Summary of the Work
of the
Minnesota Adult Mental Health Statewide Task Force

January 1, 1995

Pursuant to 1993 Minn. Laws First
Spl. Sess. Chap. 1 Art. 7 Sec. 48

Introduction

The 1993 State Legislature passed a law requiring the Commissioner of the Department of Human Services (DHS), a statewide task force, and local task forces to develop recommendations for improving the state's public mental health system(s) for adults. Twenty-four local task forces submitted recommendations to the statewide task force and to DHS in June, 1994. DHS will submit its own recommendations in January, 1995, based in part on local recommendations and the work of the statewide task force.

The statewide task force after a year-long effort, was unable to reach consensus on findings or recommendations. This document, therefore, does not include recommendations. It is instead a summary of the work of the statewide task force, submitted in lieu of a final report.

Executive Summary

The 1993 legislation (see Appendix) required that DHS convene a statewide task force "to study and make recommendations concerning adult mental health services and funding." Further, the legislation required the task force to:

> "examine all possible county, state, and federal sources of funds for adult mental health with a view to improving methods of coordinating services and maximizing all funding sources and community support services, and increasing federal funding."

The legislation also required that the task force be composed of representatives from over 40 specific groups or entities, many with divergent viewpoints and interests. The task force combined these entities into nine stakeholder groups: advocates, consumers, county employees, county governments, cultural minorities, legislators, community service providers, state agencies, and state employees.

The state task force's year-long effort to achieve consensus on significant recommendations proved unsuccessful, as differing stakeholder interests could not be resolved. The task force did produce a report to assist the work of local task forces, and increased among its members mutual understanding of stakeholder positions. The task force discussed many serious problems with the current systems, some of these brought forward by the consumer (mental health client) members of the task force. The task force examined information on mental health problems and reform in other states.

County-based local mental health advisory councils (LACs) were encouraged by the legislation to form local task forces. As with the state task force, these local task forces were to include representation of specific interest groups. They were to forward their recommendations to the state task force and to the Department of Human Services. Twenty-four local task forces, representing thirty counties, submitted over 600 recommendations. The combined population of these thirty counties totals 75% of the state's population.

The inability of the state task force to reach consensus on recommendations should not diminish the importance of improving the adult mental health system. Many task force members believe that the mental health system needs reform, and that the barriers preventing this from occurring should be removed. The task force could not agree on *how* to reform the current systems.

Mandate and Goals

Laws of Minnesota (1993), First Special Session, Chapter 1, Article 7, Section 48, (see Appendix) required the Commissioner of Human Services to convene a statewide task force "to study and make recommendations concerning adult mental health services and funding." The legislation required the task force to...

> "examine all possible county, state, and federal sources of funds for adult mental health with a view to improving methods of coordinating services and maximizing all funding sources and community support services, and increasing federal funding."

The task force's primary goal was to produce a set of findings and recommendations for the Legislature and the Department, describing the changes that should be made in the current financing and services systems. Another goal was to produce a preliminary report that would assist local task forces in organizing and in producing their own recommendations. A third goal of the state task force was to increase its members' understanding of the various stakeholder viewpoints and interests.

Resources

The legislation appropriated $100,000 to pay for task force expenses and facilitation of meetings. These funds were administered by DHS. The Department provided staff to support the work of the task force, and private individuals and corporations contributed $3,000 for expenses.

Facilitation was provided by a three-member team, drawn from Belden Hyatt and Open Field, two St. Paul based consulting firms. The task force selected these facilitators through a public bid process.

Organization

The authorizing legislation identified over 40 entities or groups to be represented on the state task force, with more than one representative required from most groups. In order to implement the statutory requirements, DHS initially appointed 49 members. After further discussion with these initial 49 members, DHS agreed to appoint a total of 93 members to fully comply with the intent of the legislation. The task force then agreed to create smaller sub-groups to perform most of its work. As part of this process, the task force combined the statutorily identified groups into a more manageable total of 9 groups (Figure 1). The task force relied on this definition of the key stakeholder groups in forming most of its workgroups. Each stakeholder group contributed one member to each workgroup, resulting in balanced representation.

The first such workgroup recruited, screened, and hired the facilitators required by the legislation. Based on that successful model, the task force next created a steering committee, also with equal representation from each of the nine stakeholder groups, to provide leadership and streamline decisionmaking. This committee was empowered to make operational decisions and to make substantive recommendations to the task force under the conditions described below.

Additional workgroups were formed throughout the year. One studied, mapped, and

Figure 1
Stakeholder Groups Comprising the Task Force

Statutory Language (adapted *)		Working Groups
The task force shall consist of: the commissioners of health, jobs and training, corrections, and commerce; the director of the housing finance agency; two members of the house of representatives and two members of the senate; persons diagnosed with mental illness and family members of persons with mental illness; mental health professionals; county social services personnel; public and private service providers; advocates for persons with mental illness; representatives of the state mental health advisory council; and public employee representatives from each of the state regional treatment centers serving adults with mental illness, from the division of rehabilitative services, and from county public employee bargaining units. Public employee representatives must be selected by their exclusive representatives.	▸	Advocates Consumers County employees County government Cultural minorities Legislators Community providers State agencies State employees

* See Appendix for complete statutory language.

reported on the key components of the mental health system, and the relationship of services to funding. Another workgroup, in the course of six meetings over five months, reviewed and categorized over 600 recommendations from the local task forces. Consumer workgroups developed reports for the task force and other workgroups, in order to assist them in understanding the consumer perspective. Finally, three "focus-area" workgroups undertook the core task of developing findings and recommendations for the task force. The focus areas of these three workgroups were: a) financing, b) community-based services, and c) publicly operated services.

Decisionmaking

In order to ensure a broad base of support for any recommendations that would emerge, the task force decided to work from a consensus decisionmaking model for all substantive decisions. The task force implemented consensus decision-making in the following manner:

The steering committee employed a majority rule for decisions about procedural issues, and a unanimity rule for votes on substantive issues. The steering committee then referred these substantive decisions to the full task force for final vote.

The full task force decided at an early stage to employ an 80% not-objecting rule for decisionmaking. In this approach, if more than 20% of present and voting members of the task force objected to a motion, then that motion was defeated.

Workgroups, particularly those attempting to develop recommendations in the three focus areas, employed a unanimity rule.

The full task force met on a monthly schedule from October, 1993 through September, 1994. The steering committee met bi-monthly from March, 1994 through December, 1994.

Information Gathering

Throughout most of its duration, the task force engaged in information gathering by which to inform its decisionmaking. DHS staff supplied the task force with a variety of materials, including descriptions of the mental health system, funding and service utilization statistics, information on state and national health care reform issues, and reports on mental health reform in other states. Individual members of the task force shared informational materials as well as their expertise and experiences. The consumers on the task force were especially enlightening in their descriptions of personal experiences in the system. Finally, the 24 reports from local task forces provided the state task force with hundreds of examples of system problems and both specific and global recommendations for change.

Workplan and Results

The major steps of the task force's workplan were to: a) achieve an organizational and decisionmaking structure that would accomplish the goals, b) assist local mental health advisory councils in forming local task forces that would prepare reports as provided in the legislation, c) reach an understanding of the current mental health systems and its problems, d) decide on which components or aspects of the system to focus its work, e) conduct more intensive study of focus areas, f) develop recommendations for change in each focus area, and g) write a final report.

The results of this workplan were mixed. While most of the development steps were completed, the primary goal of reaching consensus on recommendations for the Legislature was not achieved. Some of the reasons for this are explained in the next section.

The task force succeeded in issuing a report to local mental health advisory councils in January, 1994, which described how these councils might form their own task forces in accordance with the legislation. Members of the task force also succeeded in enriching their awareness of problems in the system and their understanding of various viewpoints on issues related to efforts to correct these problems. Figure 2 contains a list of some of the issues discussed by the task force.

The consumer members of the task force published the *Portfolio*, a collection of accounts of personal experiences in the system. This document was enlightening to the non-consumer members of the task force.

Finally, the task force reached tentative agreement on a set of "guiding principles" for improving system financing and services (see Figure 3). These were only agreed to with the understanding that the language would be further clarified in the final report, a step that was not completed.

Commentary

The inability of the state task force to achieve its primary goal was due to a combination of factors. The public mental health system is a complex of government agencies, public and private service providers, legal mandates, and funding systems, attempting to provide the right services to a client population with varied and individual needs. The mission outlined for the task force in the legislation proved not only immense, given the time and resources available, but

compelled the task force to deal head-on with the system's most intransigent issues, those relating to changes in funding and service coordination.

Some members of the task force found participation more difficult than did other members. Consumers and family members received no compensation for their time, whereas most other members' time was paid for by their employers or bargaining units. Persons living in rural areas distant from the metro meeting locations found it difficult to attend workgroup meetings. Future efforts to involve these groups in statewide activities could suffer similar participation problems if these inequities cannot be eliminated.

Figure 2
Some Issues Discussed by the Task Force

- **RESOURCES**
  - Instability of funding
  - Cost-shifting from private health plans to public sector
  - Community vs. institutional appropriations
  - Flexible vs categorical funding
  - Accountability
  - Human resource distribution and capacities
- **SERVICES**
  - Fragmentation (lack of coordination, integration)
  - Insufficient housing, crisis, transition, employment services
  - Consumer orientation (fit system to client, not client into system)
  - Boundaries between regional treatment centers and community-based services
  - Boundaries between community-based services
  - "Recovery" vs. maintenance-only orientation
  - Evaluation of effectiveness
- **POLICY**
  - Relationship of health care reform to mental health system
  - Importance of the state mental health act

Figure 3
GUIDING PRINCIPLES

(These were only agreed to with the understanding that the language would be further clarified--a step that was not accomplished.)

Whatever system ultimately emerges from mental health reform should have the following characteristics:

- **consumer-focused service design, decisionmaking, and evaluation**
- **accessible, integrated, expanded, and comprehensive services (including a public safety net)**
- **high-quality care through professional development and training**
- **both publicly and privately provided services are necessary**
- **funding streams must be adequate to support the above**
- **consistency with the mission statement of the Mental Health Act**

There were internal difficulties in the task force as well. Stakeholder groups brought in different sets of expectations, priorities, and styles of interaction. Those groups that saw little or no benefit to themselves from the effort might have had insufficient incentive to reach consensus. Some stakeholders were more experienced at negotiating than others, or more adept at group processes, or better able to marshal support for their positions. The consensus rule allowing 20% to veto any proposal demanded a high level of agreement for passage. As difficulties in reaching agreement on major issues were encountered, the task force frequently tried new approaches; however, these "mid-course corrections" frustrated some members, who felt that they were constantly climbing on the learning curve. Frustrations with the inability to resolve the basic disagreements ultimately dissolved some of the good will and more generous relationships that had developed earlier in the process.

As a whole, the task force found that issues related to *what* needed to be changed in the system were easier to identify than were issues related to *how* that change should be implemented. Broader issues, such as the guiding principles listed above, were easier to identify than specific recommendations.

The task force found the participation of consumers and family members especially beneficial. The presence of these individuals on workgroups, their presentations to the full task force, and their *Portfolio* were invaluable to maintaining focus on the effects that system changes can have on clients and their families.

Finally, the task force was disappointed in its inability to render the many recommendations of local task forces into a statewide vision for change. The failure of the state task force to reach agreement on major issues left no framework to which local recommendations could be attached.

Acknowledgements

The Adult Mental Health Task Force acknowledges the vital assistance of DHS in staffing the massive workload and in providing financial assistance. The facilitators are also most deserving of the state's gratitude for their efforts in organizing the work and facilitating communication. Finally, the individual members themselves, who gave many hours and days of their time to struggle with intractable problems, deserve thanks.

Appendix

Adult Mental Health Task Force Membership

* Asterisk denotes members and alternates of the Steering Committee.

Membership Category	#	Members and Alternates
Senate	2	* Sen. Don Samuelson (Brainerd) Sen. Sheila Kiscaden (Rochester)
House	2	Rep. Stephanie Klinzing (Elk River) Rep. Kay Brown (Northfield)
Elected officials sub-total	4	
Human Services	1	Maria Gomez (replaced Natalie Haas Steffen)
Health	1	Richard Welch (replaced Atashi Acharya)
Jobs and Training	1	Norena Hale or Claire Courtney
Corrections	1	Dana Baumgartner
Commerce	1	Tom Hagen
Housing Finance	1	Monte Aaker
Ombudsman for MH-MR	1	* Roberta Opheim or designee
State Depts. Sub-total	7	
Consumers	5	* Shirley Sopkiewicz (St. Paul) Alternates: Jan Pettus (Mpls.) Linda Lavine (Clarissa) Glenn Smoot (St. Paul) Donna Draves (Mpls.) (resigned) * John Grobe (Duluth) Larry Radach (Waseca) Emma Westrom (Elbow Lake) Donna Abler (Duluth) Dorothy Kettner (Fergus Falls) (resigned)
Consumer Sub-total	5	
Family members	5	Paula Childers (Mpls.) Ellis Dye (St. Paul) (resigned) Debbie Schraw (Duluth) Joyce Schut (Rochester) Erica Buffington (St. Louis Park)
Advocates	4	AMI: * John Whalen, * Bee Vennes MHA: Kathy Kelso, * Bill Conley
State MH Advisory Council	4	Cindy Hart (Chanhasen) Tom Bounds (Grand Rapids) Gerry Schmidt (Mankato) * Kris Flaten (St. Paul)
Local MH Advisory Councils	4	Barbara Flanigan (Hennepin Co.) Pat Bugenstein (Hennepin Co.) Frank Schifelbein (Meeker Co.) Kevin Ferris (St. Louis Co.)
Advocate sub-total	17	
Cultural/ethnic minorities	6	Roberto Aviña (CLUES) Lester Collins (Council on Black Minnesotans) Albert Del :on (Council on Asian-Pacific Minnesotans) * Ann Magoris (Mille Lacs Reservation) Marin Swenson (Neighborhood House, St. Paul) * Lucinda York (Hoikka House, St. Paul)
Cultural/ethnic minorities Sub-total	6	
County Govt./ Social Services	4	* Dennis Johnson (Crow Wing Co.) * Tom Henderson (Brown Co.) Tish Halloran (Hennepin Co.) * Dennis McCoy (Blue Earth Co.)
County Govt. Sub-total	4	

Membership Category	#	Members and Alternates
MH Professionals	4	MN Psychological Ass'n.: * Robert Butler (HSI, Oakdale) MNA: Mary Pollard (Abbott Northwestern, Mpls.) NASW: Jay Willet (replaced Nick Johnston) Psychiatric Society: Sharon Woods, M.D. (VA Medical Center)
Rule 36	2	Peggy Vincent (Grindstone Lodge) Glenn Anderson (People, Inc.)
Mental health centers	2	* Ron Brand (MACMHP) Jim Hermanson (Zumbro Valley)
Community Support Programs	2	Roger Miller (Western HDC, Marshall) Jim Gruba (Duluth HDC)
Hospitals	1	Hospital Ass'n.: Rick Palmisano (HealthSpan, Mpls) or * Mary Jo Brueggeman (Mercy Medical, Coon Rapids)
Community Provider sub-total	11	
County Employee Unions	8	AFSCME Council 14: * Sharon Johnson (Dakota Co) Nancy Fleming-Norton (Hennepin Co.) (resigned) * Alex Lape (Ramsey Co.) Sara Raines (Scott Co.) Charles Burfeind (Washington Co.) AFSCME Council 65:George (Corky) Berg (Kandiyohi Co.) Gloria Cypher (Stearns Co. AFSCME Council 96:Alan Netland (St. Louis Co.)
County Unions Sub-total	8	
DRS Employee Unions	2	MAPE: Rita Doucet (Minneapolis) Miriam Jondahl (Blaine)
RTC Employee Unions	29	AFSCME Council 6: * Tom Beer — Barbara Zuk (Brainerd) Tammy Hughes (St. Peter) Tammy Ceminsky (St. Peter) — Donna Theis (Anoka) Barb Sampson (Fergus Falls) — Terry Curtis (Ah-Gwah-Ching) Dean Steiner (St. Peter) — Carl Haglund (Moose Lake) Steve Johnson — Chris Eaton (Anoka) Don Lighthizer, (Willmar) (replaced Rolf Hage) MAPE: Chuck Curtis (St. Peter)(resigned) — Bill Hern (Willmar) Eldon Dietel (Fergus Falls) — Marcia Opstad (Moose Lake) Deb Schmitt (Anoka) — Jane Monson (Brainerd) * Jane Richey MMA: Gary Denault(replaced Sandi Blaeser) * Doyle Royal SRSEA: Robert Idso; alternate * Renee Scholen MNA: * Linda Lange — Denise Moreno (Moose Lake) Judy Tollefson (Willmar) — Ethel Macheel (Fergus Falls) Jan Remmel (St. Peter) — Kay Folkens (Ah-Gwah-Ching) Denise McClain (Anoka) — Teresa Steele (Brainerd)
State Union Sub-total	31	
Grand Total	93	

* Asterisk denotes members and alternates of the Steering Committee.

To obtain an alphabetical listing of members with addresses and phone numbers, call Margee Holt at the Department of Human Services, 612/296-2307.

Sec. 48. [ADULT MENTAL HEALTH SERVICES AND FUNDING.]

Subdivision 1. [STATEWIDE TASK FORCE.] The commissioner of human services shall convene a task force to study and make recommendations concerning adult mental health services and funding. The task force shall consist of the commissioners of health, jobs and training, corrections, and commerce, the director of the housing finance agency, two members of the house of representatives, and two members of the senate. The task force shall also include persons diagnosed with mental illness, family members of persons diagnosed with mental illness, mental health professionals, county social services personnel, public and private service providers, advocates for persons with mental illness, and representatives of the state advisory council established under Minnesota Statutes, section 245.697, and of the local advisory council established under Minnesota Statutes, section 245.466, subdivision 5. The task force must also include public employee representatives from each of the state regional treatment centers that treat adults with mental illness, the division of rehabilitative services, and county public employee bargaining units whose members serve adults with mental illness. Public employee representatives must be selected by their exclusive representatives. The commissioner of human services shall contract with a facilitator-mediator chosen by agreement of the members of the task force. The task force shall examine all possible county, state, and federal sources of funds for adult mental health with a view to improving methods of coordinating services and maximizing all funding sources and community support services, and increasing federal funding. Programs to be examined shall include, but not be limited to, the following: medical assistance, title XX social services programs, jobs and training programs, corrections programs, and housing programs. The task force may consult with experts in the field, as necessary. The task force shall make a preliminary report and recommendations on coordination of services and funding sources by January 1, 1994,

to facilitate the development of local protocols and procedures under subdivision 2. The task force shall submit a final report to the legislature by January 1, 1995, with its findings and recommendations. Once this report has been submitted, the task force will expire.

Subd. 2. [DEVELOPMENT OF LOCAL PROTOCOLS AND PROCEDURES.] (a) By January 1, 1994, each local adult mental health advisory council established under Minnesota Statutes, section 245.466, subdivision 5, may establish a task force to develop recommended protocols and procedures that will ensure that the planning, case management, and delivery of services for adults with severe mental illness are coordinated and make the most efficient and effective use of available funding. The task force must include, at a minimum, representatives of county medical assistance and mental health staff and representatives of state and county public employee bargaining units. The protocols and procedures must be designed to:

(1) ensure that services to adults are adequately funded to meet the adult's needs;

(2) ensure that planning for services, case management, service delivery, and payment for services involves coordination of all affected agencies, providers, and funding sources; and

(3) maximize available funding by making full use of all available funding, including medical assistance.

(b) By June 1, 1994, each council may make recommendations to the statewide task force established under subdivision 1 regarding the feasibility and desirability of existing or proposed methods of service delivery and funding sources to ensure that services are tailored to the specific needs of each adult and to allow where feasible greater flexibility in paying for services.

(c) By June 1, 1994, each local advisory council may report to the commissioner of human services the council's findings and the recommended protocols and procedures. The council may also recommend legislative changes or rule changes that will improve local coordination and further maximize available funding.

Subd. 3. [FINAL REPORT.] By February 15, 1995, the commissioner of human services shall provide a report to the legislature that describes the reports and recommendations of the statewide task force under subdivision 1 and of the local advisory councils under subdivision 2, and provides the commissioner's recommendations for legislation or other needed changes.

Budget Report for Adult Mental Health Services Task Force

This table shows the direct costs for this project, including preparation of a preliminary report to local task forces a year ago, costs of all task force meetings and direct costs of the task force's final report and the related DHS report. This relates to an original appropriation of $100,000 provided by the Legislature to implement Laws of Minnesota (1993), First Special Session, Chapter 1, Article 7, Section 48.

	BUDGET	ACTUAL (BY MONTH PAID)										EST. TOTAL	BAL-ANCE
		10/94 - 2/95	MAR	APR	MAY	JUNE	JULY - AUG.	SEPT.	OCT.	NOV.	EST. DEC.-JAN.		
Contract-Facilitators	$ 50,000	0	10,719	8,198	5,075	3,852	7,641	2,594	4,734	1,250	2,000	46,063	3,937
Contracts-Mediation Consultants	5,000	0	0	0	1,000	0	825	0	0	0	0	1,825	3,175
Printing and Postage	5,000	1,025	0	701	180	283	350	0	0	0	2,400	4,939	61
Room Rental & Meeting Lunches	15,000	3,608	1,009	977	976	1,508	1,631	17	140	384	50	10,300	4,700
Travel for Task Force Members	20,000	9,999	2,588	2,991	1,743	1,695	2,421	1,988	245	14	100	23,784	(3,784)
Supplies & Materials	5,000	3,872	0	0	0	126	23	0	5	0	100	4,126	874
													0
TOTAL	$ 100,000	18,504	14,316	12,867	8,974	7,464	12,891	4,599	5,124	1,648	4,650	91,037	$ 8,963

DHS Mental Health Division

December 22, 1994