating as of July 1, 1980, to meet licensing requirements of the commissioner pursuant to sections 245.781 to 245.813".

Without the 25 bed limit limitation, some providers will simply expand their number of beds as a means of gaining additional revenue.

This section also sets the maximum resident capacity for new programs. The capacity figure chosen for this category reflects the current trend toward smaller, home-like programs as opposed to large scale institutions. In addition, two currently licensed Rule 36 programs operate at approximately this capacity lending justification for the limit chosen.

2. Department of health licensing standards. This section insures that all Rule 36 licensed facilities will also meet health standards appropriate to the level of care provided (as authorized in Minn. Stat. §245.802). Compliance with health standards will safeguard the physical well-being of residents. Failure of the facilities to do so results in penalties pursuant to Minn. Stat. §245.813, Subd. 1.

There is a specific set of Health Department regulations that apply to Supervised Living Facilities that will create some difficulties for Rule 36 facilities. The SLF regulations were initially developed with regard to facilities for the mentally retarded; their applicability to that type of facility is not in dispute. The issue arises when the same standards are applied to facilities for the mentally ill and chemically dependent. For example, even though MI residential facilities have, as an objective, the movement of residents to a higher level of independent living, they would be required under literal application of the SLF standards to have commercial kitchen equipment and to restrict residents from its use. Even if residents could learn to cook on commercial equipment, few if any will have that kind available to them in an apartment or their own home. (There are other physical plan/safety requests that have the same effect, that of being contrary to the stated purpose for which these facilities exist. A detailed written analysis is available on request.)

In essence, both the Department of Public Welfare and the Department of Health acknowledge that SLF as currently written does not differentiate between the three major types of facilities to which it applies, and that it does need revision. The Health Department has agreed to consider granting blanket waivers on the four or five most inappropriate requirements. If that will not be done, then a commitment to quickly process individual requests for waivers would constitute a reasonable compromise. These waivers do not affect life/safety considerations.

3. and 4. Intake information and medical information. Records will be maintained to assist staff in assessing residents' needs (individual program plan), for responding to psychiatric or medical crises and to maintain information essential for aftercare planning and program evaluation. (Supported by Minn. Stat. §256E.05, Subd. 3(d)). These additional records need to be maintained in order to assure the appropriateness of admission; for obtaining assistance quickly at times of psychiatric or medical crises, since staff ratios and skill level of staff is less in this category; and also to provide for substantive aftercare planning and evaluation. There is support for this requirement in Minn. Stat. §256E.05.

Intake information is necessary to determine the appropriateness of the program for the individual resident referred.

A medical examination is necessary to detect physical disorders or illness harmful to the resident or potentially harmful to fellow residents. Records of examinations, conditions and medications are necessary for crisis situations, as well as routine medical concerns.

5. Program director. This section allows flexibility for educational equivalency while guaranteeing training and experience or a bachelor's degree with two years' experience. This provision allows rural areas to fill positions where there exists a shortage of applicants with masters degrees. Though conclusive research does not exist to support these equivalency guidelines,[9] Minnesota health professionals consider mental health work experience essential to managing a program for mentally ill persons.

6. and 7. Administrator and mental health counselors and workers. See the comments for this section of Category I.

8. Staffing ratios. The minimum ratio of staff-to-residents is lower in this category than in Category I because most mental health services will be provided in the community rather than at the residential facilities.

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[9]Evaluation of Education and Experience as a Selection Device Apart, State of Illinois 75IL05.

Staffing ratios and patterns defined in this section will provide 24-hour coverage. This will guarantee that staff is available for crisis situations, as well as evening activities. These ratios represent a minimum staffing standard based on literature, clinical judgment and provider experience and are not intended to limit programs where the needs of residents necessitate increased staffing. For purposes of the hearing, oral testimony will be provided.

R. Variances. Under Minn. Stat. §15.0412, Subd. 1a, the Department may only grant a variance if procedures and standards for the granting thereof are promulgated in rule. This section does this.

S. Appeals. This acknowledges the statutory right of providers to appeal decisions made by the licensing authority and makes reference to the mechanism established.

The Department intends to support the Statement of Need and Reasonableness with the following expert witnesses. Accompanying this list is a summary of their testimony.

Dr. George Pettersen, Commissioner, Minnesota Department of Health, or designee - relationship between program and health standards; importance of both in ensuring a minimum level of care for adult mentally ill persons.

Rep. John Brandl, co-author Rule 36 appropriation bill - social policy, legal and fiscal implications of the rule.

Ginny Dayton, chairperson, Rule 36 Citizen Advisory Task Force, or designee - reflection of proposed rule as a community effort.

Tish Halloran, Director, Hennepin County Mental Health Division - historical context of the rule from a program development, implementation and continuum of care perspective as viewed from both the state and local level.

Mila Hundley, Treatment Director, SLIC, Inc. - rationale for the definitions used in the rule.

Harriet Grinstead, Executive Director, Hope Transition, Inc., and Roger Lynn, Executive Director, Wellspring Therapeutic Community, Inc. - applicability of the requirements relating to the licensing process, license changes, program policy and procedures manual, statement of purpose and policies, program organization and management, documentation and reports, personnel policies, and procedures and personnel files from an administrator/provider perspective.

Bill Johnson, consumer, and Roger Lynn - rationale for resident rights requirements.

Marge Wherley, Resident Program Consultant, Hennepin County Mental Health Division - rationale for the admission, discharge and transfer policies, the program service requirements, living unit requirements, and an explanation of and rationale for the creation of two categories of program.

Bob Ryan, Administrator, Guild Hall, Inc. - applicability of the evaluation and resident records requirements and assisting Marge Wherley in her presentation.

* Bill Conley, Director of Public Affairs, Mental Health Association of Minnesota, and/or Steve Becker, Legislative Public Affairs Coordinator, Mental Health Advocates Coalition - summation of key social policy, legal and fiscal issues and concerns related to the development and implementation of the standards.

Sept. 3, 1981
date

Commissioner, Department
of Public Welfare,
Minnesota