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MOOSE LAKE TRANSITION PROJECT EVALUATION: IMPACT ON MENTAL HEALTH SERVICES

FINAL REPORT

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EXECUTIVE SUMMARY

This document represents the results from the evaluation of the replacement of Moose Lake Regional Treatment Center (MLRTC) with alternative community-based mental health services, including State Operated Services (SOS), community-based programs, and inpatient mental health treatment in community hospitals.

The evaluation objectives as agreed upon by the Minnesota Department of Human Services Mental Health Program Division in contract with the Minnesota Institute of Public Health (MIPH) had the purposes to:

1) assess the impact of client outcomes on the replacement of MLRTC with enhanced mental health service infrastructure;

2) assess the impact of transition on client service utilization and costs of services in the catchment area; and

3) assess the planning and implementation of the transition in the MLRTC catchment area.

This evaluation project began in July of 1994 and concluded in June of 1997. A multi-method, multi-level assessment strategy was employed to meet the goals of the project. The remaining components of the study addressed client outcomes, costs and utilization of services, and the effectiveness of the transition planning process.

FINDINGS

Limitations of the study notwithstanding, the following conclusions from the study are made:

- Replacing MLRTC with an enhanced community mental health infrastructure does not lead to a decrease in the effectiveness of services for persons with serious and persistent mental illness, and in fact seems to increase the options available to them.

- The Moose Lake area transition has not resulted in an increase in costs of public mental health funding to counties in the region.

- The range and quality of services has not been limited but has very likely been enhanced by the transition.

- Regarding the planning process assessment, most participants and observers feel the program was a success.

There is a preponderance of evidence that the Moose Lake area transition has been and continues to be successful. Client clinical outcomes and satisfaction are at least stable before and after implementation of the program. The cost analysis indicates that the transitional services established to replace MLRTC capacity has not resulted in an increased burden to counties in the region.

INTRODUCTION

This document summarizes the results of an evaluation of the replacement of Moose Lake Regional Treatment Center (MLRTC) with alternative community-based mental health services, including state operated services (SOS), community-based programs and inpatient mental health treatment in community hospitals.

Included in this report are summaries of the client outcome assessment, assessment of the costs and service utilization impacts of the transition, and assessment of the planning process to prepare for the Moose Lake RTC closure.

IMPETUS: The 1993 legislature passed legislation to transition MLRTC from a psychiatric hospital to a 100-bed facility for persons with psychopathic personality disorders. In addition, a 500-bed medium security prison was to be developed at the site. The legislation closing MLRTC also called for creation of an enhanced community infrastructure in the 11 county Moose Lake catchment area to replace the psychiatric capacity at MLRTC. This enhanced capacity included:

- Local creation and enhancement of the community mental health infrastructure, utilizing about $3 million per year in new state appropriations for non-inpatient, non-residential services;
- Development of state operated services (S)S to provide inpatient, outreach, crisis support, transition and other services for people with mental illness;
- Implementation of community hospital contracted beds to provide inpatient services for persons with mental illness;
- Development of additional inpatient capacity at Brainerd Regional Human Service Center.

The purpose of this new capacity was to provide an enhanced community-based mental health infrastructure replacing the RTC that would be as effective and efficient as existed previously and, if possible, provide more and improved service options.

EVALUATION: The Department of Human Services (DHS) contracted with the Minnesota Institute of Public Health (MIPH), located in Anoka, Minnesota, to evaluate the MLRTC transition. The evaluation has three main purposes.

1. To assess the impact of the replacement of MLRTC with an enhanced mental health service infrastructure on client outcomes;
2. To assess the impact of the transition on client service utilization and costs of services in the catchment area;
3. To assess the planning and implementation of the transition in the MLRTC catchment area.

The evaluation began in July 1994 and was initially intended to conclude in December 1996. To allow for more patients to be included in the study, its conclusion was extended to March 1997.

BACKGROUND

Implementation and evaluation of the Moose Lake transition occurred within the publicly funded mental health system of Minnesota.

THE MINNESOTA PUBLIC MENTAL HEALTH SYSTEM

The Minnesota Department of Human Services (DHS) is responsible for oversight of public mental health services in the state which are provided or administered by county social services agencies. The Department also provides services directly through regional treatment centers, state-operated services and a state nursing home.

A major responsibility of DHS is supervision and coordination of mental health services to persons with Serious and Persistent Mental Illness (SPMI). The Comprehensive Mental Health Act lists the criteria which constitutes SPMI.

The Current System

Historically the inpatient service provider of last resort for persons with SPMI in Minnesota has been the state hospital system. Now called Regional Treatment Centers (RTCs), these institutions must offer treatment to anyone with mental illness who has been committed to inpatient care because it has been determined by the court that they are a danger to themselves or others.

Moose Lake RTC

Established by an act of the legislature in 1935, the Moose Lake Regional Treatment Center opened in May 1938, with its first admissions being individuals transferred from other state facilities. Until its closure in 1995, MLRTC provided services to persons with mental illness, chemical dependency and developmental disabilities in Northeastern Minnesota (see Figure 1 on the next page).

Highly specialized programs were developed to serve each of these populations and the RTC provided therapeutic and rehabilitative services including technical assistance, crisis intervention, state-operated residential and day program services, vocational rehabilitation, consultation and training. Like all other Minnesota RTCs, MLRTC's goal was to provide intensive services to persons with mental illness to permit and help those requiring inpatient services to return as quickly as possible to their home communities and remain there.

Figure 1: Moose Lake RTC Reception Area

Commitment

Appendix A shows the essential steps in the commitment process. In most cases commitment begins with a petition filed by a concerned person. This is sent to the County Attorney. Petitions accepted by the County Attorney are sent for trial or hearing before a District Court judge or referee.

Two kinds of outcome may result from a petition hearing. The first is a court ordered commitment of the person, generally to a state inpatient facility. The second kind of outcome is a negotiated settlement in which the court issues a stay of commitment and the person accepts a voluntary placement in an appropriate mental health facility, or agrees to a specific course of treatment in the community.

Not all commitments result in placement in an RTC. The general philosophy of placement is to provide a treatment setting which is the least restrictive possible. It is this philosophy which motivates the continuing effort to provide short and intermediate term community alternatives to RTC institutionalization.

RTC Services

Once commitment to an RTC has been ordered by the court, the RTC accepts responsibility for the case and may discharge the patient at any time. They feel the individual has reached maximum benefit from treatment. Initial commitments may last no longer than six months. If a patient has not been discharged from an RTC at the end of six months, a petition for an extension of commitment may be filed with the court. Extensions are limited to one year without another hearing.

Under Rule 79, persons committed to an inpatient facility are assigned a case manager by their county social service agency. The case manager works with the RTC treatment team, attends (or at least is invited to) quarterly case reviews at the RTC and is involved in discharge planning.

If the conditions of the provisional discharge are violated, the case manager may request that the client be returned to the RTC.

Post Discharge Services

The treatment and support services available to the discharged RTC patient are quite varied in large, urban counties and may be more restricted in less populated, rural counties. Some clients are discharged from RTCs to Rule 36 inpatient residential treatment facilities, others to some form of supported living and still others to their families or their own homes in the community. Available to most discharged persons with SPMI are an array of resources, including the following:

- Participation in psychosocial rehabilitation programs.
- Medications monitoring.
- Home visits from nurses and assistance from personal care attendants.
- Participation in Day Treatment Programs and Community Support Programs (CSP).
- Participation in vocational assessment and training.

The Moose Lake Transition

Planning for the Moose Lake transition began prior to the expected legislation, continued during closure of the facility and implementation of the enhanced infrastructure, and is ongoing today in the form of monitoring, planning, technical assistance and adjustment.

Regional Planning

A transitional work plan was collaboratively developed by the Department of Human Services (DHS) and the 11 county catchment area social services directors to define tasks, identify lead persons and develop community services. Regional meetings were held at MLRTC with state, county and public and private providers for the purposes of planning, coordination and collaboration.

County Planning

A key component of the transition was the provision of flexible funding to the 11 counties in the Moose Lake catchment area to enhance existing programs and create new services to meet the needs of persons who had been discharged from MLRTC at its closure or who would have been admitted to the facility had it been available.

A total allocation of $2.2 million per year in new mental health funding was divided among the 11 counties according to a formula agreed upon by the County Social Service Directors. Each county was charged with developing a flexible funding plan outlining how it would use the available funds.

The five counties in Region 7E[1] planned many of their services collaboratively. St. Louis County instituted parallel planning processes in its north (Range cities) and south (Duluth) areas. The initial flexible funding plans are shown in Appendix B.

State Operated Services

A central feature of the Moose Lake transition was implementation of community-based State Operated Services (SOS) in the area. Staffed by mental health professionals and paraprofessionals formerly employed by MLRTC, these programs were intended to fill any gaps in the service array that remained after county social service plans had been implemented. Three SOS programs were implemented as part of the transition:

[1] Chisago, Pine, Isanti, Kanabec, and Mille Lacs

Cambridge Outreach Service -- A mental health staff team located in Cambridge, Minnesota, provides intensive wrap-around services and a 24-hour crisis response capacity to the five county area known as Region 7E.

Duluth Crisis/Transition Unit and Outreach Service -- Bridge House, a 12-bed crisis/transition unit in Duluth, also provides a mobile outreach capacity, mobile crisis intervention, and nursing home consultation.

Eveleth Health Services Park -- A 15-bed inpatient intermediate care psychiatric unit (up to 90 days) in Eveleth also has one crisis bed and a small mobile outreach team.

Community Hospital Contract Beds

Four community hospitals in the Moose Lake area provide inpatient psychiatric beds on a contract basis for MA-eligible patients. These are:

Cambridge Memorial Hospital, Cambridge, Minnesota

Miller-Dwan Hospital, Duluth, Minnesota

University Medical Center-Mesabi, Hibbing, Minnesota

Itasca Medical Center, Grand Rapids, Minnesota

Patient stays in these inpatient facilities are limited to 45 days or less, following commitment.

Enhanced Capacity at Brainerd RHSC

Thirty additional inpatient psychiatric beds were established at the Brainerd Regional Human Service Center. To date, additional capacity beyond the 30 has not been warranted.

METHODS

A multi-method, multi-level assessment strategy was employed to meet the goals of the evaluation project. The three main components of the study addressed client outcomes, costs and utilization of services and the effectiveness of the transition planning process.

CLIENT OUTCOME ASSESSMENT STRATEGY

A key component of the evaluation is an assessment of clinical outcomes of clients affected or potentially affected by the transition.

Comparison Groups

The purpose of the client outcome assessment was to determine the impact of the replacement of MLRTC with an enhanced community mental health infrastructure on the functioning of two groups of clients.

MLRTC Sample

The first group of clients consisted of 48 former MLRTC patients who were discharged to the community or to other residential facilities as a consequence of the closure. These discharges took place between September 1994 and May 1995.

Part of the Moose Lake RTC group are 16 clients who were transferred to the Brainerd Regional Human Services Center. They were followed using the same process and measures as the MLRTC group discharged to the community.

Also included in the MLRTC group were 31 psycho-geriatric patients transferred from Moose Lake RTC at its closure to nursing homes in Minnesota. This group consisted of very aged persons and persons with physiological conditions which made it clinically inappropriate to discharge them to the community. They were followed using the assessment tool described below. The psycho-geriatric discharges took place between December 1994 and May 1995.

Community Sample

The second sample consists of 19 persons who ordinarily would have been admitted to Moose Lake RTC but instead received services in one of the community hospital contracted beds or in the Eveleth Health Services Park. Inclusion of these persons in the study began in December, 1994 and concluded in March 1997.

Instruments

A number of measurement devices were employed to describe patients in the study and follow their progress:

Mental Health Services Evaluation Client Information Form

This form (Appendix C) provides background and descriptive information on clients. It was completed by a clinical staff person at the discharging facility during the baseline assessment.

Minnesota Mental Health Outcome Questionnaire

This form (Appendix D) is an assessment of client self-perception of quality of life and level of functioning. It was completed by the patient at discharge and at each of the post-discharge community follow-up assessments.

Brief Symptom Index 53

Shown in Appendix E, the Brief Symptom Index 53 (BSI-53) provides a client self assessment of symptomology. It was completed by the patient at discharge and at each of the post-discharge community follow-up assessments.

Mental Health Rater Reaction Form

This form (Appendix F) had clinicians assess the accuracy of the patient self-assessments represented in the Minnesota Mental Health Outcome Questionnaire and the BSI-53. It was completed by a staff member at the discharging facility at the time of discharge and by the patient's case manager at each of the community follow-up assessments.

Treatment Participation Form

This form (Appendix G) had clinicians rate a patient's level of participation in treatment. It was completed by a staff member at the discharging facility and by patient's case manager at each of the follow-up assessments.

Global Assessment Scale

Shown in Appendix H, the Global Assessment Scale (GAS) had clinicians make a summary rating of the client's overall functioning. During the study, it was completed by a staff person at the discharging facility at the baseline assessment and by the patient's case manager at each of the community follow-up assessments.

Minnesota Geriatric Outcome Scale

This form (Appendix I) was developed for the psycho-geriatric patients in the study, and replaces the forms used for the general psychiatric sample. It was completed at baseline assessment by MLRTC staff and at subsequent follow-ups by nursing home staff in the facility.

Community-Based Client Satisfaction Questionnaire

This questionnaire (Appendix J) was mailed to clients in the study twice: four months and eight months following discharge.

Timing of Measurement

Assessment of clients' outcomes took place four times during the course of their participation in the study: once at discharge and three times during post-discharge assessment meetings with their case managers.

Baseline Assessment

The first assessment was at discharge from a facility, either Moose Lake for the MLRTC sample or one of the contract beds or Eveleth Health Services Park for the Community sample. Shortly before departure from a facility, patients were introduced to the study by a member of the facility's clinical staff and asked to participate. Signed consents to be part of the study were obtained from all participants (Appendix K). Patients who agreed to participate in the study were offered a $5.00 incentive for completing the forms at each assessment and an additional $5.00 ($25 total) if they completed all four assessments.

Facilities participating in the study were oriented to research procedures by a member of the research team and provided with a supply of forms, patient cash incentives, and return envelopes. Completed forms for patients participating in the study were sent to MIPH for processing.

Post-Discharge Assessment

Post-discharge assessments took place three times for patients participating in the study. The first assessment occurred one month following discharge, the second follow-up took place six months after the first (or seven months following discharge) and the third and final follow-up was completed six months after the second (or thirteen months following discharge).

The assessments took place at meetings between the clients and their case managers. Case managers were informed by a telephone call from staff at MIPH when a client's post discharge follow-up assessment was due, and received appropriate forms by mail, including a return envelope. Following each of the post-discharge assessments, case managers received confidential feedback on their clients (Appendix L). Later in the research county social service supervisors and others received institutional feedback (Appendix M.)

Implementing the Study

During implementation, steps were taken to assure coordination and cooperation among the many individuals and agencies in the Moose Lake catchment area necessary to the success of the study.

- An initial orientation meeting for County Social Service Supervisors was held at the Moose Lake RTC.
- Individual county supervisors were sent orientation materials by mail, followed by personal telephone calls.
- Staff at the contract bed hospitals and SOS programs were oriented individually to the study and its procedures.
- Special training programs were held in St. Louis County to orient case managers to follow-up procedures.

After the study began, contract bed providers and staff at the Eveleth Health Services Park were phoned periodically to remind staff of the study and to determine if eligible patients were likely to be discharged. Case managers whose clients were included in the study were phoned when follow-ups were due, sent the necessary materials, phoned again if materials were not returned, and sent a reminder letter if they still were not returned within 14 days after due.

COST AND SERVICE UTILIZATION ASSESSMENT

Various efforts have been made to assess the impact of the transition on the costs and utilization of services in the 11 counties comprising the Moose Lake catchment area.

Cost Assessment

The principal goal of the cost assessment was to assure that the 11 counties involved in the transition are not required to assume a greater financial burden providing mental health services to persons with Serious and Persistent Mental Illness. This goal has been addressed two ways:

Process Interviews

As part of the process evaluation, described below, key informants in the Moose Lake transition were asked whether the replacement of Moose Lake RTC had resulted in increased financial burden for the county social service departments.

"Hold Harmless" Monitoring

The second data source for the cost analysis is based on a "Hold Harmless" assessment established by DHS in concert with the counties and based on legislation enacted by the Minnesota State Legislature. The purpose of this legislation is to assure that the 11 counties in the Moose Lake region are not required to assume a greater share of the cost of mental health care as a result of the closure of Moose Lake RTC.

The "Hold Harmless" process monitors changes in mental health costs (MLRTC adult MI unit, MLRTC hold orders, Brainerd RHSC adult MI unit and Brainerd RHSC hold orders and community inpatient costs) for the three years preclosure: 1992, 1993, and 1994, compared to the three years post-closure: 1996, 1997 and 1998, with 1995 being viewed as a year of transition.

Service Utilization Assessment

The purpose of the service utilization assessment was to assure the range and quality of services available to mental health consumers was not diminished by the replacement of the Moose Lake RTC with an enhanced mental health infrastructure. This question will be approached in three ways:

Key Informant Interviews

As part of the process assessment, key informants in the transition were asked about the range and quality of mental health services available subsequent to closure of the Moose Lake RTC and its replacement with an enhanced community-based mental health services infrastructure.

Consumer Satisfaction Assessment

Consumer satisfaction with mental health services was assessed in three ways during the course of the study.

- *Mail Survey* -- As mentioned previously, clients participating in the study were mailed a consumer satisfaction questionnaire at four months and eight months subsequent to discharge. A total of 10 useable questionnaires were returned. This is a return rate of approximately 5%.

- *Telephone Survey* -- A telephone survey (Appendix N) was also undertaken to obtain consumer feedback on the quality of services received and available. A total of 10 completed interviews were obtained out of 11 attempted.

- *Consumer Discussion Groups* -- Consumer satisfaction was also assessed through three discussion groups. Discussion groups with mental health services consumers were held in Duluth, Cambridge and Grand Rapids, using the discussion outline in Appendix O. A total of 42 consumers participated in the discussion groups.

Comparison of Client Treatment Participation

Level of actual client participation in mental health services was estimated through clinician rating of treatment participation. At discharge and at all follow-ups, three dimensions were assessed: degree of treatment participation, compliance with medication regimen and role in treatment plan.

Comparison of Client Reported Service Use

The final means for assessing service use was comparison of the reported service use by patients discharged from the MLRTC with reported service use by clients discharged from one of the contract bed hospitals or SOS programs.

PROCESS ASSESSMENT STRATEGY

Supplementing the client outcome and cost and service utilization studies in this report is an assessment of the planning and implementation process guiding the Moose Lake transition.

Method

In-person and telephone interviews were used to obtain the perceptions and experiences of key informants in the planning and implementation process. A total of 54 interviews were completed.

Informants

Informants include those directly involved in the planning as well as those with an interest in the outcome of the planning process. The composition of the sample is shown in Tables 1 and 2. The list of people participating in the assessment is included in Appendix P.

Informants for the planning process assessment were identified using snowball sampling. Beginning with a list of nominations from the Department of Human Services and supplementing this list with persons identified during implementation of the client outcome evaluation, the sample was developed by asking each, "Who else should I talk to?"

Table 1
Organizational Affiliation of
Process Evaluation Informants

AFFILIATION	N	%
County Social Service Department	22	41%
Mental Health Provider	11	20%
Contract Hospital	9	17%
MLRTC or SOS	6	11%
Department of Human Services	3	5%
Other	3	6%
TOTAL	54	100%

Table 2
Geographic Location of Process Evaluation Informants

LOCATION	N	%
North Region	35	64%
Southern Region	16	30%
State Agencies	3	6%
TOTAL	54	100%

NOTE: The Northern Region consists of St. Louis, Carlton, Cook, Lake, Koochiching, and Itasca Counties. The Southern Region consists of Chisago, Isanti, Kanabec, Pine and Mille Lacs Counties.

Interview Schedule

The interview schedule used in the process assessment had four sections, described below. The full content of the process evaluation interview schedule is located in Appendix Q.

Planning and Implementation

This section addresses planning and implementation of the Moose Lake area transition, with particular emphasis on factors influencing the success of the planning.

Current Status

Questions in this section focus on the current status of the services available subsequent to the transition.

Critical Incidents

In this section, informants were asked to identify critical incidents in the planning and implementation of the transition.

Further Inquiry

Informants are asked in this section to, first, suggest others, either individuals or groups, who should be included in the process evaluation and, second, to propose questions to be addressed by the evaluation of the transition.

RESULTS

This section summarizes and analyzes the client outcome, cost and service utilization and planning process assessment components of the study.

CLIENT OUTCOMES ASSESSMENT

The client outcomes component of the study involved tracking persons who had received inpatient mental health services from the Moose Lake RTC and comparing their clinical outcomes with persons who had received inpatient services at one of the participating contract bed hospitals or a SOS program.

The client outcomes assessment section contains the following parts:

"Client recruitment" accounts for success in attracting clients into the study. "Sample attrition" accounts for retention of participants. "Description of sample" compares the RTC and contract hospital groups on a scale of demographic, clinical and treatment variables. "Consumer self report of functioning" compares the RTC and contract bed samples over the four assessment points on three outcome scales: the BSI General Symptom Index (GSI), the Level of Functioning Scale (LOF) and the Quality of Life Scale (QOL) from the Minnesota Mental Health Outcome Questionnaire. "Clinical report of client functioning" compares clinician Global Assessment scale ratings at each of the four assessment points. "Clinician assessment of geriatric sample" shows clinician ratings of geriatric sample level of functioning over time.

Client Recruitment

Clients were recruited into the study at a number of sites. Table 3 shows the number of clients recruited at each site and, where possible, gives an estimate of the percent of eligible clients at that site who could have been recruited into the study.

Table 3
Number and Percent of Eligible Clients Recruited at Each Site
Between January 1, 1995 and March 30, 1996

SITE	Number Eligible	Number Offered	Percent Offered
RTC Group			
Moose Lake RTC	160	76	48%
COMMUNITY GROUP			
Miller-Dwan	19	4	21%
Mesabi	41	11	27%
Isanti	5	1	20%
Cambridge	12	1	8%
Eveleth	31	5	16%

Table 3 suggests not every person who could have been offered participation was given a chance to be involved. Discussions with staff at the intake sites suggest the following reasons for this circumstance:

1. Confusion about which clients were eligible for the study.

2. Quick and unpredictable discharges of clients, which prevented participation from being offered.

3. Lack of staff time at the site to present the study to the client.

Sample Attrition

Table 4 compares Moose Lake RTC and community samples regarding client recruitment and continued participation in the study.

Table 4
Participating Clients in Moose Lake Area

SITE	Base	1 Month Follow-up	7 Month Follow-up	13 Month Follow-up
MLRTC Sample				
Participating	48	30	28	30
Unable/missing/refused	28	17	19	17
PERCENT REMAINING ACTIVE	63%	39%	37%	39%
GERIATRIC Sample				
Participating	31	30	22	24
Unable/missing/refused	1	1	9	7
PERCENT REMAINING ACTIVE	97%	94%	68%	75%
COMMUNITY SAMPLE				
Participating	19	14	11	9
Unable/missing/refused	3	5	6	10
Percent Participating	86%	64%	50%	41%

NOTE: The percentages in the table are based on the total number of patients initially eligible to participate: 76 for MLRTC, 32 for Geriatric, and 22 for Community samples.

At the first follow-up, one month following discharge, less than half (37%) of Moose Lake RTC patients and approximately two thirds (64%) of clients discharged from one of the contract hospitals or SOS programs who were initially asked to participate in the study were still active. Most geriatric patients were active (94%) at the first follow-up and three quarters (75%) were active throughout the study.

Discussions with staff at participating intake facilities, county case managers, and county social service supervisors suggests the following explanations for the failure of clients to continue in the study:

- Client inability and/or unwillingness to complete the forms once they were outside a structured setting.
- Inability of case managers to locate clients once they have left the discharging facility.
- Unwillingness of case managers to threaten rapport with clients by applying too much pressure to continue.
- Case manager losing the forms or forgetting to bring them to meetings with clients.
- Poor match between the regularly scheduled meetings of clients and their case managers and the times of follow-up for the study.

Informal discussions with case managers reveal that many appreciated the clinical feedback that was part of the study and feel such is an incentive for encouraging clients to continue participation. Problems with follow-up are examined more fully in the Discussion chapter of this report.

Comparison of patients who refused and agreed to participate in the research does reveal significant differences between the two groups on diagnosis. As can be seen in Table 4a, people diagnosed with schizophrenia were more likely to refuse than participate.

Table 4a
Comparison of MLRTC Area Patients Who Agreed and Refused to Participate by Diagnosis

	Refused	Agreed
Schizophrenia	50%	29%
Affective Disorder	24%	16%
Schizoaffective Disorder	15%	15%
Other	9%	20%
Not Recorded	3%	20%
TOTAL %	100%	100%
N	34	69

Description of Sample

The Moose Lake and Community samples of clients who began participation in the study are described according to demographics, treatment process and clinical variables in Tables 5 to 10, on the next pages. The MLRTC sample is broken into two subgroups: geriatric patients (discharged to nursing homes) and general psychiatric patients (discharged to the community).

Demographic Variables

Tables 5, 6 and 7 on the next pages compare the MLRTC and Community samples according to sex, race and age. As these tables show, the two samples are generally comparable on age and race. As should be expected, the geriatric sample is considerably older than Moose Lake patients and patients in the Community sample.

Clinical Variables

Tables 8 and 9 compare the MLRTC and Community samples according to mean GAS score and diagnostic category. GAS scores are not available for the MLRTC geriatric sample. The MLRTC sample is generally comparable with the Community sample on discharge GAS score. The MLRTC and Community samples are also generally comparable on discharge diagnosis, the most frequent diagnosis being schizophrenia and schizoaffective disorder.

Treatment Process Variables

Table 10 compares the MLRTC and Community samples according to inpatient length of stay. As might be expected, the Geriatric MLRTC sample has a much greater length of stay than the Brainerd MLRTC sample and the Geriatric and Brainerd samples both exceed the MLRTC General sample. All three MLRTC sample cases greatly exceed the length of stays in the community contract bed hospitals and SOS programs.

Table 5
Mean Patient Age for MLRTC Sample and Community Samples

AGE	Geriatric Sample	MLRTC Sample	Community Sample
Number	19	73	22
Mean	61.1	38.48	39.78
Range	50-88	19-61	21-72

Table 6
Patient Gender for MLRTC and Community Samples

SEX	Geriatric Sample	MLRTC Sample	Community Sample
Male	55%	55%	57%
Female	45%	45%	42%
Unknown	0%	0%	1%
Total %	100%	100%	100%
N	31	76	22

Table 7
Patient Race for MLRTC and Community Samples

RACE	MLRTC General Sample	Community Sample
White	84%	100%
Black	0%	0%
Native American	5%	0%
Asian	4%	0%
Unknown	4%	0%
Total %	100%	100%
N	76	22

*Chi square not significant p=.05

Table 8
Patient Global Assessment Score at Discharge

GAS SCORE	MLRTC Sample	Community Sample
Number	71	19
Mean	53.48	54.00
Range	40-81	35-70

*t not significant p=.05

Table 9
Discharge Diagnosis for MLRTC and Community Samples

DIAGNOSIS	MLRTC Sample	Community Sample
Schizophrenia	32%	36%
Bipolar Disease	16%	5%
Depression	5%	9%
Schizoaffective Disorder	17%	9%
Chemical Dependency	5%	9%
Other	8%	23%
Not Recorded	17%	9%
Total %	100%	100%
N	76	22

Chi square not significant p=.05

Table 10
Mean Patient Length of Stay (LOS) in Days for MLRTC Sample and Community Sample

LOS	MLRTC Sample	Community Sample
Number	73	22
Mean	425.03	39.88
Range	15-4992	7-76

t significant p=.001

Self Report of Functioning

Tables 11, 12 and 13 on the next pages compare the MLRTC Community samples on various scales related to self reports of clinical symptomatology, level of functioning, and quality of life. This listing does not include the Geriatric Sample, which is described separately. The three measures used in the comparison are

General Symptom Index: A summated scale from the BSI which ranges from 0 to 100, with a higher score indicating a lesser severity of psychotic symptoms reported by the client. There is a modest upward trend for both the MLRTC and community sample on this measure. The differences between the two samples over time are not significant.

Level of Functioning: This is a scale of items from the Minnesota Mental Health Client Outcome instrument. The items range from 0 to 100, with higher scale values indicating a higher reported level of client functioning.

Quality of Life: This scale of items from the Minnesota Mental Health Client Outcome instrument ranges from 0 to 100, with higher scale values indicating a higher level of reported client quality of life. Scores on this measure remain relatively unchanged for both the MLRTC and Community samples.

Psychoticism Score: A summated scale from the BSI which ranges from 0 to 4, with a higher score indicating a greater severity of psychotic symptoms reported by the client. There is a modest upward trend for both the MLRTC and community groups on this measure.

The results for each of these measures, including discussion of any observed statistical significance, will be discussed following the tables.

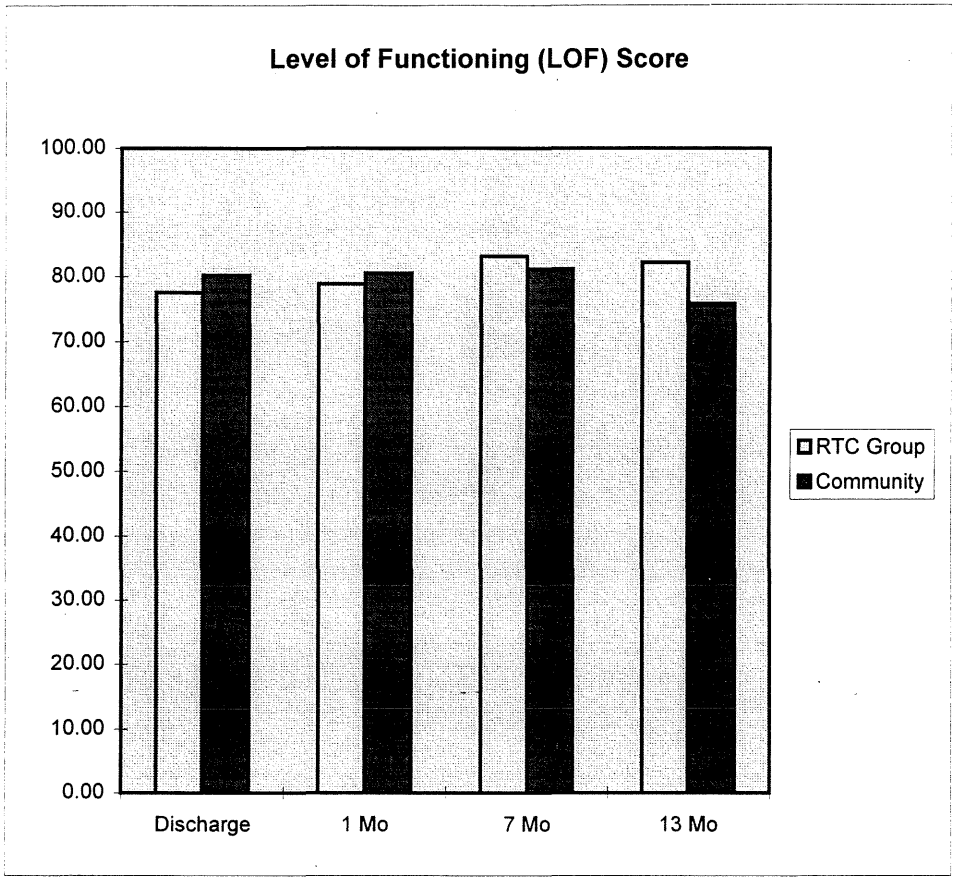


Table 11: Level of Functioning (LOF) Score At All Assessment Points for Moose Lake RTC and Community Group

		Discharge	One Mn F-up	Seven Mn F-up	Thirteen Mn F-up
RTC Group	Mean	77.53	78.86	83.14	82.15
	N	48	31	30	27
Community Group	Mean	80.21	80.47	81.16	75.84
	N	18	14	9	11

Note: None of the mean differences are significant at p=.05.

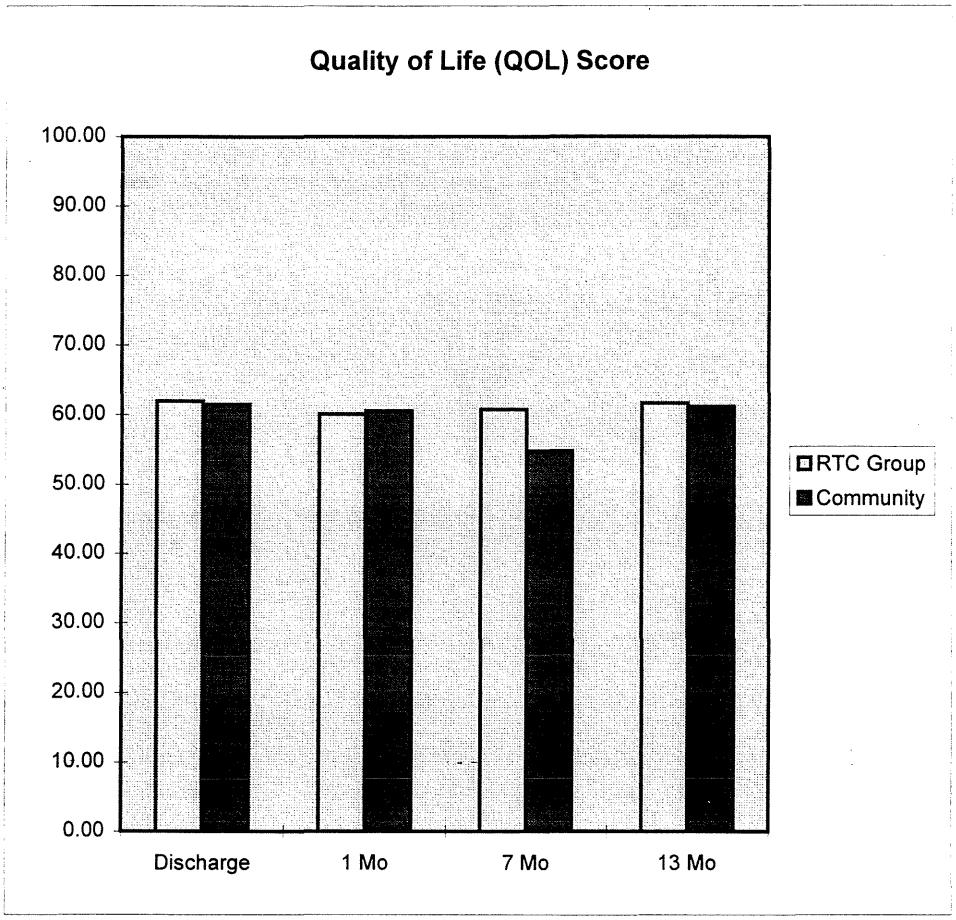


Table 12: Quality of Life (QOL) Score At All Assessment Points for Moose Lake RTC and Community Group

		Discharge	One Mn F-up	Seven Mn F-up	Thirteen Mn F-up
RTC Group	Mean	61.96	60.05	60.76	61.69
	N	48	30	30	27
Community Group	Mean	61.51	60.51	54.76	61.17
	N	18	14	9	11

Note: None of the mean differences are significant at p=.05.

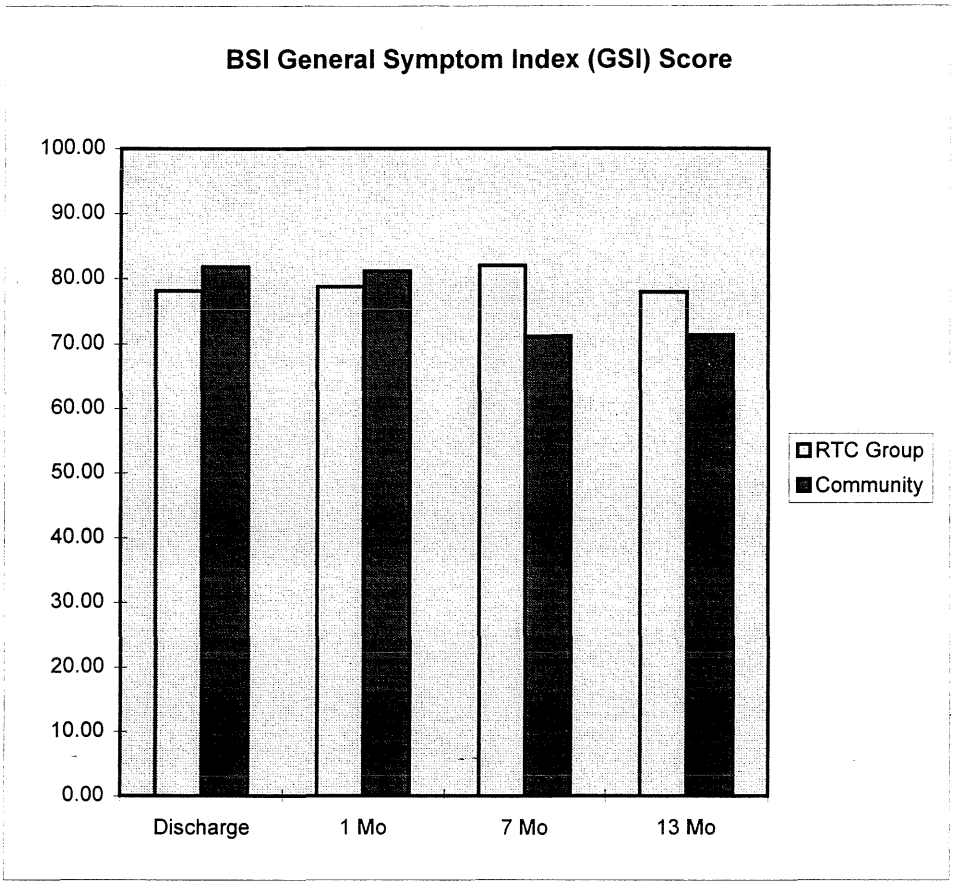


Table 13: BSI General Symptom Index (GSI) Score At All Assessment Points for Moose Lake RTC and Community Group

		Discharge	One Mn F-up	Seven Mn F-up	Thirteen Mn F-up
RTC Group	Mean	78.16	78.71	81.98	77.93
	N	48	29	30	27
Community Group	Mean	81.80	81.12	71.12	71.30
	N	19	14	9	11

Note: None of the mean differences are significant at p=.05.

Note: The GSI scale has been inverted so that higher scores indicate higher mental health functioning

Clinician Assessment of Client Functioning

Table 14 on the next page compares the MLRTC samples and Community samples regarding clinician report of client functioning. The basis for this assessment is the Global Assessment Scale (GAS), a clinician rating of functioning which ranges from 0 to 100, with higher scores indicating a higher level of functioning.

The GAS scores generally show a modest decrease in clinician rating of functioning from the baseline assessment to the one month follow-up for the MLRTC but not for the Community group. It should be noted that different raters are making this assessment.

Outcomes According to Diagnosis

The comparatively high number of unrecorded discharge diagnoses make it problematic to analyze differences in outcome as a function of diagnosis. Table 15 shows outcomes in each sample at each follow-up for persons with schizophrenia compared with persons with all other types of discharge diagnosis. The differences at each follow-up are not significant.

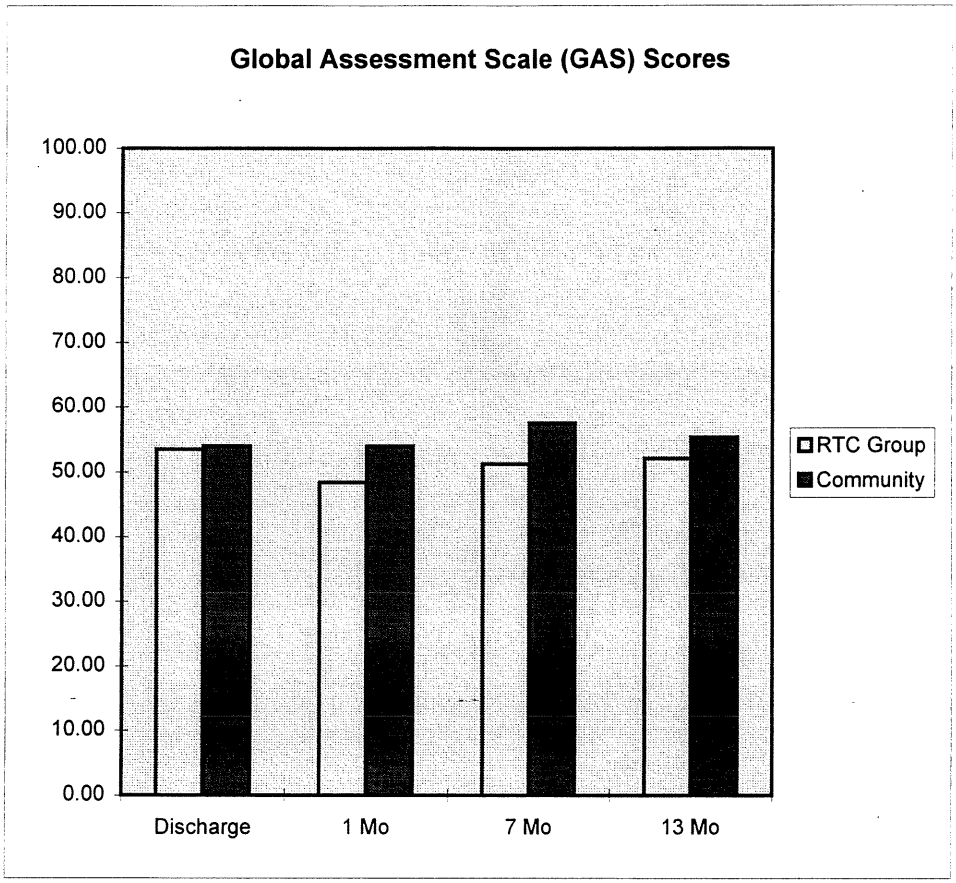


Table 14: Global Assessment Score At All Assessment Points for Moose Lake RTC and Community Group

		Discharge	One Mn F-up	Seven Mn F-up	Thirteen Mn F-up
RTC Group	Mean	53.47	48.41	51.27	52.11
	N	71	29	33	27
Community Group	Mean	54.00	54.00	57.55	55.36
	N	19	16	11	11

Note: Different raters assigned Discharge GAS scores compared with the three community follow-ups.

Note: None of the mean differences are significant at p=.05.

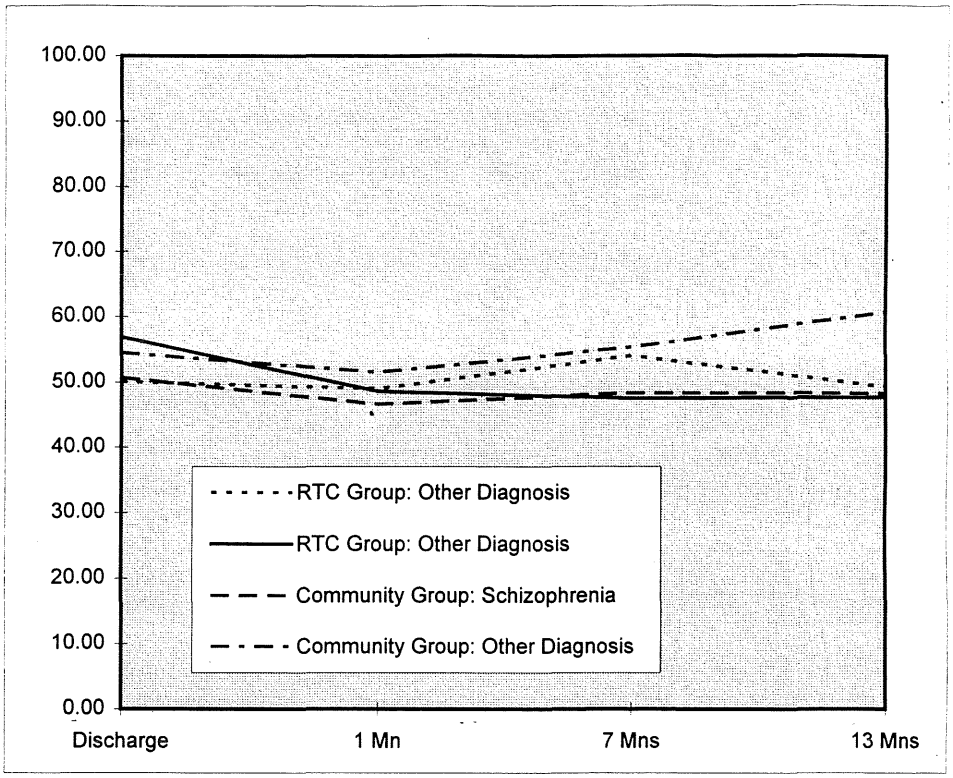


Table 15 Global Assessment Score At All Assessment Points for Moose Lake RTC and Community Group by Grouped Diagnosis

			Discharge	One Mn F-up	Seven Mn F-up	Thirteen Mn F-up
RTC Grp	Schiz	Mean	50.09	49.00	54.00	49.30
		N	21	7	8	10
	Other	Mean	56.88	48.57	47.5	47.67
		N	17	7	6	6
Com Grp	Schiz	Mean	50.67	46.60	48.33	48.33
		N	6	5	3	3
	Other	Mean	54.50	51.50	55.33	60.67
		N	4	4	3	3

Note: Different raters assigned Discharge GAS scores compared with the three community follow-ups.

Note: None of the mean differences are significant at p=.05.

Clinician Assessment of Geriatric Sample

Table 16 on the next page shows the progress over time of the 31 MLRTC clients in the geriatric sample. The scores shown are derived from items in the Minnesota Geriatric Outcome Questionnaire. These scales are generally comparable to those derived from the Minnesota Mental Health Outcome Questionnaire used by the general MLRTC sample

Although there is a slight decline in the geriatric scores, as should be expected in an older and frailer group of clients, the overall picture seems to be one of stable functioning for the geriatric sample.

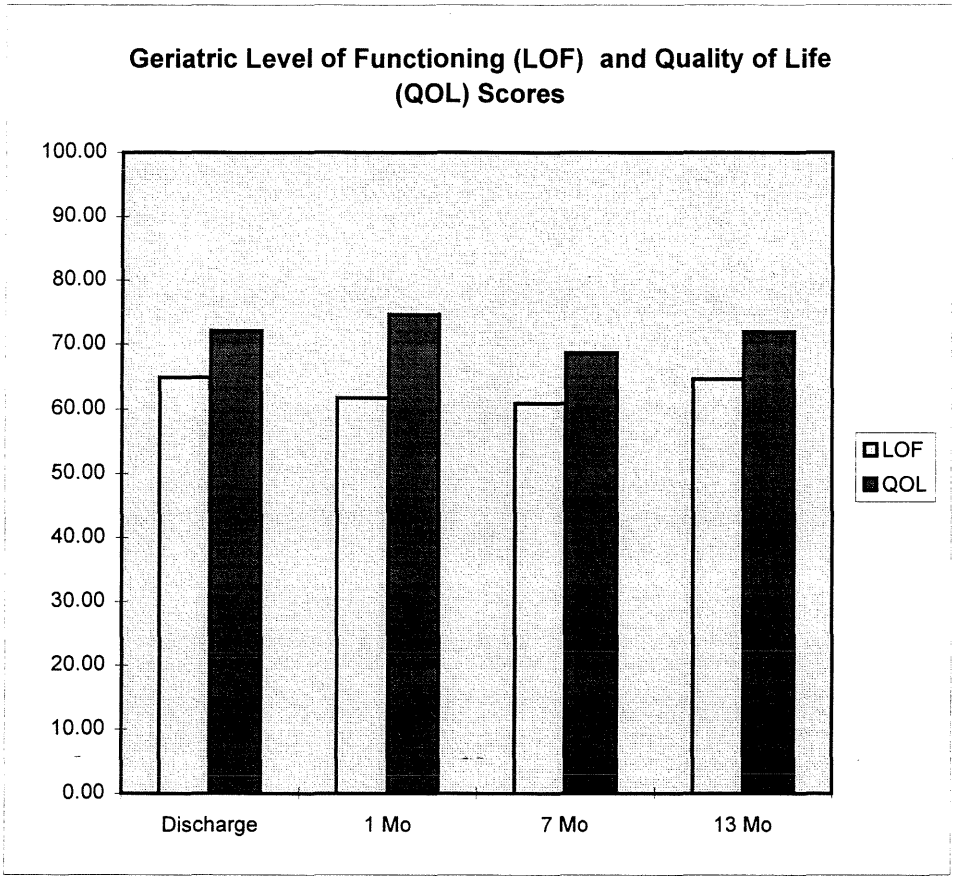


Table 16: Level of Functioning (LOF) Score At All Assessment Points for Moose Lake RTC Geriatric Group

		Discharge	One Mn F-up	Seven Mn F-up	Thirteen Mn F-up
LOF	Mean	64.88	61.73	60.87	64.62
	N	27	25	20	19
QOL	Mean	72.07	74.58	68.67	71.89
	N	13	15	13	14

Note: None of the mean differences are significant at p=.05.

COST AND SERVICE USE ASSESSMENT

An attempt was made to assess changes in the financial burden sustained by the 11 counties in the Moose Lake area as a result of the transition, as well as changes in client service use and satisfaction.

Cost Assessment

Two mechanisms assessed the impact of the transition on county mental health costs:

"Hold Harmless" Study

The first mechanism is based on a process agreed upon by the Moose Lake area counties and the Mental Health Division of the Minnesota Department of Human Services to compare the actual public mental health costs in the catchment area before and after the transition. Table 17 shows figures from 1992 to 1994 (prior to the transition), compared with figures from 1995 and 1996 (after the transition). As can be seen, in 1996 all but one of the counties reported expenditures below the per transition baseline.

Table 17
Hold Harmless CY 96 for Moose Lake Catchment Counties
County Share of Funding Only

	1996 Actual County Expenditures	1996 Hold Harmless Adjusted Baseline	Amount Above/Below () Baseline	Percent Above/Below () Baseline
MLRTC Region	$1,226,274	$2,160,130	($933,856)	-43%
Region III	$951,022	$1,631,375	($680,353)	-42%
Region VII E	$275,252	$528,755	($253,503)	-48%
Carlton	$69,793	$178,439	($108,646)	-61%
Chisago	$66,138	$174,017	($107,879)	-62%
Cook	$2,195	$13,214	($11,019)	-83%
Isanti	$78,888	$135,982	($57,094)	-42%
Itasca	$147,055	$110,503	$36,552	33%
Kanabec	$15,668	$42,615	($26,947)	-63%
Koochiching	$17,721	$74,597	($56,877)	-76%
Lake	$6,528	$13,846	($7,317)	-53%
Mille Lacs	$58,930	$85,969	($27,040)	-31%
Pine	$55,628	$91,055	($35,426)	-39%
Saint Louis	$707,730	$1,241,112	($533,383)	-43%

NOTE: The 1996 Hold Harmless baseline figure includes an adjustment for increased RTC per diems, but does not include estimated county population increases. The Hold Harmless figures are based on the county share of expenditures (Poor Relief and Hold Orders) for RTC inpatient use of Brainerd and Moose Lake and Eveleth after the Moose Lake closure. It also includes community hospital orders and the county share of State Operated Services.

Key Informant Assessment of County Costs

The second means to assess the impact of the Moose Lake transition on county costs was analysis of key informant process interviews. As part of these interviews, informants were asked: "Were issues related to costs adequately addressed during planning? Have the counties been 'held harmless' as required by the legislation?"

While many key informants felt it was too soon to fully answer this question, of the 26 respondents stating an opinion, more than three-quarters (77%) felt that it was likely that the counties were not sustaining an increased burden as a result of the closure of Moose Lake and its replacement with an enhanced, community-based mental health infrastructure.

Service Utilization and Consumer Satisfaction

Service use and consumer satisfaction with services were addressed in three ways: key informant interviews, a three-part consumer satisfaction assessment, and reported service use utilization to the Community Mental Health Reporting System (CMMHRS).

Key Informant Assessment of Quality of Services

Key informants were asked about the range and quality of mental health services available subsequent to the closure of the Moose Lake RTC and its replacement with an enhanced, community-based mental health services infrastructure.

When asked the question, "At the present time, are individuals with SPMI in the Moose Lake area receiving a worse, the same, or a better level of mental health services since the closure of the RTC?" As can be seen in Table 18, almost three-quarters (73%) thought services were better, seven percent thought they are the same and 4% think they are worse.

Table 18
Key Informant Interview:
"Are Mental Health Services in the Moose Lake Area Worse, Same, or Better Since Transition?"

CHANGE IN MH SERVICES	County Associated	State Employee	MH Provider	Contract Hospital	TOTAL
Better	71%	56%	82%	86%	73%
Same	18%	11%	18%	0%	14%
Worse	7%	0%	0%	0%	4%
No Answer	4%	33%	0%	14%	9%
TOTAL %	100%	100%	100%	100%	100%
N	28	9	11	7	55

Chi square not significant p=.05

Among the more frequent explanations for believing mental health services have improved for persons experiencing SPMI are the following:

- **More and better crisis services.** Said a county case manager, "Consumers experiencing stress have more means of support available to them. As a case manager I have options rather than putting people back in the hospital."

- **More and better outreach services.** A SOS staff member commented, "Because we have more services to put into the community, we are able to keep track of people and intervene much earlier in the illness, before they need lengthy and expensive hospitalization."[2]

- **Improved drop-in and social programs for clients.** Said a mental health care provider, "Clubhouses and other truly client-oriented programs are wonderful. They keep people involved and give them something to do besides smoke cigarettes and watch television."

[2] A SOS person told the following story. "I was a ward nurse at Moose Lake and know many of the people who have been at Eveleth. Before, we would have to wrestle them into restraints. Now they come in the door, shake my hand and say 'Hi. I'm here for a tune up."

- **Flexible funding.** Said a county social service supervisor, "The flexible funds give us options to be creative. Within limits, we can do what is necessary to help a client stay where they belong -- in the community."[3]

- **More choice for clients.** A county social service supervisor commented, "Because more programs have been created, clients have more options. They can go elsewhere if they are not respected. This means they receive more respect."

- **Improved coordination and cooperation among service providers.** A number of people involved in planning for the transition commented on the new spirit and a new structure which seem to exist in the Moose Lake area. There are program and client level groups which meet on a regular basis to improve the efficiency and effectiveness of public mental health services.

RANGE OF SERVICES -- When asked the question, "At the present time, is the range of services available for individuals with SPMI in your area worse, the same, or better since the transition?" More than four-fifths (86%) thought the range of services is better, six percent think they are the same and zero percent think the range of services is worse (see Table 19, below).

Table 19
Is the Range of Mental Health Services in Moose Lake Area Worse, Same or Better Since Transition?

RANGE OF MH SERVICES	County Associated	State Employee	MH Provider	Contract Hospital	TOTAL
Better	79%	78%	100%	100%	86%
Same	14%	0%	0%	0%	7%
Worse	0%	0%	0%	0%	0%
No Answer	7%	22%	0%	0%	7%
TOTAL %	100%	100%	100%	100%	100%
N	28	9	11	7	55

Chi square not significant p=.05

[3] A social service supervisor recounted a story about one of the clients in his county who was a chicken farmer. The client needed to be hospitalized for a short time, but would lose all his chickens if that happened. The county arranged for chicken feed to be purchased so that the farmer would still have his birds and his livelihood when he left the hospital."

The following were mentioned most frequently as additional services needed:

- **Outpatient psychiatry**. Said a case manager, "There are too few psychiatrists in this community. We use 'Rent-a-Docs' who are only here for a short time. This makes medications management a nightmare. And there is very little physician rapport with the client."

- **Transportation**. Said a provider, "Too many clients are isolated in their homes. In rural parts of the state it is really difficult to move around if you don't have a car."

- **Housing**. Said a case manager, "Finding safe and affordable places for people to live is difficult. Many are in restrictive settings simply because there is no alternative."

- **Support to reduce case manager case loads**. A county social service supervisor commented, "Most case managers would like to do a lot more, but when they have sixty clients it's difficult."

Consumer Satisfaction Assessment

Consumer satisfaction with mental health services was assessed in three ways during the course of the study:

Satisfaction Surveys

Persons participating in the study were mailed a consumer satisfaction questionnaire at four months and eight months subsequent to discharge.

A telephone survey was also undertaken to obtain consumer feedback on the quality of services received and available.

The small sample size makes meaningful comparison of the samples problematic. In general, however, both samples were satisfied with services.

Consumer Discussion Groups

Consumer satisfaction was also assessed through three discussion groups. A total of 42 consumers participated in these groups. A full summary of the results of these discussions is shown in Appendix R.

In general, there seems to be no differences between consumers who received inpatient services in Moose Lake RTC and in the contract bed hospitals or one of the SOS programs. Consumers who participated in the discussion groups seemed mostly concerned about:

- Crisis services. Said one consumer, "I need to know there is someone I can talk to late at night, and someplace I can go where they care about me." Said another, "The things I struggle with do not work according to business hours."

- Case management services. All discussion group participants were positive about the quality of case management services and about the willingness of their case manager to help them. Some, however, reported difficulty keeping in contact with their case manager because of burgeoning caseloads. Said one consumer, "I leave a message on the answering machine but sometimes it's days before I get an answer."

- Housing. Housing was a major concern. Many participants complain that lack of adequate low income housing means that consumers can be forced to stay in inappropriate or overly restrictive lodging. Some participants also felt that landlords were "gouging and exploiting" consumers, while waiting lists of publicly supported housing are too long. Many participants called for greater help and support for consumers to find homes and be able to remain in them.

- Employment. Employment was also a major issue for many participants. Many consumers wish to work but have difficulty obtaining work training and assistance in finding jobs that pay a living wage. New efforts like Project Employability are promising, but there are often waiting lists and it is not clear if these programs will continue to be funded over time.

- Medications management. Because of problems with medical coverage, some consumers were not able to see the psychiatrist they wished. Others felt that their psychiatrist did not spend enough time with them. Still others were not able to see the same psychiatrist consistently and felt they had to change medications too often and unnecessarily.

Comparison of Client Treatment Participation

Tables 20, 21 and 22 compare the MLRTC and community samples on three treatment participation variables: degree of participation, medication compliance, and active role in planning. As can be seen, there is little difference over time between the two samples.

Table 20
Comparison of Clinician Assessment
Treatment Participation of MLRTC and Community/SOS Samples

TREATMENT PARTICIPATION	Base	1 Month Follow-up	7 Month Follow-up	13 Month Follow-up
MLRTC Sample	7.26	8.15	7.58	7.50
N =	27	21	21	25
Community Sample	8.88	2.21	8.10	6.50
N =	16	19	10	9

Note: Treatment participation is given by a rating from 1 to 10, with 10 being high.
Note: None of the mean differences are significant at p=.05.

Table 21
Comparison of Clinician Assessment
Medications Compliance of MLRTC and Community Samples

MEDICATIONS COMPLIANCE	Base	1 Month Follow-up	7 Month Follow-up	13 Month Follow-up
MLRTC Sample	3.86	3.80	3.50	3.96
N =	27	20	24	25
Community Sample	3.88	4.00	3.70	4.00
N =	16	19	10	9

Note: Medications compliance is given by a rating from 1 to 5, with 5 being high compliance.
Note: None of the mean differences are significant at p=.05.

Table 22
Comparison of Clinician Assessment Consumer Participation in Treatment Planning of MLRTC and Community Samples

TREATMENT PLANNING	Base	1 Month Follow-up	7 Month Follow-up	13 Month Follow-up
MLRTC Sample	3.45	3.70	3.50	3.52
N =	27	20	24	25
Community Sample	3.44	3.37	3.50	2.50
N =	16	19	10	9

Note: Participation in treatment planning is given by a rating from 1 to 5, with 5 being high.
Note: None of the mean differences are significant at p=.05.

Comparison of Client Reported Service Use

Table 23 compares the Moose Lake RTC and Community samples regarding reported use of services following discharge. While the sample sizes are limited, it appears there are no apparent differences between the two groups in access to and use of community services.

Table 23
Comparison of Client Reported Service Use for MLRTC and Community Samples

TYPE OF SERVICE	Base	1 Month Follow-up	7 Month Follow-up	13 Month Follow-up
Drop-in Center				
MLRTC Group	35%	26%	30%	27%
Community Group	39%	43%	27%	33%
Food Shelves				
MLRTC Group	17%	29%	14%	7%
Community Group	24%	13%	18%	33%
Free Hot Meals				
MLRTC Group	17%	10%	14%	13%
Community Group	6%	7%	18%	11%
Self Help Groups				
MLRTC Group	51%	48%	39%	44%
Community Group	55%	43%	45%	36%
Counseling by Clergy				
MLRTC Group	50% **	33% **	54% **	43%
Community Group	6%	7%	9%	11%
Emergency Room				
MLRTC Group	40%	19%	23%	23%
Community Group	33%	35%	36%	44%
Police or Sheriff Assistance				
MLRTC Group	22%	7%	15%	20%
Community Group	39%	7%	27%	11%
Crisis/Emergency Center				
MLRTC Group	23%	10%	19%	23%
Community Group	9%	14%	45%	33%
Crisis Hotline				
MLRTC Group	26% **	13%	15%	20%
Community Group	9%	21%	46%	44%
Case Management				
MLRTC Group	65%	71%	77%	90%
Community Group	89%	92%	91%	89%
Day Treatment Programs				
MLRTC Group	45%	43%	50%	43%
Community Group	72%	46%	45%	38%
Community Support Programs				
MLRTC Group	38%	52%	48%	41%
Community Group	33%	29%	36%	22%
Inpatient Hospital Services				
MLRTC Group	52%	16%	38%	32%
Community Group	89%	43%	54%	44%
NUMBER OF CASES				
MLRTC Group	48	31	26	28
Community Group	18	14	11	9

* Percents indicate proportion of clients stating they use the service at least once a month.
** Chi square significant at p=.05.

PLANNING PROCESS ASSESSMENT

As was described in the Methods section of this report, the Moose Lake transition planning process was assessed through interviews with participants and close observers of the process. This section summarizes selected sections of the interviews.

Overall Assessment of the Planning Process

Informants in the planning process assessment were asked the following question: "Overall, how successful was planning for and implementation of the Moose Lake transition?"

As can be seen in Table 24, no informant thought the planning process was unsuccessful and 80% thought it was "very" or "somewhat" successful.

Table 24
Key Informant Interview:
"How Successful Was Planning for and Implementation of the Moose Lake Transition?"

ASSESSMENT	County Associated	State Employee	MH Provider	Contract Hospital	TOTAL
Very Successful	22%	33%	36%	43%	29%
Mostly Successful	61%	45%	36%	29%	51%
Neither	11%	11%	28%	14%	14%
Mostly Unsuccessful	0%	0%	0%	14%	2%
Very Unsuccessful	4%	0%	0%	0%	2%
No Answer	4%	0%	0%	0%	2%
TOTAL %	100%	100%	100%	100%	100%
N	28	9	11	7	55

Chi square not significant p=.05

The following are typical elaborations regarding informant ratings of the success of the transition:

- "I am very happy with what we accomplished. I don't know how it could have been better." (Rated: Very Successful)
- "It was a lot of work, but the final product was worth the effort." (Rated: Mostly Successful)
- "I'm a hard grader. There is always something that could have been done better." (Rated: Mostly Successful)

- "I don't know how successful it's been. Come back in a year . . . when things are fully operational. And things have had a chance to settle into place." (Rated: Neither)

Strengths of the Process

Various factors were mentioned as contributing to the success of the planning process:

Inclusiveness

Many informants pointed to the inclusiveness of the planning process, both at the regional and the local levels, as being important. Said one informant, "Everyone was at the table."

Openness and Honesty

Also important to many participants was the openness and honesty of the planning discussions. One informant commented, "There were real differences in philosophy going in, and jobs and programs were on the line. Yet we managed to stay focused . . . and at the end we were able to smile and shake hands."

Clear and Specific Focus

A number of informants mentioned the clear and specific focus of the planning as contributing to the openness of the process. "The key element," said one informant, "was agreement to focus on consumer needs. When things got tense someone would say, 'What's in the best interest of the consumer?'"

Authority to Plan Locally

The importance of authority to plan locally was mentioned consistently. Remarked one informant, "I was suspicious from the start. I know others were too. I thought we were wasting our time [and] that the state would take over. But they never did." Another put it more directly, "Promises that were made, were kept."

Assistance and Support

Information and technical assistance at both the local and regional levels were generally seen by informants as useful. Said one informant, "When we had questions, we got answers. [DHS] was very responsive."

Money and Resources

The availability of sufficient resources for new programming was frequently mentioned as important. One informant commented, "The process worked because we had real resources to work with and the freedom to put them where they needed to be."

Continued Coordination and Communication

An important outgrowth of the project to many informants was the continuing coordination and communication among agencies and programs that is evident in the area. In both the southern and northern regions, planning, monitoring, and treatment coordination groups that were developed in the planning process continue to meet.

Weakness of the Process

Some weaknesses of the Moose Lake transition planning process were also mentioned:

Not Inclusive

While a strength of the process to many was its inclusiveness, some informants felt that not everyone was involved who should have been. Concern was expressed that planning was an exclusive prerogative of mental health professionals, that others such as consumers and allied professionals (e.g. law enforcement, public health) were not given an opportunity to participate. Some concern was also expressed that the perspective of case managers was not fully represented in negotiations, although many of the case managers interviewed felt they had been fully involved and informed.

Not Comprehensive

A few informants were concerned that important decisions regarding the transition were made outside the process. Most of these concerns had to do with the legislative agreement to safeguard the jobs of RTC employees through the creation of the SOS programs.

State Bureaucracy

Also troubling to some informants was the cumbersomeness of state government bureaucracy. Particular concern was expressed about the difficulty in obtaining signed services contracts on time and in obtaining the necessary licenses and permits to open the SOS programs.

Client Eligibility Problems

A number of informants expressed concern regarding the difficulty of placing Medicare-eligible in the contract beds. Said one case manager, "That screw-up has really hindered the start-up of the program."

Delays in Start-up

Some informants expressed dissatisfaction with the delays in fully implementing the transition. Problems in determining sites and implementing SOS programs and in resolving the Medicaid/Medicare eligibility conflicts were frequently noted.

Brainerd HSC Not Involved

A number of informants suggested that there were difficulties in coordinating admissions to Brainerd HSC and that this could have been worked out earlier if representatives from the facility had been involved in planning.

Problems Integrating Local and Regional Planning

A few informants felt that the usefulness of the regional planning sessions at MLRTC was hindered by poor integration of the information from these sessions into local planning.

Demands of the Process

Many informants commented on the time demands of the planning process and on the difficulty of completing the work when "things got rushed at the end."

Assessment of the SOS Programs

Informants were asked two questions about the role of the SOS programs in the success of the transition.

SOS Competition

Informants were asked, "Do the SOS programs compete with or supplement the provision of established community health services?"

As can be seen in Table 25 on the next page, two thirds of informants (66%) feel that the SOS programs primarily supplement the existing community mental health system. Five percent feel the SOS programs offer competition. Many informants seemed to agree with the sentiments of a county case manager, "The potential for competition is always there, but the SOS programs have worked hard to fill gaps."

Table 25
Key Informant Interview:
"Do SOS Programs Compete With or Supplement the Provision of Established Mental Health Services?"

SUPPLEMENT OR COMPETE	County Associated	State Employee	MH Provider	Contract Hospital	TOTAL
Supplement	79%	89%	18%	57%	66%
Both	14%	0%	55%	29%	22%
Compete	0%	0%	18%	14%	5%
No Answer	7%	11%	9%	0%	7%
TOTAL %	100%	100%	100%	100%	100%
N	28	9	11	7	55

Chi square significant p=.05.

SOS Integration

Informants were also asked, "Are the SOS programs parallel to or integrated with the mental health service system?"

As can be seen in Table 26 below, about two-thirds (66%) of informants feel the SOS programs are integrated or are becoming integrated with the existing mental health service system in the Moose Lake catchment area.

Table 26
Key Informant Interview: "Are the SOS Programs Parallel to or Integrated With the Mental Health System?"

INTEGRATED OR PARALLEL	County Associated	State Employee	MH Provider	Contract Hospital	TOTAL
Integrated	71%	89%	46%	57%	68%
Both	18%	0%	36%	14%	18%
Parallel	0%	0%	18%	29%	7%
No Answer	11%	11%	0%	0%	7%
TOTAL %	100%	100%	100%	100%	100%
N	28	9	11	7	55

Chi square not significant at p=.05

Said a mental health provider, "We've made a fair start. We'll probably keep tripping over each other for a time, but with continued support and communication, it may work out in time."

Comments on the SOS Programs

The following comments by informants in the planning process assessment about the SOS programs were typical:

> Many informants commented on the late start-up of the SOS programs and suggested that full assessment of the worth would require time and experience.
>
> Some informants, particularly those affiliated with mental health providers were concerned about the potential for competition with existing programs. Said one informant, "The potential for competition is there. And they have the power and resources of the state to back them up."
>
> Many informants, even those concerned about the SOS programs, commented positively about current SOS staff. "They are working hard not to compete and to provide services no one else can," said one informant. "Good people and well led," said another.

Critical Incidents

A particular feature of the key informant process interviews was identification of critical incidents in the planning for and implementation of the Moose Lake transition. The purpose of identifying these incidents was to attempt to learn what factors helped shape the outcome of the effort.

Various factors were identified by the informants. Those mentioned by three or more informants are described below. The incidents are categorized in two groups: incidents which occurred during planning for the transition, and incidents which occurred during implementation. They are grouped in order of occurrence.

Incidents During Planning

The following incidents which occurred during planning for the transition were thought to be important:

- *Announcement of the Closure* -- The first critical event was announcement of the closure of MLRTC. While some informants questioned the wisdom of closure ("They closed the best RTC in the State," said one case manager), and others felt it was coming ("The corrections people had been closing in on us for years," said a former MLRTC employee), a clear, definite and unequivocal public statement helped. In the words of a county supervisor, "to galvanize and focus" interest. Said a county social service supervisor, "Once we knew it was coming, we knew we had to get serious."

- *Availability of Lead Time* -- A related factor was availability of lead time between the announcement of the transition and closure of the RTC. This was important both to permit preparation for a major system change, but also, as a case manager put it, "To allow for grieving and to permit us to come to grips with the reality [of the closure]."

- *Conclusion of Outside Agreements* -- Many informants commented on the political and economic agreements which were concluded outside the transition planning process. Most of these comments centered on the agreement with the state employees' union to continue RTC staff jobs and to assure the creation of mental health SOS programs in the Moose Lake region. Some informants seemed to agree with a provider, who commented "Ninety percent of the MLRTC budget was set aside for the SOS programs. We never saw it or had anything to say about it. All we got was the table scraps." Others were more optimistic. Said a case manager, "It will depend on how good the SOS's are. If they will fill gaps and provide more services [that] no one else can, it will be fine. If not, well . . .". Some informants seemed to feel, as a county social service supervisor said, "It helped to know what was and was not on the table."

- *Provision of a Planning Process* -- A key factor, according to many participants, was the existence of a coherent planning process to prepare for the transition. Said one informant, "We weren't just left to hang out to dry. There was something to do. We didn't all believe it would be meaningful or useful, but it was better than being just told to go home."

- *Agreement on an Allocated Formula* -- It was widely believed that a key factor in the success of the transition was an agreement reached among county social service directors regarding a formula to allocate about $3 million in state flexible funds among the counties to develop community-based programs to replace the RTC. Said one informant, "Without this agreement, everything would have stopped dead." Three factors were thought to account to this agreement:

    -- Recognition of the importance of coming to an agreement.

    -- Availability of commonly accepted decision rules and background information.

    -- A commitment to fairness and, as one participant put it, "To doing what is best for the consumer."

- *Availability of Resources and Freedom to Plan* -- Another widely mentioned "critical event", though it occurred at different times for different informants, was recognition, as one participant put it, "That we had real resources and real freedom to plan." Another participant put it this way: "I kept waiting for the rug to get pulled out, but it never happened. We had to work hard locally to come to an agreement, but the State never intervened and always kept its promise."

Incidents During Implementation

A number of incidents that occurred during implementation of the transition were mentioned:

- *Protracted Closing MLRTC* -- MLRTC was closed over time in a staged process. A few informants felt this hindered the transition by giving those opposed to the closure something to lean on. Said one, "They should have just closed [MLRTC] and moved ahead." Most, however, felt the delayed closing of the facility was helpful. "We needed backup," said one, "while we waited for the state operated services and contract hospitals to get up to speed.

- *Delays in Opening SOS Programs* -- Opening of the state operated services, particularly Bridge House in Duluth and the Eveleth Health Facility, was delayed. While these delays frustrated many in the area, some felt the added time was helpful because it allowed additional time for program development, and particularly because it gave SOS staff liberty to work in the community to establish and strengthen relationships with other programs. Said a psychologist who was involved in training SOS staff, "Early in the process many just were not ready to function in the community. They needed time to get their feet under them [and] to find out who could and could not do community mental health."

- *Absence of Technical Assistance to Contract Hospitals* -- At least early in the process there were some problems in the contract hospitals in working with patients with SPMI. A particular concern had to do with responding to the legal reporting requirements that are part of commitment. Said one contract hospital informant, "We had to drive down to the Cities to see how [the contract hospitals] were managing it." Another contract hospital informant had concerns about reimbursement -- "They take forever to pay and when they do it is the wrong amount." There may also have been some initial problems in the contract hospitals working with a new clientele. A person with SPMI in one of the consumer discussion groups remarked, "I think at first they didn't know what to make of us. They're used to country club matrons."

- *Medicare Ineligibility* -- Many informants in the process interviews remarked on the negative impact on the transition of the ineligibility of persons with Medicare coverage for placement in the contract hospitals. "This was a major screw up," said one informant, "it should have been anticipated." A related positive incident in the transition was the State making funds available to the contract hospitals to subsidize the operations of the units and allow admissions to the unit.

- *Improved Interagency Cooperation* -- Consistently mentioned as a positive result of the transition was improvement in communication and cooperation among mental health organizations in the region. This was seen as resulting from planning process groups that were formed to prepare for the transition. Particularly in the southern portion of the Moose Lake region and in St. Louis County, planning groups still meet to monitor services and respond to any clinical or administrative problems that have emerged.

DISCUSSION

While the study is limited in some respects, information is available to suggest answers to the questions which motivated it. Limitations can also be identified and recommendations can be offered for future efforts of this kind.

CONCLUSIONS

Examination of all of the data available at this time suggests the following conclusions about the outcome of the Moose Lake transition:

Client Outcome Findings

In general, the findings of this research are not consistent with the notion that replacing a RTC with an enhanced community-based mental health infrastructure results in a decrease in the effectiveness of services for persons with serious mental disease. Patient self reports and clinician ratings do not show a pattern of differences for persons discharged from MLRTC compared with those who would have gone to the facility but instead received services in the community.

In fact, accumulated evidence suggests that the contrary may be true; that an enhanced infrastructure results in improved services. Many persons in the planning process assessment expressed the conviction that the need for hospitalization of committed persons is declining in the MLRTC area and that the lengths of stay for persons who are hospitalized is also declining, with no apparent increase in recidivism.

Costs

Early information suggests that the closure of Moose Lake RTC and its replacement with an enhanced community mental health infrastructure has not resulted in increased costs to the counties in the catchment area. Both the very early results from the "Hold Harmless" study and the views of informants in the key informant interviews are consistent with this conclusion. However, the final conclusion awaits the conclusion of the "Hold Harmless" study, and as one key informant put it, "The success of the transition depends on continued support. Without it, all we've gained could be lost."

Service Use

Indirect analysis of patterns of service use in the catchment area dispel the conclusion that the range and quality of services has been harmed by the transition. Client and clinician assessment of service use and key informant evaluation of the range and quality of services following implementation of the

program suggest that there has at least been maintenance of a minimum level of care and that it is much more likely there has been an improvement.

Planning Process Assessment

Key informant interviews focused on assessment of the transition planning process and led to two conclusions:

That most participants and observers of the planning and implementation of the transition feel that it was a success.

That most participants feel that the quality and range of mental health services established through the planning process has improved since the closure of Moose Lake RTC.

LIMITATIONS OF THE STUDY

A number of problems and limitations threaten the ultimate validity of the study's conclusions.

Size of Patient Sample

One threat to validity is the size of the patient sample. Fewer mental health patients than expected have been admitted to the study, particularly from the contract hospitals and SOS programs. The apparent reasons for this are:

- Not all eligible patients in the inpatient facilities were offered a chance to participate.
- Utilization of contract beds by patients has been hindered by late start-up of some programs, problems admitting some patients to the programs because of Medicare eligibility, and a possible decline in some counties in the need for hospitalization of mentally ill persons.

To address this problem, the data collection portion of the study was extended three months. Even with these additional intakes, however, the number of persons participating in the study has been less than hoped.

Bias in the Patient Sample

A related problem concerns the composition of the patient sample. Because not all eligible clients have been admitted to the study and because many clients who agreed to participate at intake later refused or were unable to continue participation at subsequent follow-ups, the sample of patients represented in the database is arguably at a higher level of social and psychological functioning and more cooperative than would otherwise be the case.

RECOMMENDATIONS FOR FUTURE RESEARCH

Based on the experience of this study, recommendations can be offered for future research of this kind:

Recruitment of Clients

Recruitment of a representative sample of clients is essential. Success in recruitment in a decentralized project requires:

- Designation of a recruitment coordinator at each site to oversee intake of patients into the study and provision of institutional and personal incentives to encourage and support cooperation.
- Development of client eligibility criteria to enable onsite intake persons to identify appropriate candidates.
- Close monitoring and coordination of intake recruitment to identify and remedy problems as they arise.

While client eligibility criteria and intake materials were developed for the study, and these were distributed together with training to recruitment coordinators at each site, there were difficulties in obtaining a representative sample.

There were a number of reasons for this. In the first place, all of the sites were under development when the study was implemented. The SOS programs were literally being constructed and the contract hospitals were devising new administrative and clinical procedures. The research program was one more complication in an already turbulent time. Moreover, there was no particular incentive or reward for cooperation with research protocol, nor were there sanctions for lack of cooperation. All of the recruitment coordinators made sincere efforts to be helpful, but it was clear that the press of other commitments made client recruitment a comparatively low priority. Lastly, maintaining continuity among the recruitment coordinators over two years was a problem. During the study, one coordinator retired, another took six months maternity leave, and another passed away.

Successful client recruitment requires (1) leadership commitment at each site to the research so that compliance with the protocol is a staff priority, (2) provision of support to the institution (perhaps in the form of a stipend) to defray costs of participation, and (3) development of personal incentives for coordinators (perhaps in the form of authorship of reports and papers that might be produced). Also, negotiation concerning these issues should take place before the beginning of the project in order that the research protocol should meaningfully reflect the input of all those concerned with the success of the project.

Coordination of Follow-up

Even given a large and representative sample of clients, research can founder if post-discharge follow-up is unsuccessful. In the MLRTC transition evaluation, community follow-up was the responsibility of the client's case manager. Successful coordination of follow-up requires the following:

- Commitment from case managers to follow the study protocol and to encourage their clients to continue participation.
- Development of measurement materials which meet the goals of the study but which also are easy to use and a minimum burden on case managers and their clients.
- Development of a mechanism for distributing and recovering client follow-up materials in a timely manner but which also is a minimum burden on case managers.
- Close monitoring and coordination of client follow-up to identify and remedy problems as they arise.

While all four of these elements in successful follow-up were attempted in this study, sample attrition was nevertheless a problem. There were a number of reasons for this. In the first place, case manager meetings with their clients did not always match with those called for by the study protocol. Materials sometimes arrived after a meeting or well before the next one. In the second place, not all clients retained case management services throughout the course of the study. Some clients were discharged before the one-year or even the six-month follow-up, and others left case management services without permission ("went AWOL"). In the third, some clients decompensated in the community and were unable or unwilling to continue participation in the study. Overall, as with patient recruitment, commitment of those responsible for follow-up may have been a problem. The case managers had little direct incentive to assist with the study, and although most were very helpful, at least some county case managers and county supervisors saw the project as simply another task in their already overburdened calendars.

As with client recruitment, successful follow-up requires (1) greater county leadership commitment so that compliance with the protocol is a case manager priority, (2) provision of support to the counties (perhaps in the form of a stipend) to defray costs of participation, and (3) development of personal incentives for the case managers (perhaps in the form of authorship of reports and papers that might be produced). Also, negotiation concerning these issues should take place before onset of the research in order that the research protocol should meaningfully reflect the input of all those concerned with the success of the project.

Measurement of Client Outcomes and Satisfaction

A third element important to the success of the project is valid and reliable assessment of client treatment outcomes and satisfaction with services. Success in this requires:

- Use psychometrically validated measures of outcome and satisfaction.
- Collection of client outcome information in a manner which minimizes distortions due to rater inconsistency.
- Use of multiple measures so that cross-validation of assessments may be attempted.
- Use of multiple perspectives in assessment of both client outcomes and satisfaction with services.

Extensive reliance on client self report was a possible source of bias in the Moose Lake transition evaluation study. Although clinician ratings of both outcome through the GAS score and treatment participation were attempted, the use of different raters at different assessment points limits the utility of these measures. Also, reliance solely on client report of satisfaction with services raises the concern that the report of others, such as family members, would reveal a different perspective.

An Alternative Research Design

At least some of the problems which challenged the Moose Lake transition evaluation study could be mitigated through use of an alternative research design. Elements in this design would include the following:

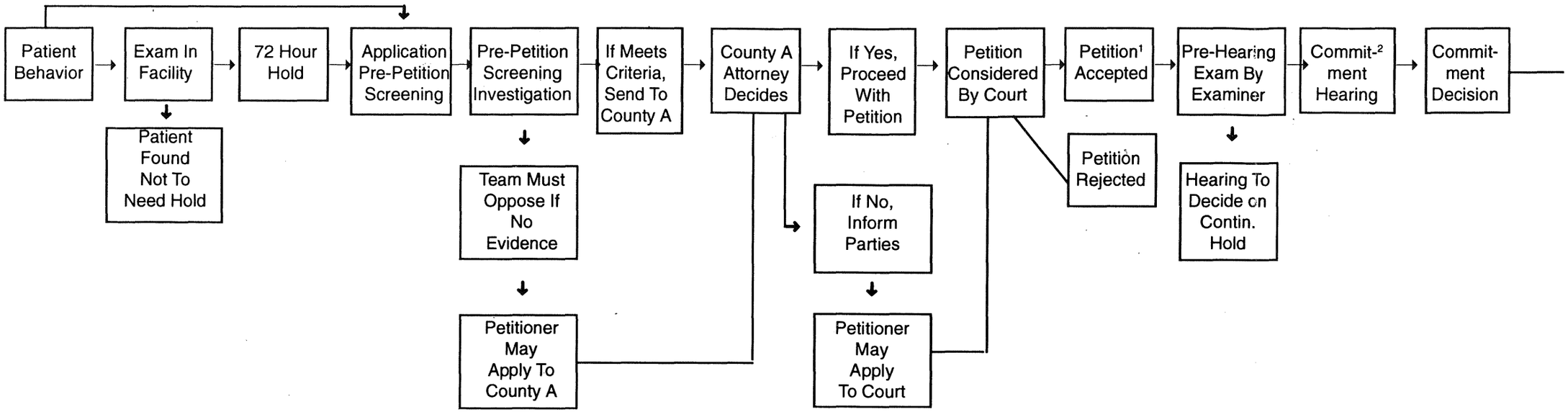
- Postponement of the study, or at least portions of the study, until the new programs have been implemented and stabilized. This would minimize distortions in outcomes due to variations in performance that are characteristic of program start-up.
- Random recruitment of a limited number of clients at a restricted number of sites. Acquiring subjects in a disciplined fashion at a limited number of sites would likely have enhanced the representatives of the sample.
- Use of independent, carefully trained clinicians to evaluate clients at each assessment. This would have minimized distortions due to inter-rater inconsistency.
- Use of multiple measures and perspectives in assessment both of satisfaction and clinical outcome. This would permit cross-validation of assessments.

CONCLUSION

Despite the limitations of the study, the preponderance of evidence is that the Moose Lake transition was a success. Client clinical outcomes and satisfaction are at least stable before and after the transition. The cost analysis suggests that the transition has not occasioned an excessive burden on the counties in the catchment area. Participants in the planning feel the process was effective and produced an enhanced community mental health infrastructure that provides an improved range and quality of public mental health services.

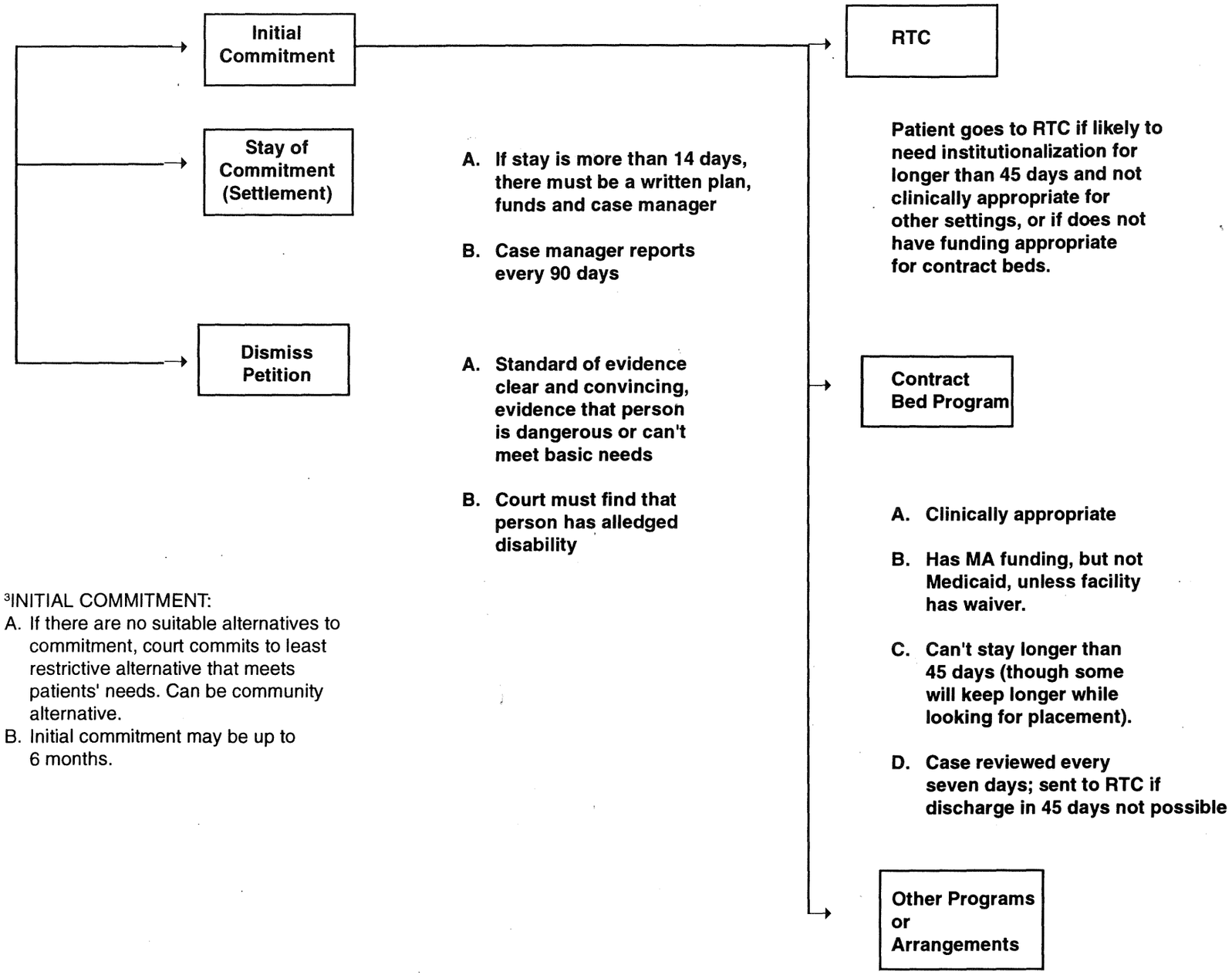
APPENDIX A:
Commitment Process

COMMITMENT



[1]COURT:
A. Appoints examiner
B. Appoints attorney for patient
C. Appoints 2nd examiner, requested by patient
D. Issues summons for
   1. Pre-hearing exam
   2. Commitment hearing
E. Issues appealed or hold order, if need
F. Sets probable cause hearing

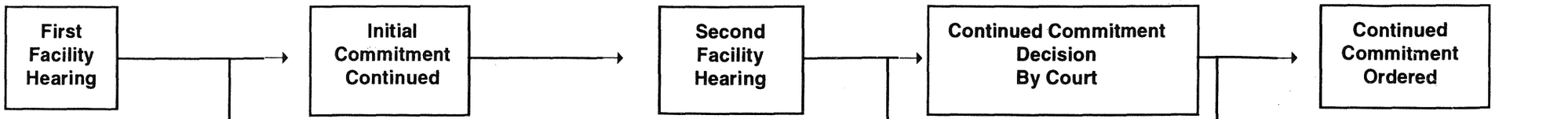
[2]COMMITMENT HEARING:
A. Within 14 days of petition, unless extended up to 30 days for good cause
B. 5 days notice of hearing, 2 of place and time
C. Patient or head of facility may demand immediate hearing
D. Patient may attend, testify and cross-examine
E. Patient may not be influenced by medications, unless court decides



[3]INITIAL COMMITMENT:

A. If there are no suitable alternatives to commitment, court commits to least restrictive alternative that meets patients' needs. Can be community alternative.
B. Initial commitment may be up to 6 months.

MONITORING COMMITMENT



60 to 90 days after commitment, facility sends court report.

There is no report if person has been discharged.

If report recommends more treatment, commitment is continued.

Discharge

If no report or if institutionalization no longer needed.

Before end of commitment, facility sends a second report to the court.

There is no report if person has been discharged.

Court appoints 2nd examiner and holds hearing within 14 days.

Discharge

Person is discharged if further institutionalization is not recommended, or report is not filed.

If hearing at end of 6 months shows that criteria for continued treatment are satisfied, court must commit for "probably length of treatment necessary, or 12 months, whichever is less."

Criteria: Clear and convincing proof that patient is probably not able to care for basic needs or dangerous to self or others.

Discharge

No extension of commitment is permitted unless a new petition is filed, with the court hearing and determination. Under a new petition, the initial _____ period must be "the probable _____ of commitment necessary or 12 months, whichever is less."

NOTE: Quarterly meetings are held at facility to monitor treatment progress and for discharge planning. Case managers are invited to this meeting.

DISCHARGE, REVOCATION, AND EXTENSION

Direct Discharge

A patient may be discharged directly, with no further court supervision

Provisional Discharge →

Head of facility may provisionally discharge patient. Aftercare plan* must have been developed with patient which includes:

- Specified time period and services for PD
- _____ goals for final discharge
- Conditions or restrictions
- Grounds for revocation

*THIS IS THE INDIVIDUAL COMMUNITY SUPPORT PLAN (ICSP)

Patient Receives Services As In Plan →

Including:
CM (Rule 79) and,
_____:

- Rule 36
- Support appartment
- SLIC
- Personal care attendant

Quarterly Review By PT, CM

→ **P.D Expires**

PD expires on date indicated, unless specific action is taken to extend or revoke it.

→ **Extend PD** → **Preliminary Conference With Patient and Family** → **Recommend-ation to Head of Facility** → **Decision By Head of Facility**

May occur only if goals of PD plan are not achieved

No extension may extend commitment beyond the period of commitment provided in court's commitment order.

→ **Revoke PD** → **Before 60 Days**

PD may be revoked if patient has violated conditions of plan or is a threat to self or others

CM may revoke provisional discharge

→ **After 60 Days**

Any interested party may make request to head of facility

Non-Emergency → **Revocation Notice Sent to PT** → **Review Requested** → **Court Holds Hearing**

→ **Finding of Probable Cause**

PD is revoked

No revocation may extend commitment beyond the period provided in court's original commitment order

Emergency

CM may ask court to uphold revocation. Court may do so before a hearing if there is evidence of

No Review Requested → **Finding of No Probable Cause**

If no review, revocation is final

PT returns to PD status

APPENDIX B:
Initial Flexible Funding Plans

MLRTC COUNTY FLEXIBLE FUNDING PLANS

Following is a brief synopsis of county plans to use new flexible funding to meet the needs of patients with mental illness currently at MLRTC and the needs of persons who would use MLRTC if its' services were to continue to be available. This summary information is designed to assist social workers and other treatment team members in the discharge planning process. Each county will have new or enhanced services that can be beneficial to you to know about as you consider the needs of the individuals you are discharging.

A total allocation of $2.2 million per year in new mental health funding will be available to the 11 counties in the catchment area and two additional counties (Hennepin and Olmsted) who have a number of committed patients at MLRTC. The counties agreed on a formula for allocating the funding based on their county population, their utilization of MLRTC and other factors. The funding is very flexible and will be used to enhance existing programs and create new services where gaps have been identified in county mental health service systems.

REGION 7E FLEXIBLE FUNDING PLANS

CHISAGO, MILLE LACS, ISANTI, KANABEC, PINE will be adding:

* Additional County Case Management Staff
* Additional CSP Staff Time through Five County Mental Health Center
* Crisis Bed in a Foster Care Setting
* 24 hour Crisis Assistance (through Cambridge Hospital and, State Operated Services)
* Supported Employment in the community
* Independent Living Skills Services
* Transportation (except Kanabec)
* Housing (rent) Subsidies
* Client Fund to pay for furnishings, supplies, medications, food, phones, clothing, and other items clients need to live in the community

PINE COUNTY will also be adding these services:

* Friendly Visitor and Medication Management Services through Pine County Public Health Nursing Services
* Nursing Home Supports--including staff training and temporary staffing needs

REGION 3 FLEXIBLE FUNDING PLANS

CARLTON
* Specialized MI/CD services
* Housing Subsidies
* Community Support Services and Recreational Services
* Client Fund for individual needs--including meds
* Foster Care and training for foster care providers
* Friendly Visitor Services
* Supported Employment
* Team Case Management

COOK
* Total allocation ($26,628) will likely be used to meet the needs of one Cook Co. patient at MLRTC

ITASCA
* Enhanced Services at Esther House R-36 and B&L Facilities (Wanderguard system, increased staffing, transitioning services, aftercare)
* Psychiatric Consultation
* Intensive In-home Community Support Services
* Transportation
* Client Fund--includes funds for meds and recreation
* Supported Employment
* Mobile Crisis Assistance
* Drop-in Center

KOOCHICHING
* Family Based Community Support Services
* Client Funds
* Intensive Community Support Services
* Community Health Extension Services--independent living skills assistance

LAKE
* Client Funds
* Community Support Services--Drop-in Center, Intensive Supports, Transitioning services from MLRTC
* Training to MH Crisis Team--including law enforcement

ST.LOUIS (NORTH)
* Additional County Case Management staff who will have smaller case loads and can provide more intensive services--cellular phones for case managers
* Client Fund--moving expenses, clothing, negotiated bed hold, personal needs, housing subsidies, etc.
* Supported Employment
* Crisis Outreach Team through Range MHC--to respond to acute psychiatric issues and do med. management

Mental Health Services Evaluation
Client Information Form

One copy of this form should be completed for each patient included in the evaluation study. If you have any questions call **Jerry Jaker** at the Minnesota Institute of Public Health. His number is **1-800-247-1303.**

A. CLIENT IDENTIFICATION

Name _____

Social Security Number _____

WID Number (if RTC) _____

Medical Assistance Number _____

B. CONTACT INFORMATION

Client Address at Discharge:

Name _____

Address _____

_____

_____

Phone _____

C. CLIENT'S FOLLOW-UP CONTACT

Name _____

Address _____

_____

Phone _____

D. COUNTY CASE MANAGER

Name _____

Address _____

_____

Phone _____

E. CLIENT INFORMATION

1. Gender

❒ Female ❒ Male

2. Date of Birth: _____ / _____ / _____
month day year

Marital Status

❒ Never married ❒ Separated ❒ Widowed
❒ Now married ❒ Divorced

3. Race

❒ American Indian/ Alaskan Native
❒ Asian or Pacific Islander
❒ Black/African American
❒ White
❒ Other

Hispanic Origin:
❒ Yes
❒ No

F. INTAKE INFORMATION

1. Presenting Problems at Intake *(check as many as apply)*

❒ Marital/family problem
❒ Social/interpersonal (other than family problem)
❒ Problems coping with daily roles and activities (includes job, housework, daily grooming, financial management, etc.)
❒ Depression or mood disorder
❒ Attempt, threat, or danger of suicide
❒ Involvement with criminal justice system
❒ Alcohol
❒ Drugs
❒ Medical/somatic
❒ Eating disorder
❒ Abuse/assault/rape victim
❒ Runaway behavior
❒ Homeless, without shelter
❒ Threatens to harm others, danger to others
❒ Left residential program
❒ Discontinue case mgmt.

2. Legal Status

❒ Committed MI
❒ Committed MI & CD
❒ Committed CD
❒ Rule 20
❒ Voluntary
❒ Hold order
❒ PP

3. Admission Date: _____ / _____ / _____
month day year

G. HISTORY OF PREVIOUS MENTAL HEALTH

1. INPATIENT SERVICES

a. At this facility in past year?

- ☐ Yes
- ☐ No

b. At another facility in past year?

- ☐ Yes If yes, which facility _____
- ☐ No

c. Does the patient have a history of resistance to mental health treatment?

- ☐ Yes
- ☐ No

If yes, please describe. _____

_____

_____

2. SOURCE OF REFERRAL AT ADMISSION

- ☐ Self
- ☐ Police (except court or correction agency)
- ☐ School system or education agency
- ☐ Family or friend
- ☐ Court or correction agency
- ☐ Social service agency

Inpatient/residential organization (indicate specific type):

- ☐ State or county psychiatric hospital
- ☐ General hospital inpatient psychiatric program
- ☐ Other inpatient psychiatric organization
- ☐ Alcohol treatment inpatient/residential organization
- ☐ Drug abuse treatment inpatient/residential organization
- ☐ Nursing home, extended-care organization
- ☐ Community residential organization
- ☐ Other (detail should be maintained)

Other referral source (indicate specific type)

- ☐ Multiservice mental health agency (include community mental health centers)
- ☐ Outpatient psychiatric service or clinic
- ☐ Private psychiatrist
- ☐ Other physician
- ☐ Other private mental health practitioner
- ☐ Partial day organization
- ☐ Shelter for the homeless/abused
- ☐ Alcohol treatment organization other than inpatient/residential
- ☐ Drug abuse treatment organization other than inpatient/residential
- ☐ Community support program
- ☐ Crisis Program
- ☐ State-operated service
- ☐ Other _____

3. CAUSE OF ADMISSION:

What was the precipitant for admission (choose all that apply):

- ☐ Medication noncompliance
- ☐ Noncompliance with treatment plan (including AMA discharge)
- ☐ Suicide risk
- ☐ Dangerous to others (briefly describe):
- ☐ Highly volatile, unpredictable behaviors
- ☐ Substance abuse
- ☐ Criminal/legal problems (excluding commitment)
- ☐ Severe thought disorder and/or behaviors and/or severe impairment of judgment that adversely affected continued stay in community setting
- ☐ Inappropriate sexual behavior
- ☐ Community inpatient reimbursement ended
- ☐ Self-injurious behaviors (SIB) (briefly describe):

- ☐ Unknown
- ☐ Other, please specify:

4. DISCHARGE INFORMATION

a. Discharge Date: ____ / ____ / ____
month day year

b. Diagnosis at Discharge: DSM-IIIR ; DSM-IV

AXIS I _____; AXIS II _____;

Use Coding

AXIS III _____ (Write in)

Sheet: _____

AXIS IV _____

AXIS V _____ (write in)

c. Financial Eligibility

- ☐ SSI
- ☐ SSDI
- ☐ Self Pay
- ☐ RSDI
- ☐ GA
- ☐ None of the above

5. RESIDENTIAL ARRANGEMENT AT DISCHARGE

- ☐ Forensic Facility/Security Hospital
- ☐ Regional Treatment Center
- ☐ Community Residential Treatment MH - Rule 36
- ☐ Residential Treatment - CD- Rule 35
- ☐ Nursing Home
- ☐ Adult Foster Care
- ☐ House/Apartment with Support Services
- ☐ House/Apartment
- ☐ Board and Lodging
- ☐ State-operated service

6. LIVING ARRANGEMENT AT DISCHARGE

The patient's usual living arrangement:

- ☐ Lives alone
- ☐ Lives with relatives
- ☐ Lives with nonrelated persons

7. DISCHARGE STATUS

Indicate the presence, within the past six months, of the following that may have a bearing on discharge planning:

- ☐ Polydypsia
- ☐ Eating disorder
- ☐ Learning disability
- ☐ Firesetting
- ☐ Incontinence
- ☐ Persistent substance abuse

8. REFERRAL AT DISCHARGE

☐ No referral (self, family, friend took responsibility)

Inpatient/residential care (indicate specific type)

- ☐ State or county psychiatric hospital
- ☐ General hospital inpatient psychiatric program
- ☐ Other inpatient psychiatric organization
- ☐ Drug abuse treatment residential organization
- ☐ Alcohol treatment residential organization
- ☐ Community residential organization
- ☐ Nursing home/extended care organization
- ☐ Return to penal/correctional institution
- ☐ Other (detail should be maintained)

Other referrals (indicate specific type)

- ☐ Multiservice mental health agency
- ☐ Outpatient psychiatric service or clinic
- ☐ Private psychiatrist
- ☐ Other physician
- ☐ Alcohol treatment organization other than inpatient or residential
- ☐ Other private mental health practitioner
- ☐ Partial day organization
- ☐ Drug abuse treatment organization other than inpatient or residential
- ☐ Returned to court for adjudication
- ☐ School system or education agency
- ☐ Social service agency
- ☐ Crisis program
- ☐ State-operated facility
- ☐ Housing agency/service
- ☐ Vocational services
- ☐ Other (detail should be (maintained)
- ☐ Public health nursing
- ☐ Anoka Alternatives

9. MEDICATIONS AT DISCHARGE

a. Mode of Administration

(Check one)

- ☐ Patient is taking medication voluntarily
- ☐ Patient is taking medication involuntarily
- ☐ Patient is refusing medication
- ☐ No psychiatric medications are ordered

b. Type of Medications

(Check all that apply)

- ☐ Anticonvulsants
- ☐ Antianxiety
- ☐ Antidepressants
- ☐ Oral Neuroleptics
- ☐ Sedatives/Hypnotics
- ☐ Clozaril
- ☐ None of these types
- ☐ Intra-Muscular Neuroleptics

10. DOES PATIENT HAVE ADVANCED DIRECTIVE?

An advance directive is a legal document for patient's choice of future mental health treatment if the patient is incapacitated

☐ Yes ☐ No

11. CLIENT STATUS AT DISCHARGE

a. To what extent do mental problems interfere with this patient's ability to participate in routine community activities?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not at All	Mildly	Moderately	Severely	Very Severely

(Use the scale below to answer questions 12b to 12k.)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Definitely Yes	Probably Yes	Possibly	Probably No	Definitely No

If given the opportunity, would the patient:

b. Take his medication independently?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

c. Keep appoints for clinics and other mental health services?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

d. Use money correctly to purchase whatever he needs?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

e. Hold on to a paying job?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

f. Perform activities necessary to maintain a home or apartment?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

g. Use public transportation?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

h. Maintain an adequate diet?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

i. Take initiative or seek assistance with own problems?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

j. Abuse drugs?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

k. Abuse alcohol?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

12. SUICIDAL/SEVERE ASSAULTIVE RISK

(Severe Assaultiveness is defined as unprovoked extended acts of hitting with fists, use of a weapon, e.g., that could or have resulted in damages to persons and/or property.) (Check as many as apply)

		CURRENT	HISTORY OF
a)	Evidence of suicide and/or severe assaultive attempts	❒	❒
b)	Presence of self injurious behaviors	❒	❒
c)	Suicide/severe assaultive risk aggravated by substance abuse while in the community	❒	❒
d)	None of the above	❒	❒

13. SUPPORT SYSTEMS

(Check all that apply)

- ❒ Support system is available, but support persons live considerable distance away.
- ❒ Patient has, in the past, successfully developed a positive network of supports.
- ❒ Patient has family, friends, others who are concerned about the patient's welfare and are available to support the patient upon discharge.
- ❒ Family, friends are unsupportive/alienated. Briefly describe:

- ❒ No support system

14. FACILITY INFORMATION

a. Name of Facility

_____

b. Person Completing This Form:

Name _____

Phone _____

15. PRIOR INPATIENT HOSPITALIZATIONS

How many times prior to this hospitalization has this person received an inpatient psychiatric hospitalization?

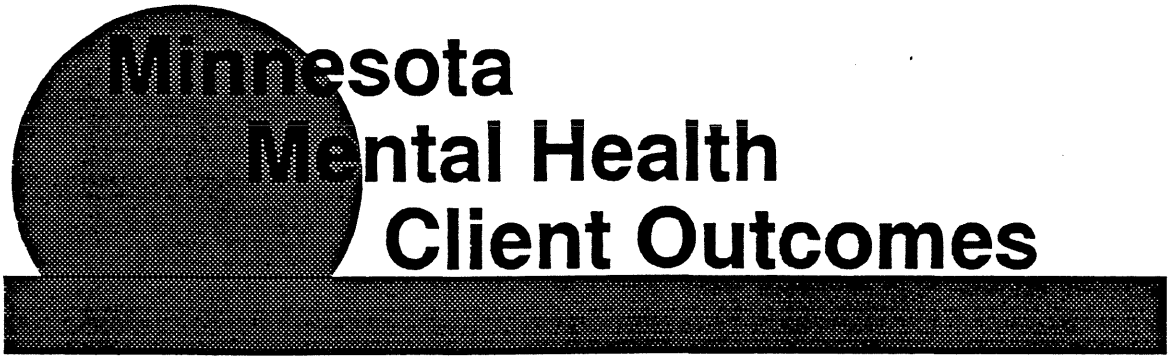
In an RTC or State Hospital _____

In a Community Hospital _____

(This information should be found in the patient's pre-petition screening report.)

APPENDIX D:
Minnesota Mental Health Outcome Questionnaire

Minnesota Department of Human Services



Thank you for participating in a study of mental health programs by the Minnesota Department of Human Services. It usually takes approximately 20 to 30 minutes to complete the questions asked in this form.

The *Minnesota Mental Health Client Outcomes* instrument was developed as part of a set of instruments to evaluate community-based mental health services. It measures changes in a person's level of functioning over time, an individual's quality of life from their perspective, and asks some questions about service utilization. The results of the evaluation will be used to determine needed changes to the types of mental health services available, they way these services are provided, and the impact they have on clients.

If you have any questions or would like to receive the final results of this study, please call the Mental Health Information/Evaluation Team at:

(612) 297 2734

Client's Name: _____

Administered by: _____

Date: _____

INFORMATION ABOUT YOUR HEALTH

1. **In general, would you say your overall health is . . .**

Excellent	[ ]
Very Good	[ ]
Good	[ ]
Fair	[ ]
Poor	[ ]

2. **Compared to one year ago, how would you rate your overall health now . . .**

Much better than one year ago	[ ]
Somewhat better than one year ago	[ ]
About the same	[ ]
Somewhat worse now than one year ago	[ ]
Much worse now than one year ago	[ ]

HOW HAVE THINGS BEEN GOING ?

3. **During the <u>past month</u>, have you had problems with the following ? (Check one box for each item.)**

ITEM	No Problems	Yes - Minor Problems	Yes - Major Problems	Does Not Apply To Me
a. Relationships with friends	[ ]	[ ]	[ ]	[ ]
b. Finding or keeping a place to live	[ ]	[ ]	[ ]	[ ]
c. Performing well	[ ]	[ ]	[ ]	[ ]
d. Getting along with your family	[ ]	[ ]	[ ]	[ ]
e. Money management	[ ]	[ ]	[ ]	[ ]
f. Sleeping	[ ]	[ ]	[ ]	[ ]
g. Getting or staying employed	[ ]	[ ]	[ ]	[ ]
h. Getting help when you need it	[ ]	[ ]	[ ]	[ ]
i. Getting up in the morning	[ ]	[ ]	[ ]	[ ]
j. Concentrating on work	[ ]	[ ]	[ ]	[ ]
k. Controlling your behavior	[ ]	[ ]	[ ]	[ ]
l. Taking care of things you own	[ ]	[ ]	[ ]	[ ]
m. Keeping appointments	[ ]	[ ]	[ ]	[ ]

HOW WELL ARE YOU DOING NOW ?

4. During a typical day, are you limited in any of the following activities ? (Check one box for each activity.)

ACTIVITY	Not Limited At All	Somewhat Limited	Limited A Lot	Does Not Apply To Me
a. Preparing meals	[ ]	[ ]	[ ]	[ ]
b. Doing volunteer activities	[ ]	[ ]	[ ]	[ ]
c. Keeping house/room clean	[ ]	[ ]	[ ]	[ ]
d. Going places	[ ]	[ ]	[ ]	[ ]
e. Having fun	[ ]	[ ]	[ ]	[ ]
f. Dressing or bathing	[ ]	[ ]	[ ]	[ ]
g. Taking medication(s)	[ ]	[ ]	[ ]	[ ]
h. Visiting family/friends	[ ]	[ ]	[ ]	[ ]
i. Eating	[ ]	[ ]	[ ]	[ ]
j. Getting along with neighbors/other people	[ ]	[ ]	[ ]	[ ]
k. Using car or public transportation	[ ]	[ ]	[ ]	[ ]
l. Enjoying leisure time	[ ]	[ ]	[ ]	[ ]
m. Getting along with roommates	[ ]	[ ]	[ ]	[ ]

5. Do you have difficulty with the following ? (Check one box for each category.)

CATEGORY	No Difficulty	Some Difficulty	A Lot of Difficulty	Does Not Apply To Me
a. Shopping	[ ]	[ ]	[ ]	[ ]
b. Using the telephone	[ ]	[ ]	[ ]	[ ]
c. Protecting yourself from danger	[ ]	[ ]	[ ]	[ ]
d. Receiving medical services	[ ]	[ ]	[ ]	[ ]
e. Asking others for help	[ ]	[ ]	[ ]	[ ]
f. Communicating so others understand	[ ]	[ ]	[ ]	[ ]
g. Traveling from residence without getting lost	[ ]	[ ]	[ ]	[ ]
h. Side effects of medications	[ ]	[ ]	[ ]	[ ]
i. Being alone	[ ]	[ ]	[ ]	[ ]

QUALITY OF LIFE

6. How well are <u>your needs</u> being met ? (Check one box for each of the following.)

MY NEED FOR THE FOLLOWING IS BEING MET	Not At All	Very Little	Somewhat	Fairly Well	Extremely Well
a. Friendship (finding, keeping, visiting with in person or on the phone)	[ ]	[ ]	[ ]	[ ]	[ ]
b. Food (receiving adequate, nourishing meals on a regular basis)	[ ]	[ ]	[ ]	[ ]	[ ]
c. Housing (safe, comfortable, affordable)	[ ]	[ ]	[ ]	[ ]	[ ]
d. Clothing (clean, comfortable, proper for the season, style you like)	[ ]	[ ]	[ ]	[ ]	[ ]
e. Acceptance within the Community (no strange looks, friendliness)	[ ]	[ ]	[ ]	[ ]	[ ]
f. Dental Services (locating, accessing, receiving)	[ ]	[ ]	[ ]	[ ]	[ ]
g. Work (finding, achieving, maintaining)	[ ]	[ ]	[ ]	[ ]	[ ]
h. Education or Job Training Opportunities (attending, paying for, locating)	[ ]	[ ]	[ ]	[ ]	[ ]
i. Security (feeling safe, protected from harm to yourself)	[ ]	[ ]	[ ]	[ ]	[ ]
j. Financial (adequate money to meet daily needs)	[ ]	[ ]	[ ]	[ ]	[ ]
k. Medical Services (locating, accessing, receiving)	[ ]	[ ]	[ ]	[ ]	[ ]
l. Transportation (availability, convenience)	[ ]	[ ]	[ ]	[ ]	[ ]

WHAT SERVICES DO YOU USE ?

7. How often do you use the following services ? (Check the box that comes closest for each service.)

SERVICE	Not at All	Use, but Less than Once a month	1 or 2 Times a Month	3 or More Times a Month
a. Drop-in centers	[ ]	[ ]	[ ]	[ ]
b. Food shelves	[ ]	[ ]	[ ]	[ ]
c. Public or charitable resources for free hot meals	[ ]	[ ]	[ ]	[ ]
d. Self-help groups	[ ]	[ ]	[ ]	[ ]
e. Counseling by clergy member	[ ]	[ ]	[ ]	[ ]
f. An emergency room (for mental/emotional problems)	[ ]	[ ]	[ ]	[ ]
g. Assistance by police/sheriff's department	[ ]	[ ]	[ ]	[ ]
h. Crisis/emergency shelter	[ ]	[ ]	[ ]	[ ]
i. Crisis hotline	[ ]	[ ]	[ ]	[ ]
j. Counseling by mental health therapists	[ ]	[ ]	[ ]	[ ]
k. Case management	[ ]	[ ]	[ ]	[ ]
l. Day treatment programs	[ ]	[ ]	[ ]	[ ]
m. Community Support Programs	[ ]	[ ]	[ ]	[ ]
n. Inpatient hospital services	[ ]	[ ]	[ ]	[ ]

INFORMATION ABOUT YOURSELF

I live:
- [ ] Alone
- [ ] With Non-related Persons
- [ ] With Relative(s)
- [ ] With Spouse or Significant Other

During the past 6 months, I was homeless for approximately _____ nights.

For most of the past 6 months, I have had:
- [ ] No employment
- [ ] Part-time employment
- [ ] Full-time employment

My usual residence during the past 6 months has been:
- [ ] A hospital or an RTC
- [ ] An adult residential treatment facility (Rule 36)
- [ ] A room and board facility with a shared bedroom
- [ ] A room and board facility with a private bedroom
- [ ] An apartment or other rented residence
- [ ] A home I own
- [ ] Other: _____

Minnesota Department of Human Services
Community Mental Health Division
444 Lafayette Road
St. Paul, MN 55155-3828

APPENDIX E:
Brief Symptom Index 53

BSI®

Brief Symptom Inventory™

Leonard R. Derogatis, PhD

Last Name First MI

ID Number

)e Gender Test Date

DIRECTIONS:

1. Print your name, identification number, age, gender, and testing date in the area on the left side of this page.
2. Use a lead pencil only and make a dark mark when responding to the items on page 3.
3. If you want to change an answer, erase it carefully and then fill in your new choice.
4. Do not make any marks outside the circles.

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Printed in the United States of America.
"Brief Symptom Inventory" is a trademark and "BSI" is a registered trademark of)nard R. Derogatis, PhD.

DO NOT SEND TO NATIONAL COMPUTER SYSTEMS
USE ONLY FOR HAND SCORING

NCS™

Product Number
05627

INSTRUCTIONS:

On the next page is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	EXAMPLE HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	●	4	Bodyaches

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	3	4	Nervousness or shakiness inside
2	0	1	2	3	4	Faintness or dizziness
3	0	1	2	3	4	The idea that someone else can control your thoughts
4	0	1	2	3	4	Feeling others are to blame for most of your troubles
5	0	1	2	3	4	Trouble remembering things
6	0	1	2	3	4	Feeling easily annoyed or irritated
7	0	1	2	3	4	Pains in heart or chest
8	0	1	2	3	4	Feeling afraid in open spaces or on the streets
9	0	1	2	3	4	Thoughts of ending your life
10	0	1	2	3	4	Feeling that most people cannot be trusted
11	0	1	2	3	4	Poor appetite
12	0	1	2	3	4	Suddenly scared for no reason
13	0	1	2	3	4	Temper outbursts that you could not control
14	0	1	2	3	4	Feeling lonely even when you are with people
15	0	1	2	3	4	Feeling blocked in getting things done
16	0	1	2	3	4	Feeling lonely
17	0	1	2	3	4	Feeling blue
18	0	1	2	3	4	Feeling no interest in things
19	0	1	2	3	4	Feeling fearful
20	0	1	2	3	4	Your feelings being easily hurt
21	0	1	2	3	4	Feeling that people are unfriendly or dislike you
22	0	1	2	3	4	Feeling inferior to others
23	0	1	2	3	4	Nausea or upset stomach
24	0	1	2	3	4	Feeling that you are watched or talked about by others
25	0	1	2	3	4	Trouble falling asleep
26	0	1	2	3	4	Having to check and double-check what you do
27	0	1	2	3	4	Difficulty making decisions
28	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
29	0	1	2	3	4	Trouble getting your breath
30	0	1	2	3	4	Hot or cold spells
31	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
32	0	1	2	3	4	Your mind going blank
33	0	1	2	3	4	Numbness or tingling in parts of your body
34	0	1	2	3	4	The idea that you should be punished for your sins
35	0	1	2	3	4	Feeling hopeless about the future
36	0	1	2	3	4	Trouble concentrating
37	0	1	2	3	4	Feeling weak in parts of your body
38	0	1	2	3	4	Feeling tense or keyed up
39	0	1	2	3	4	Thoughts of death or dying
40	0	1	2	3	4	Having urges to beat, injure, or harm someone
41	0	1	2	3	4	Having urges to break or smash things
42	0	1	2	3	4	Feeling very self-conscious with others
43	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
44	0	1	2	3	4	Never feeling close to another person
45	0	1	2	3	4	Spells of terror or panic
46	0	1	2	3	4	Getting into frequent arguments
47	0	1	2	3	4	Feeling nervous when you are left alone
48	0	1	2	3	4	Others not giving you proper credit for your achievements
49	0	1	2	3	4	Feeling so restless you couldn't sit still
50	0	1	2	3	4	Feelings of worthlessness
51	0	1	2	3	4	Feeling that people will take advantage of you if you let them
52	0	1	2	3	4	Feelings of guilt
53	0	1	2	3	4	The idea that something is wrong with your mind

APPENDIX F:
Mental Health Rater Reaction Form

MINNESOTA MENTAL HEALTH CLIENT OUTCOMES
RATER REACTION

1. Use the scale below to indicate your overall assessment of the accuracy of the client's answers in the Minnesota Mental Health Client Outcomes Questionnaire. Circle the number which best indicates your overall assessment.

+2	Client answers generally suggest a much higher level of functioning than is the case.
+1	Client answers generally suggest a somewhat higher level of functioning than is the case.
0	Client answers generally suggest an accurate self-assessment of functioning.
-1	Client answers generally suggest a somewhat lower level of functioning than is the case.
-2	Client answers generally suggest a much lower level of functioning than is the case.

2. What are your general comments about the accuracy of the client's self assessment?

3. How long did it take to complete the questionnaire? _____

4. Please place this form inside the Minnesota Mental Health Client Outcomes Questionnaire and return with other materials to:

Minnesota Institute of Public Health
Attention: Sherri Lincoln
2829 Verndale Avenue
Anoka, MN 55303

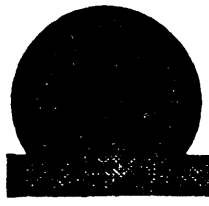
APPENDIX G:
Treatment Participation Form

Date: _____
Client's Name:_____

Global Assessment Score (GAS) (See Scoring Sheet): _____

)ount of Assistance Client Needed for Survey:_____
1) No assistance; 2) Some assistance; 3) Needed it read to them; 4) Client not able to complete; 5) Client refused

Minnesota Department of Human Services
Moose Lake Alternatives



Case Manager's Form

TREATMENT PARTICIPATION
Last 30 Days

Based on available treatment history information, rate the client's A) degree of treatment participation B) compliance with medication, and C) involvement in own treatment planning by circling the proper value on the seven point scale presented below. This rating should apply to the entire treatment plan, not just case management services. Circle one number only.

	Level	Score
A. Degree of Treatment Participation		
Attended almost all scheduled sessions (about 90%) and had very valid reasons for not attending those session which were missed. Clearly attempted to participate in treatment activities.	Full participation	01
Attended the majority of scheduled sessions (about 75-80%) and usually had a valid reason for canceled or missed sessions. Missed appointment did not interfere with treatment plan.	Participation	02
Attended many scheduled sessions (about 65%), but missed enough sessions) warrant some concern about client's alliance with staff and dedication to treatment plan.	Moderate participation	03
Has a very inconsistent record of attending scheduled appointments (about 50%) and often does not have reasonable explanation for missed appointments.	Marginal participation	04
Missed more than half of scheduled appointments (about 60% missed) and frequently had no reasonable explanation for missed appointments. Missed appointment made treatment continuity difficult to maintain.	Low participation	05
Frequently missed scheduled appointment (about 70% missed) and usually did not have a reasonable explanation for missing sessions.	Very low participation	06
Attended very few scheduled treatment sessions (less than 20%) and rarely provided an explanation for missing sessions. Typically expressed indifference or annoyance with treatment activities. Missed appointments serious undermined treatment plan goals.	Non participation	07

B. How often does the client take his/her medication, as prescribed?	Most of the time	01
	Sometimes	02
	Rarely	03
	Never	04
	Not applicable	NA

C. _oes the client assume an active role in his/her own treatment plan?	Yes	01
	Sometimes	02
	No	03

APPENDIX H:
Global Assessment Scale

Global Assessment Scale (GAS)

The Global Assessment Scale is a single rating scale for evaluating the overall functioning of a patient or subject at a specified time period on a continuum of psychological or psychiatric health-sickness.* The time period that is assessed is generally the last week prior to an evaluation, although for special studies a longer time period, such as one month, may be more appropriate.

The range of scale values is from 1, which represents the hypothetically sickest possible individual, to 100, the hypothetically healthiest. The scale is divided into ten equal interval ranges beginning with 1—10, 11—20, and ending with 81—90 and 91—100. The defining characteristics of each 10 point range comprise the scale. The two highest ranges, 81—90 and 91—100, are for those fortunate individuals who not only are without significant symptomatology, but exhibit many traits often referred to as "positive mental health," such as, superior functioning, wide range of interests, social effectiveness, warmth and integrity. The next range, 71—80, is for individuals with no or only minimal symptomatology but who do not possess the positive mental health features noted above. Although some individuals rated in the three highest ranges may seek some form of assistance for psychological problems, the vast majority of individuals in psychological or psychiatric treatment will be given ratings in the range from 1 to 70. Most outpatients will be in the four ranges from 31 to 70, and most inpatients on admission will be in the four ranges from 1 to 40.

Because the scale covers the entire range of severity it can be used in any situation or study where an overall assessment of severity of illness or degree of health is needed. In most studies only a portion of the scale will be actually used. For example, community studies will rarely have individuals in the lowest ranges, whereas studies involving newly admitted psychiatric patients will rarely have individuals in the highest levels. However, following a course of treatment, many individuals who may have been rated in a very low range on admission may be sufficiently recovered at follow-up to warrant a rating in one of the highest ranges. This is particularly true of patients with affective disorders whose functioning between episodes may be normal or even superior. It is also true that many patients given a diagnosis of schizophrenia during a period of personality disorganization, eventually recover and may later function at a relatively high level.

Since the ratings are for overall functioning during a specific time period, it is important that the rating be based on functioning and symptomatology during that time period and not be influenced by considerations of prognosis, previous diagnosis, or of the presumed nature of the underlying disorder. In a similar fashion, the rating should not be influenced by whether or not the patient is receiving medication or some other form of help.

The information needed to make the rating can come from any source: direct interview of the patient, a reliable informant, or a case record. Little information may be needed to make a rating at the low end of the scale. For example, knowledge that the individual made a serious suicidal attempt which almost resulted in his death is sufficient by itself to warrant rating a patient in the 1—10 range. On the other hand, before an individual can be given a very high rating it is necessary to not only determine the absence of symptomatology and any serious impairment in functioning, but also to ascertain the presence of signs of "positive mental health."

In making a rating one first selects the lowest range which describes the functiong during the one week time period. For example, a subject whose "behavior is considerably influenced by delusions" (range 21—30) should be given a rating in that range even though he has "marked impairment in several areas" (range 31—40). Then the defining characteristics of the two adjacent ranges are examined to determine whether the subject is closer to one or the other. For example, a subject in the range 31—40 who is much closer to the 21—30 range than the 41—50 range should be given a specific rating of 31, 32, or 33. A subject who seemed to be equally distant from the two adjoining ranges would be given a rating of 34, 35, 36, or 37.

---

*The original idea for a single rating scale of 1 to 100 for the health-sickness continuum with defined anchor points is embodied in Luborsky's Health Sickness Rating Scale. The Global Assessment Scale differs from it in the larger number of defined ranges, the avoidance of diagnostic considerations in defining anchoring points, and the use of brief clinical descriptions in the anchoring definitions.

Global Assessment Scale (GAS)

Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph. D.

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30), should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

GAS Rating: _____

100 | 91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity. No Symptoms.

90 | 81 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everyday" worries that only occasionally get out of hand.

80 | 71 No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70 | 61 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick."

60 | 51 Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50 | | 41 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40 | | 31 Major impairment in several areas, such as work, family relations, judgment, thinking or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), OR single suicide attempt.

30 | 21 Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive)or judgment (e.g., acts grossly inappropriately).

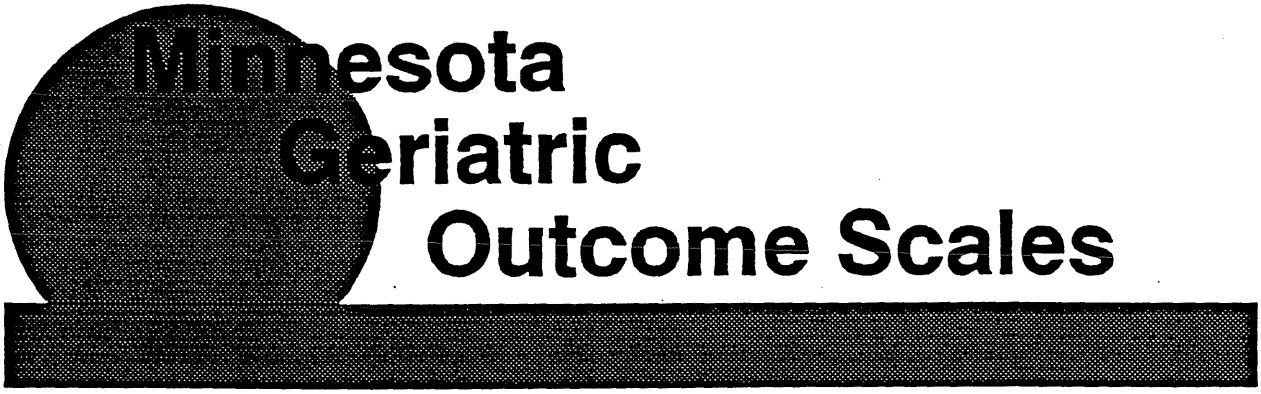
20 | 11 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (e.g., largely incoherent or mute).

10 | 1 Needs constant supervision for several days to prevent hurting self or others (e.g., requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

APPENDIX I:
Minnesota Geriatric Outcome Scale

Minnesota Department of Human Services

Moose Lake Alternatives



Thank you for participating in a study of mental health programs by the Minnesota Department of Human Services. It usually takes approximately 20 to 30 minutes to complete the questions asked in this study.

The *Minnesota Geriatric Outcome Scales* were developed as part of a set of instruments to evaluate the transfer of residents from a mental health facility to a community nursing home.

A number of questions are taken from the Minimum Data Set (MDS) required by the Nursing Home Reform Act (OBRA) and the Minnesota State Case Mix classification used for nursing home reimbursement. To prevent unnecessary duplication in collecting information, the questions also appearing in the MDS and Case Mix have the MDS or Case Mix number in parenthesis following the question.

If you have questions or would like to receive the final results of this study, please call the Mental Health Division's Information and Evaluation Team at:

(612) 297 2734

Patient's Name: _____

Name of Facility: _____

Completed by: _____

Date Completed: _____

Baseline Medical Data and Health Care Needs

This section is to be completed by staff having direct knowledge of the physical care and health needs of the resident and who also have access to medical records.

Unless directed otherwise, use the past 30 days as the time reference.

1. **Current health status of resident:**
   - [ ] Relatively good health, no current medical concerns
   - [ ] Currently experiencing minor ailments being treated and expected to clear within several days to several weeks. (Examples include cold, flu, bed sores, minor wounds, minor infections)
   - [ ] Suffering major health impairment(s) such as heart or lung problems, requires specialized nursing care, tube feedings, ostomies and catheters, etcetera.
   - [ ] Seriously ill, has had recent major surgery or will require major surgery soon
   - [ ] Seriously ill, no treatment options available -- appears terminal and may be or near comatose
   - [ ] Deceased within this reporting period

2. **List current neuroleptics and daily dosage (Case Mix 35-37)**

   _____

   _____

   _____

   _____

3. **List all other psychotropics and daily dosages (Case Mix 35-38)**

   _____

   _____

   _____

   _____

4. **How many times were prn medications given for agitation/anxiety ?** _____

5. **Caloric Intake / Appetite (check the appropriate box)**
   - [ ] Usually eats full meal or most of what is served. Receives adequate caloric intake.
   - [ ] Eats somewhat poorly, on occasion refuses meals or often refuses parts of meals. Avoids certain foods entirely.
   - [ ] Eats very poorly, often refuses meals or requires special programs/foods to maintain adequate caloric intake.
   - [ ] Inadequate caloric intake, losing weight, and/or special programs and diet are not maintaining weight.

6. **Resident's current weight: (MDS Sec L, Page 7)** _____

7. **Sleep patterns (check all applicable boxes)**

   a. [ ] Unchanged from previous patterns typical for this resident
   b. [ ] Sleeping noticeably more or less than usual pattern for this resident
   c. [ ] Restless, nightmares, disturbed sleep, or increased wakening
   [ ] Wanders for most or all of the night, has inability to sleep

8. **Average number of hours per night resident sleeps:** _____

Level of Functioning

Check the alternative that fits the resident or best describes the resident's behavior. Unless directed otherwise, please use the past 30 days as a time reference.

9. Dressing (Case Mix 14)	[ ]	Dresses without help of any kind
	[ ]	Needs supervision or programming such as laying out clothing, fastening, or whose performance is being monitored
	[ ]	Needs help from another person to put on clothing, resident participates
	[ ]	Needs to be dressed, unable to participate
	[ ]	Never dressed
10. Personal Hygiene (Case Mix 15)	[ ]	Grooms self without help of any kind
	[ ]	Needs supervision or programming
	[ ]	Needs help from another person, but participates
	[ ]	Unable to participate, needs to be groomed by another person
11. Bathing (Case Mix 16)	[ ]	Bathes without help of any kind
	[ ]	Needs minimal supervision or programming
	[ ]	Needs supervision only
	[ ]	Needs help in and out of tub
	[ ]	Needs personal help washing and/or drying body
	[ ]	Unable to participate, needs to be bathed by another person
12. Eating (Case Mix 17)	[ ]	Feeds self without help of any kind
	[ ]	Needs minimal supervision (reminders) or programming in eating
	[ ]	Needs personal assistance from direct care staff to cut meat, arrange food, et cetera
	[ ]	Needs partial feeding from another person including observation for choking or inappropriate behavior such as taking food from others or throwing food
	[ ]	Needs total feeding from another person, tube feeding, or intravenous feeding
13. Bed Mobility (Similar to Case Mix 10)	[ ]	Moves independently in bed
	[ ]	Changes position with help of equipment such as a trapeze
	[ ]	Assistance needed to sit up or to turn
	[ ]	Must be turned and positioned, does not participate
	[ ]	Resistive to turning, requires 2 or more staff to help

14. Transferring
(Similar to Case Mix 19)

[ ] Transfers independently
[ ] Independent with aid of devices/equipment
[ ] Transfers with help/supervision of **one** staff member (with or without equipment)
[ ] Transfers with help/supervision of **two or more** staff members (with or without equipment)
[ ] Needs to be transferred by another, does not participate, requires hoyer lift, etcetera

15. Walking: ***Guidance to a destination does not constitute a dependency in walking.***
(Case Mix 20)

[ ] Walks without help of any kind
[ ] Needs help of a device such as cane, walker, or crutches
[ ] Needs personal help of **one** person
[ ] Needs personal help of **two** persons
[ ] Unable to walk

16. Wheeling
(Case Mix 21)

[ ] Does not use wheelchair
[ ] Uses wheelchair independently, needs no personal help
[ ] Needs help negotiating doorways/elevators/ramps/locking brakes or uses power driven wheelchair
[ ] Needs total help with wheeling

17. Communication
(Case Mix 22)

[ ] Communicates needs and readily understood
[ ] Communicates needs with difficulty, but can be understood
[ ] Communicates needs with sign language, symbol board, written messages, gestures, or interpreter
[ ] Communicates inappropriate content, makes garbled sounds, or displays echolalia
[ ] Does not communicate needs

18. Toileting
(Case Mix 27)

[ ] Has catheter, is continent of bowel
[ ] Has ostomy, is continent of urine
[ ] Has catheter or ostomy and needs help to toilet
[ ] Independent (includes resident managing the problem of dribbling)
[ ] Needs help to toilet, no incontinence
[ ] Occasional incontinence, not more than once a week (includes resident receiving help with dribbling)
[ ] Nocturnal incontinence only
[ ] Incontinent bladder, more than once a week
[ ] Incontinent bowel, more than once a week
[ ] Incontinent bowel and bladder

19. Care of Own Living Space

[ ] Takes care of without any help
[ ] Needs occasional cues and reminders from staff
[ ] Needs frequent reminders and cues from staff
[ ] Needs personal assistance from staff but assists
[ ] Staff must perform, unable or unwilling to assist

20. Orientation to Place/ Person (Similar to Case Mix 25)

[ ] Oriented to place/person on consistent basis
[ ] Minor disorientation, occasionally needs to be reminded where living
[ ] Partial or intermittent periods of disorientation for several days, may lose orientation to place
[ ] Totally disoriented to place, does not know where living or location of place where living
[ ] Disoriented to person, does not recognize own name or identity

21. Restraints - Waking Hours (Similar to MDS Sec P3 page 7)

[ ] No need for mechanical restraints
[ ] Needs for several hours or less on an infrequent basis (a few days per week)
[ ] Needs for several hours or less daily
[ ] Needs more than several hours daily or for several episodes per day (Example: each meal)
[ ] Needs most or all waking hours

22. Restraints - During Sleep (Similar to MDS Sec P3, page 7)

[ ] Not used (include bed rails, trunk restraints, etc.)
[ ] Used less than every night
[ ] Used nightly

23. Recent Memory: (Similar to MDS Sec B2/B3, page 4)

Past several days, such as visitors, unusual events, last meal's contents, crafts recently completed, etcetera

[ ] Recalls details and sequences of recent experiences
[ ] Recalls details but confuses sequence of events
[ ] Cannot recall details, but recalls over-all event (Example: recalls family visit, but not which family member)
[ ] Cannot recall entire events without prompting
[ ] Cannot recall entire events, even with prompting

24. \ ldering (Similar to MDS Sec M3, page 3)

[ ] Not a problem
[ ] Wanders within facility, reliably returns (for meals, med's, activities, etcetera)
[ ] Moves aimlessly without destination, requires directives/reminders to return
[ ] Wanders and becomes lost, needs to be escorted back to room, etcetera
[ ] Wanders and becomes lost, resists directives and escorts

Responsive to Nursing Home Environment and Staff Directions

This section asks for ratings on several behaviors reflecting adjustment to the nursing home environment and staff management of residents.

25. Responses to various types of staff redirection and the frequency of these responses.

	Never	Rarely	Sometimes	Frequently	Always/Often
a. Responds to verbal directions with first prompt or cue	[ ]	[ ]	[ ]	[ ]	[ ]
b. Responds to directions only after repeated requests	[ ]	[ ]	[ ]	[ ]	[ ]
c. Requires manual redirection or manual prompts	[ ]	[ ]	[ ]	[ ]	[ ]
d. Hits, slaps at staff during manual redirection/prompts	[ ]	[ ]	[ ]	[ ]	[ ]
e. V ally abusive during manual or verbal redirection	[ ]	[ ]	[ ]	[ ]	[ ]

26. **Tolerance for Major Changes:** A major change is a significant change in daily living patters. Examples include a change in roommates, change in rooms, a change in family visiting pattern. This resident is likely to react to a major change by:

[ ] Limited or minimal distress or anxiety.

[ ] Moderate distress, agitation, or depression that can be managed by staff support or staff counseling.

[ ] Pronounced distress, agitation, or depression that is not easily managed by staff interventions. Resident's behavior in number of different functions, such as eating or sleeping, may deteriorate for a brief period of time.

[ ] Becoming highly aggressive, verbal outbursts, or self-abusive until adjusts to the change.

27. **Tolerance for Minimal Changes:** Minimal changes are very minor modifications of the daily routine. Examples would be a change in smoking time, change in eating, a change in where the resident sits in the day room. This resident is likely to react to minimal changes by:

[ ] Limited or minimal distress or anxiety.

[ ] Moderate distress, agitation, or depression that can be managed by staff support or staff counseling.

[ ] Pronounced distress, agitation, or depression that is not easily managed by staff interventions. Resident's behavior in a number of different functions, such as eating or sleeping, may deteriorate for a brief period of time.

[ ] Becoming highly aggressive, verbal outbursts, or self-abusive until adjusts to the change.

Interpersonal Behaviors and Emotional Responses

This section asks for frequency ratings on a number of emotional and interpersonal behaviors reflecting the mental health status of the resident. Check the column best describing the frequency of each behavior. Please use the past 30 days as a time reference.

	Never	Rarely	Sometimes	Frequently	Always/Often
28. Asks for help when needed	[ ]	[ ]	[ ]	[ ]	[ ]
29. Initiates contact/conversation with residents	[ ]	[ ]	[ ]	[ ]	[ ]
30. Initiates contact/conversation with staff	[ ]	[ ]	[ ]	[ ]	[ ]
31. Complains of pain, somatic problems	[ ]	[ ]	[ ]	[ ]	[ ]
32. Is agitated, cannot sit still, plays with hands, etcetera	[ ]	[ ]	[ ]	[ ]	[ ]
33. Exhibits or reports caring/concern for others	[ ]	[ ]	[ ]	[ ]	[ ]
34. Reports hearing voices or seeing things not actually there (hallucinations)	[ ]	[ ]	[ ]	[ ]	[ ]
35. Reports feeling sad, blue, depressed	[ ]	[ ]	[ ]	[ ]	[ ]
36. Reports strange ideas and beliefs that do not make sense (delusions)	[ ]	[ ]	[ ]	[ ]	[ ]
37. Sits unless directed into activities	[ ]	[ ]	[ ]	[ ]	[ ]
38. Is irritable and grouchy	[ ]	[ ]	[ ]	[ ]	[ ]
39. Is withdrawn, does not notice or attend to people or events around him/her	[ ]	[ ]	[ ]	[ ]	[ ]
40. Exhibits appropriate humor responses, smiles, laughs	[ ]	[ ]	[ ]	[ ]	[ ]
41. Reports various fears (dying, serious illness)	[ ]	[ ]	[ ]	[ ]	[ ]
42. Is tearful, has crying episodes	[ ]	[ ]	[ ]	[ ]	[ ]
43. Highly intrusive (gives lectures and directions to other residents, manually guides them against will)	[ ]	[ ]	[ ]	[ ]	[ ]
44. Talks about family and past life	[ ]	[ ]	[ ]	[ ]	[ ]
45. Knows and calls staff by their names	[ ]	[ ]	[ ]	[ ]	[ ]

	Never	Rarely	Sometimes	Frequently	Always/Often
46. Exhibits mood swings without cause	[ ]	[ ]	[ ]	[ ]	[ ]
47. Argues with other residents	[ ]	[ ]	[ ]	[ ]	[ ]
48. Reports fears of having things stolen	[ ]	[ ]	[ ]	[ ]	[ ]
49. Reports suspicions that people speak behind his back	[ ]	[ ]	[ ]	[ ]	[ ]
50. Reports positive things about self, good self-image	[ ]	[ ]	[ ]	[ ]	[ ]
51. Exhibits emotions in facial expressions / hand gestures	[ ]	[ ]	[ ]	[ ]	[ ]
52. Complains of memory problems	[ ]	[ ]	[ ]	[ ]	[ ]
53. Complains of being nervous and tense	[ ]	[ ]	[ ]	[ ]	[ ]

Quality of Life / Social Support - Resident Responses

Ask the resident each question and check the box that best paraphrases the response to the question.

If the resident is unable to communicate, indicate so and skip this section.

54. Is the resident able to communicate? [ ] YES [ ] NO

55. How happy are you with how often your family and friends come to visit?

[ ] Generally happy, satisfied, might be nice to have a few more visits

[ ] Somewhat satisfied and dissatisfied, would like more visits, not distressed by frequency of visitation

[ ] Dissatisfied, would like many more visits, does not exhibit undue distress, however

[ ] Very dissatisfied, feels abandoned by family, greatly distressed by lack of contact, may cry or express anger

56. Do you like living here?

[ ] Yes, very much, expresses satisfaction

[ ] Not sure, does and does not like present living situation

[ ] Does not like living situation

57. How many friends do you have here -- people you like and like to talk to?

Do not accept response that everybody is a friend, verify some preference to be around those identified as friends

[ ] No friends

[ ] One friend

[ ] Two friends

[ ] Three friends

[ ] Four or more friends

58. Do you feel safe here, that nothing bad is going to happen to you?

[ ] Feels safe

[ ] Somewhat safe, sometimes is afraid

[ ] Often afraid, does not feel safe

59. Do you think other residents and the staff like you?

[ ] Most do

[ ] Some do, some do not

[ ] Most do not

60. **How happy are you with the number of things or activities you can do here?**

[ ] Happy with number of activities he/she takes part in
[ ] Generally satisfied, but would like a few more things to do or be involved in
[ ] Very unsatisfied, would like a number of more things to do, feels bored, restless

61. **How do you feel about your medical care here?**

[ ] Very good, no complaints or only minor complaints
[ ] Good care, some complaints, but more satisfied than dissatisfied
[ ] Very dissatisfied, feels either quality or quantity of care is poor

62. **How do you like the food served here?**

[ ] Generally likes, reports positive evaluations about dinners and lunches served
[ ] Ambivalent, likes some, some not liked
[ ] Generally dislikes, but reports a few meals or menus liked or special foods that are served
[ ] Very negative, does not like, cannot think of any food or menu liked

Quality of Life / Social Support – Staff Responds

Ask staff the following questions.

63. **How often does resident receive visits from family or friends not residing at the nursing home?**

[ ] No visits
[ ] Once or twice a year
[ ] Three to eleven times a year
[ ] Once or twice a month
[ ] Once a week or more often

64. **How often does resident take part in activities, crafts, games, sing-alongs, any type of activity or hobby ?**

[ ] Several activities each day (do not count weekends)
[ ] Usually one activity each day (do not count weekends)
[ ] One or two activities across several days
[ ] Approximately one activity a week
[ ] One or two activities a month
[ ] No activities

Minnesota Department of Human Services
Community Mental Health Division
444 Lafayette Road
St. Paul, MN 55155-3828

APPENDIX J:
Community-Based Client Satisfaction Questionnaire

Minnesota Department of Human Services

Mental Health Division

Community-Based Client Satisfaction

Name: _____

Date: _____

Thank you for participating in a study of mental health programs by the Minnesota Department of Human Services. It usually takes approximately 15 to 20 minutes to complete this questionnaire on satisfaction with mental health services you received during the past six months.

The *Minnesota Community-based Satisfaction Survey* was developed as part of a set of instruments to evaluate mental health services delivery in Minnesota. The results of this evaluation will be used to determine needed changes to the types of services available, the way these services are provided, and the impact they have on clients.

The first part of this survey asks which services you received, the second section asks questions about your satisfaction with the services received, and the final section asks for comments and inquires about additional services you would have found helpful.

If you have any questions or would like to receive the results of this study, please call the Mental Health Division's Information / Evaluation Team at:

(612) 297 2734

WHAT SERVICES DID YOU USE ?

During the past 6 months, have you used the following services ? (Check one box for each service.)

SERVICE	Not at All	Very Little	Somewhat	Quite Regularly
a. Case Management	[ ]	[ ]	[ ]	[ ]
b. Psychiatrist(s)	[ ]	[ ]	[ ]	[ ]
c. Rule 36 Facility	[ ]	[ ]	[ ]	[ ]
d. Community Support (CSP) and/or Day Treatment	[ ]	[ ]	[ ]	[ ]
e. Professional Counseling Services	[ ]	[ ]	[ ]	[ ]
f. Crisis Services	[ ]	[ ]	[ ]	[ ]

IN GENERAL

Please answer the following questions about mental health services you received during the past 6 months.

Overall. . .

Were the services what you expected ?

- At All Times [ ]
- Most of the Time [ ]
- Generally [ ]
- Occasionally [ ]
- Never [ ]

How satisfied are you with your involvement in the treatment plan ?

- Very [ ]
- Pretty Much [ ]
- Somewhat [ ]
- Not at All [ ]

Was the combination of services you received helpful ?

- Very [ ]
- Pretty Much [ ]
- Somewhat [ ]
- Not at All [ ]

Have your medications been helpful in your recovery ?

- Very [ ]
- Pretty Much [ ]
- Somewhat [ ]
- Not at All [ ]

Please continue rating how satisfied you are with services you received from specific programs during the past 6 months.

PSYCHIATRIC SERVICES	Not At All	Not Too Satisfied	Somewhat Satisfied	Fairly Well Satisfied	Extremely Satisfied
a. Adequate Written Information (in addition to verbal explanations and instructions)	[ ]	[ ]	[ ]	[ ]	[ ]
b. Accessibility (convenience, getting appointments and/or advice)	[ ]	[ ]	[ ]	[ ]	[ ]
c. Family and/or Significant Other Involvement (encouraged, accepted, informed)	[ ]	[ ]	[ ]	[ ]	[ ]
d. Psychiatrist's Respect for you (listened and understood, considerate)	[ ]	[ ]	[ ]	[ ]	[ ]

RULE 36 RESIDENTIAL SERVICES	Not At All	Not Too Satisfied	Somewhat Satisfied	Fairly Well Satisfied	Extremely Satisfied
a. Accommodations (cleanliness, comfort, meals, privacy)	[ ]	[ ]	[ ]	[ ]	[ ]
b. Mental Health Services (MH services made available by the facility met your needs)	[ ]	[ ]	[ ]	[ ]	[ ]
c. Feeling Safe (non-threatening environment and location)	[ ]	[ ]	[ ]	[ ]	[ ]
d. Staff's Respect for you (listened and understood, considerate)	[ ]	[ ]	[ ]	[ ]	[ ]

VARIOUS CRISIS SERVICES	DID NOT USE	Not Satisfied	Somewhat Satisfied	Fairly Well Satisfied	Extremely Satisfied
a. Telephone Hotline (availability, accommodating, helpful)	[ ]	[ ]	[ ]	[ ]	[ ]
b. Emergency Room (accessible, helpful, timely service)	[ ]	[ ]	[ ]	[ ]	[ ]
c. Mobile Crisis Team (responsive, timely, helpful)	[ ]	[ ]	[ ]	[ ]	[ ]
d. Crisis Beds (available, accommodating, safe, accessible)	[ ]	[ ]	[ ]	[ ]	[ ]

SERVICES RECEIVED FROM SPECIFIC PROGRAMS

Thinking about each of the following programs, rate how satisfied you are with services you received during the past 6 months. Please skip any section asking about services that do not apply to you personally.

CASE MANAGEMENT	Not At All	Not Too Satisfied	Somewhat Satisfied	Fairly Well Satisfied	Extremely Satisfied
a. Availability of the Case Manager (ease of contacting, timely, available)	[ ]	[ ]	[ ]	[ ]	[ ]
b. Frequency of Meetings (when needed)	[ ]	[ ]	[ ]	[ ]	[ ]
c. Case Manager's Knowledge of the System (services available, program contents, accessing services)	[ ]	[ ]	[ ]	[ ]	[ ]
d. Case Manager's Knowledge of your Illness (aware of diagnosis, understands nature and effects of the illness)	[ ]	[ ]	[ ]	[ ]	[ ]
e. Case Manager's Respect for you (listened and understood, considerate)	[ ]	[ ]	[ ]	[ ]	[ ]

CSP/DAY TREATMENT	Not At All	Not Too Satisfied	Somewhat Satisfied	Fairly Well Satisfied	Extremely Satisfied
a. The CSP Programs (helpful, useful)	[ ]	[ ]	[ ]	[ ]	[ ]
b. Day Treatment Services (helpful, useful)	[ ]	[ ]	[ ]	[ ]	[ ]
c. CSP/Day Treatment Providers' Respect for you (listened and understood, considerate)	[ ]	[ ]	[ ]	[ ]	[ ]

PROFESSIONAL THERAPY	Not At All	Not Too Satisfied	Somewhat Satisfied	Fairly Well Satisfied	Extremely Satisfied
a. Helpful (positive approach to achieving goals and problems)	[ ]	[ ]	[ ]	[ ]	[ ]
b. Availability (accommodating, accessible, fit your schedule)	[ ]	[ ]	[ ]	[ ]	[ ]
c. Counselor's Respect for you (listened and understood, considerate)	[ ]	[ ]	[ ]	[ ]	[ ]

OMMENTS

Please list and comment on those mental health services you received during the past 6 months that were MOST helpful:

Please list and comment on those mental health services you received during the past 6 months that were LEAST helpful:

What services that you did NOT receive would have been helpful?

Mental Health Services:

Other Services:

If you have additional comments, please list them on back of this form.

Additional Comments:

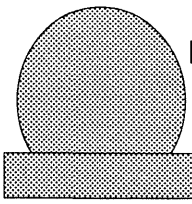
Minnesota Department of Human Services
Community Mental Health Division
444 Lafayette Road
St. Paul, MN 55155-3828

APPENDIX K:
Consent Form

We would like you to be part of a study. The State Department of Human Services wants to find out how helpful the mental health services in your area are. The Minnesota Institute of Public Health is doing the study for the State. You were chosen to be part of this evaluation because of the mental health services you receive.

Minnesota Department of Human Services

Moose Lake Alternatives



Mental Health Services Evaluation Participation Form

Your part in the study will last about one year. During this time you will help complete a survey about yourself four times: 1) today, 2) in one month, 3) in seven months, and 4) in 13 months. Someone will help you with the surveys each time.

The purpose of the survey is to see how the services you receive are helping you. The surveys ask questions about how you feel and how you are doing. It will take about 30-40 minutes. If there is a question you don't want to answer, you can skip the question.

Each of the four times you complete the survey you will be paid $5. And, for completing all 4 surveys a $5 bonus will be paid. This means that you could receive up to $25 for completing the 4 surveys.

If you choose to be part of the study, you may stop at any time. The services you receive will not depend on whether you complete the survey or agree to be in the study.

Any information we get from this study about you will remain private. Only agencies involved in the study can share information about you. These agencies are the Mental Health Division of Minnesota Department of Human Services, the Minnesota Institute of Public Health, and your case manager/social worker, if you have one. The information from the surveys will be used to see how people are doing. In any written reports or publications, you will not be identified.

As part of the study we will need to contact you during the next 13 months to have you complete the surveys. If you have a mental health case manager/social worker, they will contact you and help you with the surveys. They will also give you the $5 for the survey. In case we have trouble contacting you, we would like to have the name of a person whom we can contact to help find you.

If you have questions or concerns about the study, please contact Jerry Jaker at the Minnesota Institute of Public Health at 1-800-247-1303. Thank you.

I agree to participate in this study and you may contact:

Name: _____

Address: _____

Phone: _____ to help contact me.

_____ _____ _____ _____

Signature of Consumer/Guardian Date Signature of Witness Date

APPENDIX L:
Case Manager Feedback Format

This report is confidential under the Minnesota Data Privacy Act. Disclosure of its contents outside the welfare system is subject to criminal prosecution.

Case Manager Report for CLIENT

Level of Functioning, Quality of Life and Clinical Symptomatology Pre-Discharge and 30 Days Post-Discharge Results

by the
MLRTC MI TRANSITION EVALUATION TEAM

Overview

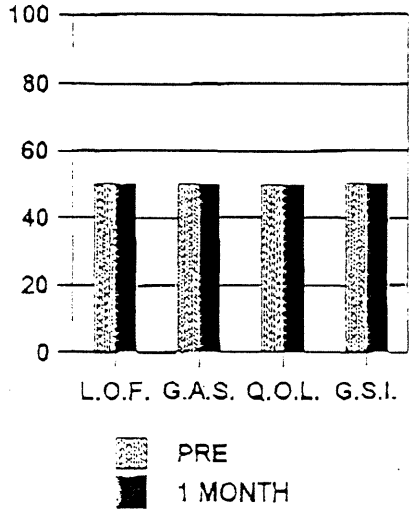
As patients of the Moose Lake RTC and the State-contracted hospital beds are discharged into an enhanced, community-based infrastructure, the Moose Lake Transition Evaluation Team is reviewing level of functioning, quality of life, clinical symptomatology, consumer satisfaction, and costs to the counties to determine changes in each of these areas. A report summarizing the results of the evaluation will be given to the legislature.

A set of instruments was completed, by those patients agreeing to participate in the study, less than 30 days prior to the patient's discharge into the community. County case managers administer the same set of instruments to the patient 30 days post-discharge, 6 months later, and again 13 months after the discharge.

This report summarizes the results for each instrument completed by the above-named client and discusses, briefly, the battery of instruments. It is not intended to replace a clinical synopsis of the patient nor to be a psychological diagnosis.

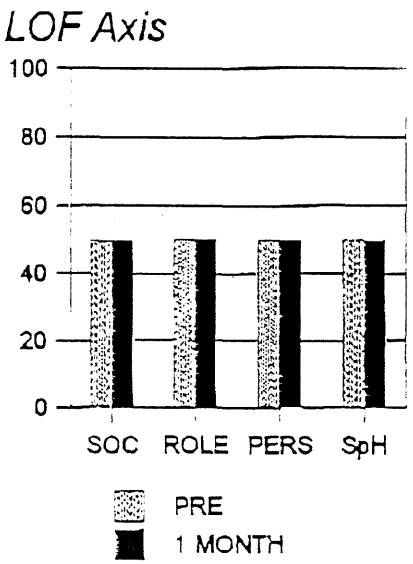
Note: The right (verticle bar graphs) and upper (horizontal bar graphs) bars represent results of the most recently completed instruments. The left/lower bars are the results for the previous administration of the battery of instruments.

The Minnesota Mental Health Client Outcomes Instrument measures level of functioning, quality of life and self-perception of overall health. In addition, some questions regarding service utilization (patient's perspective) and living situation are also collected for background information. Scores for each section are reported in a scale ranging from 0 to 100 -- the higher the score the better the patient is doing.



The *Self-perception of Health (SpH)* score reflects answers to two questions in the instrument. The patient is asked how, in general, he feels and how today's overall health compares to one year ago.

Global Level of Functioning (LOF) is determined by asking the person to rate degree of limitedness for 13 activities, problems with 13 items relating to level of functioning, and difficulty with 9 categories of activities. These answers are further sub-scaled into 3 axes: social, role, and personal.



Social Functioning (SOC) addresses personal relations with family members and others in one on one situations in addition to arranging interactions and maintaining group activities in the community.

The scale for *Role Functioning (ROLE)* measures ability to perform functions society tends to expect of all of us. This includes maintaining one's residence, money

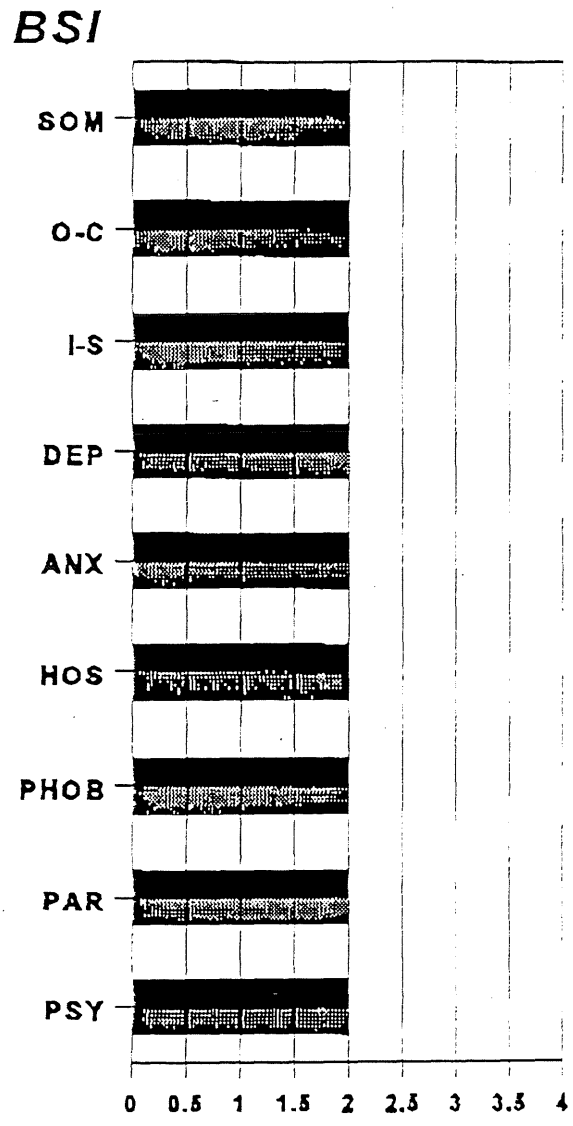
management, and work-related activity when relevant.

Personal Functioning (PERS) refers to taking care of oneself. In addition to measuring ability to take care of nutritional and hygiene needs, leisure activities and maintaining mental health are measured.

The Quality of Life (QOL) score, reported on a scale of 0 to 100, addresses how the individual feels THEIR NEED for each of 12 basic needs representing aspects of a quality lifestyle is being met.

The **Global Assessment Scale (GAS)** is the scale in this battery not based upon a patient's self-rating. This score is determined by the case manager on a scale of 1 to 100 with a higher number indicative of a higher level of functioning.

The Brief Symptom Inventory™ (BSI) is a self-reported symptom inventory developed by Leonard R. Derogatis, PhD. The respondent checks the degree he is distressed by each of 53 different symptoms associated with mental illness. In addition to a *Global Severity Index (GSI)*, this instrument has nine symptom dimensions. The higher the score the more the distress for a symptom.



The *Somatization (SOM)* dimension reflects distress arising from perceptions of bodily dysfunction. Items focus on cardiovascular, gastrointestinal, and respiratory complaints

The *Obsessive-Compulsive (O-C)* dimension includes symptoms that are often identified with the standard clinical syndrome of the same name.

Interpersonal Sensitivity (I-S) centers on feelings of personal inadequacy and inferiority, particularly in comparison with others. Self-deprecation, self-doubt, and marked discomfort during interpersonal interactions are characteristic of this syndrome.

Depression (DEP) reflects a representative range of the indications of clinical depression. Symptoms of dysphoric mood and affect are represented as are lack of motivation and loss of interest in life.

The *Anxiety (ANX)* dimension includes nervousness and tension, panic attacks and feelings of terror, and cognitive components involving feelings of apprehension.

The *Hostility (HOS)* dimension includes thoughts, feelings, or actions that are characteristic of the negative affect state of anger.

Phobic Anxiety (PHOB) is the persistent fear response -- to a specific person, place, object, or situation -- that is irrational and disproportionate to the stimulus and leads to avoidance or escape behavior.

Paranoid Ideation (PAR) represents a disordered mode of thinking with primary aspects of this disorder including projective thought, hostility, suspiciousness, grandiosity, centrality, fear of loss of autonomy, and delusions.

The *Psychoticism (PSY)* scale was developed to represent the construct as a continuous dimension of human experience. Items indicative of a withdrawn, isolated, schizoid lifestyle are included as are first-rank symptoms of schizophrenia, such as thought control.

The Moose Lake RTC Transition Evaluation Team with its contractor, the Minnesota Institute for Public Health, is reviewing progress for individuals with a serious and persistent mental illness requiring hospitalization under the public, mental health system. This includes the population discharged from the Moose Lake RTC after January 1, 1995 and persons using a State-contracted hospital bed during calendar year 1995. The State-contracted beds are located in Duluth, Grand Rapids, Hibbing, Cambridge and the Metro area.

For details on the evaluation contact the Community Mental Health Division at the Minnesota Department of Human Services or phone either:

Gary Mager at (612) 297 2096
or
Jerry Storck at (612) 296 1858

APPENDIX M:
Institutional Feedback

MOOSE LAKE REGION
PROCESS ASSESSMENT

June 6, 1996

INFORMANTS

POSITION OF INFORMANTS

	N	%
DHS staff	3	9%
County staff	11	33%
Providers	9	27%
State employees	6	18%
Contract hospital staff	3	9%
Other	1	4%
TOTAL	33	100%

LOCATION OF INFORMANTS

	N	%
State Government	3	9%
Northern Region	17	51%
Southern Region	13	40%
TOTAL	33	100%

HOW SUCCESSFUL WAS THE PLANNING PROCESS?

1. **Overall, how successful was planning for and implementation of the Moose Lake transition?**

	N	%
Very successful	10	30%
Mostly successful	18	55%
Neither successful nor unsuccessful	5	15%
Mostly unsuccessful	0	0%
Very unsuccessful	0	0%
TOTAL	33	100%

What were the strengths?

Inclusiveness

Openness and honesty of participants

Clear specific focus; public agreement to focus on consumer needs

Authority to plan locally; promises kept by those in power

Technical assistance and support, regionally and locally

Money and resources were available to support planning

Ongoing evaluation and monitoring meetings

What were the weaknesses?

Not everyone involved; particularly consumers and law enforcement not involved.

Things got rushed at the end

State bureaucracy; deadlines not met

Decisions made outside the process, particularly regarding the SOCS

Lots of time consumed at the local level

Poor integration between local and regional planning

Brainerd not included in planning

Medicare/Medicaid conflict regarding eligibility for contract beds

APPENDIX N:
Consumer Satisfaction Telephone Survey

RTC EVALUATION CONSUMER SURVEY

CLIENT INFORMATION

CONSUMER NAME: _____

CONSUMER PHONE: _____

DATE OF INTERVIEW: _____

CLIENT INFORMATION

Record contact information below:

RTC EVALUATION CONSUMER SURVEY

INTRODUCTION

Hello, my name is _____. I am working with the Minnesota Department of Human Services on an evaluation of mental health services in Minnesota. You may remember that when you were receiving services at _____ you agreed to participate in a study of the effectiveness of mental health treatment in Minnesota. This interview is part of that study.

I would like to ask you some questions about services you may have used in the past year. Your answers and those of others I talk to will be used to improve services. No one will know your answers to my questions and you do not have to answer any questions that you do not want to.

SERVICE USE

During the past year you may have used a variety of mental health services. I would like to know your opinion of each that you have used

How often they used it:
(Only Questions 1 to 6)

Less than once a month = 1
1-2 times a month = 2
3 of more times a month = 3

How helpful was the service?

Very helpful = 1
Mostly helpful = 2
Somewhat helpful = 3
Not helpful = 5

		Used?	How Often?	How Useful?
1.	Case management	Y/N	_____	_____
2.	Psychiatrist	Y/N	_____	_____
3.	CSP or Day Treatment	Y/N	_____	_____
4.	Professional Counseling	Y/N	_____	_____
5.	Crisis ervices	Y/N	_____	_____
6.	Supportive Employment	Y/N	_____	_____
7.	Housing support (to live in your own home or apt)	Y/N	_____	_____
8.	Halfway house or Rule 36 facility	Y/N		_____
9.	Inpatient psychiatric hospital	Y/N		_____

SATISFACTION WITH SERVICES

10. Overall, how satisfied are you with the mental health services that you have received?

___ Very satisfied
___ Satisfied
___ Neither satisfied nor dissatisfied
___ Dissatisfied
___ Very Dissatisfied

3. How could services be made better for you? This could include improving existing services OR adding new services?

Those are all my questions. Do you have anything you would like to add. Thank you for your time.

APPENDIX O:
Consumer Discussion Group Outline

APPENDIX P:
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APPENDIX Q:
Process Assessment Interview Schedule

MOOSE LAKE TRANSITION PROCESS EVALUATION
— INTERVIEW QUESTIONS —

The Moose Lake planning process evaluation interview has four main components. Some parts of the interview might not be relevant to your experience or perspective. If so, those questions will be omitted in the interview.

Planning and Implementation

The first section concerns planning and implementation of the closure of Moose Lake RTC and the development of community-based mental health alternatives. Questions include:

1. How directly have you been involved in planning and implementing an enhanced community-based mental health infrastructure in the catchment area?

2. Were all stakeholders in the transition given an opportunity to become involved in planning and implementation?

3. Were all important issues and concerns raised and addressed during planning and implementation?

4. Was there sufficient information and technical assistance for effective planning and implementation?

5. Was there sufficient time for effective planning?

6. Were sufficient human resources available for effective planning and implementation?

7. Were sufficient funds available for effective planning and implementation?

8. Was oversight of planning and implementation effective?

9. Overall, how successful was planning for and implementation of the Moose Lake transition?

10. Was there anything outside the planning and implementing process which affected the outcome in either a positive or negative sense? What?

11. How could the planning and implementation process have been better? If you were in charge and could redo the entire process, what would you do differently?

Current Status

The second section focuses on the current status of the Moose Lake transition.

12. At the current time are individuals with SPMI in [your county/the catchment area] receiving worse, the same or a better level of mental health services since the closure of the RTC?

13. At the current time is the range of services available for individuals with SPMI in [your county/the catchment area] worse, the same or better since the closure of the RTC?

14. What is the role being played by state operated community services in the catchment area?

Identification of Critical Incidents

The third section asks you to identify critical incidents in the planning and implementation for the program.

The central question is this:

> "What incidents can you think of that were critical in determining the outcome of planning and implementing the Moose Lake transition? From your point of view, what occurrences were most important in either a positive or negative sense in shaping the outcome of effort?"

Suggestions for Further Inquiry

The fourth section asks you, first, to suggest others (either individuals or groups), who should be included in the process evaluation and second, to propose questions that you would like to see addressed in the evaluation report.

APPENDIX R:
Consumer Discussion Group Results Summary

MEMO

TO: J. Storck, J. Jorgenson

FROM: S. Lund

DATE: May 22, 1997

RE: Duluth Consumer Discussion Group

This memo summarizes the results of the three Moose Lake Consumer Discussion Groups.

DESCRIPTION OF THE GROUPS

To assure coverage of the Moose Lake catchment area, three separate discussion groups were organized. The groups were organized and participants were recruited by the Minnesota Mental Consumer/Survivor Network.

Location and time:

The Duluth group was held on February 12th, from 5:00 PM to 7:30 PM.

The Cambridge group was held on February 21st, from 1:00 PM to 3:00 PM.

The Grand Rapids group was held on February 26th, from 5:00 PM to 3:00 PM.

Participants

Number of participants

Approximately 30 consumers participated in the Duluth discussion group. Because participants came and went during the meeting, the number of active participants was usually 10 to 15 persons. Ten consumers participated in the Cambridge Group. Two consumers participated in the Grand Rapids group.

Description of participants

Duluth consumers from three counties: Carlton, Lake and St. Louis. Camgbridge consumers were also from thee counties: Pine, Kanebec and Isanti. Both Grand Rapids consumers were residents of Itasca county.

Overall, consumers showed a range of diagnoses, functioning levels and experiences with the mental health system. One person, for example, had recently been discharged from the Eveleth facility, and another had been discharged from Moose Lake RTC twenty four years ago.

Moderator Impression

The discussion was lively and informative. Consumers did not seem reluctant to express their views candidly, nor were they hesitant to disagree with each other. Although a few mental health professions attended part of the discussion, their pretense did not seem to shape or hinder the group dynamic.

THEMES

In general the discussions followed the scripted dialogue (Appendix A), though relatively few of the consumers were aware of or concerned about the closure of Moose Lake RTC. Most wanted to talk about the strengths and weaknesses of the current system. The following themes emerged.

QUALITY OF INPATIENT SERVICES

Most consumers in the discussion groups had not had a recent inpatient mental health admission. Those who had a recent admission were generally, but not universally, positive about their experience.

POSITIVE ASPECTS ABOUT INPATIENT ADMISSION

The following were identified as positive features of at least some inpatient admissions.

- Caring staff who understand the concerns of SPMI persons
- Existence of aftercare, outreach and crisis programs
- Good facilities (e.g., clean and well maintained)
- Good access to physicians
- Feeling respected and having a sense of participation in treatment and aftercare planning

NEGATIVE ASPECTS ABOUT INPATIENT ADMISSION

The following were mentioned as negative features of at least some inpatient admissions.

- Uncaring staff who do not understand SPMI persons and are perhaps threatened by them

- Excessive and inappropriate use of physical restraints and also of electro-shock therapy

- Absence of therapy and other meaningful activities (e.g., "They put you in front of a television and let you sit there.")

- No smoking policy

- Nothing to do at night and on weekends

- Poor facilities (e.g., "The beds are too hard.")

DISCUSSION OF INPATIENT PROGRAMS

While there were too few participants in any particular inpatient program to make meaningful programmatic comparisons, there were some differences in experience and perception.

- All four consumers who had received inpatient services in a SOCS program were positive about their experience. "They made me feel safe," said one. Bridgehouse in particular and also the Eveleth Health Facility were widely praised.

- The one participant who had received inpatient services in Brainerd HSC was negative about the experience. Other consumers reported that prevailing opinion was that "Brainerd is worse than Moose Lake and Eveleth is better than Moose Lake." Many consumers seemed to feel, as one Duluth participant phrased it, "Smaller and more humane programs, close to home, are best."

- There was considerable diversity of opinion regarding hospitals participating in the contract bed program. In general, consumers were more positive about hospital within the catchment area (Miller-Dwan, Itasca, Hibbing and Cambridge) than hospitals outside the catchment area (St. Paul Ramsey and St. Paul United).

  Many consumers seemed to agree with a Duluth participant who stated, "[the contract bed] hospitals seem to be getting better as the learn how to work with [SPMI persons]."

QUALITY OF COMMUNITY SERVICES

Almost all consumers had significant experience with community oriented mental health services. Most were positive about the services available to them.

POSITIVE ASPECTS OF COMMUNITY PROGRAMS

The following were identified as positive features of community programs.

- Programs have caring staff who are aware of issues important to SPMI persons. Said a Duluth participant, "The people at Bridgehouse know me. They know when I need help and when I just need to sit and be quiet."

- A wide range of programs are available and consumers have some choice among programs. Many participants think this has improved since the Moose Lake Transition.

- There is good communication and coordination among programs. Many also think this has improved since the Moose Lake Transition. A consequence of this improved communication and coordination, said one Duluth participant, is an increased "client orientation" and greater consumer ease in moving among programs.

- Availability of Drop-in centers and other consumer organized programming. A Grand Rapids participant remarked "Keisler House has been a God-send."

PROBLEMS AND ISSUES CONCERNING COMMUNITY PROGRAMS

The following were identified as problems and issues concerning mental health community programming.

- Limited or inadequate crisis services. Said one Cambridge participant, "I have my worst moments in the middle of the night, when there is no one to talk to." Said a Duluth participant, "When I call the crisis line at St. Lukes all they do is tell me to take a bath."

- Activities not available during midday or late at night. A Duluth participant

commented, "If there is nothing to do I stay at my apartment and play pool."

- Problems with transportation. In cities like Duluth, moving around a night and in the winter can be a problem, particularly for women. In more rural areas merely getting from home to a program is often difficult to arrange.

- Problems with psychiatric coverage and medications management. Because of problems with medical coverage some consumers were not able to see the psychiatrist they wished. Others felt that their psychiatrist did not spend enough time with them. Still others were not able to see the same psychiatrist consistently and felt they had to change medications too often and unnecessarily.

DISCUSSION REGARDING SUPPORT IN THE COMMUNITY

Consumer interest and concern was greatest regarding mental health community programming. As one participant put it, "We want help staying out of the hospital and in the community." Discussion of optimal community support for mental health service consumers touched on a number of topics.

CASE MANAGEMENT SERVICES

About half of the participants in the three groups were currently using case management services. All were positive about the quality of case management services and about the willingness of their case manager to help them. Some, however, reported difficulty keeping in contact with their case manager because of burgeoning caseloads. Said a Cambridge participant, "I leave a message on the answering machine but sometimes its days before I get an answer."

HOUSING

Housing was a major concern. Many participants complain that lack of adequate low income housing means that consumers can be forced to stay in inappropriate or overly restrictive lodging. Some participants also felt that landlords were "gouging and exploiting" consumers, while waiting lists for publically supporting housing are too long. Many participants called for greater

support for consumers to find homes and be able to remain in them.

EMPLOYMENT

Employment was also a major issue for many participants. Many consumers wish to work but have difficultly obtaining work training and assistance in finding jobs that pay a living wage. New efforts like Project Employability are promising, but there are often waiting lists and it is not clear if these programs will be continue to be funding over time.

CONCLUSION AND RECOMMENDATIONS

While few consumers attributed recent changes in the public mental health system to the closure of Moose Lake RTC, most seem to feel the system is functioning well and many feel it has gotten significantly better in recent years. A number or recommendations were offered for further improvement. These incluced the following.

- Do not weaken the current system. Many consumers were fearful that welfare reform and managed care would limit the assistance available to them.

- Strenthen investment in crisis services, aftercare and community support for consumers. Mobile crisis teams, more programs like Bridgehouse (Duluth) and Keisler House (Grand Rapids) were widely recommended, as was 24 hour availability of crisis counseling.

- Straighten out and clarify problems with medical coverage for mental health services, and remove impediments to work and independent living.

- Provide coverage for medications. Said one consumer, "The new medications are wonderful, but they are too expensive. I can't afford to take them."

APPENDIX S:
Roster of Evaluation Advisory Committee

Ms. Pam Brumfield
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phone 679-4740

Mr. Kevin Ferris
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Mr. Kurt York
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APPENDIX T:
List of Evaluation Consultants

RTC EVALUATION PROJECT

— Project Consultants —

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APPENDIX U:
RTC Project Mini-Newsletters

RA 790.65 .M6 M67 1997

Moose Lake transition
project evaluation

RA 790.65 .M6 M67 1997

Moose Lake transition
project evaluation

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Update

An Activity Update on the RTC Transition Evaluation Project

Spring 1995, Number 1

Since We've Begun

by Jerry Jaker and Sander Lund

The Minnesota Institute of Public Health (MIPH) is pleased to have been contracted by the State for this important study. We hope to help profile what is learned about the transition of clients from RTCs to community based settings. The key to the study is of course the tracking of outcomes for clients. Since the project has begun, we have now started outcomes for over 100 clients in the system from a combination of Moose Lake RTC and Anoka-Metro catchment areas. We anticipate something around 400 clients through the study by the project year's end in December 1996.

Please take a moment and look at the catchment area update figures later in this newsletter. This will help give you a picture of the status of the study with the clients, and underscore the need for your assistance and cooperation. It is very much valued.

If we can be of assistance to you or if you have questions, contact us at 1-800-247-1303 Greater Minnesota, and 427-5310 Twin Cities metro. ♦

From the State

by Jerry Storck

As part of the Moose Lake RTC transition and the development of contracted hospital beds for Anoka-Metro RTC, an evaluation is being conducted to determine the impact of these changes on the clients of these services as well as the system in general. The Minnesota Institute of Public Health has the contract to carry out the evaluation activities. A key component of the evaluation is the tracking of client outcomes through a client completed survey administered in the hospital and by case managers. In addition, a consumer satisfaction survey will be mailed to clients. The other major aspect of the evaluation will be interviews with people involved in planning and implementing the transition as well as those who have been affected by the change. A third aspect will be examining the impact on service use and costs. We feel that tracking the impact of this change can be beneficial to you as well as the Legislature and possibly even other states.

A key to the success of carrying out the evaluation is your cooperation. We are trying to increase client participation by offering a $5 incentive to the client for each time he/she participates. We are also trying to make the case manager's involvement meaningful by providing feedback to case managers on the clients they serve who are part of the evaluation. In addition, this mini-newsletter will serve to periodically update you regarding plans and developments as well as share information from the evaluation. We thank you for your interest, involvement, participation and support. We welcome your feedback as always. ♦

Let Us Hear From You

We welcome your feedback and would like to consider printing your comments and questions about the RTC Transition Evaluation Project. FAX your comments or questions to Jerry Jaker of the Minnesota Institute of Public Health at 612-427-7841, or call 612-427-5310. ♦

If a colleague should see this Update, please route it.

Catchment Area Update

The chart below profiles for your catchment area the RTC and contract bed intake and follow-up numbers. Anything you can do to help expedite the participation will be most appreciated.

	No. of Intakes into Study	No. of Refusals	One Month Follow-up Received
Moose Lake RTC			
Adult	38	26	14
Geriatric	23	0	21
Contract Bed			
Miller Dawn	2	0	2
Itasca	1	0	0
Mesabi	2	0	1
Cambridge	0	0	0
Anoka-Metro			
Anoka RTC	3	0	1
HCMC	16	9	2
St. Paul Ramsey	0	0	0
Mercy	3	2	1

(as of June 25, 1995)

The Players

Department of Human Services

- Sharon Autio, Director of Adult Service System Development
- Gary Mager, Director of Quality Management Services
- Jerry Storck, Research Analysis Specialist

Evaluation Advisory Committee

- Pam Brumfield, Kanabec County Family Services
- Kevin Ferris, Mental Health Consumer/Survivor Network
- Judy Holden, St. Louis County Social Services
- Don Holmquist, Ramsey County Human Services
- Mary Huggins, Hennepin County Adult Services
- Rick Immler, Anoka-Metro Regional Treatment Center
- Bruce McNickle, Moose Lake Regional Treatment Center
- Kurt [illegible] Moose Lake Treatment

Project Staff

- Jerry Jaker, Project Director
- Sander Lund, Research Consultant
- Sherri Lincoln, Clerical Support

Project Consultants

- Cliff Nelson
- Zig Stelmachers
- Thomas Kiresuk, Licensed Consulting Psychologist, Kiresuk, Inc.
- Scott Lenz, Research Associate, Program Evaluation Resource Center ♦

What will happen next?

By the time you receive this newsletter the Moose Lake RTC will have been closed. It is critical we continue to track clients in the community and we thank Dr. Bruce McNickle for all of his assistance, as well as thanking in advance staff for their assistance with us in tracking clients in the Moose Lake catchment area.

Periodic updates to you through this mini-newsletter format will come your way. If you have ideas or issues you'd like us to attempt to address in such a mini-newsletter format as this, please let us know.

Additional work to assess the cost analysis of clients to the state and counties at various points in time will take place as part of this study.

A process evaluation is about to begin in both the Moose Lake and Anoka-Metro regions. Interviews with participants and stakeholders in the mental health system in the State as a whole and in the two catchment areas will help to identify features of change planning which seem particularly helpful and perhaps not so helpful.

Results of the evaluation will be used to improve planning for future change. You may be contacted by us. ♦

Minnesota Institute of Public Health
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Fall 1995, Number 2

Update

An Activity Update on the RTC Transition Evaluation Project

From the State

by Sharon Autio

The implementation of a community-based mental health infrastructure in the eleven Moose Lake counties and the establishment of contract beds in both the Moose Lake and Anoka-Metro area represent major initiatives for the Mental Health and State Operated Services Division as well as the counties in these areas.

The Evaluation of these major initiatives should provide the counties and the State with invaluable data to assess the impact of these new service delivery models on the lives of individuals as well as the quality and costs of these alternative services. We expect that the results of this study will help to inform future policy decisions as we examine how to best deliver quality mental health services in new and creative ways.

The results of the evaluations will only be as good as the data we receive. Overall, we have had excellent cooperation from the case managers and staff of the contract hospitals. I thank you for your extra efforts in assisting us with this important study and ask for your continued cooperation. ♦

RTC EVALUATION -- CLIENT SURVEY INFORMATION RECEIVED **Month: through Aug. 31, 1995**

Intakes Into Study -- Moose Lake Area

		Refusal at Intake	
		Client Refusal	Unable
MLRTC	52	16	9
Geriatrics	29		
Central Mesabi	3	2	
Miller-Dwan	3	1	
Itasca	0		
Cambridge	2		
Eveleth	1		

TOTAL INTAKES INTO STUDY FROM MOOSE LAKE AREA = 90
(active numbers--no refusals)

Intakes Into Study -- Anoka-Metro

		Refusal at Intake	
		Client Refusal	Unable
United			
AMRTC	22	3	
HCMC	28	8	
St. Paul-Ramsey	2	1	
Mercy	5	1	

TOTAL INTAKES INTO STUDY FROM ANOKA-METRO AREA = 57
(active numbers--no refusals)

FOLLOW-UP FROM COUNTY--MOOSE LAKE

	30 day	6 Month	13 month	Non-participation summary: Client Refusal	Can't Locate Client	Client Unable to do	No CM Response
Carlton	2			1			
Cook							
Itasca	2						
Koochiching	2						
Lake							
St. Louis	19	2		5	1	3	
Chisago						1	
Isanti	2			1			
Kanabec	2						
Mille Lacs	3						
Pine							
Ah-Gwah-Ching	9	4					
Other Nursing Home	22	6					

FOLLOW-UP FROM COUNTY--ANOKA-METRO

	30 day	6 Month	13 month	Non-participation summary: Client Refusal	Can't Locate Client	Client Unable to do	No CM Response
Anoka	1			1	1	1	
Dakota							
Hennepin	11			5	3		
Ramsey							
Sherburne					1		
Washington							

Overview of Cost Analysis Study

by Cliff Nelson

MIPH consultants have been working with various DHS staff on fiscal issues relating to the RTC Transition Evaluation Project. DHS-provided individual cost data has been under study for the purpose of testing the "inclusiveness" of the cost data available through DHS. This source provided client-specific fiscal data such as total case management costs, number of MLRTC days, total MLRTC costs, total non-MLRTC costs and total county costs; all of which are available in 6-month increments on all services received, retroactive to July 1, 1994.

With some minor adjustments of this data by DHS, these costs represent accurate enough data to show various programmatic and fiscal trends on individual clients. Costs can be identified for approximately 34 different services as listed in the Service Activity and Funding Estimate (SAFE) Report, such as case management, day treatment programs, adult residential, outpatient treatment, etc.

Currently this DHS individual-client information system is being authenticated on six active St. Louis County clients by Judy Holden and two active Kanabec County clients by Pam Brumfield. Actual costing out of individual MLRTC clients will begin shortly after October 1, 1995, when the last client is admitted into this project.

A second system of determining costs currently under study by DHS and affected counties is known as the "Hold Harmless" legislation. The purpose of this legislation is to assure that the 11 counties in the MLRTC area are not required to assume an increase in the county share of cost of care as a result of the closure of MLRTC.

This process will look at various categories of costs (MLRTC adult MI unit, MLRTC hold orders, acute care -- including hold orders, sos county share, Brainerd RTC adult MI unit and Brainerd RTC hold orders) for the following calendar years: 1992, 1993, 1994, 1996, 1997 and 1998. 1995 will be viewed as a year in transition.

The first system is more individually and clinically-oriented through the use of individual client data; whereas the second system is more global and looks at county funding. DHS's intent is to have both systems developed as fully as possible, as each will give different programmatic and management evaluative and decision-making data on the closing of MLRTC.

Financially, with regard to the Anoka-Metro RTC, the RTC Transition Evaluation Project will focus on individual clients, both programmatically and fiscally. The scope of study will also be larger in that it will include collateral costs associated with the mentally ill commitment process in each of the three metro counties -- Hennepin, Ramsey and Anoka. This will involve looking at additional costs generated by units outside DHS, such as the Hennepin County Departments of Courts and Adult Services. ♦

The Players

Department of Human Services

- Sharon Autio, Director of Mental Health and State Operated Services Division
- Gary Mager, Manager of Quality Management Services
- Jerry Storck, Research Analysis Specialist

Project Staff

- Jerry Jaker, Project Director
- Sander Lund, Research Consultant
- Sherri Lincoln, Administrative Asst.

Project Consultants

- Cliff Nelson
- Zig Stelmachers
- Thomas Kiresuk, Licensed Consulting Psychologist, Kiresuk, Inc.
- Scott Lenz, Research Associate, Program Evaluation Resource Center

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- Judy Holden, St. Louis County Social Services
- Don Holmquist, Ramsey County Human Services
- Mary Huggins, Hennepin County Adult Services
- Rick Immler, Anoka-Metro Regional Treatment Center
- Bruce McNickle, Moose Lake Regional Treatment Center and Anoka-Metro Regional Treatment Center
- Kurt York, Moose Lake City Council
- Darnell Nelson, Consumer/Family Regional Resource Center

Let Us Hear From You

Comments or questions on the RTC Evaluation Project should be directed to Jerry Jaker of the Minnesota Institute of Public Health 612-427-5310 or 1-800-247-1303. ♦

Prepared for County Leaders, Case Managers, Advocates, Mental Health Services Providers and other Interested Individuals by the Minnesota Institute of Public Health, on contract with the Mental Health Division, State of Minnesota

Spring 1996, Number 3

Update

An Activity Update on the RTC Transition Evaluation Project

From the State

by Sharon Autio

We are at the half-way mark in the evaluation process to assess the impact of the Moose Lake RTC (MLRTC) closure and the development of contract bed capacity in the metropolitan area. Both studies are designed to assess three major areas: 1. consumer outcomes, 2. service utilization and cost of services, and 3. the planning and implementation process.

At this midway point, 106 clients the MLRTC area, 31 geriatric patients and 107 individuals in the Anoka-Metro RTC catchment area have entered the study. Seven measures, including a consumer satisfaction survey, are being employed to measure a range of outcomes. Preliminary data indicate that level of functioning and quality of life are the same or better than at baseline. One of the major concerns we are facing is the significant decrease in the client base as we go forward. Without consistent numbers to make sound comparisons, we may be faced with a lack of meaningful data from which to make assumptions and to generalize the findings.

At this time, the service utilization and cost data are too preliminary to report and will be described in detail at the completion of the study.

The process interviews of key stakeholders are nearing completion. In the MLRTC catchment area, 38 individuals have been interviewed. Of that number, 74 percent felt persons with serious and persistent mental illness were better served since the closure of MLRTC. Ninety (90) percent felt the range of mental health services were improved. State operated services were seen as integrated into and supplemental to the delivery system. A small number of interviewees expressed some concern that the potential for competition between the State and the pre-existing mental health provider network existed. With respect to the planning process, the majority felt the process went well. Positives included the authority to plan locally, inclusiveness at the regional and local level, a clear specific focus on consumer needs and the availability of resources. Areas that presented some difficulties included time demands on the planning process, delays due to the cumbersomeness of the state bureaucracy and issues related to integration of regional and local planning.

Seventeen (17) stakeholders in the AMRTC area have been interviewed. Decreased waiting lists at AMRTC, shorter lengths of stay in community hospitals and greatly reduced diversions to outstate RTC's were identified as positive outcomes. The most commonly mentioned problem has been the relatively restricted base of clients, due to reimbursement issues, who could access the contract beds when needed.♦

Let Us Hear From You

We welcome your feedback and would like to consider printing your comments and questions about the RTC Transition Evaluation Project. FAX your comments or questions

Jerry Jaker of the Minnesota Institute of Public Health at 612-427-7841, or call 612-427-5310. ♦

If a colleague should see this Update, please route!!

What's Up Next

Among the next steps for the project are these:

- Produce draft process evaluation reports. Summaries will be sent to respondents for comment before final reports are prepared.
- Conduct service satisfaction interviews by telephone of former and current clients.
- Deliver feedback of results to the institutions participating in the client level evaluations.
- Continue cost and service use analysis for the Anoka-Metro and Moose Lake areas.

We'll keep you posted. ♦

Catchment Area Update

Month: through Feb. 29, 1996

Intakes Into Study -- Moose Lake Area

		Refusal at Intake	
		Client Refusal	Unable
MLRTC	52	16	9
Geriatrics	31		
Central Mesabi	9	3	
Miller-Dwan	4	2	
Itasca	1		
Cambridge	2		
Eveleth	7	3	

TOTAL INTAKES INTO STUDY FROM MOOSE LAKE AREA = 106
(active numbers--no refusals)

Intakes Into Study -- Anoka-Metro

		Refusal at Intake	
		Client Refusal	Unable
United			
AMRTC	45	9	
HCMC	41	30	
St. Paul-Rams	11	3	
Mercy	10	1	

TOTAL INTAKES INTO STUDY FROM ANOKA-METRO AREA = 107
(active numbers--no refusals)

FOLLOW-UP FROM COUNTY--MOOSE LAKE

	30 day	6 Month	13 month	Non-participation summary: Client Refusal 30	6	13	Can't Locate Client 30	6	13	Client Unable to do 30	6	13	No CM Response 30	6	13
Carlton	5	3	1	1											
Cook															
Itasca	2	2		2						1			1		
Koochiching	2	2										1			
Lake															
St. Louis	26	11	3	5	3		3						4		
Chisago	1			2						2					
Isanti	3	2		3											
Kanabec	2	1													
Mille Lacs	4									1					
Pine	1			1			1								
Ah-Gwah-Ching	9	12	10												
Other Nursing Home	22	15	12												
TOTAL (excl. Geriat.)	*46*	*21*	*4*	*14*	*3*	*0*	*4*	*0*	*0*	*4*	*0*	*1*	*5*	*0*	*0*
TOTAL (incl. non-part.)	*73*	*24*	*5*	*non-participation totals*									*27*	*3*	*1*

FOLLOW-UP FROM COUNTY--ANOKA-METRO

	30 day	6 month	13 month	Non-participation summary: Client Refusal 30	6	13	Can't Locate Client 30	6	13	Client Unable to do 30	6	13	No CM Response 30	6	13
Anoka	5	2		3						1			2		
Dakota	2			1											
Hennepin	36	13		6	2		3	3					4		
Ramsey	10	1		3						2			6		
Sherburne				2									1		
Washington	1	1											1		
TOTAL	*54*	*17*	*0*	*15*	*2*	*0*	*3*	*3*	*0*	*3*	*0*	*0*	*14*	*0*	*0*
TOTAL (incl. non-part.)	*88*	*21*	*0*	*non-participation totals*									*35*	*5*	*0*

The Players

Department of Human Services

- Sharon Autio, Director of Mental Health and State Operated Services Division
- Gary Mager, Manager of Quality Management Services
- Jerry Storck, Research Analysis Specialist

Project Staff - Minnesota Institute

- Jerry Jaker, Project Director
- Sander Lund, Research Consultant
- Sherri Lincoln, Administrative Asst.

Project Consultants

- Cliff Nelson
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- Thomas Kiresuk, Licensed Consulting Psychologist, Kiresuk, Inc.

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- Bruce McNickle, Moose Lake Regional Treatment Center and Anoka-Metro Regional Treatment Center
- Curt Yort, Moose Lake City Council
- Darnell Nelson, Consumer/Family Regional Resource Center