MENTAL HEALTH

Department of Public Welfare
Comprehensive Program Bureau
Mental Health Program Division
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MINNESOTA MENTAL HEALTH PLAN FOR 1975

Minnesota Comprehensive
Mental Health Plan

Mental Health Program Division
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INTRODUCTION

This plan is a Departmental statement regarding the Mentally Ill/Behaviorally Disabled group. The plan is based upon statutory responsibilities of the Department of Public Welfare, Area Community Mental Health Programs, State Hospitals and County Social Service Departments in relation to the Mentally Ill/Behaviorally Disabled population. It was developed to complement and expand upon the Comprehensive Plan of the Department of Public Welfare in the area of Mental Health. This plan provides the base upon which future departmental mental health planning will be developed.

The antecedents of this plan are the previous Community Mental Health Center Construction Plans which were required by Federal Statutes and Regulations. This plan incorporates recommendations of previous reports of Task Forces, namely Behavioral Disabilities Task Force, Minnesota State Planning Agency, and the Grant-in-aid Guidelines Committee of the Community Mental Health Programs, DPW.

The Mental Health Plan establishes a framework through which planning can occur recognizing state and local responsibilities. It is based upon statutes and provides a brief historic overview of both the national and state development and trends in mental health practices and services. The current state of the art and the complexity of mental health programming is reflected. The framework for a continuum of mental health services for special target groups is presented.

Emphasis is placed on quality and accessibility of services, clear definition of accountability, necessity of knowledgeable planning and evaluation, involvement of area Community Mental Health Programs and other appropriate departments, agencies, organizations and consumers, respect and protection of human rights of service recipients, and the need for a sound funding base. Community Mental Health Programs are required to provide primary, secondary and tertiary preventive services.

The plan recognizes that resources should be adequate to meet the needs of the residents of Minnesota. At the present time, resources are not sufficiently developed to do so. Basic to development of the necessary resources is the clear delineation of responsibility, accountability, evaluation and provision of adequate manpower and fiscal resources. Fundamental to this, the purpose of any program of service delivery is to respond to the very individual needs of the person experiencing emotional stress. This person must be central and the system of delivery must always be checked with respect to how it responds to those persons for whom the system is developed.

The Comprehensive Mental Health Plan is not, in and of itself, a "blue print" for action. It presents fundamental principles essential to mental health programming. It is on these principles that a course of action should be developed. Recommendations are presented in the last Chapter of this plan. These recommendations are based upon an evaluation of the current state of mental health in Minnesota. As in any plan which seeks to project into the future, it is recognized that developments in a variety of sectors may impinge upon the direction that will eventually result.

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CHAPTER I

DEPARTMENT OF PUBLIC WELFARE: MENTAL HEALTH AUTHORITY AND RESPONSIBILITIES

A. Authority and Responsibility of the Commissioner of Public Welfare

The Commissioner has three major responsibilities in relation to a State Comprehensive Mental Health Program:

1. To provide leadership for:

   a. Comprehensive assessment and planning for state and local needs.

   b. The development of needed state and local resources.

   c. The appropriate assessment, modification, utilization, coordination, and evaluation of existing state and local programs and resources.

2. To provide administration, supervision, support, and regulation, as follows:

   a. Administration of and development of regulations for state hospitals' MI/BD Programs.

   b. Supervision of and development of regulations for county welfare boards.

   c. Support of and development of regulations for community mental health programs through grant-in-aid contracts.

   d. Administration of Cost of Care for residential services for emotionally disturbed children.

   e. Licensure of day and residential services and programs for the MI/BD adults.

   f. Licensure of residential treatment centers for emotionally disturbed children.

3. To provide assessment, evaluation, and planning for specific services.

The Minnesota statutory base for the Commissioner's authorities and responsibilities are briefly cited and statute number is provided for reference to these statutes in Appendix A. Statutes may be found in State of Minnesota Public Welfare Laws 1972. Those statutes which are not provided in the above reference are also placed in the appendix of this State Plan.

B. Mental Health Program Division

Mental Health Program Division (MHPD) is a unit within the Comprehensive Programs Bureau of the Department of Public Welfare (DPW). This Division was developed in the reorganization of DPW in the beginning of fiscal year 1973-74. Responsibilities and authorities of this Division are derived from legislative authorities assigned to the Commissioner of Welfare. The Commissioner has delegated particular authorities and responsibilities to the Assistant Commissioner of Comprehensive Programs Bureau, who in turn has delegated the Mental Health Program Division the authority and responsibility for the development, maintenance and evaluation of the State Comprehensive Mental Health Plan, to address the problems of the mentally ill and behaviorally disabled (MI/BD) population.

The development of the MI/BD Comprehensive Plan is influenced by other divisions within the Comprehensive Programs, other bureaus in the Department, other state departments and the Federal Department of Health, Education and Welfare, particularly the Alcohol, Drug and Mental Health Administration (ADAMHA).

The manner of influence and involvement of the above, on the planning and maintenance of the Plan, are briefly presented.

1. Within the Department of Public Welfare:

a. Residential Services Bureau (RSB) is responsible for administration of state facilities. Comments and recommendations are made to the RSB regarding MI/BD services. Implementation of the recommendations is dependent upon RSB.

b. County Welfare Bureau (CWB) is responsible for the supervision and direction provided to the county welfare departments. Recommendations made to the CWB by the MH Program Division relate primarily to the social services provided to the MI/BD population and the mental health portion of the county social service plans.

The state Social Service Plan and Title XIX Plan are developed and managed by divisions within the CWB. These plans have impact on the provision of mental health services, both in state and non-state residential, partial-residential and nonresidential facilities and agencies.

2. With the Comprehensive Program Bureau:

a. The Licensing Division manages and monitors the MI residential licensing as well as other types of licensing.

b. The Community Program Division administers the funding of the state community mental health programs.

c. The Consumer Concerns Division provides advocacy services for the MI/BD population among others.

d. Other program Divisions in the Comprehensive Bureau also relate to each other. An organization chart of Department of Public Welfare is shown in Figure I-1 which depicts these relationships.

3. Other State Departments:

a. The Minnesota Department of Health (MHD) provides health and safety licensing to all residential facilities, as well as hospital licenses and nursing home certification. The Health Department also issues Certificates of Need to hospitals, nursing homes, and board and care homes.

b. The Department of Education: Many of the children and young adults with mental health problems are served by the public school system. Many of the community mental health programs have agreements and contracts with local school districts for the provision of mental health services to the schools. The Department of Education administers the federal funds provided by the Elementary and Secondary Education Act, which funds services to children with mental and emotional handicaps and the state educational funds.

Vocational Rehabilitation, a Division of the Department of Education, provides services for the MI/BD population in workshops and vocational training facilities.

c. The Department of Corrections and Judicial System: This population, which includes criminal offenders and the mentally ill, as well as the sex offenders and inmates who become psychotic, is shared between the two Departments. The Judicial System frequently functions as a source of entry into the mental health system.

d. State Planning Agency: Human service legislation is administered by the State Planning Agency. Mental health is included in the Human Services Act.

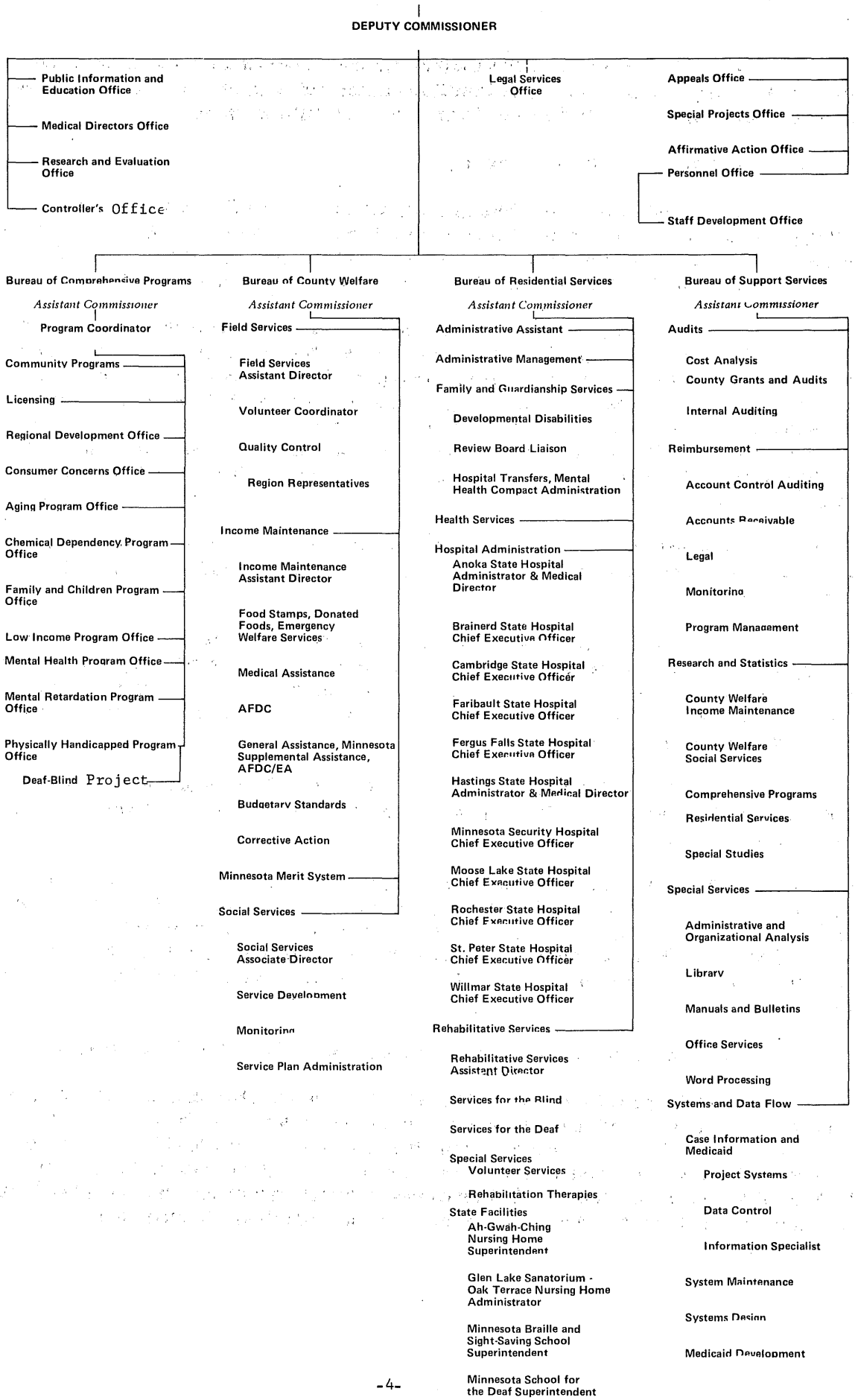
Comprehensive Health Planning has the responsibility for administering federal Certificate of Need (PL 92-603, Section 2211), which includes mental health facilities. They also manage the funding of B agencies (local comprehensive health agencies) which are to do comprehensive health planning. Mental health is included within the broad definition of health for these purposes.

4. Region V, Department of Health, Education and Welfare and ADAMHA:

ADAMHA provides community mental health staffing grants and construction grants. 314(d) funds are provided under the Federal Public Health Services Act. This is a block grant to the state for Public Health with a designated amount of funds set aside for community mental health funding. ADAMHA also provides Hospital Improvement Program grants and Hospital Staff Development grants to state hospitals for mental health purposes.

FIGURE I-1

DPW-145
(4-74)



Federal laws, rules and regulations apply to state mental health programs and activities. Federal funds for grants or reimbursement for services in programs for the MI/BD population require compliance with the standards and regulations established and/or recognized by the federal administration.

The mental health program plan must be relevant to the MI/BD target population and the needs of this population. The plan provides for a continuum of quality mental health services which are available to the disability group. There is provision for utilization of mental health resources, both public and private. There is a necessity to link together the various mental health resources and services which are supportive or related to mental health.

Under the Minnesota Hospitalization and Commitment Act, 253A.17 Subdivision 9, "Every person hospitalized or otherwise receiving services under this act shall be entitled to receive proper care and treatment best adapted, according to the contemporary professional standards,..." This requires a provision of appropriate quality services to all persons covered under this Act, including adults, children, aged persons, and the MI criminal offenders.

The Mental Health Program Division will establish an ongoing planning mechanism with representation from consumers, mental health professionals, area programs, state mental health facilities, county welfare departments, other state departments which relate to mental health and other mental health services providers. The ongoing planning mechanism includes plan assessment, evaluation, planning, and implementation. The process does not terminate at the completion of the Plan but, rather, continues with the modifications and changes as indicated by the assessment and evaluation activities which are integral components of this ongoing planning mechanism.

Program evaluation involves judgements about the measured movement of the program toward a defined goal. Evaluation is based upon: data from an appropriate management information and guidance system; measurement of programs and services in accordance with established standards or rules; programmatic review by a team, which includes professional programmatic representation to assess the program in terms of established goals, implementation of policies, rules and laws, appropriateness, effectiveness and accessibility of the programs and services in the overall mental health system. Evaluation must be useful and relevant to program management, planning and development.

C. State Level Responsibilities

From the state level, as the central administrative body for the institutions and supervising agency for county welfare boards and the contracting agency with community mental health boards, the Department of Public Welfare shall assist the boards, institutions and agencies in the following manner:

1. Provide, in the form of policy statements, interpretations of the laws pertaining to mental illness/behavioral disabilities;

2. Establish statewide minimum levels of service expectations for boards, institutions and agencies;

20. See to it that research programs are developed and carried out to determine the effectiveness or lack of effectiveness;

21. Administer Cost of Care for emotionally disturbed children;

22. Design methods for determining and improving the efficiency of the operation of the Community Mental Health Act.

D. Community Mental Health Program Responsibilities for Mental Health

The Area Board/Community Mental Health Program Board is responsible for mental health programming and services in the Minnesota Community Mental Health Centers Act, 245.61-245.69 and the Minnesota Hospitalization and Commitment Act, 253A. Responsibilities are assigned for the Mental Retardation and Chemical Dependency Programs, as well as for the MI/BD and emotionally disturbed.

The major community mental health program responsibilities are identified as:

1. Plan and execute a comprehensive mental health program, which provides for the continuum of mental health services, for the catchment area, as identified in Chapter V.

a. Utilizing recommendations and information from the mental advisory committee, consumers, and other agencies in the development of a comprehensive plan.

b. Collecting and utilizing data that relates to mental health problems.

2. State funded Community Mental Health Program must provide:

a. Collaborative and cooperative services with public health and other groups for programs of prevention of MI/BD.

b. Information and educational services to general public and lay and professional groups.

c. Consultation services to schools, courts, health and welfare agencies both public and private.

d. Emergency services.

e. Outpatient diagnostic services.

f. Outpatient treatment services.

g. Rehabilitative services for MI/BD disorders, particularly those who have received treatment in an inpatient facility.

h. Evaluation of program.

i. In-service training for personnel.

3. Provide consultation to boards, institutions and agencies to assist them in the design, development, execution and evaluation of their programs;

4. Assist in the development and implementation of various working agreements among boards, institutions and agencies;

5. Evaluate the extent to which boards, institutions and agencies carry out their plans for the delivery of services and reduction of problems;

6. Establish review boards in state institutions and federal veterans administration hospitals;

7. Set up methods of determining whether or not the Minnesota Hospitalization and Commitment Act is actually functioning as it is designed to;

8. Set up methods for determining and improving the efficiency of the operation of the Minnesota Hospitalization and Commitment Act;

9. See to it that modification in the law based on the above assessments of its effectiveness are accomplished;

10. Promulgate rules and regulations regarding eligibility of community mental health programs to receive state funds;

11. Prescribe standards for qualification of multi-disciplinary personnel and quality professional service;

12. Prescribe standards for in-service training and educational leave programs for personnel in community mental health programs;

13. Establish and/or approve fee schedules that assure that no one is denied services due to inability or ability to pay;

14. Establish state policies relating to contracting and collection of fees for indirect and direct services of community mental health programs;

15. Review and evaluate local programs and the performance of administrative and mental health personnel and make recommendations to the community mental health board and administrator;

16. Provide consultative staff services to communities to assist in ascertaining local needs;

17. Employ qualified mental health personnel at state level to provide the necessary planning and technical assistance support to the community mental health programs;

18. Licensing of residential and day services for the MI/BD;

19. Design methods for determining and improving the efficiency of community based mental health programs;

3. Participating with staff of county welfare departments and the state hospital in pre-discharge planning for individuals who are hospitalized.

4. Participating with county welfare departments in pre-commitment screening process and in developing appropriate alternative treatment plans.

5. Participating with county welfare departments and other agencies to assure adequate planning for aftercare services/rehabilitative services.

6. Assuring that regular communication with county welfare departments, public health nursing agencies, vocational rehabilitation, education and special education and other support service providers is maintained;

7. Assuring of the employment of qualified multi-disciplinary mental health professionals;

8. Assuring of the provision of multi-modalities of treatment.

9. Federally funded community MH Center must provide:

   a. Outpatient service.

   b. Inpatient service.

   c. Partial hospitalization.

   d. Consultation and education.

   e. Emergency services.

10. Community Mental Health Program may provide services or contract with another agency to deliver the service. However, contracting agencies are subject to the same regulations and standards as Community Health Programs.

E. <u>County Welfare Department Responsibilities for Mental Health</u>

The county welfare departments have a range of responsibilities for various population groups and responsibilities in regard to providing financial assistance, child and adult protection services, adoption, money management, family and children services guardianship, and services related to employment and rehabilitative activities and other social services.

In addition to the above, the county welfare department is assigned some responsibilities in relation to MI/BD population.

1. To assure the provision of Federal Social Security Act benefits to eligible persons disabled due to mental illness;

2. To obtain a social history prior to the commitment hearing. In some counties this responsibility has been expanded to develop a precommitment screening process. The county welfare department is expected to utilize the resources of the community mental health center staff to explore and to develop appropriate alternative treatment plans.

3. To participate with the staff of the state hospital and the community mental health center in developing a plan for discharge, provisional discharge, partial hospitalization, or other types of release; obtain assistance from other agencies or persons, including community mental health centers, public health nursing agencies, vocational rehabilitation personnel, as is necessary to assure adequate planning and provision of after-care services.

a. Assist the formerly hospitalized patient in finding employment.

b. Assist the formerly hospitalized patient in finding suitable shelter.

c. Assist the formerly hospitalized patient to obtain adequate medical and psychiatric/mental health care.

d. Aid in the patient's readjustment to the community.

4. To maintain a mechanism for payment to residential treatment centers for emotionally disturbed children through mechanisms such as cost of care, AFDC/FC, Title IV-A, etc., and utilize the expertise of the mental health center staff in determining appropriate placement for children with emotional disturbances.

5. To submit data that relates to mental illness, for example: number, age, residence (where the client lives), race, marital status, income, employment, education, for each of the following:

a. Pre-commitment screening process and disposition of each individual.

b. Individuals with specific mental health disturbances provided social services and the type of service provided by the welfare department.

c. Reason and/or purpose for placement in a foster home, group home, treatment center, or placement out of the state or county.

This information should be given to the area program to enable better mental health program planning for the area.

6. To participate with community mental health center staff and other resources in the provisions of rehabilitative services as appropriate.

7. Staff of the county welfare department should be alert to signals or indications of emotional difficulties that need mental health intervention, in groups of persons they serve, for example: child protection services address a specific high risk group, of which some individuals may need specialized mental health services, etc., and see to it that specialized mental health services are made available.

CHAPTER II

HISTORICAL OVERVIEW OF THE MANAGEMENT AND CARE OF PERSONS WITH MENTAL HEALTH PROBLEMS

A. National Overview

The American prototype for handling and care of these persons closely paralleled the European model, in general, and more specifically, that of the English. Our jails and almshouses were copied after the British facilities. They housed all kinds of people whose behavior or situation was unusual and/or unacceptable to the community at large. These included the homeless, the aged, the poor, the sick, the mentally retarded and all those displaying any noticeable form of aberrant behavior. There was no real treatment and what care was given was at the level of sustenance only.

The above situation continued into the early Nineteenth Century. After William Tuke began to effect changes in England, his work later influenced the development of two mental hospitals in New York. Subsequently, Dorothea Dix and Clifford Beers led crusades in this country to improve conditions for persons with mental health problems. Care of these persons, however, only gradually improved, and treatment programs were to come much later.

World War I gave impetus to the search for more answers to the multitude of problems recognized among our armed forces. Psychiatry became a recognized and acceptable specialty in medicine. New training programs sprang up after World War I emphasizing mental health problems, diagnosis, and treatment. Psychologists, social workers and other related specialties began to add new dimensions to the care, treatment, identification and research in this new field. The Veteran's Administration and universities began formalized training programs for mental health personnel.

In spite of this, change was slow until World War II. Again, there was increased focus placed on the numbers of young men who had to be rejected for service or given medical discharges because of emotional instability. The mass news media publicized these facts and journalists such as Albert Deutsch helped to expose the sordid conditions in our hospitals.

Public reaction aided Congress and state legislators in initiating new programs. The National Mental Health Act of 1946 established funds for training of personnel and for research. States began to grant increased appropriations for the care and treatment of persons with emotional problems and gradually hospital conditions improved.

The Community Mental Health Center Act of 1963 has given new direction to this entire movement. Emphasis was placed on local (community) responsibility for earlier identification and treatment. This movement is continuing today and across the country states are considering the closing of large, removed state hospitals and the further development of community programs.

The 1971 amendment to the Federal Social Security Act, P.L. 92-603, Section 249F, mandates the establishment of Professional Standard Review Organizations

(PSRO). This places a new emphasis on medical plan review of services relating particularly to appropriate admission norms of care and data profiles of patients and services. PSRO's are to be established by January, 1975. Initial focus will be on inpatient service; however, Section 249F allows for expansion to outpatient services. PSRO makes references to quality assurances. PSRO is designed primarily for accountability for utilization of medical services provided through Medicare and Medicaid patients and those covered by Maternal and Child Health programs.

B. Minnesota Overview

Even a cursory review of the effects of Minnesota legislative activity in the field of mental illness reveals a definite trend in public involvement and public responsibility in the care and treatment of the mentally ill. At first, the legislative thrust was to remove individuals identified as being "insane" from the community. This removal involved a loss of rights. The concept of care did not include provision for treatment. The desirability of treatment and the need to protect the rights of the mentally ill individual became increasingly evident over the years. Also evident is the historical development of facilities for the mentally ill from isolated institutions to comprehensive community based programs.

The prevention and treatment of mental disorders in the most effective, efficient and economic way possible is the focus of current concern. Continued efforts are being directed towards determining how:

a. the number of persons acquiring a mental disorder can be reduced;

b. the duration of those mental disorders which do occur can be shortened;

c. to minimize the amount of disability and distress caused by mental disorders which cannot be prevented and become chronic.

1. Mental Illness Legislation of Historical Significance

The public determination of mental illness and the responsibility for care goes back to the territorial period in Minnesota history.

The territorial legislature of 1851 enacted legislation giving the probate court authority to make provision for the care and custody of the mentally ill. The investigation was carried out by a jury of six persons including one physician. Persons of "unsound" mind included the mentally ill, the mentally retarded and the alcoholic. The legislation was oriented toward controlling the conduct of these individuals, and this included control and custody of the estate as well as of the person.

In 1866, legislation was enacted which allowed patients to retain property through relatives and friends. Relatives and friends of private patients were considered financially responsible for them while the counties assumed

expenses for public patients. The legislature approved the establishment of the first state hospital at St. Peter.

The distinction between public and private patients was abolished by the 1872 Legislature which stipulated that all state residents who were found to be mentally ill be kept at public expense. Commitment required a physician's statement that the person was "insane" and in need of hospitalization. An interesting feature of mental illness legislation enacted during this session was the provision for the return to the counties, when overcrowding occurred in the hospital, of those patients who were determined to be chronic and harmless.

Legislation enacted in 1893 contained a definitive statement on mental illness. It set forth that:

> No person shall be deprived of his liberty in this state by being committed to custody as insane unless his insanity is established in the manner and form prescribed in this act, and his commitment to custody is recommended because:
>
> 1. He has perpetuated acts dangerous to himself or to others or to property, or
> 2. It is reasonably certain, by his threats or otherwise, that he has dangerous tendencies or uncontrollable propensities toward crime, or
> 3. He wanders about and is exposed to want of food, shelter, or accidents, or
> 4. He is ill-treated or neglected by relatives or friends, or
> 5. His disease is of such a stage, as to require, for his recovery, care and treatment while under legal restraint.

The county attorney appeared on behalf of the alleged insane person and took such action as he deemed necessary to protect the rights of such person.

The legislation stated that no alleged insane person shall be arrested and committed to jail unless he has committed a crime or is dangerous and disorderly.

In 1903, the Legislature specified that no harmless person who cannot benefit from treatment should be committed and that the hospitals could discharge any person capable of caring for himself or who could be cared for by relatives and was not dangerous to himself or the community. This legislation further specified that no person should be committed merely because he was suffering from epilepsy, imbecility or senility.

New definitions emerged in subsequent legislation. The Psychopathic Personality Law enacted in 1939 defined such a person as an individual who used poor judgment and/or fails to appreciate the consequences of his act and thus is irresponsible with respect to sexual matters and is thereby dangerous to others. In 1953, the Sex Offender Law was passed. Comparison of the 1953 Chapter 617 "Offenses Relating to Chastity, Moral, Decency" and the current sex offender legislation indicates marked changes in public attitude.

In 1949, the term "insane" was officially dropped. This legislative session made a point of stressing that no shame or stigma should be attached to the mentally ill population. It specifically addressed the issue of treatment which was to be accomplished through a program of detection, diagnosis and treatment of the mentally or nervously ill. This Legislature also provided for the establishment of state clinics for this purpose and provided subsidies for research.

The Community Mental Health Services Act of 1957 provided for state grant-in-aids to match local funds for support of community mental health facilities. While the communities establishing mental health centers would control such programs locally, the Commissioner of Welfare was specifically authorized to establish standards for quality of service, professional staff qualifications and standards for fiscal and statistical accounting. Initiative and prime responsibility for establishing a community mental health program were left to the local community.

The establishment of Review Boards for the State Hospital system came about in 1971. The function of the review boards mandated for each state institution was to review admissions and discharges of patients. Patients were given access to these review bodies.

The Minnesota Hospitalization and Commitment Act was passed in 1967. This significant legislation identified the rights of those persons determined to be mentally ill and in need of treatment.

2. Central State Agencies

The first central state agency was established in 1883. It was known as the Board of Corrections and Charities, and its purpose was to prevent irregularities in state institutions. This became the State Board of Control in 1901 with broader powers and responsibilities as the number of state institutions increased.

This administrative arrangement remained until 1939 when the Department of Social Security was established. This agency was structured with three divisions.

These divisions were called:

a. Social Welfare Division
b. Public Institutions Division
c. Employment and Social Security Division

The present Department of Public Welfare was established in 1953. The Medical Services Division of this Department was given the responsibility for the state mental health program. The reorganization of the Department of Public Welfare in 1973 established the mental health program office as part of the Bureau of Comprehensive Programs. The development of a comprehensive mental health plan for the state is the responsibility of this office.

3. The Mental Health Delivery System Supported by the Department of Public Welfare - Brief Historical Overview

a. State Institutions - As noted above, St. Peter State Hospital, extablished in 1866, was the first state institution established for the care of the mentally ill. There are now eight (8) state hospitals and the Minnesota Security Hospital that provide services to the mentally ill/behaviorally disabled population. The most recently established was at Brainerd in 1958. Table II-1 gives a summary of the development of these institutions. The population trends in these institutions are discussed in Section C of this Chapter.

b. County Welfare Departments - As mentioned above, Minnesota's first Central Agency was created in 1883 under the name of Board of Corrections and Charities. The Board had no authority over the state institutions, but was merely investigatory and made recommendations. This Board continued to function until 1901, when the Legislature established the State Board of Control. The new Board had jurisdiction over the correctional and charitable state institutions. Child Welfare Boards were established and functioned also in areas of the retarded, illegitimacies and adoptions. The State Board of Control continued until 1939 when the Division of Social Welfare was created. In 1953, the Legislature consolidated the Division of Social Welfare and the Division of Public Institutions into the Department of Public Welfare.

In 1937, the Legislature created County Welfare Boards in each county of the state. The law charged these boards with the duties of administration of all forms of public assistance and public welfare, both of children and adults. These boards were also given the responsibility for "enforcement of all laws for the protection of defective, illegitimate, dependent and neglected children" under supervision of the State Board of Control. Except for a few counties in which relief was handled by town and village boards, Minnesota had an integrated welfare agency on the county level. The 1967 Hospitalization and Commitment Act assigned specific responsibilities regarding precommitment and predischarge to County Welfare Boards. Other changes have occurred over the years, both on the State and County level, but basically County Welfare Boards and their Departments continue to function as before.

c. Community Mental Health Programs - With the passage of the Community Mental Health Services Act in 1957, a major new mental health program was inaugurated in Minnesota. As with any new program, there are historical antecedents. The 1949 legislation resulted in the establishment of two state supported outpatient clinics in Albert Lea and Fergus Falls. Prior to that, the Wilder Foundation sponsored the St. Paul Child Guidance Clinic which was established in 1924. A child guidance clinic was established in Duluth through the effort of the Junior League of Duluth. The Rochester-Olmsted County Counseling Clinic was founded in 1948, and a child guidance program was sponsored by the Washburn Foundation in 1950. All of the aforementioned programs which formed the basis for the community outpatient clinic movement in Minnesota have subsequently received grants-in-aid through the Community Mental Health Services Act. Within the first year of the passage of this

TABLE II - 1

MINNESOTA STATE
INSTITUTIONS

State Hospital	Date Operational	Comments
Anoka	1900	Designated as transfer asylum 1948-designated as center for treatment of TB among the MI; TB treatment center closed out 1967 1951-transfer status changed to receiving center 1970-72-program for emotionally disturbed children 1965-73-adolescent treatment program 65 chemical dependency center 65 geriatric and infirmary service Average Population 1970-71 440 1960-61 1025 MI Physically present avg. 1974- 226 1973 Per Capita Cost $9,508
Brainerd	1958	Provide training and treatment for mentally retarded from Northern third of the state. 1965-developed unit system for retarded 1970-Minnesota Learning Center for educable, retarded children 1971-Programs for MI, Chemical Dependency Program Average Population (MR Pop. Only) 1970-71 1036 1960-61 588 MI Physically Present Avg. Aug.-74 28 1973 Per Capita Cost $7,501
Cambridge	1919	1925-opened colony for epileptics under administration of Minnesota School for Feeble-Minded 1927-became independent-Minnesota Colony for Epileptics

State Hospital	Date Operational	Comments
		Average Population 1970-71 1137 1960-61 2078 MI Physically Present Aug.-74 -0- 1973 Cost Per Capita $7,468.13
Faribault	1881	Established as a residential facility for mentally retarded and for epileptic children and adults. Rehabilitation, care, treatment, training center for mentally retarded. Average Population 1970-71 1657 1960-61 3174 MI Population Aug.-74 -0- 1973 Cost Per Capita $7,066.40
Fergus Falls	1890	1967-established physical therapy program 1968-established vocational rehabilitation program 1969-mentally retarded program, chemical dependency program. Average Population 1960-71 563 (all patients) 1960-61 1835 MI Physically Present Aug.-74 114 1973 Per Capita Cost $8,169.14
Hastings	1900	Custodial Care for Mentally Ill 1968-Regional Service for Drug Dependency, Psychiatric Service Chemical Dependency Program Mental Retardation Service Average Population 1970-71 220 1960-61 896 MI Physically Present Aug.-74 113 1973 Per Capita Cost $10,764.71

State Hospital	Date Operational	Comments
Moose Lake	1938	Inebriacy Program-Chemical Dependency Program Geriatric Program. Token economy, reality therapy and therapeutic Community Programs.
	1970	Established Program for MR Average Population 1970-71 572 (Total Pop. Group) 1960-61 1120 MI Physically Present Aug.-74 193 1973 Per Capita Cost $7,812.03
Minnesota Security Hospital	1911	Established for MI and disturbed men. Average Population 1970-71 131 1960-61 245 MI Physically Present Aug.-74
Rochester	1879	Designated as second hospital for the insane. 1969-MR Patients came 1971-Surgical center for DPN Average Population 1970-71 660 1960-61 1544 MI Physically present Aug.-74 343
St. Peter	1866	1968-Minnesota Valley Social Adaption Center opened for MR 1970-Chemical Dependency unit opened. Average Population 1960-71 279 1960-61 1993 1973 Per Capita Cost $8,628.03
Willmar	1912	Center for care and treatment of alcoholic 1917-MI patients General psychiatric care and treatment Chemical Dependency Program Adolescent Treatment Program Medical-surgical service Glacial Ridge training center-MR Average Population 1970-71 579 (MI only) (MI & CD) 1960-61 1113 MI Physically present Aug.-74 289 1973 Per Capita Cost $7,406

act, three new mental health centers were opened. By 1969, every county in the state was served by a community mental health program. These community mental health programs and the counties they serve are listed in Figure IV-1, Table IV-1. The Community Mental Health Services Act, as amended, is to be found in Appendix C.

These programs were established in the belief that community needs can be better met at a local rather than a state level and gave encouragement to communities to develop programs according to individual community needs. Prior to 1957, a very large majority of professional mental health services in Minnesota were concentrated in the metropolitan areas. The goal was the development of a comprehensive community mental health service staffed by a highly qualified multidisciplinary professional team within each area. The preventive aspect of the program and the continuous and comprehensive manner gave each program a broad social base.

C. Evolution of the Continuum of Care:

Nationally, the decline in the number of residents that began in 1955 was moderate until 1960 when the decline began to accelerate more rapidly, from 500,000 to 370,000 by 1969; that is, a 26% decrease in state hospital population. Between 1969 and 1973, the total population decreased by approximately 30%; that is, a decline from 370,000 to 255,000 patients.

In Minnesota, the decline in the number of residents was more dramatic, in that in 1960, the population was 10,000 and in 1974, had dwindled to 1,875. Between 1969 and 1974, the total MI/BD population decreased at a rate of 45%, from 3,396 to 1,875, which is higher than the national average rate of decline. Population trends of Minnesota state hospitals are presented in Figure II-1, Table II-2 and Figure II-2. The state institution population is currently what it was in 1890.

Thus, in the last two decades, the population in state hospitals, nationally, has been reduced by almost 50%. Reduction in Minnesota was somewhat higher. It is interesting to note in this regard that one of the aims of the original legislation relating to community mental health centers was to reduce the number of patients under custodial care by 50% within a decade or two (P.L. 88-164, 1963).

During the period under consideration, national statistics indicate that while there was a remarkable decline in the number of residents in state hospitals, there was a concomitant increase in the number of admissions to these hospitals. Between 1955 and 1971, there was a steady increase which peaked in 1971, and a slight decline noted then was continuing through December, 1973. This is a national trend which can mask quite large variations between states.

The trend in Minnesota reflected in Figure II-3 indicates the various modes of entry into state hospitals. Voluntary, first admissions, readmissions and returns from provisional discharge have declined in the past ten years. When all modes of entry are combined, this includes judicial commitments as well as those identified above. The trend indicates a small increase in 1966 and

FIGURE II-1

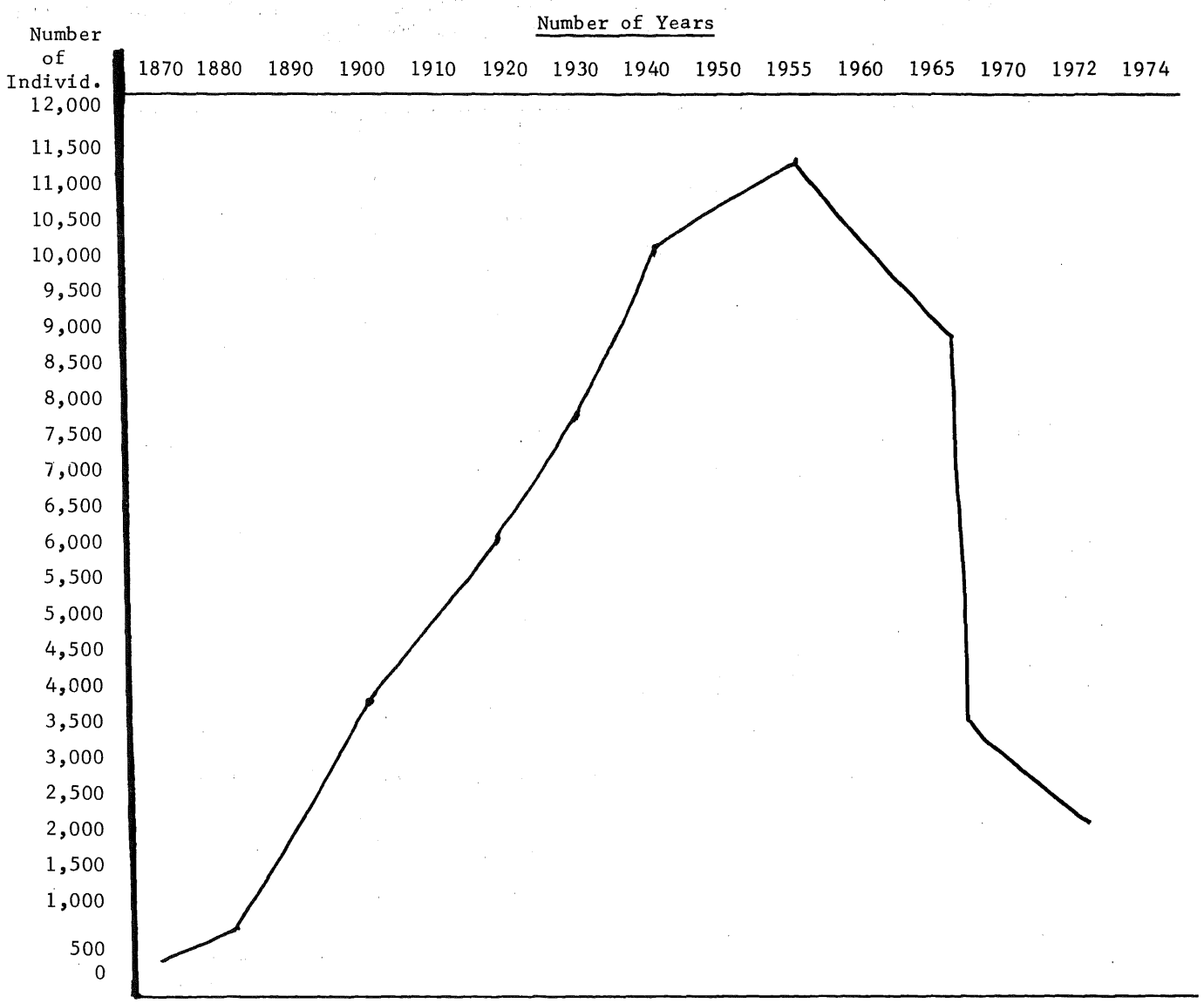
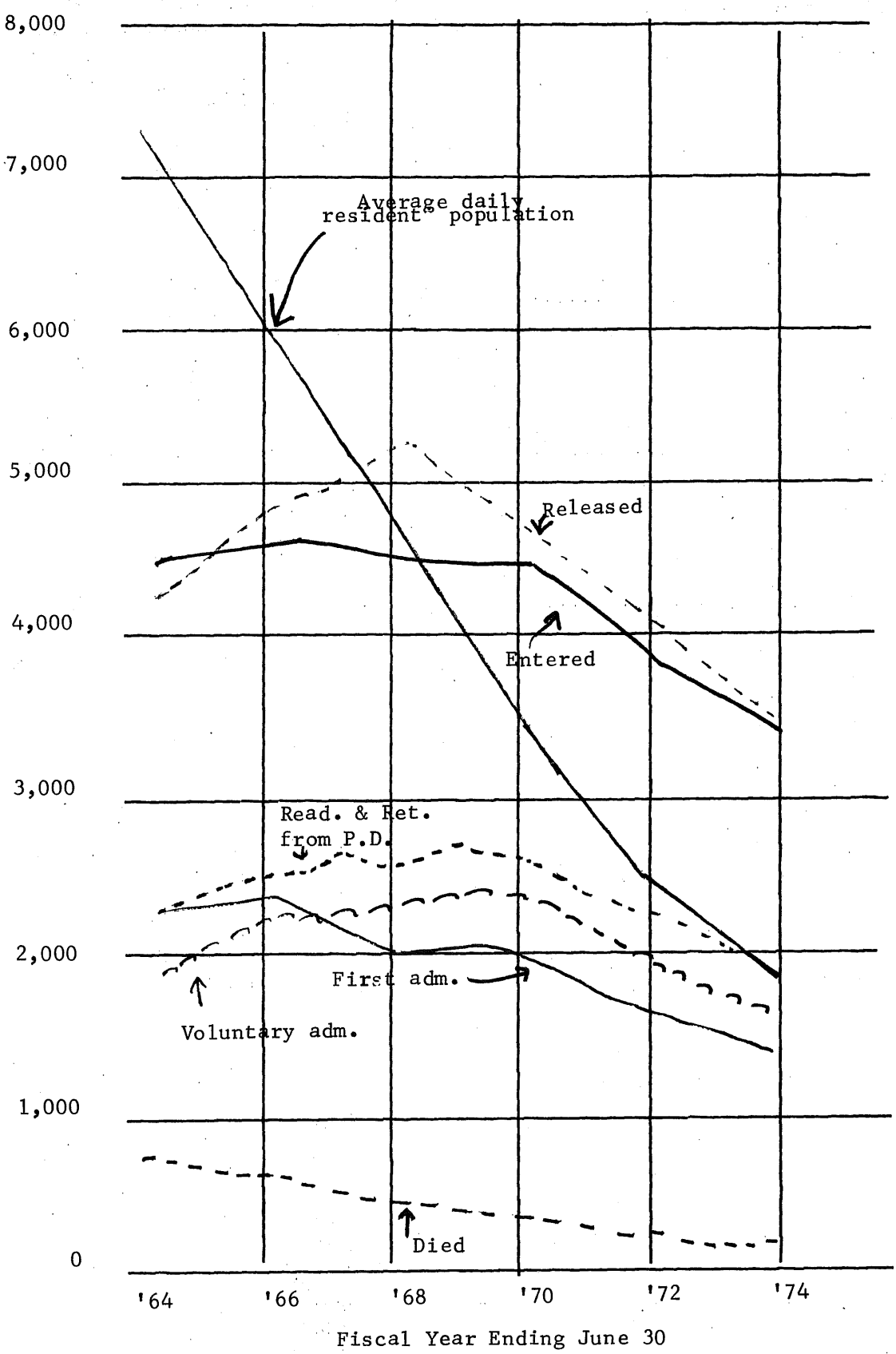


TABLE II-2 Number of Mentally Ill in State Institutions

YEAR	NUMBER OF INDIVIDUALS
1870	206
1880	679
1890	1951
1900	3589
1910	4861
1920	6090
1930	7800
1940	10,174
1950	10,464
1955	11,269
1960	10,073
1965	9223
1970	3124
1971	2687
1972	2286
1973	2102
1974	1961

Figure II-2

Minnesota State Hospital MI/BD Population Changes Fiscal Years Ending June 30, 1964 through June 30, 1974



Monthly Statistical Report, Minnesota State Public Welfare Institutions and Retardation Guardianship Services, June, 1974

TABLE II-3

MINNESOTA STATE HOSPITALS
MI POPULATION

(FY 1973-74)

State Hospital	Average Daily Census FY 1973-74	Capacity	Utilization Rate
Anoka	274	288	95%
Brainerd	50	65	77%
Fergus Falls	141	158	89%
Hastings	144	157	92%
Moose Lake	226	275	82%
Minnesota Security	106	120	88%
Rochester	451	492	92%
St. Peter	207	257	86%
Willmar	351	347	100%
TOTALS	1,950	2,159	90%

The MI Population does include patients that are in the infirmary units of state hospitals.

"Average daily census data is from "Minnesota Department of Public Welfare Monthly Statistical Report, June 1974."

Average daily census includes resident population that are physcally present plus those individuals on visits of 7 days or less.

then a very gradual decrease until 1970, which introduces a markedly rapid decline. This pattern of entry, as we compare it to the patterns of release, reflects some correlation with the exception that significantly more individuals were released in 1968 than were admitted. However, by 1970, again there is a comparable trend of decrease, and by 1974, the rate of entry and release is quite close. This gives rise to the question whether the population which is reflected in these statistics depicts primarily the existence of a residual population in the state hospitals. However, the overall trend in Minnesota, as well as nationally, is a decreasing one.

In the face of these data and contrary to many current opinions, the total number of state hospitals in the past decade has remained rather constant at around 320, though the number raised above that in the period from 1971 through 1972 to 327 hospitals in the United States. New hospitals were opened in Delaware, Florida, Georgia, New York, Virginia and Washington. Between 1961 and 1969, twenty states established 43 hospitals, and seven states closed 14 hospitals. It was at the end of 1973 that the number of state hospitals in the United States was approximately 320. In the last two years or so, several states have closed a number of hospitals and some hospitals have been reclassified as community mental health centers.

The 320 state hospital beds account for approximately 71% of all available mental health beds and 30% of all hospital beds in the United States. By contrast the Veterans Administration and private hospitals account for 13% of mental health beds. Residential treatment centers of emotionally disturbed children account for 5%, community mental health centers for 5%, and psychiatric services in general hospitals for 6%. The distribution of beds in states varies greatly ranging from 40% of the total mental health beds in New York to 10% of these mental health beds being located in New Mexico. This established a base line of approximately 320,000 state hospital beds with a national occupancy rate of approximately 85%.

In Minnesota, eight state hospitals and Minnesota Security Hospital provide services for the MI/BD population and currently provide 2159 beds. The utilization rate based upon average daily census (including resident population physically present and those individuals on visits of 7 days or less), for fiscal year 1973-74, was 90%. The residential treatment centers for emotionally disturbed children have a capacity for 615 beds, the two Veterans Administration Hospitals have 622 beds, general hospitals with identified psychiatric units (including those that have affiliate agreements with community mental health centers) provide 1211 psychiatric beds.

The provision of hospital psychiatric beds and residential treatment center beds for mental health services are reflected in the following:

State Hospital MI/BD.....2159 beds and provide 47% of mental health beds in Minnesota. (Table II-3)

Residential Treatment Center..... 615 beds and provide 13% of mental health beds in Minnesota. (Table II-4)

General Hospitals with Psychiatric Units.....1211 beds and provide 26% of mental health beds in Minnesota. (Table II-5)

Veterans Administration
Hospital..... 622 beds and provide 14% of mental health beds in Minnesota. (Table II-5)

There is a total capacity of 4607 for hospital and residential treatment centers.

At the same time, those who have been involved in the state hospital system for a period of time are aware of the tremendous changes that have taken place over the last decade or so in the treatment delivery systems of state hospitals. There has been increased use of more effective therapeutic procedures, including drugs and innovative treatment modalities; more effective discharge procedures; more effective utilization review procedures; an increase in the availability and use of alternative resources in the community, including nursing homes and transitional facilities as well as outpatient and partial hospitalization facilities; and gradual reduction of the average length of stay; and overriding all of these factors, the deliberate executive decision to reduce the resident population.

Other factors having a bearing on the reorganization of state hospitals are the increase in number of mental health services in general hospitals, and an increase in the number of mental health facilities serving children and youth. Currently, there are two identifiable youth mental health programs provided by the state hospitals, the adolescent units at Willmar State Hospital and Rochester State Hospital. Other state hospitals do accept children and youth but there is no identifiable program for them. They are placed with the adult population and efforts are made to develop individual treatment plans for them, which usually seems to be provision of an educational component delivered or provided by the public education system. There are 16 private residential treatment centers in the state and they serve approximately 600 emotionally disturbed children, Table II-4.

From 1960 to 1974, the state hospitals themselves have changed from remote, inward "total institutions", to more community linked facilities exhibiting greater diversification of mental health disciplines, particularly in the areas of activity therapies and newly emerging "human services" functions. The quality of personnel have gradually improved by the introduction of more extensive and continuing in-service training programs and a push for more fully qualified professional staff.

We can go back approximately 50 years to trace the cultural and therapeutic forces that have led to the present state hospital system. In the past 50 years, we have witnessed a change from custody as the essential motif of care, with its punitive and restrictive methods such as seclusion, cold sheet packs, continuous tubs, chemical and physical restraints, etc., to therapy, with its emphasis on helping the person grow toward understanding, communication and self realization.

TABLE II-4

NAMES AND LOCATIONS OF RESIDENTIAL TREATMENT CENTERS
FOR EMOTIONALLY DISTURBED CHILDREN

CENTER	CAP.	CENTER	CAP.
Archdeacon Gilfillan Center Box 744 Bemidji, MN	36	Lamberton Home for Children 211 Huff Street Winona, MN 55987	24
Arlington House 1060 Greenbrier Street Group Living for Boys & Girls St. Paul, MN	29	Minnesota Sheriffs Boy's Ranch P.O. Box 604 Austin, MN 55912	24
Bar-None Boys' Ranch Box 871 Anoka, MN	60	Brown House 1471 Como Avenue West St. Paul, MN	19
Bethany Lutheran Home for Children 40th Avenue West & 8th Street Duluth, MN *	36	Friendhsip Hall 235 East South Street St. Paul, MN 55101	15
Bush Memorial Children's Center 180 South Grotto St. Paul, MN	30	Northwood Childrens' Home 714 College Street Duluth, MN 55811	36
Galloway Boys' Ranch Route 1 Wahkon, MN 56386	36	St. Cloud Children's Home 714 College Street St. Cloud, MN 56301	20
Gerard Schools, Inc. Box 715 Austin, MN	42	Woodland Hills 4321 Allendale Avenue Duluth, MN 55803	50
Home of Good Shepherd 5100 Hodgsen Road St. Paul, MN 55112	60	St. Joseph's Home for Children 12th Avenue South & East 47th St. Minneapolism, MN 55407	140

* Affiliated with Community Mental Health Center

TABLE II-5

GENERAL HOSPITALS IN MINNESOTA
WITH PSYCHIATRIC UNITS

REGION	NAME & LOCATION OF HOSPITAL	CAPA-CITY	AVERAGE DAILY CEN.	UTILIZATION RATE
I	Northwestern Thief River Falls*	20	10	50%
II	None			
III	Miller Dwain Duluth	21	18	86%
	St. Lukes Duluth	40	31	78%
	St. Mary's Duluth	34	NA	NA
	Hibbing General Hibbing*	10	NA	NA
IV	St. Ansgar Moorehead	28	22	78%
V	None			
VI	Hutchinson Community Hutchinson*	12		
	Rice Memorial Willmar*	18	12	65%
VII	St. Cloud St. Cloud *	29	27	93%
	St. Cloud Veterans Adm. St. Cloud	561	NA	NA
VIII	None			
IX	Immanuel-St. Joseph's Mankato	26	22	85%
X	Rochester Methodist Rochester	68	62	91%
	St. Mary's	50	NA	NA

NA - Information not available
* Affiliated with Community Mental Health Center

GENERAL HOSP. IN
MINNESOTA WITH
PSYCHIATRIC UNITS
PAGE TWO

REGION	NAME & LOCATION OF HOSPITAL	CAPA-CITY	AVERAGE DAILY CEN.	UTILIZATION RATE
XI	St. Mary's Minneapolis	59	53	90%
	**Fairview Minneapolis	75	68	91%
	**University of MN Minneapolis	65	45	75%
	Metropolitan Minneapolis	115	108	94%
	**Abbott Minneapolis	81	NA	NA
	Northwestern Minneapolis	25	NA	NA
	**Golden Valley Health Center Minneapolis	177	133	75%
	North Memorial Minneapolis	22	18	83%
	*Hennepin County Gen. Minneapolis	20	22	110%
	Veterans Adm. Minneapolis	61	NA	NA
	**Ramsey St. Paul	64	49	77%
	**Miller United St. Paul	59	56	95%
	Mounds Park St. Paul	49	NA	NA
	St. Joseph St. Paul	44	NA	NA

** These Hospitals also have special units for children. Information obtained by telephone survey and Metropolitan Council Health Board data.

* Affiliated with Community Mental Health Center

The development of the "therapeutic community" helped to develop the therapeutic interaction potential between patients and staff. It assisted in breaking down barriers between staff and patients and utilized the principle that progress expectations can serve as a catalyst for a better life for all the hospital's citizens.

Also, included in this transition from custody to therapy was the evolution of various somatic treatments such as shock therapy, insulin, and lobotomy. There is still considerable controversy regarding these somatic procedures. However, we tend to forget the therapeutic excitement that accompanied the introduction of shock treatments, especially Electric Shock Therapy (EST), and a considerable stimulation of having discovered a valuable treatment tool.

The Development of the concept of the therapeutic community signaled the advent of collaboration between mental health and social science. This ushered in an era wherein social psychiatry has become a treating of the "whole person" as he or she must attend to the various demands arising from the social milieu. In keeping with the concept of therapeutic community, an additional influence in the role of mental hospitals was effected by the development of the community mental health centers. This represented additional thrust by extending the continuum of care thus enhancing the process for the rehabilitation of the hospital resident into the community at large. This thrust was characterized by lowering the barriers to rehabilitation through earlier discharge, "open doors", day and evening treatment facilities, transitional facilities, community volunteers, and citizen education.

However, as promising as the logic behind a continuum of care is, this portion of the Minnesota Mental Health System must be expanded. There is a genuine dearth of day and evening treatment resources and transitional partial supportive and treatment residential facilities. There is little provision for mental health programming so that individual regression can be prevented, although data are not available to identify the extent of this problem.

As noted above, in the 1960's the mental health system began to move in the direction of small comprehensive community mental health centers. The designation of a catchment area/geographic area for the mental health center requires a responsibility for mental health programming and service delivery that is a powerful but very simple event. The catchment area concept promotes and establishes an accountability for mental health programming.

In many states the state hospitals have become a part of the community mental health programs. There have evolved outreach programs, bridging services to community satellites, joint planning by hospital with community boards and service agencies for a total mental health delivery system, the burgeoning of home treatment, family and network therapies, identification of risk groups, and preventive intervention of those risk groups.

In Minnesota, there has been community mental health coverage throughout the state since the late 1960's. The Minnesota Community Mental Health Act has provided for the catchment areas and has ascribed areas of responsibilities for the community mental health program. The amendment to the Community Mental Health Act in 1971, which provided for the Lakeland area group homes, set a precident in that state hospital personnel may be used in the provision of community services. It appears that this amendment does set a direction for linking state hospital resources to community mental health center resources to extend and expand the continuum of mental health services.

CHAPTER III

MENTALLY ILL/BEHAVIORALLY DISABLED POPULATION

A. Target Population and its Service Distribution

One of the major objectives of epidemiological and statistical research in mental health is to provide systematic, uniform historical data on trends in the frequency of occurrence of mental disorders and the patterns of use of psychiatric services. Such data can provide quantitative measures of changes in the care of the mentally ill resulting from the application of available knowledge for modifying the amount of mental disorder occurring in a population.

In general, the mentally ill/behaviorally disabled population includes individuals within a broad range of behavior and functioning levels. While no single phenomenona can be identified as characteristic of this population, the behavior is described and classified in a variety of context. Legal concerns arise when community intervention is found to be necessary in the lives of specific individuals. Such intervention is clearly spelled out and controlled by statutes. The Minnesota Hospitalization and Commitment Act (MHCA) is such a statute and describes a mentally ill person as being any person having a psychiatric or other disorder which substantially impairs his mental health and who is in need of treatment or supervision. However, the statutory definition is applied to only a small part of the population suffering from problems of emotional disturbance. See Appendix B. Some emotional problems may be recognized by the individual or by the community. These problems may be reflected in behavior which may or may not be disturbing to the community at large, but, it includes behavior which is disturbing, disruptive, dangerous, perverse, odd, irrational or otherwise results in socially dysfunctional behavior which needs to be treated. The range of such dysfunction varies widely and classification of these disorders is based upon the symptoms or behaviors which are expressed.

Although the above description is very broad, it serves to identify the universe that embraces those persons who are manifesting socially maladaptive behavior arising from emotional problems. In searching the literature, one finds many terms used to describe the target population. This seeming problem in semantics should not be a barrier to determine whom we are to serve.

In anticipating the need for service to these individuals, the key questions which must be addressed are:

1.) How many persons in the population are likely to represent a high potential for service? See Appendix G for information regarding "Social Dysfunction" rating in Minnesota.
2.) What is the locus of service provision (facility) for this group?
3.) What are the implications for future service based on the continuum of care concept and the historical patterns of distribution of service?

Unfortunately, in Minnesota there is as yet no single authoritative source of data which would yield precise answers to these questions. However, there

are studies available from the National Institute of Mental Health which provide national estimates regarding these inquiries. And, by introjecting their conservative estimates to Minnesota, the possibility of overestimation of potential need is minimized. The possibility of underestimation, however, will remain.

It has been variously estimated that the number of persons who would exhibit serious dysfunctional behavior requiring episodic care constitute anywhere from 2% to 20% of the total population.

From the data of Table III-1, it may be seen that the number of patient care episodes in all psychiatric facilities increased from 870,560 in 1946 to 4.1 million by 1971. These figures represent a rate of patient care episodes which increased from 629.1/100,000 population to 1988.1/100,000 population. The significant increase in the rate/100,000 population can be attributed to increased reporting resulting from the addition of service facilities over the years. These are: outpatient psychiatric clinics, residential treatment centers for emotionally disturbed children, and community mental health centers in these tables. On a federal level, these facilities were recently established and were first reported for 1971. In 1974, less than half the population were being served by these facilities.

The addition of these kinds of facilities to the continuum of care also bear some interpretive implications regarding the questions of both incidence and prevalence of need. These are:

1.) That although the absolute number of patient care episodes in mental hospitals has remained relatively constant since 1955, they have decreased in state and private hospitals but the constancy has been maintained by an increase in episodes of care in VA hospitals.
2.) That the rate of increase in episodes of care provided by the additional facilities mentioned above is much greater than would be necessary to absorb the rate of decrease noted in the care episodes of state and private facilities. This suggests that, in addition to the increased incidence of need for service which would accrue simply with an increase in population, the prevalence rate of problems is much greater that was being served historically.
3.) Moreover, it has been previously noted that the national number of episodes of care given in 1971 was 4.1 million. Obviously, these episodes do not represent 4.1 million persons because reports probably include more than one service episode per individual.

The end points of inference, however, would be that either 4.1 million persons received one care episode apiece or 1 person received 4.1 million episodes of care. The reality probably is more consonant with the inference that in 1971 a little over 2 million persons experienced 2 care episodes apiece for both inpatient and outpatient services or 1% of the total population did actually receive service. Expanding on this very tentative theme it would follow that such estimates are in keeping with the conservative estimates that 2% of the population are in potential need of service; and there is probably a potential for at least twice as many care giving episodes as were currently being provided in 1971.

TABLE III-1

NUMBER AND PERCENT OF PATIENT CARE EPISODES AND RATE PER 100,000 POPULATION, BY TYPE OF PSYCHIATRIC FACILITY: UNITED STATES, 1946, 1955, 1963 and 1971

Type of Psychiatric Facility	Number of Patient Care Episodes			
	1946	1955	1963	1971
All Facilities	870,560 a/	1,675,352 b/	2,235,940 b/	4,081,796
Mental Hospitals	762,108	1,030,418	1,037,286	1,020,022
State and County	587,568	818,832	799,401	745,259
Veterans	91,655	88,355	109,973	176,800
Private	82,888	123,231	127,912	97,963
Psychiatric Services of General Hospitals	108,452	265,934	349,654	542,642
Outpatient Psychiatric Clinics	NR	379,000	849,654	1,693,848
Residential Treatment Centers for Emotionally Disturbed Children	NR	NR	NR	28,637
Community Mental Health Centers	NA	NA	NA	796,647
	Percent			
All Facilities	c/	100.0	100.0	100.0
Mental Hospitals	c/	61.5	46.4	25.0
State and County	c/	48.9	35.7	18.3
Veterans	c/	5.3	4.9	4.3
Private	c/	7.3	5.7	2.4
Psychiatric Services General Hospitals	c/	15.9	15.6	13.3
Outpatient Psychiatric Clinics	c/	22.6	38.0	41.5
Residential Treatment Centers for Emotionally Disturbed Children	c/	d	d	0.7
Community Mental Health Centers	c/	NA	NA	19.5
	Rate per 100,000 Population			
All Facilities	629.1	1,032.2	1,197.8	1,989.1
Mental Hospitals	550.7	634.8	555.7	497.1
State and County	424.6	504.5	428.2	363.2
Veterans	66.2	54.4	58.9	86.2
Private	59.9	75.9	68.5	47.7
Psychiatric Services of General Hospitals	78.4	163.8	187.3	264.4
Outpatient Psychiatric Clinics	NR	233.5	454.8	825.4
Residential Treatment Centers for Emotionally Disturbed Children	NR	NR	NR	14.0
Community Mental Health Centers	NA	NA	NA	388.2

NR Not reported

NA Not applicable (community mental health centers were not in existence in these years).

a/ Total excludes outpatient psychiatric clinics and residential treatment centers which did not report.

b/ Total excludes residential treatment centers.

c/ Percent distribution not computed due to nonreporting of some types of facilities.

d/ Although data were not reported in these kyears, percentages were probably less than one percent.

B. Kinds of Problems and Locus of Service

From the data of Tables III-2a, 2b and 2c the distribution in rates/ 100,000 population of episodes of care is broken down by sex, diagnosis, and facility for the year 1971.

For all facilities combined, schizophrenia was the leading diagnostic category (22.5%) followed by depressive disorders (15%) and organic brain syndromes (5%). Excluding mental retardation and chemical dependency, all other disorders constituted 33.9% of all patient care episodes. Of these disorders considered here, depressive disorders seem to vary markedly by sex. The split within this category is 9.8% males and 21.1% females.

In addition, there is a slight tendency for services to be provided to females more than males in all facilities except VA hospitals and state and county mental hospitals where males receive the preponderance of service. In private mental hospitals, however, significantly more females are service recipients.

From a national point of view, Tables III-3a, III-3b and III-3c represent the extent to which needs for psychiatric services would be met in relation to various assumptions of need taken as a function of population growth. According to census forecasts, it is estimated that the population of the U.S. will have increased from 195 million in 1970 to about 242 million by 1985. More significantly, this increase will embody changes with respect to various socioeconomic characteristics, in addition to those of race, income level, educational level, etc. Of particular importance is the fact that large increases will be occurring in age groups that are known from past experience to be characterized by consistently high admission rated to psychiatric facilities. Table III-4 reflects the most common diagnoses which occur for different age groups.

The expected percent changes in the numbers of persons in the various age groups therefore, have many implications for the delivery of services, particularly those provided by state and county mental hospitals, private hospitals with psychiatric services, VA hospitals outpatient psychiatric services and community mental health centers.

For example, if the level of services to the population that existed in 1971 were maintained through 1985 for persons in the age group 25-34, the number of episodes that would be experienced in that age group would be 63% greater than the corresponding number in 1971 - while the total population increase is expected to be 19%.

According to Table III-3a, under any population estimate of need - 2%, 10%, or 20% - the extent to which need would be unmet is considerable.

Table III-3b represents the implications that expected population changes will have the need for personnel to provide services to persons in need. (Source: Division of Manpower and Training NIMH.)

TABLE III-2a

NUMBER, PRECENT DISTRIBUTION AND RATES PER 100,000 POPULATION OF PATIENT CARE EPISODES BY DIAGNOSIS AND SEX, BY TYPE OF PSYCHIATRIC FACILITY, ALL PSYCHIATRIC FACILITIES 1/ UNITED STATES, 1971

Sex and Diagnosis	Total All Facilities	Inpatient Services of: State & County Mental	Private Mental	VA Hospitals	Gen.Hosp. Inpt.Psych Units (excl.VA)	Community Mental Health Centers	Outpatient Services of: Community Mental Health Centers	Other Outpatient Psychiatric Services
				Rate Per 100,000 Population				
BOTH SEXES	1953.8	363.2	47.7	86.2	264.4	63.4	303.5	825.4
Mental Retardation	59.7	19.6	0.1	0.1	1.7	1.2	11.5	25.5
Organic Brain Syndromes	105.3	50.7	2.6	9.1	12.0	2.5	6.3	22.2
Schizophrenia	439.1	138.1	10.9	29.3	69.4	14.1	30.7	146.7
Depressive Disorders	299.8	31.9	18.2	10.3	80.8	15.6	39.0	104.0
Other Psychoses	30.1	3.8	1.3	0.6	5.4	2.5	3.6	13.0
Alcohol Disorders	172.0	60.9	4.3	15.8	22.2	7.7	19.2	41.9
Drug Disorders	57.0	13.9	1.3	2.2	13.3	2.5	10.5	13.3
All Other	633.8	36.2	8.3	17.8	53.6	12.4	121.7	383.8
Undiagnosed	156.8	8.0	0.8	1.0	6.1	4.8	61.0	75.1
Males	2049.2	412.8	39.8	172.8	250.7	59.3	299.7	814.1
Mental Retardation	76.0	23.4	0.2	0.2	2.8	1.5	13.6	34.3
Organic Brain Syndromes	118.6	47.7	2.1	18.3	14.2	2.5	7.1	26.3
Schizophrenia	452.9	142.1	8.6	58.3	75.1	12.8	29.5	126.3
Depressive Disorders	201.7	22.7	12.0	20.2	45.8	10.2	23.7	67.1
Other Psychoses	22.5	2.4	0.8	1.2	5.6	2.4	3.0	7.1
Alcohol Disorders	283.8	101.7	6.3	32.4	33.8	11.7	31.3	66.6
Drug Disorders	83.2	20.8	1.6	4.2	18.6	2.7	15.1	20.1
All Other	641.6	41.4	6.6	36.0	44.8	10.8	116.9	384.0
Undiagnosed	169.4	10.6	0.6	2.0	10.0	4.6	59.5	82.2
Females	1863.5	316.2	55.2	4.1	277.5	67.3	307.2	836.1
Mental Retardation	44.4	16.0	0.1	-	0.7	1.0	9.5	17.1
Organic Brain Syndromes	93.1	53.5	3.0	0.4	9.8	2.5	5.5	18.3
Schizophrenia	426.1	134.3	13.0	1.8	64.0	15.3	31.8	169.9
Depressive Disorders	392.7	40.6	24.1	0.9	113.9	20.7	53.6	138.9
Other Psychoses	37.4	5.2	1.7	0.1	5.3	2.5	4.2	18.5
Alcohol Disorders	66.3	22.3	2.4	0.1	11.3	3.9	6.9	18.4
Drug Disorders	32.3	7.3	1.1	0.2	8.3	2.3	6.2	6.8
All Other	626.5	31.3	8.9	0.7	61.8	14.0	126.1	383.7
Undiagnosed	144.8	5.6	0.9	-	2.4	5.0	62.5	68.4

TABLE III-2b

NUMBER, PERCENT DISTRIBUTION AND RATES PER 100,000 POPULATION OF PATIENT CARE EPISODES BY DIAGNOSIS AND SEX, BY TYPE OF PSYCHIATRIC FACILITY, ALL PSYCHIATRIC FACILITIES 1/ UNITED STATES, 1971

Sex and Diagnosis	Total All Facilities	Inpatient Services of: State & County Mental Hospitals	Private Mental Hospitals	VA Hospitals	Gen.Hosp. Inpt.Psych Units (excl.VA)	Outpatient Services Of: Community Mental Health Centers	Community Mental Health Centers	Other Outpatient Psychiatric Services
				Number of Patient Care Episodes				
BOTH SEXES	4,009,506	745,259	97,963	176,800	542,642	130,088	622,906	1,693,848
Mental Retardation.....	122,609	40,227	302	233	3,495	2,509	23,588	52,255
Organic Brain Syndromes	216,153	104,015	5,292	18,627	24,573	5,184	12,903	45,559
Schizophrenia	901,119	283,462	22,289	60,045	142,493	28,885	62,934	301,011
Depressive Disorders...	615,261	65,420	37,422	21,099	165,749	32,018	80,135	213,418
Other Psychoses	61,851	7,785	2,568	1,330	11,078	5,049	7,383	26,658
Alcohol Disorders.....	353,020	125,022	8,782	32,456	45,563	15,803	39,483	85,911
Drug Disorders.....	117,069	28,513	2,686	4,455	27,333	5,175	21,612	27,295
All Other.....	1,300,728	74,300	17,051	36,599	109,911	25,542	249,662	787,663
Undiagnosed.....	321,696	16,515	1,571	1,956	12,447	9,923	125,206	154,078
Males	2,044,576	411,907	39,756	172,433	250,086	59,133	298,985	812,275
Mental Retardation.....	75,790	23,370	156	233	2,762	1,456	13,595	34,218
Organic Brain Syndromes	118,032	47,595	2,145	18,246	14,201	2,524	7,072	26,249
Schizophrenia.....	451,824	141,804	8,619	58,158	74,971	12,789	29,426	126,057
Depressive Disorders...	201,222	22,616	12,009	20,166	45,688	10,142	23,632	66,969
Other Psychoses.....	22,432	2,353	793	1,242	5,539	2,430	2,954	7,121
Alcohol Disorders.....	283,115	101,477	6,239	32,320	33,674	11,690	31,253	66,462
Drug Disorders.....	83,015	20,772	1,549	4,213	18,601	2,743	15,040	20,097
All Other.....	640,113	41,332	7,624	35,899	44,714	10,760	116,669	383,115
Undiagnosed.....	169,033	10,588	622	1,956	9,937	4,599	59,344	81,987
Females	1,964,930	333,352	58,207	4,367	292,555	70,955	323,921	881,573
Mental Retardation	46,819	16,857	146		733	1,053	9,993	18,037
Organic Brain Syndromes	98,121	56,420	3,147	381	10,372	2,660	5,831	19,310
Schizophrenia.....	449,295	141,658	13,670	1,887	67,522	16,096	33,508	174,954
Depressive Disorders...	414,039	42,804	25,413	933	120,061	21,876	56,503	146,449
Other Psychoses.....	39,419	5,432	1,775	88	5,539	2,619	4,429	19,537
Alcohol Disorders.....	69,905	23,545	2,543	136	11,889	4,113	8,230	19,449
Drug Disorders.....	34,054	7,741	1,137	242	8,732	2,432	6,572	7,198
All Other.....	660,615	32,968	9,427	700	65,197	14,782	132,993	404,548
Undiagnosed.....	152,663	5,927	949	-	2,510	5,324	65,862	72,091

TABLE III-2c

NUMBER, PERCENT DISTRIBUTION AND RATES PER 100,000 POPULATION OF PATIENT CARE EPISODES B. DIAGNOSIS AND SEX, BY TYPE OF PSYCHIATRIC FACILITY, ALL PSYCHIATRIC FACILITIES 1/ UNITES STATES, 1971

Sex and Diagnosis	Total All Facilities	Inpatient Services of:					Outpatient Services of:	
		State & County Mental Hospitals	Private Mental Hospitals	VA Hospitals	Gen.Hosp. Inpt.Psych Units (Excl.VA)	Community Mental Health Centers	Community Mental Health Centers	Other Outpatient Psychiatric Services
		Percent Distribution by Diagnosis						
BOTH SEXES	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Mental Retardation.....	3.1	5.4	0.3	0.1	0.6	1.9	3.8	3.1
Organic Brain Syndromes	5.4	14.0	5.4	10.5	4.5	4.0	2.1	2.7
Schizophrenia.....	22.5	38.0	22.8	34.0	26.3	22.2	10.1	17.7
Depressive Disorders...	15.4	8.8	38.2	11.9	30.6	24.6	12.8	12.6
Other Psychoses.....	1.5	1.0	2.6	0.8	2.0	3.9	1.2	1.6
Alcohol Disorders.....	8.8	16.8	9.0	18.4	8.4	12.2	6.3	5.1
Drug Disorders	2.9	3.8	2.7	2.5	5.0	4.0	3.5	1.6
All Other.....	32.4	10.0	17.4	20.7	20.3	19.6	40.1	46.5
Undiagnosed.....	8.0	2.2	1.6	1.1	2.3	7.6	20.1	9.1
Males	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Mental Retardation.....	3.7	5.7	0.4	0.1	1.1	2.5	4.5	4.2
Organic Brain Syndromes	5.8	11.6	5.4	10.6	5.7	4.3	2.4	3.2
Schizophrenia.....	22.1	34.4	21.7	33.7	30.0	21.6	9.8	15.5
Depressive Disorders...	9.8	5.5	30.2	11.7	18.3	17.1	7.9	8.3
Other Psychoses.....	1.1	0.6	2.0	0.7	2.2	4.1	1.0	0.9
Alcohol Disorders.....	13.8	24.6	15.7	18.8	13.4	19.8	10.5	8.1
Drug Disorders.....	4.1	5.0	3.9	2.5	7.4	4.6	5.0	2.5
All Other.....	31.3	10.0	19.2	20.8	17.9	18.2	39.0	47.2
Undiagnosed	8.3	2.6	1.5	1.1	4.0	7.8	19.9	10.1
Females	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Mental Retardation.....	2.4	5.1	0.2	-	0.2	1.5	3.1	2.1
Organic Brain Syndromes	5.0	16.9	5.4	8.7	3.5	3.8	1.8	2.2
Schizophrenia.....	22.9	42.5	23.5	43.2	23.1	22.7	10.4	19.8
Depressive Disorders...	21.1	12.8	43.8	21.4	41.0	30.8	17.4	16.6
Other Psychoses.....	2.0	1.6	3.0	2.0	1.9	3.7	1.4	2.2
Alcohol Disorders.....	3.5	7.1	4.4	3.1	4.1	5.8	2.5	2.2
Drug Disorders.....	1.7	2.3	2.0	5.6	3.0	3.4	2.0	0.8
All Other.....	33.6	9.9	16.2	16.0	22.3	20.8	41.1	45.9
Undiagnosed.....	7.8	1.8	1.6	-	0.9	7.5	20.3	8.2

TABLE III-3a

EXTENT TO WHICH NEEDS FOR PSYCHIATRIC SERVICES WOULD BE MET IN RELATION TO VARIOUS ASSUMPTIONS OF NEED: ASSUMING 1971 USE RATES ONLY, BY AGE, UNITED STATES, 1975 AND 1980

Age	Estimated Gen.Pop.a/ (in 000's) (1)	Estimated Pt.Care Episodes (2)	Estimated No.Persons Rec'v Care (3)	Estimated number of persons needing care, assuming			Number in need not receiving care, assuming			Percent unmet assuming (need)		
				2% need (4)	10%in need (5)	20%in need (6)	2%in need (7)	10%in need (8)	20%in need (9)	2%in (10)	10%in (11)	20%in (12)
1975												
Total, All Ages.....	215,324	4,237,576	3,390,061	4,306,480	21,532,400	43,064,800	1,060,510	18,142,339	39,674,739	24.6	84.3	92.1
Under 18.....	68,109	809,377	647,502	1,362,180	6,810,900	13,621,800	714,678	6,163,398	12,974,298	52.5	90.5	95.2
18-24.....	27,780	716,150	572,920	555,600	2,778,000	5,556,000	0	2,205,080	4,983,080	0.0	79.4	89.7
25-44.....	53,835	1,504,340	1,203,471	1,076,700	5,383,500	10,767,000	0	4,180,029	9,563,529	0.0	77.6	88.8
45-64.....	43,430	932,267	745,814	868,600	4,343,000	8,686,000	122,786	3,597,186	7,940,186	14.1	82.8	91.4
65.....	22,170	275,442	220,354	443,400	2,217,000	4,434,000	223,046	1,996,646	4,213,646	50.3	90.1	95.0
1980												
Total, All Ages.....	228,676	4,500,344	3,600,275	4,573,520	22,867,600	45,735,200	1,030,028	19,267,325	42,134,925	22.5	84.3	92.1
Under 18.....	69,646	859,566	687,653	1,392,920	6,964,600	13,929,200	705,267	6,276,947	13,241,547	50.6	90.1	95.1
18-24.....	29,156	760,558	600,446	583,120	2,915,600	5,831,200	0	2,307,154	5,222,754	0.0	79.1	89.6
25-44.....	62,332	1,597,622	1,278,097	1,246,640	6,233,200	12,466,400	0	4,955,103	11,188,303	0.0	79.5	89.7
45-64.....	43,489	990,076	792,061	869,780	4,348,900	8,697,800	77,719	3,556,839	7,905,739	8.9	81.8	90.
65+.....	24,053	292,522	234,018	481,060	2,405,300	4,810,600	247,042	2,171,282	4,576,582	51.4	90.3	95.1

a/ U.S. Bureau of the Census, Series D projection of the U.S. Population (Current Population Reports-Series P-25,No. 493)

Derivation of columns 2 through 12:

Col. 2 Total patient care episodes obtained by applying 1971 patient care episode rate per 100,000 population (1,968 per 100,000) to be projected 1975 and 1980 total U.S. population. Age distributions of patient care episodes obtained by applying 1971 percentage distribution of patient care episodes by age to the 1975 and 1980 estimated total patient care episodes.

Col. 3 Represents a conversion of patient care episodes into number of persons accounting for these episodes by multiplying patient care episodes by a factor of 80. This factor was derived from findings of the Maryland Psychiatric Case Register that every person in the register had an average of 1.2 episodes of care per year.

Col. 4 Col.1 x .02

Col. 5 Col.1 x .10

Col. 6 Col.1 x .20

Col. 7 Col.4 - Col.3 (NOTE: For this column negative values were assumed to be zero, i.e., the needfor services would be met. Also the total is the sum of the parts.)

Col. 8 Col.5 - Col.3

Col. 9 Col.6 - Col.3

Col. 10 Col.7 - Col.4

Col. 11 Col.8 - Col.5

Col. 12 Col.9 - Col.6

TABLE III-3b

ESTIMATED NUMBER OF PSYCHIATRISTS, PSYCHOLOGISTS, SOCIAL WORKERS, AND NURSES NEEDED TO CARE FOR ALL PERSONS IN NEED OF PSYCHIATRIC CARE ASSUMING VARIOUS LEVELS OF NEED FOR CARE AND VARIOUS AMOUNTS OF TIME SPENT PER PATIENT PER YEAR, UNITED STATES 1971, 1975. 1980

Professional Discipline and Assumed Hours per Patient per year	Percent Level of Need for Care in the Population								
	1971			1975			1980		
	2% in need	10% in need	20% in need	2% in need	10% in need	20% in need	2% in need	10% in need	20% in need
Number of persons in need of care 1/	4,085,080	20,425,400	40,850,800	4,306,480	21,532,400	43,064,800	4,573,520	22,867,600	45,735,200
Clinical Psychiatrists									
3 hrs./yr./pt.....	8,170	40,851	81,702	8,613	43,065	86,130	9,147	45,735	91,470
5 hrs./yr.pt.....	16,340	81,702	163,403	17,226	86,130	172,259	18,294	91,470	182,941
10 hrs./yr./pt.....	27,234	136,169	272,339	28,710	143,549	287,099	30,490	152,451	304,901
Psychologists									
3 hrs./yr./pt.....	8,170	40,851	81,702	8,613	43,065	86,130	9,147	45,735	91,470
6 hrs./yr./pt.....	16,340	81,702	163,403	17,226	86,130	172,259	18,294	91,470	182,941
10 hrs./yr./pt.....	27,234	136,169	272,339	28,710	143,549	287,099	30,490	152,451	304,90
Social Workers									
6 hrs./yr./pt.....	16,340	81,702	163,403	17,226	86,130	172,259	18,294	91,470	182,941
12 hrs./yr./pt.....	32,680	163,403	326,806	34,452	172,260	172,259	18,294	182,940	365,882
20 hrs./yr./pt.....	54,468	272,339	544,677	57,420	287,099	574,198	60,980	304,901	609,802
Nurses									
6 hrs./yr./pt.....	16,340	31,702	163,403	17,226	86,130	172,259	18,294	91,470	182,941
10 hrs../yr./pt.....	27,234	136,169	272,339	28,710	143,549	287,099	30,490	.52,451	304,901

NOTE: It was assumed that each profession would work 50 weeks during the year on an average of 30 hours per week or a total of 1500 hours per year.

1/ Based on U.S. Bureau of the Census estimated July 1, 1971 civilian resident population (Current Population Reports-Series P-25,No.490) and U.S. Bureau of Census Series D projection of 1975 and 1980 U. S. population (Current Population Reports-Series P-25, No. 493).

TABLE III-3c

U.S. POPULATION, ACTUAL 1970 AND ESTIMATED 1985, AND NUMERICAL AND PRESENT CHANGE IN U.S. POPULATIONS: 1970-1985, BY AGE AND COLOR

AGE	1970			1985		
	Total	White	Nonwhite	Total	White	Nonwhite
	Population (in 000's)					
Total	203,212	177,749	25,463	241,731	209,427	32,304
18	69,644	59,062	10,582	73,307	61,363	11,944
18-24	23,697	20,592	3,105	28,423	23,975	4,448
25-34	24,907	21,779	3,128	40,699	35,109	5,590
35-44	23,089	20,328	2,761	31,384	27,657	3,727
45-64	41,810	37,658	4,152	42,941	38,398	4,543
65	20,066	18,330	1,736	24,977	22,925	2,052
	Change in Number of Persons (in 000's) 1970-1985			Percent Change in Number of Persons 1970-1985		
Total	38,519	31,678	6,841	19.0	17.8	26.9
18	3,663	2,301	1,362	5.3	3.9	12.9
18-24	4,726	3,383	1,343	19.9	16.4	43.3
25-34	15,792	13,330	2,462	63.4	61.2	78.7
35-44	8,295	7,329	966	35.9	36.1	35.0
45-64	1,131	740	391	2.7	2.0	9.4
65+	4,911	4,595	316	24.5	25.1	18.2

1 / Source: U.S. Bureau of the Census, U.S. Census of Population, 1970, General Population Characteristics PC (1)-B1, Table 52

2 / Source: U.S. Bureau of the Census, Current Population Reports, Series P-25, No. 388, Tables 2 and 6 (Serives D Projection)

TABLE III-4

THREE MOST FREQUENTLY DIAGNOSED CONDITIONS AMONG TERMINATIONS FROM OUTPATIENT PSYCHIATRIC SERVICES IN TERMS OF RATES PER 100,000 POPULATION BY AGE AND SEX: UNITED STATES, 1971 1/ 2/

Age at Termination	Three Leading Diagnoses 3/ 4/ (in terms of rate per 100,000 population)	
	Males	Females
All Ages	Transient Situational Disturbances (74.3) Personality Disorders (55.3) Schizophrenia (44.7)	Depressive Disorders (64.0) Transient Situational Disturbances (60.1) Schizophrenia (49.1)
Under 18 Years	Transient Situational Disturbances (169.6) Mental Retardation (49.4) Personality Disorders (41.8)	Transient Situational Disturbances (114.8) Mental Retardation (31.1) Personality Disorders (21.7)
18-24 Years	Personality Disorders (117.9) Schizophrenia (95.0) Transient Situational Disturbances (57.3)	Personality Disorders (112.2) Depressive Disorders (100.7) Schizophrenia (62.5)
25-44 Years	Personality Disorders (91.3) Schizophrenia (87.0) Alcohol Disorders (66.7)	Depressive Disorders (126.4) Schizophrenia (105.8) Personality Disorders (99.9)
45-64 Years	Alcohol Disorders (57.0) Depressive Disorders (34.3) Schizophrenia (33.4)	Depressive Disorders (77.8) Schizophrenia (60.2) Other Neuroses (23.7)
65 Years & Over	Organic Brain Syndromes (excluding alcoholism & drug) (30.3) Depressive Disorders (15.5) Alcohol Disorders (9.6)	Organic Brain Syndromes (excluding alcoholism & drug) (26.5) Depressive Disorders (26.2) Schizophrenia (9.5)

1/ This table excludes outpatient psychiatric services affiliated with Veterans Administration hospitals and residential treatment centers for emotionally disturbed children for which the demographic characterization of admissions were not available.

2/ Rates are based on the July 1, 1971 civilian resident population by age and sex (Source: U.S. Bureau of the Census, Current Population Reports, Series P-25, No. 490, September 1972).

3 /Excludes "undiagnosed" and "other" categories; numbers in parentheses are rates per 100,000 population.

4/ For code numbers included for each diagnostic category see Appendix I, page

These computations also underscore the sizable increases in the demand for manpower which will be required to deliver services merely as a result of total population increases and without regard to its demography.

Moreover, these computations also reflect a research need. Since the foregoing national estimates were based on quite gross data, it should follow that in order to plan for local service delivery and to use existing manpower more effectively, that it is essential to give high priority to this design and implementation of research to obtain more reliable and valid data to do it.

C. Estimating Need in Minnesota

One of the more comprehensive studies for approaching the problem of estimating local need for mental health services was carried out in Montgomery County, Maryland. Its purpose was to explore a method for using the Mental Health Demographic Profile System for assessing needs. Underlying the development of this system is the assumption that certain characteristics of a population (poverty, overcrowding, low occupational status, etc.) are considered "highrisk" in terms of potential needs for mental health and other social and health services.

Data which were obtained by census tract relative to "high risk" indicators were:

1) General population data
2) Socioeconomic status
3) Ethnic composition
4) Household composition and family structure
5) Type of housing
6) Condition of housing, and
7) Community instability.

Findings from the Montgomery county study show that at least two percent of the population were in acute need of mental health service. This was compared with the number of persons receiving care in psychiatric facilities, on the assumption that everyone receiving care was in acute need. It was shown that 58% of estimated needs for care are unmet in one community and 68% of need is unmet in another (Rockville, Md.).

Because of the heterogeneity of population distribution with respect to the above "high risk" indicators, the common practice of assuming that there exists some common level of need in the population (e.g. 2%, 10%, 20%) is probably inappropriate to be uniformly applied to the entire geographic population.

One may assume that the "real" need is much higher in some population groups than is generally expected because of the nonuniform distribution in the population of demographic characteristics.

Despite the promising methodology being developed by NIMH via the Mental Health Demographic Profile System, it has not yet been adapted for use in Minnesota. Consequently, best estimates of need for and locus of service in

Minnesota must depend on the application of uniform estimates (2%) across a population which is nonuniformly distributed in terms of pathognomonic indicators. However, it must be borne in mind that, from what has already been discussed, the estimates will be quite conservative with respect to what need probably does exist and refers only to that portion of the population that at any given moment, are in acute need of mental health services.

The 1970 population of Minnesota was reported at approximately 4 million. Using the 2% estimate, this would conservatively translate into a total of about 80,000 persons who need service at this time.

To the extent that the distribution of problems and sites of service in Minnesota would correspond to the national distribution, the following expectations would obtain.

Excluding estimates of the mental health needs of the chemically dependent and mentally retarded population, the estimated prevalence of severe dysfunction associated with each disorder are given as follows:

Disorder	Minimum Expected Number of Persons Affected
Schizophrenia	17980
Organic Brain Syndrome	4300
Depressive Disorders	12275
Other Psychoses	1232
All other Disorders	37793
Unspecified	6420
	80000

However, there are inferences pertaining to Minnesota which may be more confidently drawn from national studies. These are:

1.) That the scope of prevalent, serious social dysfunction arising from emotional disturbance is probably much wider in Minnesota than conservative estimates indicate.
2.) That the incidence of dysfunction will increase not only as a function of increased population but will also be strongly influenced by demographic changes in the composition of the population.
3.) That there probably are not a sufficient number of mental health professionals currently available to meet existing needs (national estimates reflect that it would require twice the manpower to serve currently existing need, much less an expected increase of need.
4.) That there is a concomitant need for the development and utilization more sophisticated methodologies to carry out epidemiological studies of need in Minnesota. Current reporting is fragmentary and inconsistent across the continuum of care. Coordinated effort in this regard should be focused not only on the determination of need, but on parameters of service process and impact as well.

The 1971 Community Mental Health Construction Plan included a table of Social Dysfunction Tables. This ranking of needs is based upon the premise that social dysfunction correlates highly with emotional instability. The rationale for the tables and the tables of ranking are provided in the Appendix D of this Plan.

CHAPTER IV

PRESENT SYSTEMS AND SERVICES

A. Goals and Purposes

The broad goal of Minnesota's Mental Health Program is to address the problems of human dysfunctioning and maladaptive behavior. The problems are shared with other programs in the fields of welfare, health, education and criminal justice and, as a common goal, does provide the basis for joint planning with those in other fields.

One goal of the Mental Health Program is to address the issue of incidence and prevalence of human dysfunctioning and maladaptive behavior within a framework which:

1. Without violating the civil and human rights of individuals, and

2. Within the authority of the Commissioner of Public Welfare:

    a. To operate state mental health institutions and facilities;

    b. To supervise county welfare boards;

    c. To assist the local community mental health boards to develop and implement and evaluate a comprehensive mental health program for the area.

The Minnesota system is comprised of public and privately operated services. The system includes a mixture of formal and informal programs. The formal programs are administered by both public and private agencies and organizations. These programs range from delivery of a single service to delivery of an array of services which are coordinated to provide a comprehensive program.

The Commissioner of Welfare is designated as the mental health authority for the State of Minnesota. The Commissioner is the legally recognized mental health authority recognized by the Federal Government. The state hospitals are administered by the Commissioner. State funds appropriated for mental health are under the control of the Commissioner. The regulating, licensing, and standard setting for mental health services and programs are under the jurisdiction of the Commissioner.

Historically, state hospitals initially constituted the total public mental health system. Now, the function of the state hospital is primarily to provide residential treatment programs for patients who are admitted on a voluntary or an involuntary basis. Most of the institutions serve the mentally retarded and chemically dependent, as well as the mentally ill.

Each of the state hospitals is assigned a geographic area, with the exception of the Minnesota Security Hospital which provides services on a state-wide basis. Also, there have been changes in the receiving districts of the state institutions over the years. Some of the factors that have influenced changes in receiving districts are: program changes within the state hospitals, new services for specific disability groups, attempts to reduce the overcrowding that existed in some of the institutions and attempts to better distribute the population among the institutions. Currently, the question has been raised regarding whether or not there is a realistic need for nine state hospital programs for the mentally ill since the resident population has been significantly decreasing over the years, approximately 75% to 80% since 1960.

Considerable attention and effort has been given to bringing about treatment, within the community rather than simply to extend the provision of custodial care. The Legislature has also required multidisciplinary professionals and acceptable standards of treatment and acceptable standards for living. Some of the results of these changes have been:

1.) increased expenditure for the operation of the institutions;
2.) contributing factors to the decreased patient population; and
3.) the length of stay for more recently admitted patients has been reduced when compared to the previous years.

B. County Welfare Departments

The county welfare departments have been assigned some responsibilities for the MI population. One of the earliest assigned responsibilities was to assure the provision of Social Security Act benefits to the MI population, with particular regard to the categorical assistance program: the Minnesota Hospitalization and Commitment Act identifies the responsibility of the obtaining a social history prior to commitment. The Department has encouraged the exploration of suitable alternatives to institutionalization and the development of the precommitment screening process.

The Minnesota Hospitalization Act 253.15, Subdivision 12, requires participation of the county welfare board in the predischarge planning and requires them to assist the individual in his adjustment within the community and to see to it that needed resources are made available to enhance this process.

The responsibility to assist the individual to adjust within the community is handled by means of county social services. This may be accomplished by individual counseling, participation in an integrated after-care program provided by team members from other agencies, the provision of a place to live, and assistance in finding employment, etc.

The responsibilities assigned to the county welfare department by statute focus on those individuals with existing statutorily defined problems. The county also has the continuing responsibility for the overall plan for each individual. The hospital and community mental health center focus more on the care and treatment of the individual. The county welfare department is important in the after-care program as it focuses on the adjustment and well being of the previously hospitalized patient and the linking of the patient to the various resources.

For county welfare departments to perform their responsibilities, they must maintain regular communication with community mental health centers, state hospitals and support services such as: public health nursing, vocational rehabilitation, education, employment offices, etc.

The amount and quality of county social services to the MI population varies across the state. Some of the counties have separately identified units for mental health social services and some counties provide services through a caseworker who may be assigned a variety of responsibilities. This range and variance of services is to be expected since county social services departments vary considerably in size and resources.

C. Community Mental Health Programs

Minnesota's enabling legislation for the establishment of community mental health programs was passed in 1957. In 1969, the last three counties had made arrangements for community mental health programs. That made a total of 25 community mental health programs in the State of Minnesota. These programs are locally administered and they have a contractual agreement with the Commissioner for each fiscal year. These programs are assigned responsibilities for mental health, mental retardation, and chemical dependency. The programs are funded by means of a grant-in-aid mechanism, and receive up to 50% of state funds appropriated by the State Legislature for the specific purpose of their operation. See Table IV-1 and Figure IV-1 for development and location of Community Mental Health Programs.

The Community Mental Health Act assigns these programs responsibility for the following activities:

1.) Development of an area plan for MI/BD populations.
2.) Collaborative and cooperative services with public health and other groups for programs of prevention of MI/BD.
3.) Information and educational services to general public, lay and professional groups.
4.) Consultative services to schools, courts, health and welfare agencies, both public and private.
5.) Outpatient diagnostic services.
6.) Outpatient treatment services.
7.) Rehabilitative services for MI/BD disorders, particularly those who have received treatment in an inpatient facility.
8.) Evaluation of program.
9.) In-service training for personnel.

The Minnesota Hospitalization and Commitment Act defines the community mental health programs as a hospital. This definition provides that individuals may be committed to a community mental health center. The MHCA #253.15, Subdivision 12, also requires that discharge planning be done prior to the date of discharge, provisional discharge, partial hospitalization or release, in cooperation with the county welfare board, state hospital, the community mental health center, and family physician if he was previously involved with patient.

TABLE IV-1

DEVELOPMENT OF MINNESOTA COMMUNITY MENTAL HEALTH CENTERS

YEARS ESTABLISHED		CMH PROGRAM	COUNTIES
Center	Clinic		
*1959	1949	Lakeland	Becker, Clay, Douglas, Grant, Otter Tail, Pope Stevens, Traverse, Wilkin
*1960	1951	Southern MN Human Development	Faribault, Freeborn
*1957	1938	NE MN MH/MR/I	Carlton, Cook, Lake S. St. Louis
1957		Zumbro	Olmsted, Goodhue, Fillmore
1958		Mower Co.	Mower
1958		Northwestern	Kittson, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake
1958		West Central	Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, McLeod, Meeker, Renville, Swift
1959		Central MN	Benton, Sherburne, Stearns, Wright
1959		Northland Area	Aitkins, Itasca, Koochiching
1959		Southwestern	Cottonwood, Jackson, Nobles, Pipeston, Rock Hennepin
1960		Hennepin Co.	Hennepin
1960		Upper Mississippi	Beltrami, Cass, Clearwater, Hubbard, Lake of the Woods, Roseau
1960		Western	Lyon, Lincoln, Yellow Medicine, Redwood, Murray
1960		Luther W. Youngdahl Human Relations Center	Dodge, Rice, Steele, Waseca
1961		Northern Pines	Crow Wing, Morrison, Todd, Wadena
1962		Range	Upper two-thirds of St. Louis County

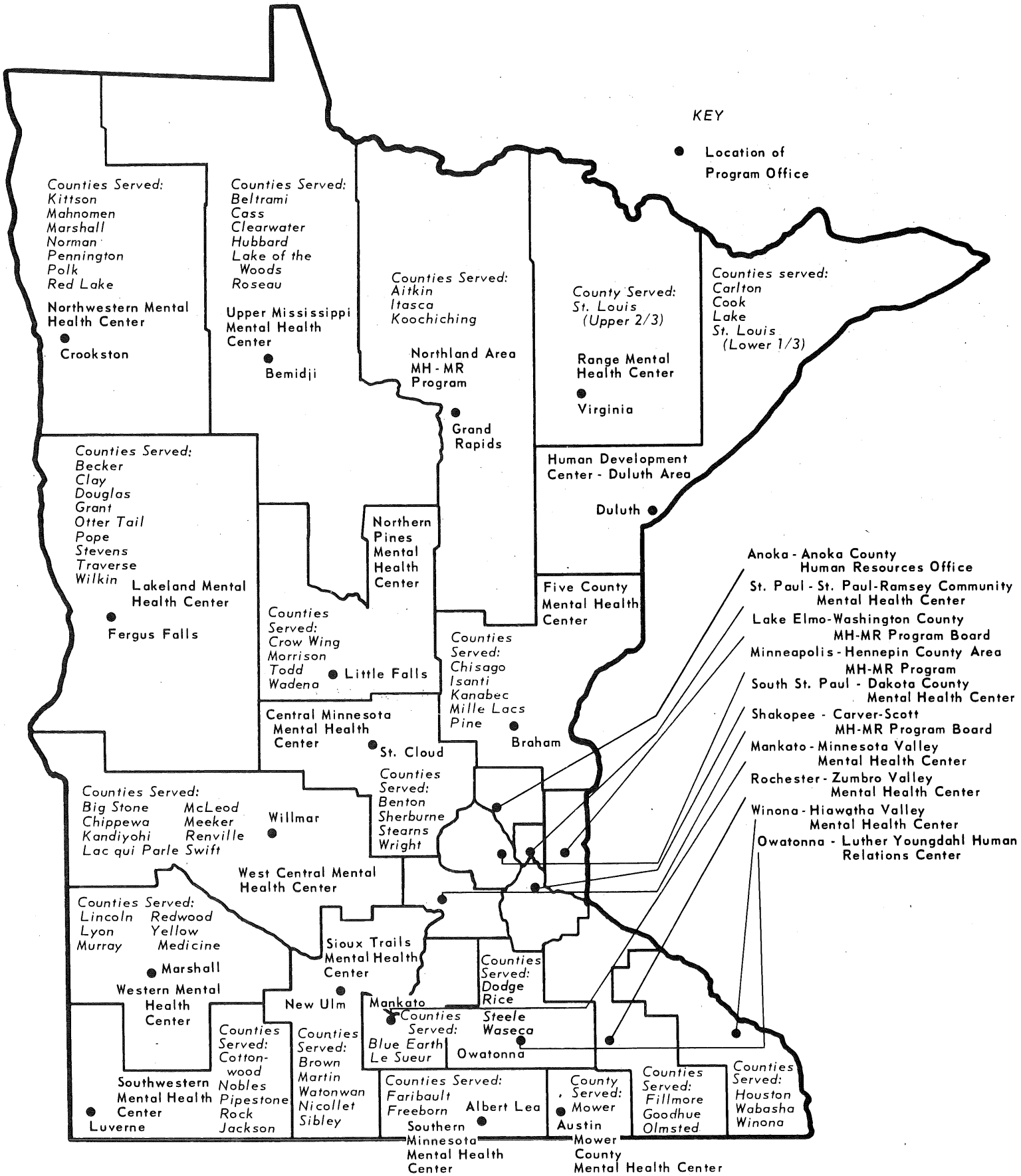
1962	St. Paul-Ramsey	Ramsey
1964	Dakota County	Dakota
1964	Five County	Chisago, Isanti, Kanabec, Mille Lacs, Pine
1965	Hiawatha Valley	Houston, Wabasha, Winona
1965	Minnesota Valley	Blue Earth, Le Sueur
1965	Sioux Trails	Brown, Martin, Nicollet, Sibley, Watonwan
1967	Anoka County Human	Anoka
1968	Washburn Child Guidance	Anyone within commuting distance
1969	Carver-Scott Area	Carver, Scott
1969	Washington Co. MH/MR Bd.	Washington

*Clinics established prior to Community Mental Health Law

FIGURE IV - 1

MINNESOTA'S

AREA MENTAL HEALTH-MENTAL RETARDATION PROGRAMS



COMPREHENSIVE MENTAL HEALTH CENTERS (1)

* Hibbing - Psychiatric Day Hospital Service
  Hibbing General Hospital

  Range Mental Health Center

* St. Cloud - St. Cloud Hospital

  Central Minnesota Mental Health Center

* Minneapolis - Metropolitan Mental Health Center
  Swedish-St. Barnabas Hospital

  Hennepin County MH-MR Program

* Rochester - Rochester State Hospital

  Zumbro Valley Mental Health Center

* Hutchinson - Hutchinson Community Hospital

  West Central Mental Health Center

* Thief River Falls - Northwestern Hospital

  Northwestern Mental Health Center

(1) Hospitalization Services sponsored jointly by Area Programs through federal grants

The Policy Statement of the Minnesota Association of Mental Health Program in Appendix E provides further description of area programs/community mental health boards.

Some distinguishing characteristics of the community mental health programs are:

1. The community mental health programs are statutorily required to have multidisciplinary professional staff with mental health expertise and to maintain required standards. The state hospitals are also required to have multidisciplinary staff with mental health expertise.

2. The community mental health programs are legislatively assigned responsibilities that are not assigned to state hospitals nor to county welfare departments. These responsibilities are:

a. To develop MI/BD plan for the area.

b. To provide collaborative and cooperative services with other groups for programs of prevention.

c. To provide information and educational services to general public, and lay and professional groups.

d. To provide consultative services to the public and private health and welfare agencies, schools and courts.

e. These programs also are assigned outpatient diagnostic and outpatient treatment responsibilities.

f. They are assigned target populations that include publicly defined mentally ill/behaviorally disabled, as well as the portion of a target population that is not publicly defined.

g. They are assigned to primary and secondary prevention activities, in addition to the tertiary prevention activities.

3. Another distinguishing factor of the community mental health programs is the requirement of a minimum population base with service delivery. The Minnesota law requires a minimum population base of 50,000. (Studies have indicated that a population base of 75,000 to 200,000 is desirable. This has been adopted by the Federal government as a desirable size.)

The requirement of a minimum population base does provide for a practical approach to establish and maintain a comprehensive mental health program which provides a continuum of preventive, diagnostic, treatment and rehabilitative services to be provided in non-residential, partial residential and residential services which offer varying amounts of care and support, depending upon the individual's need.

A spectrum of rehabilitative and supportive services helps to improve functioning and promote recovery. Services must be specific to individual needs. They must also be responsive to the varying types and degrees of stress and

dependency. Since the needs of troubled individuals do vary from time to time, services should be available that respond to these changing requirements.

4. Six of the state funded community mental health programs are also federal style community mental health centers. That is to say, six programs are receiving Federal Community Mental Health Center Staffing Funds and meet Federal Alcohol, Drug and Mental Health Administration (ADAMHA requirements). Two programs have federally funded staffing grants for children's mental health services. These programs are identified in Table IV-2.

D. Other Non-State Hospitals With Mental Health/Psychiatric Units

Community hospital based mental health programs are provided in the state in various geographic locations. In Chapter II, Table II-5 is provided to identify the hospitals and their locations. Some of these hospitals do have affiliate agreements with community mental health programs which are federally funded. The federal community health centers are required to provide inpatient hospitalization services.

The two Veteran Administration Hospitals located in Minneapolis and St. Cloud also have psychiatric units.

These hospitals are also identified in Table II-5 in Chapter II. These hospital services primarily provide residential treatment. Some of them do provide partial hospitalization programs and outpatient services.

E. The Residential Treatment Centers for Emotionally Disturbed Children

There are 16 residential treatment centers for emotionally disturbed children. These centers are located throughout the state, with the exception of the southwestern portion of the state. Table II-4, Chapter II identifies these agencies and their locations. The treatment centers are private agencies and receive funding primarily from:

1. Cost of care for emotionally disturbed children, state appropriation, which funds up to 50%.

2. Social service contracts with county welfare departments for funding at a rate of 75% federal reimbursement.

3. Funds from county welfare departments for foster care, AFDC/FC, which has funded 57.37% with federal funds and 21.5% county funds and 21.5% state funds.

Residential treatment centers may be considered a primary resource for residential treatment for children in the state. They care for approximately 600 children. Some private hospitals also provide specialized mental health programs for children and youth. Willmar State Hospital and Rochester State Hospital also operate an adolescent unit.

TABLE IV-2

FEDERAL STYLE COMMUNITY MENTAL HEALTH PROGRAMS AND RESIDENTIAL AFFILIATES

COMMUNITY MENTAL HEALTH PROGRAMS	LOCATION	RESIDENTIAL AFFILIATE	CAPACITY
Central Minnesota	St. Cloud	St. Cloud Hosp./2W	30
Hennepin County MH/MR	Minneapolis	Hennepin Co. Gen. Hosp.	20
		Metropolitan CMHC	109
Northeast Area MH/MR/I (children's program)	Duluth	St. Louis County Crisis Shelter (children & youth)	20
		Bethany Home	44
		Northwood (children)	36
		Woodland Hills (children)	45
		St. Luke Hospital	50
		Miller Dwan Hospital	20
		Community Memorial Hospital* Cloquet	
		Lakeview Memorial Hosp.* Two Harbors	
		Cook County Com. Hosp.* Grand Marais	
Northwestern MHC	Crookston	Northwestern Hospital Thief River Falls	
Range Area Human Resources	Virginia	Hibbing General Hosp.	15
		Virginia General " *	
West Central Community Service Center	Willmar	Hutchinson Com.Hosp. Hutchinson	12
		Rice Memorial Hosp. Willmar	19
Washburn Child Guidance Center	Minneapolis	University Hospital* Minneapolis	
		General Hospital*	
Zumbro Valley MHC	Rochester	Rochester State Hospital	

* These hospitals have agreements to accept patients. However, the agreements do not designate a number of beds.

F. Group Homes and Halfway Houses

There are five Fairweather Lodges that provide after-care services for the longer term mentally ill, former Anoka State Hospital patients. These lodges have written agreements with Hennepin County MH/MR program.

There are 20 group homes in the Lakeland area. These group homes have affiliate agreements with Lakeland Mental Health Center. Of these, two provide services to the mentally ill.

A questionnaire survey was made of the group homes and halfway houses, in addition to other resources, to determine the extent of mental health resources. The response rate was poor and several of these reported serving individuals with problems in addition to mental illness/behavioral disabilities. The type of program provided in these facilities generally appeared to be quite limited. A better description of these resources is needed. However, the survey indicated there are approximately 146 facilities which could be classified as group homes, halfway house, and board and lodging homes.

Rule 36, which is applicable to such facilities is soon to be implemented. This should assist in obtaining a more complete picture of the community based MI Adult Residential facilities.

G. Nursing Homes

The number of nursing homes providing services to individuals in the MI/BD population is difficult to determine. Most patients in nursing homes do not have a primary diagnosis of MI/BD. The MI/BD population in nursing homes might need to be defined as those individuals placed from state institutions or having a diagnosis of mental illness.

The Health Department has proposed to do an audit of the nursing homes in regard to the types of populations that are cared for in nursing homes.

H. Individual Professionals in Mental Health Practice

There are approximately 400 licensed clinical psychologists in Minnesota. It is assumed that a portion of the psychologists have a private practice which serves the MI/BD population. There are approximately 275 psychiatrists in the State of Minnesota. Much of the practice of psychiatrists is assumed to be in private practice. There are currently 67 psychiatric residents in Minnesota. Location of psychiatrists is identified in Table IV-3.

I. Private Agencies and Clinics Providing Mental Health Services

There are a number of private agencies and clinics which provide mental health services. Catholic and Lutheran Social Services provide services on a state-wide basis. Many of the individuals they serve have emotional problems. There are several specialized clinics staffed by mental health professionals which provide services in a private practice model. Funding for these services is varied.

TABLE IV-3

PSYCHIATRISTS IN MINNESOTA
December, 1974

Region	Location	Number	Region	Location	Number
I	Crookston	1	IX	Mankato	4
II	Bemidji	1	X	St. Peter	4
III	Virginia	1		Rochester	35
	Moose Lake	6		Albert Lea	1
	Duluth	10	XI	Winona	2
	Grand Rapids	1		Minneapolis (suburb)	125
IV	Fergus Falls	6		Burnsville	1
V	Brainerd	1		White Bear	2
VI	Willmar	4		St. Paul	50
	Hutchinson	2		Stillwater	1
VII	St. Cloud	10		Hastings	1
VIII	Worthington	1		Champlin	1
IX	LeSeur	4			

Total Number of Psychiatrists in the State: 275

Seven psychiatrists are currently out of the state but have retained membership in state professional organization.

Psychiatric Residents currently in the state and their location:

Region X	Rochestrr (Mayo)	20
	on leave from Mayo	4
Region XI	University of Minn	32
	Veterans Adm.....	10
	Wilder.....	1
TOTAL IN STATE.....		67

J. Other Agencies and Departments

As indicated in Chapter I, other programs in the fields of welfare, health, education and criminal justice share in the broad goal to reduce the incidence and prevalence of human dysfunction and maladaptive behavior. This provides a basis for joint planning with those other fields and fosters the development of an extension of services which are supportive to a mental health program, in the areas of primary prevention, early case finding, treatment and rehabilitative services.

To provide an effective and responsive mental health system, it is necessary that there be coordination and linking of the various resources. Frequently, the coordination is missing and services are fragmented. The result is that the person with the mental health problems receives only a partial service or a service that does not meet his needs. That is not stated to imply that various resources should not be autonomous. The intent is to stress the need for communication, linking or bridging between resources so individuals may have continuity of care.

This presentation of the current system is not to be considered an exhaustive review of all mental health resources in Minnesota. However, it does present another view of a major portion of the mental health resources and does indicate the complexity of the mental health system.

The current licensure and accreditation standards for mental health service providers are identified on Table IV-4.

TABLE IV-4

COMMUNITY BASED RESIDENTIAL SERVICES FOR MI/BD

Licensure and Accreditation Standards

TYPE OF FACILITY	LICENSURE & ACCREDITATION
Residential treatment centers for children under 18 years.	DPW Rule #5 MHD Board & lodging license
Public & private general hospitals with psychiatric units.	MHD license as general hospital with notation of "X" beds for JCAH Accreditation. DPW Rule #36
Veterans Hospitals Fort Snelling St. Cloud	Federal Government Certification and JCAH Accreditation
State Hospitals	MHD license general hospital JCAH Rule #36 license DPW administerd
Nursing Homes with 5 or more MI/BD patients	DPW Rule #36 MHD - Nursing Home License as ICF or SNF (under Titles XVIII and XIX).
Group Homes, Board and Lodging Homes (MI Adults)	DPW Rule #36 MHD-Rule SLF
Group Homes for emotionally disturbed children	DPW Rule #8 MHD Board & Lodging License
Federally Funded Community MH Centers	NIMH Manual for Community MH Centers
Mental Health Centers	

CHAPTER V

MENTAL HEALTH SERVICE NEEDS

A. Overview of Service Needs

In spite of the varying characteristics of the MI/BD and their need for a variety of services, the publicly supported mental health system still tends to be dominated by inpatient services at state institutions. The proportion of population for public institutions in Minnesota and nationally has decreased. The number of individuals served elsewhere has increased. Without adequate hard data, it is difficult to determine, specifically, what the ratio currently is. However, factors such as an increase in the amount of other resources and the utilization rates of these resources and the decline of utilization of state facilities all indicate a shift in the service delivery. Some of the significant factors have been discussed in Chapter II.

Institutional and community-based terminology are often used as though they were opposites. This Plan endeavors not to place these in opposite roles, nor in terms of one being good and one being bad. Professional staffing, modern progressive treatment and improved living conditions in institutions has altered the previous negative view of institutions.

The shift of emphasis in delivery of services will be addressed in terms of what is more effective for the individuals to be served and more feasible and practical for the delivery of services. The focus of this Plan is on improving delivery of services to the MI/BD population. The goal must be to provide a continuum of services for the MI/BD population that is responsive, effective, accessible and practical.

Of major importance in establishing a unified, coordinated program are "Continuity of Care," "Accessibility," "Catchment Area Concept," "Administration," and "Community Involvement". These factors are vital to the operation of an effective program. A comprehensive mental health program which provides a continuum of services requires a minimum economic and population base.

B. Essentials for Developing Comprehensive Mental Health Programs

1. The following requirements are essential to the development and operation of a comprehensive mental health program:

a. Qualified Staff - There must be a sufficient number and variety of qualified staff to perform the functions. There should be adequate backup for, supervision of, and collaboration between personnel. In addition, there must be provision for in-service training.

b. Adequate Space - The facilities of a comprehensive mental health program must provide appropriate and sufficient space to house staff and the clients and to permit the effective operation of the program.

c. Other Requirements - For direct patient services, there must be:

(1) A sufficiently wide range of treatments. The mental health program must provide a sufficiently wide range of treatments to meet patients' needs. Such treatment may include, though is not limited to, individual, family, and group therapy, play therapy, behavior modification, indicated somatic therapies such as chemotherapy, and appropriate occupational and recreational therapies. Whenever indicated, treatment should extend beyond the identified patient to involve family members and/or significant others.

(2) An active treatment plan for each patient - Each individual receiving direct services must have an active treatment program plan. Such a plan must include the therapies to be offered, identified treatment objectives which relate to the problems and the strengths and liabilities of the individual, provisions to address his other needs as well as a plan for transferring the patient to other service components of the system and/or discharging him.

(3) A plan for evaluation of service needs for each patient - The need for continuing any service element for each individual patient must be evaluated with sufficient frequency to ensure proper arrangements have been made for discharge, for transfer to other elements of service, or for referral to another service provider when clinically appropriate.

C. Continuum of Care

A comprehensive mental health program provides a continuum of preventive, emergency, and diagnostic treatment, and rehabilitative services which offer varying amounts of support, treatment and care, depending upon the individual patient's needs and indirect services such as consultation and education. This range of services is from minimum treatment and support to maximum level of treatment and support available on a 24-hour basis. The continuum, as presented in Figures V-1 and V-2, is not a direct line of progression, but rather demonstrates the varying amount of support and care. The conceptual framework of the continuum is applicable to the special target groups.

The continuum includes the following services:

1. Direct Service Needs

a. Emergency Service - An emergency situation should be defined by consumer of service not the provider. The emergency service must provide immediate mental health care and evaluation for persons in crisis on a 24 hour-a-day, seven-day-a-week basis. It is important to insure that patients can be readily referred to other components of service. There are two major components of the emergency service: face to face contact and a crisis telephone service.

The face to face crisis intervention must be provided by mental health professionals or qualified mental health workers. In the instance where the nonprofessional mental health workers are utilized, there must be appropriate

FIGURE V-1

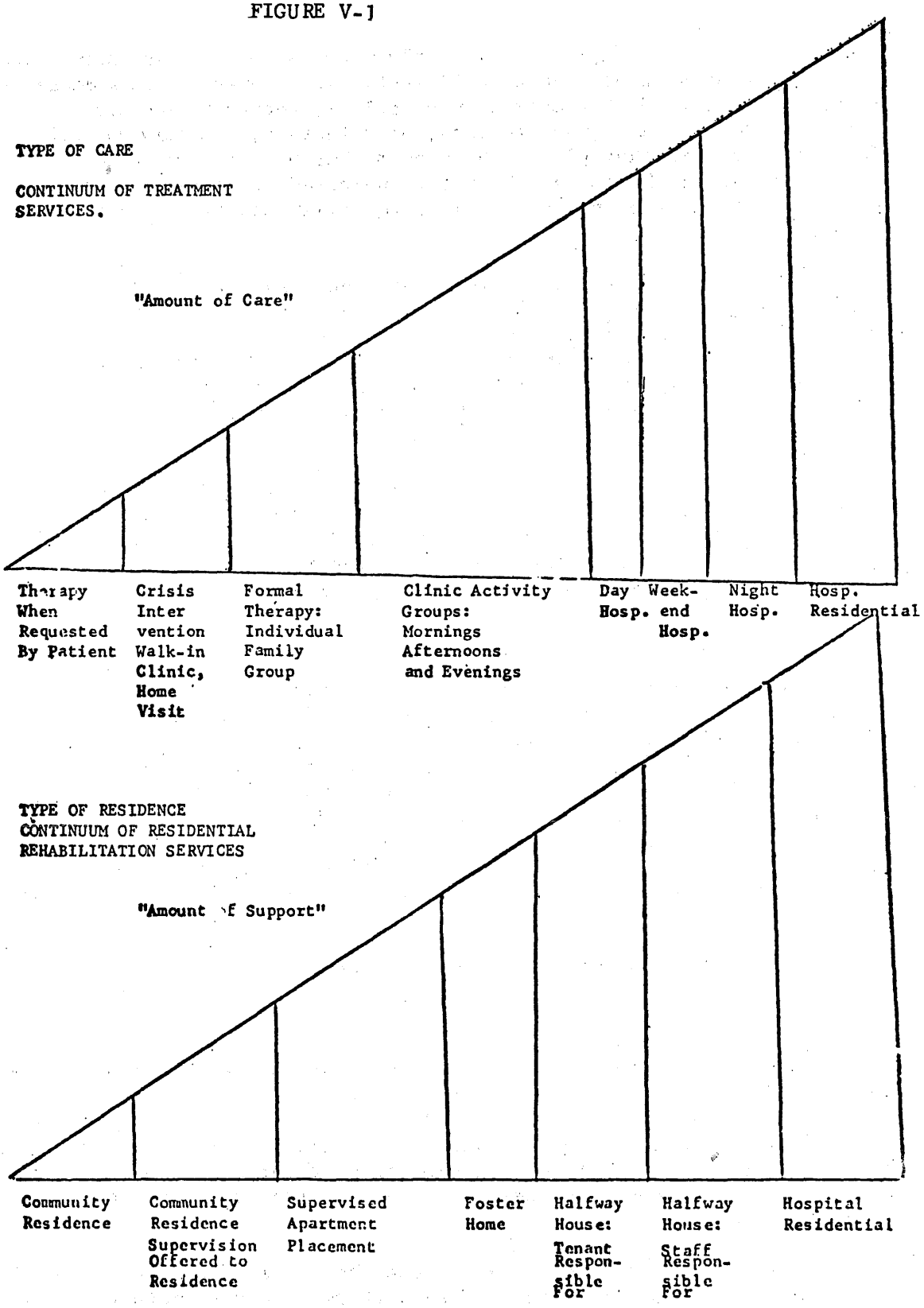
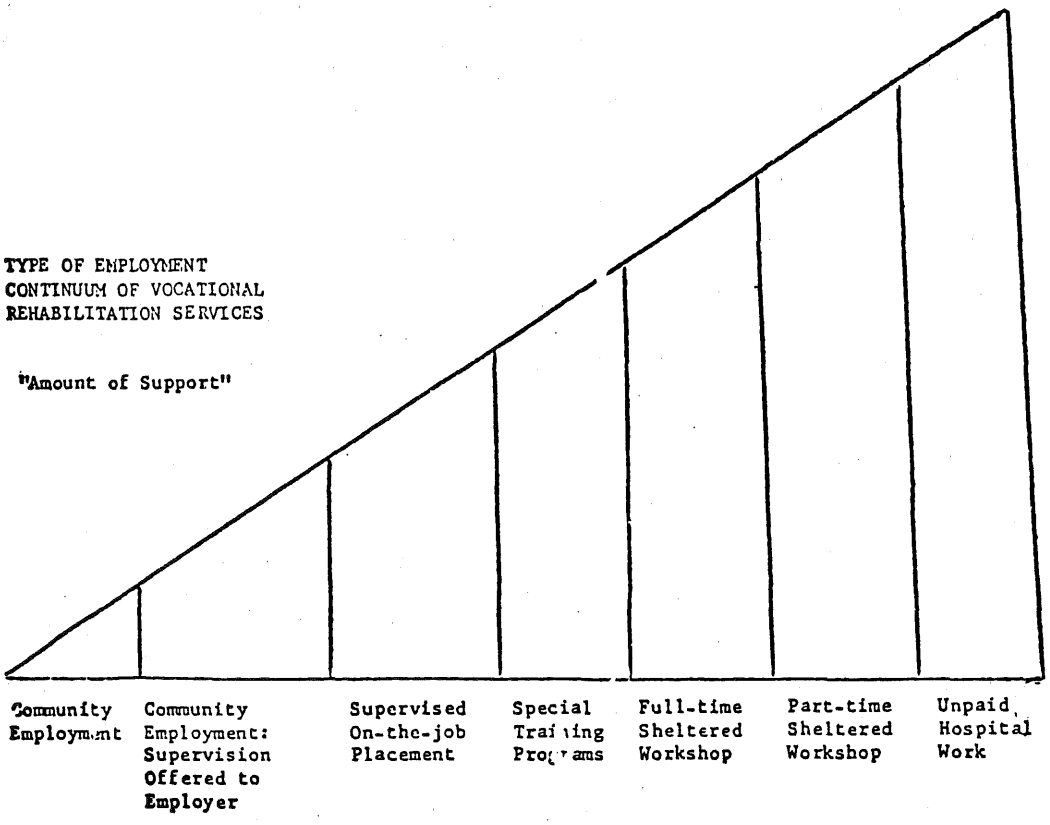

TYPE OF CARE
CONTINUUM OF TREATMENT SERVICES.
"Amount of Care"
Therapy When Requested By Patient
Crisis Intervention Walk-in Clinic, Home Visit
Formal Therapy: Individual Family Group
Clinic Activity Groups: Mornings Afternoons and Evenings
Day Hosp.
Week-end Hosp.
Night Hosp.
Hosp. Residential
TYPE OF RESIDENCE
CONTINUUM OF RESIDENTIAL REHABILITATION SERVICES
"Amount of Support"
Community Residence
Community Residence Supervision Offered to Residence
Supervised Apartment Placement
Foster Home
Halfway House: Tenant Responsible For
Halfway House: Staff Responsible For
Hospital Residential

FIGURE V-2


TYPE OF EMPLOYMENT
CONTINUUM OF VOCATIONAL
REHABILITATION SERVICES
"Amount of Support"
Community Employment
Community Employment: Supervision Offered to Employer
Supervised On-the-job Placement
Special Training Programs
Full-time Sheltered Workshop
Part-time Sheltered Workshop
Unpaid Hospital Work

training for such personnel and there must be a mental health professional immediately available for consultation and direct service as needed. There are several ways by which face to face crisis intervention may be provided. It may be provided in one or more facilities within the catchment area, through a mobile crisis intervention team, or through a combination of mechanisms.

Telephone service for a 24 hour-a-day should be manned by mental health professionals or trained mental health workers. This type of telephone service can provide the basic mechanism for the evaluation of the crisis and the determination of the steps necessary to ensure rapid provision of appropriate care.

In event it is geographically necessary to have more than one centralized phone number for emergency service, the phone numbers should be clearly listed in the directories of the area. Some geographic areas may require more than one phone number listing for emergency services. When the telephone service is manned by nonprofessional mental health workers, there must be a mental health professional available for consultation, and there must be an appropriate training program for the mental health workers.

b. Residential service including inpatient hospital - The inpatient/residential service provides opportunities for the provision of intensive care in alternative settings. Hospitalization is usually justified on the basis that the patient's disorder or dysfunctioning is so severe that it requires the intervention of therapies available only within a hospital setting, the need for physiological and neurological diagnostic measures and/or the need for medical treatment that necessitates the resources of a hospital. Many patients receiving mental health services in a hospital do not use many of the other resources provided by a hospital.

The inpatient/residential service provides a therpeutic service for persons requiring 24-hour care. This service should be utilized only when, and for as long as, other services are not as appropriate. The goal of the 24-hour care and treatment service is to provide appropriate and effective treatment to facilitate the patient's earliest return to the community. These efforts are enhanced through the provision of followup services and by means of consultation to various community agencies.

The basic concept of inpatient services is that the environment in which the individual is treated, in itself, is an important factor in the success of treatment. In addition to pleasant (and if necessary, secure) surroundings, this approach is reflected in programs that stress the individual's resources rather than his deficits. One of the principles is to keep the individual involved in therapeutic activities.

c. Partial Hospitalization/Partial Residential - Partial residential care is designed to provide a therapeutic program for those persons who require less than a 24 hour-a-day care, but more than outpatient care (usually between two and twelve hours). Partial residential care has proven to be an effective alternative to 24-hour care and has emerged as a treatment of choice for many persons. Partial residential care intensive treatment has produced the benefits of hospitalization for active treatment and and sta-

bilization without causing the disadvantages associated with disrupting family, social and occupational ties.

Studies comparing day hospitalization to an inpatient hospitalization have demostrated that day patients return to full-time life in the community and resume occupational roles sooner than inpatients, even though the initial level of dysfunction was comparable.[1]

Partial residential care includes service provisions such as day care, night care, weekend care, semi-day care, evening care, and may include programs such as special educational classes in schools for disturbed children, rehabilitative programs such as job training, and therapeutic nursery schools.

d. Outpatient/Scheduled Intervention - Outpatient service provides the necessary therapies for individuals whose treatment is conducted with little disruption of their regular routine. Outpatient services are usually provided on a regularly scheduled basis with arrangements for non-scheduled visits during times of increased stress or crisis.

This service may also provide such services as walk-in clinics and diagnostic services for a variety of community agents. This service also offers an array of treatment modalities. To promote availability, the services must be available at appropriate times to meet the needs of the residents of the area. This need not be provided on a 24-hour basis. There must be provision of adequate, appropriate space. Space for this service should specifically provide for the special needs of children and adolescents and must allow for the patients' privacy and for confidentiality of discussions, as necessary. The basic principle should be to tailor the delivery of outpatient services to best fill the needs of clients of the catchment area.

(1) Diagnostic services may be provided on an outpatient basis or within a hospital or residential treatment center.

(2) "Rehabilitative services refers to activities which attempt to discover and develop the patient's assets in contrast to treatment which is a direct attack on the patients disability."[2]

Bockoven states, "Relationships of therapeutic value can be thought of as those that aim at giving relief from psychic pain and eliminating psychopathology. Relationships of rehabilitative value, on the other hand, can be thought of as those that aim at strengthening the patient's ability to cope with the world at large by providing direct aid, by coaching him, and giving him practice in finding for himself."[3]

[1]M. I. Herz, Jean Endicott, R. L. Stitzer and A. Mesnikoff, "Day Basis Inpatient Hospitalization: A Controlled Study", American Journal of Psychiatry, April, 1971.

[2]R. M. Glasscote, Elaine Cumming, I. D. Rutman, J. Sussex, S. M. Glassman, Rehabilitating the Mentally Ill in the Community: A Study of Psychological Rehabilitation Centers, (Washington D.C.: Joint Information Service, 1971) p. 15.

[3]J. S. Bockoven, Moral Treatment in Community Mental Health (New York, Springer Publishing Company, 1972) p. 173.

Rehabilitation services make a unique and essential contribution to the continuum of care. One might say rehabilitation gets down to the brass tacks of everyday living. Rehabilitation services become crucial after the crisis oriented services have been withdrawn. For many, sustaining help is needed for a longer time period of recovery to a maximal level of functioning. It is the long pull or the sustaining of the response to the crisis and treatment services that poses the challenge. Rehabilitative service must be designed to reduce the residual deficits of emotional disturbance and to facilitate the adjustment of patients to the community. Rehabilitation involves a variety of vocational and social programs including but not limited to, vocational testing, counseling, job placement, consultation to other agencies providing primary/direct care, and other relevant group activities, as appropriate. Rehabilitation services are discussed further in section 3 of this unit, on page

2. Indirect Service Needs

a. Consultation and Education - Consultation and education services emphasized through a variety of means allow for the increase prevention of emotional disturbance within the area.

Consultation involves the provision of mental health assistance, by qualified personnel, to a wide range of community agencies and care givers, including, but not limited to schools, courts, county social service departments, police, clergy, and health care personnel such as physicians and public health nurses. In <u>case consultation</u> this may take the form of collaboration with community agencies, and enable them to deal effectively with the clients. In <u>program consultation</u>, the emphasis is not on an individual client, but on the planning and development of mental health related programs within the range of community agencies. Such consultation might be reflected in the development of public school classes for the emotionally disturbed children, etc.

Education program has two major functions. First, its goal is to increase the visibility, identifiability, and accessibility of the mental health program for all residents of the catchment/service delivery area. A mental health program cannot serve as an effective resource if large sections of the community are unaware of its purposes, its function, its location, or its relevance to community needs.

The second major goal of the educational program is to promote mental health and to prevent emotional disturbance through the distribution and dissemination of relevant mental health knowledge. The educational program should be directed to the priority needs within the catchment area.

Consultation and education services must be a coordinated, goal-oriented service. It must be coordinated with all other mental health services. Through effective consultation and education care givers will be enabled to manage their clients more effectively, enhance continuity of care, as well as extending service to underserve groups in the area.

b. Training - The delivery of quality service is greatly enhanced by planned, continuing staff development. The purpose of the training service is to increase the job-related mental health skills of all mental health personnel, through the provision of lectures, seminars, workshops, and other educational programs.

In addition, to providing training for mental health personnel there should be an organized training service to provide basic and meaningful orientation for all staff, members of the boards, advisory groups, and volunteers.

c. Research and Evaluation - Research and evaluation provides objective information regarding community needs and resources, the impact of the service delivery, and the extent to which goals and objectives are being met. This includes appropriate measurement, data collection and analysis.

Program evaluation includes activities aimed at determining the extent to which and by which, the program fulfill its objectives. Basic to program evaluation is the keeping of statistics to describe the functioning of the program.

3. Rehabilitative Services and Community Residential Services

a. Rehavilitative Services - Rehabilitative services are usually categorized as: 1) socialization training and socialization opportunities; 2) work; and 3) living arrangements. Typically, this includes ex-patient clubs, sheltered workshops and halfway houses. The purpose of these resources are to reduce the residual deficits of mental disorder and to facilitate the adjustment to community living. A psychosocial rehabilitation center is a comprehensive, coordinated program that offers social, vocational and residential services under unified organizational auspices and often is linked to a community mental health program. Such rehabilitation centers foster self-help and self-government under the supervision of professionals. The participants perceive themselves as members rather than as patients.

b. Community Residences - The term of community residences is usually associated with a halfway house, although there are other models of community based residential services. The varying types of community residences include the following:

(1) A group residence is generally one that does not require that the residents move out of the house for total independent living within a specified time period.

(2) Halfway houses provide three types of services to individuals.

(a) Halfway houses of a transitional nature provide aftercare following a structured treatment program and focus on assisting the individual in his adjustment to the community. The people to be served are generally employable, may be employed or seeking employment, or receiving services from Vocational Rehabilitation to assist them in becoming employed, or developing other skills they may need for independent living. The estimated length of stay might be up to six months.

Services might include, but are not limited to: counseling, drug or medication maintenance, and other supportive services such as groups and goal-directed activity programs.

(b) Some halfway houses or group homes or foster homes provide partial treatment and supportive living arrangement on a longer term basis. The residents might be employed but, perhaps to a degree that does not provide for self-sustaining income. These residents may have need for the partial structure and support to enable them to cope with daily community problems.

(c) A partial treatment and support program may also serve as an alternative to hospitalization with a treatment plan program developed by combining various community resources.

(3) Board and care facilities provide some supervision and programming. The average capacity would be about 10 to 16 individuals. This type of partial support residential setting could address itself to maintaining the individuals at a level of functioning and prevent regression in psychosocial areas.

(4) A cooperative apartment or house, in contrast to the group residence and halfway house, has no live-in staff. It is a group living arrangement, perhaps in adjoining apartments or a house. This arrangement could become the person's permanent residence or it could be a transitional living arrangement. Fairweather Lodges are an example of this type of facility.

(5) Foster homes provide room and board for one to four residents within a home of a private family. There is generally some structure and support provided to the resident by the private family.

c. Characteristics that community residences should possess:

(1) They must be integrated into the community. Residents should interact with neighborhoods in various ways.

(2) They should be relatively small so that residents get to know each other well and are able to engage in self-determination.

(3) They are family-like and attempt to recreate a sound interpersonal situation so there can be assistance and security available to each resident.

(4) There must be provisions or mechanisms for responding to residents' needs for mental health, medical and social services in the local community.

(5) The daily program may have either high or intermediate expectations. The high expectations might include working or attending school. The intermediate to low expectations may include a day care program or no responsibilities outside of the house.

The above partial support community residences would provide services to individuals that have no particular physical problems that would require unusual care or that could not be handled on an outpatient basis.

d. General principles for community residences:

(1) There must be a core group of dedicated persons who conceive and pilot the project from the beginning until it becomes a functioning unit. This core group should include a recognized professional with clinical expertise in the area of rehabilitation and clientele. There should also be included a community leader who can encourage the people in the town to give active support to the program. Without this the residence has little chance of evolving into a therapeutic, meaningful resource.

(2) There should be consideration for the fiscal structure and a formula developed to insure the residence's fiscal viability.

e. State of residential resources:

The community residential services need to be developed in Minnesota. The number of MI/BD who are currently receiving services of these types of resources is difficult to determine. It is also difficult to determine the amount and quality of care that is provided. The implementation of licensing should be of assistance in obtaining a better description of the current resource.

D. Accessibility of Services

Ensuring the accessibility of all services to all residents of a catchment area is essential to the successful operation of the mental health program. The major aspects of accessibility are:

1. Physical Accessibility: Facilities should be so located that they are convenient to public transportation.

When transportation is inadequate or lacking or when the geographic area is relatively large, so that distance is a major problem, then consideration should be given to satellite units, mobile teams, and/or provision for some type of transportation. Time needed for transportation to services should not be excessive. In selecting facilities, attention should be given to the needs of children, adolescents and consideration should be given to making services accessible to the physically handicapped.

2. Visibility: A program is not accessible if it is not visible. Substantial segments of the population must be aware of the program's existence, location or its functions.

3. Procedural Accessibility: Administrative mechanisms, such as unnecessarily lengthy application forms, unneeded waiting lists for service, complicated procedures for patient movement between service elements, unreasonable time for appointments, and highly formalized and time-consuming referral procedures, seriously limit the accessibility and effective utilization of the program.

Consumers of the services must be able to promptly use those services most appropriate to their needs. Appropriate procedures must be adopted that will preclude the development of barriers to early and effective treatment.

4. Economic Accessiblity: This means that all persons in the catchment area, regardless of their income, must be able to seek and receive services and not be denied service solely on the basis of inability or ability to pay. Fee schedules must be established so as to include those who cannot pay anything and to include those who can pay the full cost of the service.

5. Psychological Accessibility: There are many psychological factors to be considered in making mental health services accessible. For example, the architecture and decor of the facilities should be inviting, comfortable and acceptable, facilities should have a good image in the community and the name should be acceptable to the population. Consideration should be given the psychological factors essential to the operation of a program that will promote utilization by all cultural, racial, socioeconomic, and age groups within the area.

6. Cultural Accessibility: Within all catchment areas there may be a variety of cultural groups and subgroups. The services must be culturally accessible. This would include consideration for factors such as life style, language, and religious beliefs. Programs should reflect the heterogeneity of the population to be served.

E. Catchment Area Concept

The Minnesota Community Mental Health Statute provides that the size of a catchment area to be no less than 50,000 population base. Federal Community Mental Health legislation limits the size to be no less than 75,000 and no more than 200,000. Justification must be made for exceptions. Justification for exception should only be made on the basis that such an exception will improve the effectiveness of the services to be provided and will not jeopardize quality of programs and services.

National studies have indicated that a minimum population and economic base is essential to provide a comprehensive mental health program. Some selected services can be provided to a smaller population base, however, it is impractical and not economically feasible to endeavor to provide the required and needed array of services within the continuum of care to a small economic and population base.

There are some highly specialized services that may be feasible to provide on a state-wide basis or jointly shared with two or more catchment areas.

The catchment area concept is a cornerstone of the community mental health programs. Through implementation of this concept, a community mental health program assumes responsibility for making available the necessary services to meet the mental health needs of the residents living within the defined geographic area. It is not necessary for a community mental health program to provide direct treatment at the center for every person within the catchment area. A community MH Program must, however, arrange for the provision of service, either directly or by means of a contractual agreement with either a public or private service provider.

The acceptance of clear, unitary responsibility for a geographically delineated population is reflected by the fact that any geographic area can be part of only one catchment area.

The fact that a community mental health program is available to serve the residents of a defined geographic area does not dictate a person must seek services. Any person may seek service at the community mental health program or from another resource within or outside of the catchment area. By the same token, a center may serve some persons from outside of the catchment area, but only if the service does not adversely affect the program's ability to serve the population for which it is responsible. Priority must be given to the catchment area residents. Boundaries for mental health catchment areas should be coterminous with the Governor's Economic Regions. More than one mental health catchment area may be within a region and one mental health catchment area may serve two regions.

F. Administration

The administration of a community mental health program must be such as to ensure the achievement of program objectives, and to assure fiscal responsibility, continuity of care, and responsiveness of the program to the mental health needs of the residents of the catchment area which it serves.

The mental health program director must be a qualified mental health professional. The director must have overall authority and responsibility for the operation of the program and for the provision of the program which is responsive to the needs of the catchment area. The director may be accountable to a board or other agents of a sponsoring group, but to ensure program and fiscal continuity and accountability, all operating elements of the program must be accountable to the director or to persons who hold coordinating positions and who are, in turn, accountable to him.

There must be provision for the assumption of medical responsibility for patients by a physician, preferably a psychiatrist. Psychiatric consultation must be available to the program staff on a continuing and regularly scheduled basis, not less than once weekly.

The community mental health program must provide methods for administering the proposed program. This would include:

1.) Policy making.
2.) Assuring continuity of care.
3.) Maintaining and sharing of clinical records.
4.) Maintaining and sharing of financial records.
5.) Fostering satisfactory relationships with the community to be served.
6.) Discharging clinical and program coordination responsibilities with affiliates and other community agencies.
7.) Assuring fulfillment of all other obligations and assurances required by state statutes and regulations and federal statutes and regulations as appropriate.
8.) Assuring coordination of the programs services with other community resources including follow-up of persons who may have been referred to other resources.
9.) Assuring community involvement.

A mental health program must have an administrative structure which is an identifiable, unified entity. This includes programs which are a part of a larger organization which provides other types of human services and those which are made up of two or more affiliating agencies.

G. Community Involvement

The mental health program must involve the community in planning, development and operation of the program. The community involvement is required to assure that the program will be responsive to the mental health needs of the community, have visibility, optimal utilization, and a public base of support. Community involvement may be formal or informal, and includes representation on policy and advisory boards.

H. Service Needs of Special MI/BD Target Populations

In addressing service needs, special attention must be paid to target population subgroups whose needs are specific to their age and particular problems, thereof. Although previously described service needs in this Chapter include the children and aging subgroups as well as the general MI/BD population, there is merit in defining the service needs of those two groups, individually, also.

The following description of service needs directs itself to subgroups within the MI population: children and youth, aging and MI/BD offenders.

1. Services for Children and Youth - There is a rising social consciousness about the strange, tragic and severly handicapping mental illnesses of early childhood. There are still pitifully few services and still fewer appropriate services available.

Mental health problems do not occur overnight. The manifestations of these problems appear as a result of what one may call unsuccessful attempts at coping with one's environment. Many mentally ill or emotionally disturbed or even poorly adjusted adults were, at one point in their lives, emotionally disturbed children. The situations and problems which these children encounter during their growing-up years contributed to the problems which these persons face now as adults.

There is need for programming to address the children who have critical emotional needs and there is equal need to be deeply concerned with the mental health of all children. Any child at some point in time may need mental health services, the distinction made between those with need and those without is a false one and could lead to premature labeling with damaging effects on the child. All children have basic developmental needs which must be met. The degree to which needs are met determines the child's mental health. A child's positive self-image, and ability to understand these concepts are the necessary components of good mental health.

The Joint Commission on Mental Health of Children has described several fundamental principles that must be followed. These fundamental principles are:

a. Emotionally disturbed children can be helped more effectively or adequately in communities that have a wide-range of educational, preventive, diagnostic and treatment facilities than in communities where there are a narrower range or with a marked lack of such facilities.

b. Services which reach children at early ages and at early stages of emotional disturbance are generally more effective and therefore, there should be a priority focus on treatment of young children and on early detection and treatment of emotional illness.

c. Continuity of treatment for the individual child and his family should be a major consideration in organizing a program.

d. The order in which various facilities are initiated varies from one community to another. This depends basically on the services available, the degree of coordination among them, and the attitudes in the community.[4]

The implementation of these principles must reflect maximum utilization of existing programs, services and funding sources, so that the demands on mental health delivery system are not raised as a result of needless duplication. However, priorities and definite commitments must be made regarding mental health services for children. All agencies which have an interest and commitment to children must recognize their responsibility towards children and form a consortium of services readily available to act on the behalf of children.

Nationally there is a trend for caring for the MI/BD child in his community in a structured environment, close to his family. Only a small portion of the population of psychotic children are in mental hospitals and even fewer should be.

Particular Service Needs for Children and Youth: The State of Minnesota has not yet been "tooled up" to assume its appropriate place in the development of a planned mental health program for children. Minnesota has achieved success in the development of its community mental health programs, however, there is need for considerable more expansion and development to make the continuum of care a reality in each area.

The community mental health programs have good potential for the delivery of mental health services for children. There is need, at the state and area level, for planning development, implementation and coordination with appropriate departments, agencies, organizations and resources to bring about a full continuum of care and treatment and linkage with appropriate supportive services for children.

An emotionally disturbed child is defined in the 1970 Report of the Joint Commission on Mental Health of Children as:

[4]Joint Commission on the Mental Health Needs of Children, Inc., 1969, p. 447

"one whose progressive personality development is interferred with or arrested by variety of factors so that he shows impairment in the capacity expected for him for his age and endowment in: 1) reasonable accurate perception of the world around him; 2) for impulse control; 3) for satisfying and satisfactory relations with others; 4) for learning; 5) any combination of these."[5]

The Commission estimated the incidence of mental and emotional disorders among children as .6% of the nation's children are psychotic; 2-3% are severly disturbed; and an additional 8-10% have emotional problems such as neurosis serious enough to require treatment. The Commission estimated that only 5-7% of those needing psychiatric help are receiving it.

Data is not available on the incidence of mental illness among children in Minnesota. Information regarding the mental health services for children has been presented in regard to residential or hospitalization resources. While the community mental health centers serve children and their families, the amount and kinds of service vary. Two of the programs have NIMH staffing grants for children. There are a few specialized children's mental health clinics in the state.

There is need to develop a plan and continuum for children's mental health programs. The continuum should contain the following specific services for children:

inpatient and or residential treatment services;
intensive partial hospitalization or residential programs including services such as day treatment, specialized classes for disturbed children, evening care, etc.;
emergency services:
diagnostic and assessment service providing initial evaluation, follow-up and after-care;
consultation and educational services;
transitional care programs such as: group homes, halfway houses, foster homes and social rehabilitation programs

Some of the essential supportive services are:

Head Start programs
Day care programs
School, including but not limited to special education
County social service departments
Public health nursing agencies
Recreational groups
Neighborhood houses
Correctional facilities
Probation and juvenile officers.

[5]Report of the Joint Commission of Mental Health of Children, Harper and Row, 1970, p. 253-254.

2. Mental Health Services for Aging - Mental Health services for the aging portion of the population are quite limited. This is a population group that needs to have services focused on them. Many of the older residents of state mental hospitals have been placed in nursing homes. The federal government established a National Institute of Aging in 1974.

A nursing home is an intermediate care or skilled nursing facility, which meets the required standards for this classification to be certified by the Health Department for this purpose. Many of the standards are based upon federal regulations so the home or provider of service will be an eligible vendor of services to receive federal funds.

Nursing homes should not be established specifically for the aging MI/BD patients. Nursing home placement should be based upon the individual's needs for this type of physical care. The emotional and thinking disorders should be stabilized prior to nursing home placement.

A practical approach is to utilize the existing nursing homes and their staff to provide care for the older former MI/BD patient. The nursing home care should be supplemented with a treatment or rehabilitative package developed through consultation process from the community mental health center staff. This would provide for utilizing the personnel employed in the nursing home to be the primary care givers.

Many of the nursing homes do have activity programs. Those who do not should be required to provide activity programs for all of the patients in the nursing homes. The nursing home operators should then include the cost of the activity program in their rates. The usual outcome of social and stimulus deprivation is a withdrawal and lessening of the reality perception and orientation.

Mental Health programs for the aging population that do not need nursing home care should include provision for services that will assist the elderly individual to be retained and active in his community. It is important for the aging to be part of his community and it is equally important for the community to have interaction with its aging population.

Particular Service Needs for Mental Health Program for the Aging: Large state mental hospitals tend to become undesirable places for elderly persons to live in and their use for this population should be phased out. However, great care must be taken to see that appropriate clinically effective alternatives are developed at the area level before the institutions cease accepting the new elderly admissions, or discharge all their presently elderly residents. The phased out use of institutions should proceed on a coordinated schedule with a phasing in of appropriate alternative community resources. All efforts to decrease the elderly census in a state mental hospital must proceed in the context of a fully developed community supportive service package. The strategy and schedule should provide for a steady lowering of state hospital census for elderly persons in a manner which provides a positive rather than a traumatic experience for the elderly individuals.

Five essential psychiatric and medical clinical services (mental health and physical health) should be provided on the area level for geriatric patients. These services include:

1.) Inpatient services (admission, evaluation, treatment, discharge planning and follow-up).
2.) Outpatient services (home visits, evaluation, treatment, discharge planning and follow-up).
3.) Partial hospitalization (night hospital and day hospital).
4.) Emergency service (available 24 hours per day, with in one of the above three services cited).
5.) Consultation and education services should be available to the community caregivers.

The five services listed above for geriatric persons should be provided through a community mental health center and in conjunction with a general hospital which may function as an integrated facility for total patient care.

Working links should be established between the community mental health center, the hospital, the Aging Program Division and Mental Health Program Division in the Department of Public Welfare, and the essential supportive serivces. The essential supportive services are:

1.) Nursing homes (extended care, skilled nursing homes, intermediate care).
2.) Whole health services (individualists, therapists, homemaker and social service worker).
3.) Nutrition (meals-on-wheels, school and non-profit agencies lunch programs, and volunteer marketing).
4.) Protective Services (legal aid, social service, ombudsman, and income maintenance).
5.) Senior Citizen Clubs (information and referral, task oriented groups, volunteers, and social service activities).
6.) Transportation (special systems).
7.) Housing (with or without home services).

Buildings and state mental hospitals located in major population centers might be renovated and used to provide housing with supportive services for elderly handicapped and their families. This would depend upon local situations. Types of funding that would be available are:

1.) The Social Security Act amendment of 1967, Title I, X and XIV (adult categories). This service delivery funding program is known as the "donated funds" program. It is administered by the Department of Public Welfare and funded at a 75% federal reimbursement level.
2.) The Older Americans Comprehensive Services amendments of 1973 (P.L. 93-29). This Act provides the cost of new social services as a part of comprehensive and coordinated systems of area plans. Some of the service providing titles of this program are: (a) Title III--Grants for State in Community Programs on Aging; (b) Title V--Multipurpose Senior Centers: (c) Title VII--Nutrition program; (d) Title IX--Community Services Employment for the Older Americans.

Another type of program of support is the Retired Senior Volunteer Program (RSVP). This Program is supported by federal funds. Volunteers from several programs which come under ACTION can be used to assist elderly people.

Recommendations for the MH program to address service needs are briefly presented in Chapter X.

3. Adult MI/BD Offenders - Adult MI/BD offenders are persons with mental illness/ behavioral disability who may require security at times because of assaultive or threatening behavior. They enter the Mental Health System through either the corrections system, the courts, or State Hospitals.

Minnesota Security Hospital, located at St. Peter, accepts referrals from the three mentioned areas. It offers a maximum security environment which includes mental health treatment. The statistical breakdown on referrals is approximately as follows:

From Department of Corrections - 30%
From Court System - 30%
From other State Hospitals - 40%

Individuals are referred to Security Hospital (MSH) for evaluation and/or treatment. The following depicts those referred for purposes of evaluation and those who remain for treatment, and from where they were referred.[6]

		Total Number Committed	Remaining Number For Treatment
a.	Committed from open hospital	3	0
b.	Committed to MSH as MI and dangerous	21	12
	or psychopathis personality - hold order	3	2
c.	From Minnesota State Reformatory	3	3
	from Minnesota State Prison	25	22
d.	Sex offender	16	10
e.	Pretrial evaluation	4	0
f.	Not guilty	5	5
	incompetent	15	15

The length of stay varies according to transfers, with the overall average length being 90.34 days. The following graph indicates the lengths of stays and is categorized according to place of referral:

a. Transfer or commitment from open hospitals — 97 days

b. Commitment from probate court as MI and D. psychopathis personality, or on hold order — 92 days
(MI and D. - 100.8 days)
(P.P. - 85.6 days)
(hold order - 6.0 days)

[6]Data from December 6, 1974 memo from Dennis Boland to Wes Restad. Data for year October 1, 1973 to September 30, 1974.

c.	Transfers from Corrections	90 days
	90 days	
	MSR (excluding D.A. transfers for B.E.A.D.)	80 days
	MSP (excluding D.A. transfers for B.E.A.D.)	74 days
	L.O.S. for B.E.A.D. program	143 days
d.	District court commitments	79 days
	committed under 246.43, subd. 2 & 6	69 days
	committed under 631.19	119 days
	committed under 631.18	88 days
	pretrial exam	36 days
Overall length of stay		90.34 days

Evaluation involves assessing the individual to determine his mental competence as it affects his responsibility for his offense. If it is determined that his psychiatric problem warrants mental health treatment, he would remain for participation in treatment.

On-going MH program/treatment - In looking at referrals from Stillwater State Prison and St. Cloud reformatory, we find that oftentimes individuals are referred to Minnesota Security Hospital for treatment and then referred back to the referring institution for completion of sentence. This may present a problem in that deterioration of the progress made in invididual's mental health treatment may occur without continued mental health supportive service within the closed setting to which he has returned.

The Minnesota Correctional Authority makes a determination as to whether the individual can be parolled into the community. Efforts are being made to address and resolve the problem via negotiations between the Departments of Corrections and Welfare and Minnesota Correctional Authority. Planning for each individual is carried out by Minnesota Security Hospital and the referring Correctional Institution.

DPW has developed guidelines for transfers from open state hospitals to Minnesota Security Hospital. Reports indicate that varying degrees of treatment expectation are presented to MSH from the open hospital. The behavior of the individual is described and forwarded to MSH. An estimated 81% of transfers do not show expected treatment from MSH, and only describe previous behavior.

It should be recognized that individuals should be transferred to MSH for specific purposes of treatment and that treatment goals be identified. Open hospitals must make every effort to provide an appropriate program to the individual prior to requesting transfer.

Court Referrals - The judge is the final determinant of competence or incompetence of an individual to stand trial. He/She may refer individuals in question to MSH to evaluate such competence and make a recommendation to him. Thus, the individual may be referred back to the court for sentencing, sentencing and treatment, or treatment for the MI/BD problem.

Female MI/BD Offender - The female MI/BD offender seems to be largely ignored in both Departments of Corrections and Welfare. Anoka State Hospital has 25 bed unit for the assultive/dangerous MI/BD female. This resource is used only by the "Welfare System". There is a need for assessment of prevelance of such problems.

Also, within the Shakopee Correctional Facility for Women, there seems to be only slight MH service offered as pertains to social adjustment, daily living, etc. They presently have a part-time psychologist.

Discussions are taking place between the executive staffs of Corrections and Welfare re: women MI/BD offenders.

Special Programs - The BEAD (Behavioral, Emotional, Attitudinal Development) Project is offered to sex offenders at MSH. The project receives transfers from Stillwater Prison, St. Cloud Reformatory and the Welfare System. Some admissions have come directly from courts. It is welfare operated and involves input from the Department of Corrections. It is a study which includes control groups which are located in correctional facilities. The BEAD project is being evaluated.

Program Principles In offering MH programs to adult MI/BD offenders or persons who are considered assualtive and dangerous there are certain basic program principles:

1.) Community Based Programming is preferred for MI/BD offenders, as it should also be for other mentally ill/behaviorally disturbed individuals and also for offenders. Rehabilitation Services for this special target group need to be developed.
2.) Oftentimes, MI/BD offenders have alienated families, friends, and even staff who have worked with them. Thus they have no true advocate to represent them, for the most part. However, they are entitled to "humane and competent treatment" even within a secure environment.
3.) The MH service need of MI/BD individuals is most likely even greater because of their disruptive behavior, than absolute numbers might suggest.
4.) A continuum of services must be developed for the MI/BD offender.
5.) Discussions are on-going between the executive staff of Departments of Corrections and Welfare. It is recommended that these negotiations continue and Task Forces be assigned to provide the depth of study that is needed so recommendations can be formulated.

Overall, it is clear that Minnesota is lacking in Mental Health resources available to the MI/BD offender. The resources are lacking even within the closed settings, let alone within the community, which is the ultimate goal of MH services to MI/BD offenders.

I. Research

State supported research efforts have primarily been funded in the state hospitals. The focus has predominantly been on institutional concerns. Research efforts should become more community oriented and applied toward problems, concerns and questions that are relevant to the mental health problems and delivery systems.

As repeatedly indicated in this Plan, there is a marked dearth of information about the Minnesota MI/BD population. The reporting that does exist is limited. Information that describes the portion of the population that is currently providing services by the existing resources is sorely lacking. Information regarding the population that is in need of services and not receiving them is nonexistant. In addition to a management information and guidance system, there is need to identify the "functioning levels" of the population.

The preceeding chapters have indicated that the MI/BD population becomes problematic when their behavior is disruptive and/or disturbing to others. The defining of mental illness/BD by statutorily, community and individually defined problems, reflects the degree or level of disruption that is perceived by others. The individual's behavior indicates the level at which individuals function.

The concept of "functioning level" perhaps relates more directly to Menninger's "well sickness model". However, this approach is compatible with other theoretical sions including both analytic and developmental theories.

This approach of defining MI/BD population by "functioning level" in consistent and compatible with the conceptual framework presented in the continuum of mental health services. The continuum presents a range of varying amounts of support and treatment. The appropriate amount of service and treatment would correspond to the individual's functioning level. That is, the lower level of functioning would require an increased amount of support, treatment and care. The lower level of functioning with the greater degree of support and care relates to the assumption that there is increased responsibility on the part of the facility or service provider for those individuals. The less amount of support, treatment and care provided to the individuals functioning at a higher level would be consistent with those individuals being capable of assuming greater responsibility for themselves.

It is recommended that studies be designed and implemented so the describers of the population that will lend themselves to a generic classification can be determined.

The use of objective, functioning level describers and a generic classification method would have multiple potentials. A few examples of potential use are: classification of care levels for various facilities including hospitals, determination of staffing ratios, determine amount of change and type of change in behavior resulting from treatment, absence of treatment, could be linked with goal attainment scaling regarding outcomes of goals, would lend itself for probability predictions for change, sustainment or regression of levels, could be used for linking treatment modalities for comparisons and analysis.

CHAPTER VI

ACCOUNTABILITY AND EVALUATION

A. Accountability

The issue of accountability to which much attention is being given, requires clear designation of responsibility for a specific function. Accountability presupposes the capability of performing the function. This entails the provision of the appropriate resources (technical, fiscal, etc.) to accomplish the task.

The Report of the Task Force on Behavioral Disabilities approved by State Comprehensive Health Planning Advisory Council and issued on December 15, 1971, made recommendations which are still pertinent. It was recommended that:

> The role of state government should emphasis fiscal support, evaluation, consultation and regulation of service programs.
>
> The utilization of local and regional agencies for the direct delivery of service to the maximum extent possible with the recommendations that the area boards assume major responsibility for dealing with behavioral disabilities within the designated areas; MI, MR and CD.

The basis for this was the assumption of the need for a continuum of care that would respond to the needs of individuals. The continuum of care requires an adequate economic and population base to warrant a sufficient array of highly specialized services, as well as the desired supportive service. The continuum of care means that any person receiving MH services shall have access to the most appropriate care and treatment as dictated by their needs.

As indicated above, the Report of the Task Force on Behavioral Disabilities has recommended some roles and responsibilities for the state and area boards. Clear designation of responsibility enables the implementation of accountability.

As with the concept of provision of service along a continuum of care, there is also a corresponding continuum of accountability in responsibility for planning, execution and evaluation of program effort to meet the needs for service to reduce problems in the emotionally disturbed population.

The broad levels of responsibility on this continuum may be characterized as successive, overlapping areas of problem solving activity. The base level is concerned with the actual delivery of service to individuals (direct service) and to the provision of consultative services on behalf of individuals (indirect service). In this context, responsibility lies with the professional and paraprofessional caregivers.

The next broader level has to do with seeing to it that necessary programs to provide services to various subgroups of the need population in the community are initiated and maintained. Such responsibility falls to area community mental health program administrators and their staff.

The next level in the sequence is the area wherein responsibility is directed towards establishing the policies under which the organization is constrained to operate. The responsible persons for assuring such adherence to policies constitute the governing board.

The broadest level of responsibility in the administrative sequence is the Legislature and its surrogate state level office to which responsibility is delegated to ensure that statutory mandates are carried out.

For the decision makers (Planners) to carry out their responsibilities in each of these areas, it is necessary that they be informed about what is going on with respect to activity which is carried out at the next narrower level of operations. For example, the state level decision makers need to know the degree to which the area program's operating policies are in concordance with statutory intent. The governing bodies of programs need to be informed of the degree to which resource utilization in programs is in accordance with current policies, etc.

In general, the total process for carrying out the responsibilities indicated above are assured to proceed in a manner that can be described as a continuous process which begins with assessing what is going on in the context of inquiry to evaluation of whether or not whatever is occurring is acceptable or desirable in the estimation of those who have responsibility for controlling the occurrence of those events. As a result of such evaluation, planning is carried out to develop strategies which would be seen as appropriate to change whatever states of affairs are not in accord with what would be desirable. Implementation of such planning depends on approval from the next broader areas of responsibility and is carried out through the utilization of resources to execute the strategies of the plan. Subsequent to implementation, the process then reverts to reassessment, reevaluation, replanning and redistribution of resources according to priorities which become established during reevaluation and replanning.

Unfortunately, the process just described is a theoretical one which, in practice, is often unsystematized because of difficulty in defining what it is that is relevant to assess within each area of decision making responsibility. Typically, there is a communication gap which exists between information producers and information users. Resulting from such lack of communication is a gap which is typified by the production of reports and numerical analysis which may or may not be germane to planning and evaluation issues.

B. Evaluation

A study from the national Institute of Mental Health reveals that "a scanning of some 1000 annotated citations dealing with evaluation in mental health yielded short of a dozen references which could be inferred to be devoted to the utilization of evaluation findings or change processes based on effectiveness measures.

Evaluation includes the development of information relating to treatment programs that is useful for policy decisions. Evaluation is the judgement that is made from the information that has been collected and assessed in relation to the measure of movement toward a previously defined goal.

Several writers have also pointed out the need for systematization of the measurement of treatment and program success in mental health. However, systems analysis, as well as other alternative approaches to planning and evaluation will mean little or nothing unless the organization internalizes, understands and appreciates the approach. Some would call this process "coordination", others, "communication", but few would dispute the need.

As an additional practical consideration, a distillation of research findings about organizational behavior suggest the conditions under which more rational planning for and evaluation of change is likely to occur. These are:

1.) When the scope of the organization's domain in relation to the wider operational environment is not curtailed or lessened by change.
2.) When the resources of the organization are enhanced by change, i.e., when their funds, facilities, antonomy and power are increased by the changes.
3.) When changes do not dramatically rearrange the power and resource allocations within the organization itself.
4.) When such change is consistent with the organizations history, ideology and mandates.
5.) When the changes are preceived to be economically practical and politically feasible.
6.) When alternatives to no change pose a threat to the organizations domain and/or resources.
7.) When the consequences of failure arising from the changes are not serious or irreversible.
8.) When other similar organization have successfully modified their programs using the same approaches to effect beneficial changes.
9.) When the need for change has been so powerfully demonstrated to the organization and the community that they cannot be ignored.
10.) When there is a strong consensus among administrative and program staff regarding the proposed modifications.

Of course, these factors are all interrelated. And, together they influence an organization's willingness to attempt new programs or to initiate new strategies on the basis of research findings. However, of particular importance is the last one listed because only through cooperative participation between planners and researchers can more rational assessment, evaluation, planning and implementation of program operations be accomplished.

In this regard, the kinds and levels of research activity which could obtain from such interaction may be described as follows.

C. Research

Since research is assessment activity, it may be generally defined as activity which is planned and undertaken to provide interested observers descriptions of what situations exist and/or how things are different from or similar to each other.

The Research and Evaluation Office, DPW, has amended the National Institute of Mental Health, Definition and Classification Committee, Southern Regional

Conference on Mental Health Statistics, Southern Regional Educational Board, to include the following types of Research and Evaluation Projects.

The outline below constitutes the classification of types of research performed in the Minnesota state hospitals. This scheme has been developed by the Office of Research and Evaluation, Minnesota Department of Public Welfare, and is based upon the third edition of DEFINITION OF TERMS IN MENTAL HEALTH, ALCOHOL ABUSE, DRUG ABUSE, AND MENTAL RETARDATION.[1] However, the terms have been reorganized and amplified to suit our needs. All research projects occurring in the mental health care system can be expected to fall in one of these categories described below. Certain projects may have more than one classification assigned; in which case the first designation would be the primary, and the other designation an additional, secondary one.

1. Basic Research: Systematic observations or experiments performed for the production of scientific knowledge through the testing of theories.

2. Clinical Research: Systematic observations, studies or experiments to determine the causes, treatments and rehabilitation of various disabilities.

3. Socio-epidemiological Research: Studies to determine incidence and prevalence of various disabilities and problems related to socioeconomic and epidemiological factors.

4. Recipient Characteristics Research: Research which seeks to describe the characteristics and interrelationship of characteristics of groups of recipients, i.e., "Let us further define (describe) the X population of recipients".

a. Demographic

(1) Sex: Male, female, undetermined

(2) Date of birth/age groups

(3) Race/ethnic background

(4) Marital status

(5) Living arrangements (including institution)

(6) Education, occupation, annual (or weekly) income, veterans status, birthplace, religion, citizenship, etc.

(7) Geographic area, with respect to residence, re: admission or discharge.

b. Presenting problem(s)/problem groups/need or condition on discharge/previous treatment history.

[1]Definition of Terms in Mental Health, Alcohol Abuse, Drug Abuse and Mental Retardation, prepared under contract from NIMH by SREB and SRCMHC, June, 1973.

c. Special diagnostic subgroups; e.g., schizophrenia, depression, organic brain syndrome.

d. Date of admission/length of stay/recidivism/chronicity.

e. Referral source/disposition or placement on discharge.

f. Legal status.

g. Recipient reimbursement status.

h. Psychometric characteristics, i.e., scores obtained on any measurement device by any recipient or group of recipients.

5. Program Evaluation Research: Utilization of scientific research methods and techniques for the purpose of evaluating a program; which may involve the discovery of knowledge, but is primarily a testing of the application of knowledge, e.g., studies of effectiveness of clinical or service methods.

a. Program administration: The extent to which the management of programs is well-ordered and businesslike.

(1) Program effort: The quantity and quality of activity that takes place or of resources that are consumed.

(2) Program efficiency: The cost in resources of attaining objectives; the relationship between effort and effect, or input and output; evaluation in terms of cost (money, time, personnel, public convenience); a ratio between effort and achievement, the capacity of an individual, organization, facility, operation or activity to produce results in proportion to the effort expended.

(3) Program needs: Surveys of existing, and projections of future needs with respect to any element of a program.

b. Program appropriateness: The extent to which programs are directed toward those problems that are believed to have the greatest importance, based on the philosophy and the value systems of decision-makers.

c. Program effectiveness: The extent to which pre-established program objectives are attained as a result of program activity; the results of effort relative to an immediate goal; the degree or extent to which success is achieved in resolving a problem. The effects achieved for a target population by a program.

(1) Degree of improvement: A judgment of the degree of change in the recipient's condition. This is the traditional way of classifying recipient's results.

(2) Problem resolution: The presenting problem of individuals or the community are categorized and rated as to whether the problems have been mitigated. (Example: less frequent bed wetting, decreased suicidal rate.)

(3) Goal attainment: Goals are set for each individual or community. Goals may be set in various terms such as "resolution of problems", "full employment", "independent social living", "reduced incidence of truancy". The extent to which the goal has been attained is then rated.

(4) Movement status changes: The progress of a recipient through a system has been used as an outcome measure to reflect further need for services. This may be a rather poor indicator of outcome but may be used.

(5) Recipient satisfaction: Reports by individuals or community recipients regarding their degree of satisfaction or improvement.

d. Program side effects: All effects of program operation other than attainment of objectives. These side effects may be desirable or undesirable and may be anticipated or unanticipated.

These kinds of methods could be applied to assess the results of programs and services being provided to each target groups and would permit planners to evaluate efforts and to determine the relative cost and effectiveness of alternative forms and patterns of service.

However, the necessary prerequisite to achieving such capacity is to accomplish closer interaction between planners (managers) and researchers (technologists) in order to clearly define the objectives which are pertinent to the managers area of responsibility and the relevant indicators which would reflect their attainment; and, to determine how best the researchers can assess changes in the relevant indicators so that the managers may be informed of any changes in order for them to evaluate and plan changes more rationally.

D. Current Use of Evaluation

Program evaluation is the determination of the degree to which a program is meeting its objectives, the problems it is encountering and the side effects it is creating. It involves monitoring indicators, and is closely related to accountability. It varies somewhat from Program Evaluation Research in that the indicators are monitored as if they were all partially dependent variables. (The classes are the same as those for Program Evaluation Research, as presented in section C above.)

The community mental health programs in Minnesota are being required to develop program evaluations. While there are some recently developed computer-based evaluation systems which have been adapted for use in community mental health programs, most of the community mental health programs do not have budget provision nor staff for establishment of the more sophisticated evaluation programs at this time.

The inability of a majority of the community mental health program directors and administrators to utilize complex computer-based evaluation systems does not negate, however, the importance of "evaluation". Rather, it places them in the midst of a profound dilemma----how do they meet the demand for accountability without adequate budgetary and staffing resources?

Hargreaves, et al. in their study of evaluation in community mental health programs found a great deal of interest in program evaluation in the majority of the programs they visited; however, the level of actual capability in any

center was rather minimal. The obstacles they found that impede effective program evaluation were compared with Delbeca and Van de Ven, 1971 study and identified five major areas of concern relevant to enhancing a program's capability for evaluation.

"1. lack of well-defined program goals.
2. lack of clarity about the roles of evaluation, or of an evaluator,
3. difficulty in making evaluation data relevant to specific management decisions,
4. technical problems in developing and maintaining a useful management information data base, and
5. lack of established methods for evaluating the effects of specific service techniques."[2]

The above include a mixture of organization and technical issues. Both must be resolved in order to develop evaluation capability in a center.

Hargreaves has identified four general stages of development of program evaluation aspects of center management: rudimentary monitoring, integrated monitoring, optimizing outcomes, and optimizing community impact.

1. Rudimentary Monitoring: Rudimentary monitoring includes the initial establishment of the scope and direction of the organization. There is usually some responsiveness to community pressures, that might be considered a rudimentary assessment of community need. This process does not adequately provide for assessment of community needs and establishing program priorities and goals. A fiscal bookkeeping system and a process for collecting basic statistics on clients are functions required by external reporting demands. These activities may satisfy the accountability requirements of funding agencies, but in the absence of any local planning initiative they rarely provide useful guides to internal management decision making. Management attention is often restricted to the short range perspective of handling the day to day problems while attempting to avoid an atmosphere of continual crisis.

2. Integrated Monitoring: Integrated monitoring is characterized by a variety of monitoring activities that have been initiated. The crucial aspect of the development is not so much the specific activities but rather the program leaders' increased attention to, and skills in, using program information for long range planning. It is in this process that the pieces of program evaluation start to come together in the service of local management. The statistical system is developed to answer recurring questions about the functioning of the program. Statistical and accounting systems must be integrated so meaningful cost finding is possible.

Program leaders take the initiative in assessing community needs, utilizing census data and a variety of simple assessment and goal setting activities. Questions such as: "Are we serving those persons we inteded to serve?"; "Are services accessible to clients?"; "Do clients get lost due to inadequacy of continuity of care?"; "Does the allocation of budget reflect the service priorities espoused?".

[2]William A. Hargreaves, Ph.D., C. Clifford Attkisson, Ph.D., Marguerite McIntyre, MBA, Larry M. Sieget, ACSW, MPH. "Current Applications of Evaluation" #9, April, 1974, Presented at the National Conference on Evaluation on Alcohol, Drug Abuse and Mental Health Programs, Washington, D.C., April 1-4, 1974.

A program at the level of integrated monitoring is likely to be very well managed by todays standards. While there is considerable discussion about ultimate effectiveness of programs, these descriptive monitoring and needs assessment activities are frequently the first applications of program evaluation. This is considered to be an entirely appropriate order by several authorities. Systematic planning and goal setting activities, statistical monitoring and routine cost finding permit the kind of stable program management within which program effectiveness can begin to be examined.

3. Optimizing Outcomes: The third level of development of evaluation is optimizing outcomes. Staff begin to answer questions such as: "Which clients were least satisfied with services?"; "Do our after-care services for schizophrenic clients successfully prevent unnecessary rehospitalization?"; "Did last year's consultation efforts with schools accomplish the goals we and they established?". A thoughtful approach to these types of questions requires skilled management and will developed program evaluation capability.

4. qtimizing Community Impact: Goals of improving the "quality of life" and "average mental health" of a community are, more appropriately, goals for the entire human service network of a community. These involve questions about the optimum components and linkage in its network. It is assumed that there is need for more basic research before communities will have the conceptual and methodological tools to evaluate the effectiveness of a human service network. A periodic review of community needs does provide an opportunity for an informal and common sense estimate of the relevance of a program to the community it services.

5. Informational Capability: It is usually necessary to develop better information capability. The "natural data systems" case records, financial records and personnel records are frequently uncoordinated and dispersed and thereby not accessible in form that lends itself to the necessary overview. The first step would be to develop a minimum set of routine management reports. As informational capability develops, greater flexibility in data analysis is acquired to keep pace with changing concerns of management, changing external reporting requirements and increasing management skill in using program data in decision making.

Smith and Sorenson, 1974; Cooper, 1973, Crawford, Morgan and Glantusco, 1974; have developed a considerable amount of new materials for management information systems. With utilization of existing information, as identified above, staff can more readily acquire those "informational tools".

E. State Expectations

The state will be requiring basic specific information regarding the programs operations and services. Each community mental health center is being required to provide basic minimum service. Other services may be provided in addition to these. Each community mental health program will be required to plan and develop the mental health continuum of services for MI/BD populations including the specialized target groups, (aging, children and those individuals with the more pronounced disvalued behavior). The continuum of services will be included in the comprehensive mental health program plan. The requirement of residential services and program expansion is contingent upon funding being made available by the state.

The continuum of mental health services in each area is to be developed and based upon the determination of need of the different services. Each area comprehensive mental health plan is expected to address and identify the anticipated impact. That is, the anticipated results of the service and the relation of the result of the services to the population and the community. Impact statement should relate to the goals and the objectives. One method that will adapt readily to this expectation identified is the goal attainment scaling. Identification of the goals provided the "previously identified goal" by which the service or program component can be measured. The rating of goal attainment scalling provides the method of measuring. This is not to imply that Goal Attainment Scaling (GAS) is the only nor the most complete method of measuring. However, GAS is recognized as an acceptable method of evaluation. Programs are encouraged to utilize GAS in addition to the "Integrated Monitoring" identified above.

The evaluator, the community mental health director, plays an important role in selecting areas that need to be evaluated. Evaluation can be effective without availability of information about everything. An objective overview of the program by the director, with the assistance of staff and an advisory committee or board can lead to the identification of specific areas which are more relevant to the policy making and planning activities of the specific community mental health program system. This requires a priority evaluation. The computer will analyze all of the information provided it, but it does not follow that the information provided the computer is equally critical important.

CHAPTER VII

STANDARDS AND MANPOWER

A. Standards

Standards are based on certain fundamental principles that reflect the philosophies, attitudes and elements that are considered appropriate and accepted criteria for quality of care and treatment. Standards serve as a measure for accessing the quality of care and provide a guide to programs in the identification, evaluation and treatment for persons with mental health problems.

1. "Humanization" and "Institutionalization": Standards are developed with consideration of two processes. These are:

a. "Humanization" includes those elements which particularly address the dignity, rights and overall considerations for the individual.

b. "Institutionalization" relates more specifically to those things which are necessary to carry out effectively the goals and objectives of the facility.

It is essential that these two processes be well integrated. If the "institutionalization" process were considered alone, the procedure, roles, and power would serve only the facility or agency and the needs of the people would not be met. On the other hand, if the "humanization" process were considered alone, without regard for roles and procedures, inconsistancies and instability would develop and chaos and failure would eventually result. Therefore, the facilities attention should be directed in a cycle, always beginning with and returning to the process of humanization.

The goals of the facility must be based on the needs of those being served, the "people" part of the "humanization" process. Roles are developed from goals, that is defining who in the organization is to do what, and who has power. Policies are established so that goals of the facility can be achieved and to ensure understanding and maintain control of services being offered. Procedures are established so policies can be carried out consistently.

Standards must give consideration to achieving a balance and integration of both of the above processes. Every facility or service provider should periodically reassess its "humanization" and "institutionalization" process. There is need to reassess the needs of the people being served and in consideration of this then, to reexamine the appropriateness and effectiveness of the facilities' goals, services, programs, roles, policies and procedures. "Humanization" and "institutionalization" should focus first on the individuals served, then the significant others including involved "institutions" in the community, and then in the overall environment and social processes that have an impact on the individual.

2. Principles: Standards should also take into account consideration of principles based upon priorities and essential elements of facility organizations and delivery and services.

a. Principle of care: The amount of support and treatment that is provided within the continuum of care varies. The nature and intensity of services that are to be provided to the individual depends upon the amount of responsibility that the facility assumes for the care of the individual. The greater the level of support and treatment for the individual, the more responsibility the facility assumes for the individual. The level of responsibility for the individual that is assumed by the facility should be a determining factor in the nature of standards that are to be applied.

b. Principle of the facility: Clinical and administrative aspects are common to all facilities. There is potential for administrative and clinical conflicts and it is recommended that standards be function oriented. The Joint Commission of Hospital Accreditation has addressed this issue by identifying functions in the following manner.

"Fundamentals of the Facility		Fundamental Needs of the Child or Adolescent
Clinical: Medical/Clinical	Individual	Physical
Assessment	Group	Psychological
Formulation	Environment	Developmental
Treatment		Chronological-age
Follow-up		Family
Prevention		Educational
Documentation		Social
Confidentiality		Environmental
Patients' Rights		Recreational
Research		
Quality Control		
Administrative: Organization		
Administration		
Political		
Legislative		
Legal		
Financial		
Physical Plant		

The medical or clinical services carried out by the facility include the assessment or examination, the formulation or determination of what is wrong, the treatment or therapeutic programs, follow-up, and prevention. There are other professional or clinical aspects that must be considered in the operation of the facility: there must be documentation; confidentiality must be assured; and patients' rights must be protected. Research, quality control, and organizational aspects fall in the center of the spectrum of services, as these have both clinical and administrative components. At the administrative end are political, legislative, legal, and financial considerations and the operation of the physical plant itself. In all of these, there must be consideration of the individual patient; the group, family, peers, significant others; and the environment, including the social systems, schools, local government, and other facilities."[1]

[1] Joint Commission on Accreditation of Hospitals, Psychiatric Facilities Serving Children and Adolescents, Accreditation Council for Psychiatric Facilities, 1974, Chicago Illinois, p. vii.

In all of these there must be consideration of the individual patient, the group, family, peers, significant others, and environment, including the social systems, schools, local and government, and other facilities.

There are some individuals qualified to assume responsibility for all of the above functions. Others may work in partnership or with a group of other qualified individuals to assure that all of the functions are carried out efficiently and effectively.

The function oriented approach recognizes a flexible range in which mental health serices can be managed, personnel utilized and services delivered.

c. Principle of Needs of the patient: Each service provider is responsible for assessing, in some depth, each of the fundamental needs of the individual: physical, psychological, developmental, family (including ethnic and cultural characteristics and background), educational, social environment (which includes socioeconomic factors), vocational and recreational.

The requirements for patient assessment would relate to and depend upon the level of support and treatment provided. For example, it is expected that a facility providing 24-hour care would have greater responsibility for in-depth patient assessment than outpatient assessment facility would have.

d. Principles of service: The mental health clinical services essentially consist of assessment, formulation, treatment, follow-up and prevention activities. The criteria for determination of qualifications of individuals providing services are usually based on training or education, supervision, consultation and practice or experience. Some providers of service may start with training then work under supervision and as their knowledge increases their need for supervision lessens and consultation may be the primary method of learning; then they move into practice with experience. Some providers of service may start with experiences, either job related or from some life experience, and then acquire specific training. For the provision of certain services, training and demonstrated competence are necessary; for others, experience and demonstrated competence are satisfactory and in some instances either training or experiences combined with demonstrated competence is appropriate.

Qualifications of services providers relates to specific functions or services that are based on science, art, philosophy, traditions or some combination of these. Some services have a specific scientific basis, others are based largely on an art of performance. Some evolve from a philosophy or a particular kind of approach, and other essentially come from a tradition or a mystique. Standards relating to the qualifications of individuals providing mental health services should relate to the type of service or certain function that is to be performed.

3. Personnel Policies: Personnel policies and practices shall be designed, established, and maintained by each board to promote the objectives of the facility and to ensure that there is an adequate number of personnel to support high quality of individual care.

Private and public autonomous agency's boards develop their own personnel policies. CWD usually are covered by merit system personnel policies. State facilities are covered by Civil Service personnel policies.

4. Staff Development: There shall be appropriate programs of staff development for the administrative, clinical, and support personnel, and there should be records maintained indicating participation in such programs. There should be evidence that the programs have been designed to keep the staff informed of significant new clinical and administrative developments and skills.

5. Minnesota Statutes requiring standards for M.H. care.

a. 246.013-246.014 - MI, Care, Treatment, Examinations and Services: These standards relate to State Hospitals and include provisions relating to staff, both professional and lay. They require that staff be trained in the diagnosis, care, and treatment of mentally ill which is consistent with modern methods of treatment.

b. 245.013-246.014 - Minnesota Community Mental Health Act states that there must be specific standards for qualifications of professional personnel, the quality of professional service, and, in-service training and educational programs for the personnel. The Commissioner is also directed to employ qualified personnel and to provide consultative staff to the communities.

6. Existing Mechanisms for Standard Setting for Mental Health Services: DPW Rules 28, 5, 8, 36 and the Health Department's Supervised Living Facility (SLF) Rule and hospital license are utilized.

Some professionals are licensed, registered or certified by the state. Persons who have been graduated from an approved educational program and have passed the state examination for their particular discipline receive a license or registration or certification to practice their particular profession in the state of Minnesota. This assures a satisfactory completion of the state examination and presumes a basic level of competence.

Mental Health Programs and services are reviewed both at the state and local levels, and are subject to all pertinent laws, rules, and regulations, including applicable DPW and Health Department rules and licensure procedures, Fire and Safety Codes. Zoning regulations, both at the state and local levels.

Standards are being developed for community mental health programs.

The Joint Commission of Accreditation for Hospitals has developed standards for Psychiatric Facilities and Psychiatric Facilities for Children and Adolescents. JCAH Standards for Community Mental Health Programs are currently being drafted. Accreditation by JCAH is voluntary and optional.

Compliance to the standards that JCAH has established indicates one recognized level of quality care and treatment. Some funding sources ask for JCAH Accreditation as a means of approval of the service vendor.

B. Manpower

Throughout this plan we have stressed the need for comprehensive services in all areas of the state. The type of staffing patterns that are needed to establish the described service network includes all kinds of staff and this is quite complex.

Community mental health programs range widely in the emphasis they place on particular training and skills. Some attitudinal characteristics are commonly shared:

1.) Staff must have faith in the potential of the patient to gain competence and ultimately be able to cope with his problems. How staff does this will vary.
2.) Personnel should understand that goals and objectives are more important than fixed roles and lines of authority.
3.) Genuine teamwork and an orientation toward problem-solving are paramount.
4.) Personnel require adequate confidence and self-reliance so as to work well in an open structure without the usual support and supervision that is available in traditional facilities.

Community mental health centers staffing pattern has significantly more mental health professionals than have state hospitals. The higher proportion of mental health professionals in community mental health centers may be attributed to their emphasis on diagnosis, active treatment and rehabilitation to reintegrate the patient into the mainstream of life and the provision of consultation and education to other agencies, caregivers, courts, schools, professional and lay groups.

The multi-disciplinary mental health professional staff function as a dynamic team, whose roles and activities change more with tasks, rather than being related to a specific discipline role. The following is a brief review of some of the major disciplines and tasks that are performed in community mental health programs.

1. Psychotherapists: for example, this role is usually filled by psychiatrists, psychologists, psychiatric social workers and psychiatric nurses. Other disciplines do provide psychotherapy also. Individual, group and family psychotherapy play a large role in community mental health programming.

2. Psychiatrists and clinical psychologist are well accepted in community mental health programs in the traditional role of diagnosis and treatment. Therefore expansion of their roles is not provided.

3. Psychiatric social workers play a major role in some of the residential facilities and the transitional residential facilities. They also play a major role in helping to arrange satisfactory community based living arrangements for discharged patients, providing consultation to various resources, participate in partial hospitalization programs, etc.

4. Psychiatric nurses also play a major role in community mental health programs. They frequently provide acute care in emergency situations, including home treatment, staffing of inpatient and partial hospitalization (day or night care) programs, after-care, both in clinics and on home visit basis and consultation with many community resources including but not limited to nursing homes, general hospitals, residential facilities, etc.

Although mental health problems always have a social component, anyone who has dealt with psychosis, severe depression, alcoholism, drug addiction, organic brain disease, and various neurological impairments recognizes the indispensable need for medically-oriented psychiatric care at specific times. Mental Health seems to have one foot in health sciences field and the other foot in social sciences field. Mental health is a specialty with orientation from health, behavioral, social sciences and is Bio-Psyco-Social. Resources from these fields make contributions to mental health.

5. Occupational and Recreational Therapists: Occupational and recreational therapy, with an emphasis upon group activities and social rehabilitation, is an important component in 24-hour care and partial support and treatment programs. Therapists also participate effectively as program consultants in the community. They may provide direct services in homes and to groups living in group living accommodations such as group homes, halfway houses, and other community settings.

6. Rehabilitation Counselors: Rehabilitation counselors are responsible for helping to place patients in sheltered workshops, though the scope of their responsibilities is often broader. Rehabilitation covers a total program of personal, social, and vocational functioning, involving family, residence, group activities and work. A rehabilitation program is designed to stimulate the patient's successful functioning in society even after years of hospitalization.

7. Paraprofessionals and Nonprofessionals: It is true that community mental health programs emphasize professionalism to a larger extent than state hospitals, the opportunities for nonprofessionals remain great. Many of the tasks to be done in a comprehensive program are ones which do not require professional expertise. The staffing of halfway houses, group homes, etc., frequently are not professional staff. Long-term institutionalized patients who have been discharged need support and friendship as they relearn how to shop for groceries, to handle money, to negotiate an urban transportation system and even just how to talk with other people.

Community mental health centers have profited from neighborhood health centers experiences. They have employed indigenous personnel who live within the localities where services are delivered. Many attendants and psychiatric technitions of state hospitals are adaptable to outreach work, after-care visiting, and the provision of homemaker assistance to residents.

8. Volunteers: Volunteers have demonstrated their usefulness in state hospitals. Their potential for effectiveness within community based comprehensive programs is even greater.

The above listing of professionals, nonprofessionals and paraprofessionals is not to be considered complete. The above is provided as an example of some of the composition of staffing.

MH Programs must have a sufficient number and variety of qualified staff to perform the functions to meet their specified goals. There should be adequate back up for, supervision of, and collaboration between all personnel. Staff, and volunteers, who have had insufficient prior training and/or experience to enable them to effectively carry out their duties must be provided with in-service training. Each program should define an adequate, organized plan for such training.

Staff composition shall be determined by the facility, based on an assessment of the needs of the individuals being served, the program goals, and all applicable federal, state, and local laws and regulations.

The staff of a mental health program facility should be organized to provide effective governance of its affairs and to ensure proper acceptance and discharge of its delegated responsibility for the quality of assessment, treatment, and care of individuals.

As area planning committees and the area administrators design comprehensive community mental health programs, they will consider varying administrative approaches to the operation of local services and each of the considerations will have significant staffing implications:

1.) The area could purchase an entire program which would be essentially private ownership and operation.
2.) The area could enter into service agreements with agencies and institutions which will use state hospital staff for portions of the program.
3.) The area program could provide all of the services.
4.) There may well be other alternatives.

Local preferences, legislative policy, resource availability, etc., will determine ultimately the choice of each area. However, regardless of which alternative is selected, resource reallocation will be required. The mental health personnel in every state is one of the limited resources. Individuals who have knowledge, skills, training in mental health will continue to be needed.

State hospitals that may be scheduled for closing together with the Department of Welfare and the Area Program should make a study of the personnel and the possible alternatives for reallocation of the staff. The community-based mental health services require different staffing patterns from those utilized in state hospitals. However, the rights of the institutional employees must be preserved.

Principles for redeployment of staff should permit sufficient flexibility at the area level so that locally responsive programs can be developed and maximize the potential for creative contributions by current state hospital personnel. It is recommended that the Department of Public Welfare in conjunction with representatives of state hospitals and area programs develop principles regarding the reallocation of state hospital personnel.

CHAPTER VIII

FUNDING

A. Current Funding System

The sources of funds currently used for delivery of mental health services consist of a variety of federal, state, county, third party payments, private philanthropy, and fees for services. Each of these sources are briefly described.

1. Federal Funding Sources: There are two major types of programs under the federal funding, insurance programs and grants for special purposes. The Social Security Act, the Civilian Health and Medical Program of the Uniform Services (CHAMPUS) and the Veterans Administration are the major insurance programs. Both types of federal funding are briefly described in the following.

a. Federal Insurance Programs: The Federal Social Security Act includes major titles that provide a form of permanent funding that is available for mental health care. Each of these titles is presented briefly.

(1) Title XVIII - Medicare: Under the law, Medicare does not cover care that is not "reasonable and necessary" for the treatment of an illness or injury. Medicare also does not cover that care which is "custodial". Medicare includes Part A - Inpatient Hospital Benefits and Part B - Supplemental Medical Insurance Benefits.

There is a limit on how many days of hospital or skilled nursing home care, and home health visits for which Medicare can assist in paying for each benefit period (spell of illness). A benefit period is a way of measuring the use of services under Medicare's hospital insurance. The first benefit period starts the first time the individual enters a hospital after the hospital insurance begins. Then the individual has been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row, a new benefit period ("spell of illness") starts the next time the individual goes into a hospital, constituting a new "spell of illness". There is no limit to the number of benefit periods except that care in psychiatric hospitals is limited to 190 days of lifetime psychiatric care.

Part A of this plan concerns hospital insurance. Coverage of hospital services for mental illness in a general hospital is provided on the same basis as are all other illnesses. The same is true for care in a general extended care facility. On the other hand, coverage of mental illness in a psychiatric hospital is available for up to 90 days in each benefit period, with a 190 day lifetime coverage. Home health visits, 100 visits per benefit period, are also available.

Part B of Medicare provides supplementary medical insurance. Beneficiaries are charged a monthly premium under this program. Physicians' services for inpatient hospital care are provided. However, a specific amount of payment is deductable annually, after which coverages are limited to 80% of reasonable charges. Payment for physician services, provided on an outpatient basis, is limited to 50% of charges, or $250 a year, which ever is less.

Other health personnel services, if provided in an organized setting and ordered by an M.D., are more subject to limitations, but payment is made to the participating facility or to the M.D. One hundred home health visits are available under this program each calendar year.

(2) Title XIX - Medicaid: Title XIX of the Social Security Act, called Medicaid, provides mental health care funding also. This program provides grants-in-aid to states to pay for specific medical services for the categorically needy. Federal contributions range between 50% and 83% of covered medical costs. In Minnesota the federal portion is about 57%.

There are limitations of Title XIX. However, there are specific requirements to the inclusion of the optional mental health benefits for those individuals over 65 years of age in psychiatric hospitals. The 1971 amendment provided for optional inclusion of psychiatric hospital services for individuals under 21 years of age. The psychiatric hospital must be accredited by the Joint Commission of Hospital Accreditation to be an eligible provider for Title XIX reimbursement.

There is limited information regarding the totality of mental health care in the Title XIX program. Medicaid has become a major resource for payment of care for the elderly in mental hospitals, particularly when Medicare benefits have been exhausted or services are not covered under Medicare.

Community Mental Health Centers: As part of the Minnesota Title XIX Plan "clinic services" may be billed to Title XIX program. The Department of Welfare defines community mental health centers as clinics. Therefore, community mental health centers in Minnesota may be reimbursed for mental health services to Title XIX eligible persons.

It is estimated that about 5% of the community mental health centers' services will be reimbursable by this mechanism.

The following constitute the direct mental health services for which Title XIX reimbursement may be claimed. These services should be listed on the claim as individual or group therapy as indicated in the table, using the appropriate code numbers and identifying the clients served.

Description of Services	Individual	Service Code	Group	Service Code
Speech Therapy	yes	90000-1	no	
Intake Evaluation	yes	90015-8	yes	
Non-Intake Evaluation	yes	90010-3	no	
Neurological Examination	yes	90020-5	no	
Psychiatric Evaluation	yes	90801-1	no	
Social Evaluation	yes	90000-1	yes	90000-1
Psychological Evaluation	yes	90825-9	yes	90825-9
Individual Psychotherapy	yes	90841-9	no	
Hypno-therapy	yes	90880-5	no	
Group Psychotherapy	no		yes	90853-2
Psychodrama	no		yes	90853-2
Therapy with groups of couples	no		yes	90849-6
Family Therapy	no		yes	90847-4
Collateral Therapy	yes	90800-5	no	
Chemotherapy	yes	90862-3	yes	90862-3
Day Treatment	yes	90898-4	yes	90898-4
Mental Health Information and Referral	yes	90831-7	no	

All patients entering state hospitals are screened by the Reimbursement Officer for possible benefits, such as, Social Security, Railroad Retirement, V.A., etc. If it appears that eligibility exists, an application is completed, or a referral made to the appropriate agency.

The Department of Public Welfare also has a formal agreement with the Social Security Administration, that sets up a prerelease procedure on eligibility determination for SSI benefits, involving patients about to be released from state hospitals. When an individual is identified by the institution for community placement, the following procedure is followed:

1. Using federal income and resources guidelines, the Reimbursement Officer determines potential eligible individuals.

2. If potential eligibility is established under No. 1 above, and individual is under 65, case is referred to the hospital based medical review team for determining potential eligibility from a standpoint of disability.

3. If potential eligibility exists under No. 1 and 2, the Reimbursement Officer assembles the necessary documents and refers the matter to the local district Social Security Office to process the application.

4. When the institution is notified of approval of the SSI application, the patient may be released to his community setting and payments commenced immediately.

SSI benefits for individuals in state institutions is limited to $25.00 per month, and only if more than 50% of cost of care is paid under Title XIX Medicaid.

See Table VIII-1, which indicates Federal Programs in State Hospitals for Cost of Care Reimbursement.

(3) Titles IV-A and XVI - Title IV and VI of the Social Security Act are also worthy of note as they relate to various health services. Legislation for Title IV-A provides for a broad range of services...educational, therapeutic and medical, rehabilitative and social on a reimbursement basis per day of service for actual and potential AFDC children up to the age of 18 years. Title VI provides for any rehabilitation service that relates to the adult categorical services for the aged, for the totally and permanently disabled, and for the blind. Payment for services is also on a per diem cost basis. Both programs must be administered through a public agency, which may in turn contract for purchase of services from private agencies.

The single state agency for Titles IV-A and VI in Minnesota is the Division of Social Service Plan Administration within the County Welfare Bureau of the Department of Public Welfare. Titles IV-A and VI have a single state agency and a state plan that includes the kinds of programs that will be implemented within this state. Therefore, if innovative programs are to be developed, the state agency must contractually agree with the federal government, either to implement or to expand the state plan to include a state-wide program of

TABLE VIII-1

CHART OF FEDERAL PROGRAMS
IN STATE HOSPITALS FOR COST OF
CARE REIMBURSEMENT

Prepared by: DPW
Support Services
Reimbursement Division
June, 1974

PROGRAM	GROUPS COVERED	SERVICES COVERED	EFFECTIVE	FINANCIAL PARTICIPATION		
Title XIX 1. Medical Assistance	MI 65 & over in Psychiatric Hosp.	All medical needs, state hosp. charges	01-01-66	yes	yes	yes
Title XIX *2.Medical	MR-all age groups in ICF-1 Facility	All medical needs state hosp. charges	07-01-72	yes	yes	no
Title XIX 3. Medical Assistance	MI under 21 in Psychiatric hosp.	All medical needs including state hosp. charges (if under active care)	01-01-73	yes	yes	yes
Title XIX 4. Medical	MR under 18 in ICF-1 Facility	All medical needs, state hosp. charges	01-01-72	yes	yes	no
5. Supplementary Security Income (SSI)	All MA recipients State Hospitals when more than 50% of cost of care is paid under Title XIX, and said recipient's unearned income is less than $45 a month may receive up to $25 a month.	Intended for clothing and personal n needs allowances for state hosp. clients	01-01-74	yes	no	no
Title XVIII 6. Medicare	65& over in program approved	All medical needs, including state hosp. care, to a maximum of 90 days each benefit period (life time maximum of 190 days psychiatric care)	07-01-66 (if under active care)	yes	no	no
Title XVIII	Disabled individuals, widows & adult depen- children draw- SS benefits, a minimum of 2 yrs.	All medical needs including state hosp. care, if under active care, to a maximum of 90 days each benefit period (life time maximum of 190 days Psychiatric care)	07-01-73	yes	no	no

TABLE VIII-1

NON-COVERED GROUPS: Medical assistance in a psychiatric hospital does not cover mentally ill or chemical dependency patients between ages 21 and 65.

*This category of MA recipients over age 18 were covered under the AD program for the period 1-1-70 through 6-30 72.

NOTE: All requests for non-emergency medical care for patients receiving MA, which cannot be provided with the state hospital system shcall be discussed with the county of financial responsibility at the point where said need is identified.

services for the entire population. In several states the Welfare Department contracts with the State Mental Health authority, who in turn contracts with local mental health agencies.

Title IV and VI are soon to be replaced by Title XX. Some mental health services may be reimburseable if the Minnesota Title XX plan includes this mental health service. The potential of this source of funding for mental health rehabilitative services such as board and care homes, halfway houses and others should be explored. To avoid misunderstandings, it is recommended that the single state agency should be explored for Title XX contract with the State Mental Health Program so that state wideness may be assured and program development may proceed in the direction established by the mental health program plan. The State Mental Health Program would, in turn, contract with Area Community Mental Health programs to assist in the development of the continuum of mental health services.

At the federal level, the administrative agency is the Bureau of Family Assistance of the Social and Rehabilitation Services within each of the Regional Offices. For programs particularly relevant to mental health and mental retardation, the Developmental Disabilities Division of Social Rehabilitation Services at the Regional level must be included in the planning with the Bureau of Family Assistance.

The Development Disabilities Act is an extension of a community mental health center act, mental retardation provisions, Public Law 88-164, which expands services beyond that of retardation to include such handicaps as cerebral palsy and minimal brain dysfunction disorders. The methodology of implementation of the single state agency and the social rehabilitative services is a contract mechanism to purchase services to help eligible people. Aside from guaranteeing such services, the plan must include a detailed description of its program and projected budget. Agreement between SRS and the state on the nature and extent of service must contractually occur. In turn, the state may contract with other agencies within the state jurisdiction to provide the services agreed upon.

Aside from the mental health care facets of both Titles VI and IV-A previously described, we should note that treatment under these Acts can be provided to the extended family, provided that this is part of the agreed plan for services and directly assists the patient involved, either in rehabilitation or in educational programs.

In Title VI, the categorical group is different, the services can include group living arrangements for the mentally retarded or handicapped person, personal care homes. Through Title XIX or VI or IV-A, services of a psychiatric team or rehabilitative team can be utilized and reimbursed when going into a facility. This is particularly helpful for the aged person, who is coincidentally, a psychiatric patient. The important thing to remember is that the wording of the contract must not be primarily for psychiatric services. Care may also include boarding home facilities that are provided for in the state. Title IV-A and VI allow for funding, whereby three federal dollars are made available for every state matching dollar. These programs serve AFDC or potentially AFDC children and the aged, blind, and the handicapped, who are eligible for categorical assistance. To obtain these funds the State Depart-

ment of Public Welfare, which is responsible for administration, must include in its state plan the specific services to be provided, and must state that in many instances these services can be provided for emotionally disturbed or mentally retarded persons.

b. CHAMPUS - Civilian Health and Medical Program for Uniformed Services: CHAMPUS is a broad health insurance program for retired members of the Uniformed Services and their dependents; dependents of active duty personnel, and dependents of deceased members. This group includes about six million people. Care in this program is provided in civilian care settings, although the same benefits may be obtained on a space-available-basis at uniformed service facilities. The benefits on mental health services under CHAMPUS are as follows:

> "in civilian treatment centers, coverage applicable to mental health conditions include all necessary inpatient care in a semiprivate accomodations and all services and supplies furnished by the inpatient facility; private accomodations are allowed when medically indicated or when semiprivate ones are not available. An inpatient facility may include a hospital, an extended care facility, or a psychiatric treatment facility. The latter is defined as "a facility engaged in the treatment of nervous, mental, or emotional disorders, and...(staff) has a professional staff including one or more full or part-time licensed physicians who are qualified psychiatrists...in addition to such ancillary psychiatric personnel...,as appropriate."[1]

As indicated above, when the inpatient care is an excess of 90 days, management of the case must be reviewed by officials of CHAMPUS under the supervision of a physician and staff of professional social workers. An advisory committee is now being formed to review cases providing service under CHAMPUS. Continued authorization would depend upon the determination that additional care would be significantly beneficial to the patient, and that it cannot be provided more effectively or economically as for:

> "outpatient care in any setting, when furnished or ordered by a physician, including house calls, were medically necessary; diagnostic examinations, prescription drugs; services of clinical psychologists who are licensed, or where a license is not required, certified by a state psychological association; services of private duty nurses when ordered by a physician; services of allied health personnel when ordered by a physician; nongovernment ambulance service; participation of family members, and others, (who are not eligible for CHAMPUS benefits in their own right) and psychiatric diagnostic and treatment programs, if in the judgment of the therapist that participation is necessary for the proper management of the patient; domiciliary or custodial care is not covered."[2]

[1]Henry Foley, "Financing Mental Health Care and Related Social Services", Multiple Sources of Funding and Management of Community Mental Health Facilities, Selected papers for NIMH Regional Funding Conference, 1970-72, p.36.

[2]Ibid.

There is school payment for care for dependents of active duty members who pay the first $25 (or $1.75 per day, whichever is greater) for inpatient care. The individual pays the first $50 and then the U.S. Government pays 80% of charges for authorized care.

As to all other beneficiaries, the Government pays 75% of reasonable costs for inpatient, hospital and professional services. For outpatient care the beneficiary pays 50% deductible and the Government pays 75% of the remainder of authorized service charges.

c. Veterans Administration Program: The aspects of mental health and physical coverage in the expanding operation of the Veterans Administration Program is of interest. This program, which serves a covered population of about 27 million veterans, provides service based on priorities of services connected or non-service connected conditions. Further services are based on degree of disability and financial need.

Despite the fact that the majority of such care is provided in Veteran Administration facilities, non-VA facilities provided $7.2 million or 284,000 inpatient days of care to this program during Fiscal Year 1970. This is almost 2% of the total psychiatric care provided in the program.

In terms of outpatient services, about 294,000 visits and $3.7 million were spent in non-VA facilities. This represents about 1/4 of the total VA outpatient psychiatric program.

The Veterans Administration is trying to develop a meaningful working relationship with community mental health centers. VA regulations, as they presently exist, prevent the use of VA facilities for non-veterans--even though members of the immediate family of the mentally ill veteran should be involved in treatment regime. This prohibition virtually prevents treatment through family psychotherapy at present. At present, it may be feasible for the V.A. to share staff with a CMHC that serves veterans. It is generally accepted that modern mental health treatment methods must involve the whole family and work close to the patient's plan of work.

d. Special Purpose Grants:

(1) Community Mental Health Center Construction Grants - A specific allocation for community mental health center construction grants is made to each state annually. Community mental health center construction grants funds are available to assist in the construction, purchase, and/or renovation of one or more facilities to house all or part of community mental health program, or for initial equipment. The federal share of construction costs may vary. Some Minnesota community mental health construction plan currently has established funding at a 50% level. Minnesota has used this funding source as indicated in Table VIII-2.

The federal community mental health legislation has been redrafted. The new provisions for community mental health center construction funds are subject to the passage of this bill.

TABLE VIII-2

FEDERAL COMMUNITY MENTAL HEALTH CENTER STAFFING GRANTS

Community Mental Health Center	Grant	Project Period	Approximate Current Federal Participation
Region I			
Northwest Community Mental Health	Staffing	10/1/69-9/30/77	$ 350,913
Region III			
Northeast Area MH/MR-I (Duluth Human Development Center)	Part F*	11/1/72-10/31/80	$ 133,985
Range Mental Health Center	Staffing	2/1/68 1/30/76	$ 172,147
Region VI			
West Central Community Service	Staffing	9/1/70-8/31/78	$ 395,321
	Growth**	9/1/70-8/31/82	$ 125,649
Region VII			
Central Minnesota Community Mental Health Center	Staffing	6/1/68-5/31/76	$ 313,852
	Growth	4/1/&0 3/31/78	$ 39,888
	Part F*	7/1/74-6/30/82	$ 195,723
Region X			
Zumbro Valley Mental Health Center	Staffing	10/1/67-9/30/75	$ 70,279
Region XI			
Hennepin County MH/MR	Staffing	5/1/69-4/30/77	$ 196,738
Washburn Child Guidance Center	Part F*	10/1/72-9/30/80	$ 30,252
	Growth**	8/1/74-7/31/82	$ 30,000

** Part F Grants are for Children's Mental Health Services
* Growth Grants are Supplemental Grants to previously Awards Grants.

(2) Federal Community Mental Health Center (CMHC) Staffing Grants - The federal matching funds are available for community mental health center staffing grants. Community mental health centers are eligible applicants. The recipient of the grant must meet federal requirements. These grants have been made for an eight year period of time. Federal participation in the staffing grant is based on a declining scale and has provisions for poverty and non-poverty designated areas. Currently, there are six federally funded staffing grants and three federally funded part F staffing grants for children services in Minnesota. With the new Federal CMHC legislation the provisions for staffing grants will also change. See Table VIII-2 for identification of grants, anniversary and termination dates of data and current amount of Federal funding.

(3) Research and Training Grants - These grants are individually applied for and eligibility requirements determined by federal regulations.

(4) Hospital Improvement Program (HIP) Grants - State hospitals are eligible applicants for HIP Grants. The maximum amount of the Grant is $100,000 per year. Grants are usually requested for up to three years with reapplications and progress reports annually. A state hospital is eligible to receive HIP Grants for a ten year period of time. These funds may not be used to replace state funding. The funds are to develop new or improved programs.

(5) Hospital Staff Development Grant (HSD) - State hospitals are eligible applicants for HSD funds. The maximum amount of this type of grant is $25,000 per year. Applications are usually made for three years with reapplication and progress reports annually. The ten year maximum period of time for utilization by a hospital also applies to the HSD Grant. The purpose of this grant is to improve the skill and knowledge of the staff so that patient care will be improved.

(6) 314 (d) Grant - Funds are available under P.L. 89-749, United States Public Health Services Act, Section 314(d). A block grant is made to states. The law currently provides that at least 15% of the state award must be used for mental health. The 85% of the grant is awarded to the Health Department. Of the mental health portion, 30% may be used for state administrative purposes, and the remaining 70% is to be used for community mental health purposes. Fiscal year 1974-75 Minnesota was awarded approximately $240,000 for community mental health purposes.

2. State Funding for Mental Health Services and Programs.

a. State Hospitals: The State Legislature appropriates funds for support and operation of the state hospitals. Eight state hospitals and Minnesota Security Hospital provide services for the MI/BD. The state institutions expenditures are identified on Table VIII-3.

b. Community Mental Health Centers: The State Legislature appropriates funding for the community mental health programs. These programs provide programming and services for the MI/BD, CD, and MR/DD disability groups. Most of the funding for CD is provided under Chapter 892 as a separate appropriation. Day activity centers for the retarded and developmentally disabled are also funded under a separate appropriation.

TABLE VIII-3

MINNESOTA STATE HOSPITALS EXPENDITURES AND PER CAPITA COSTS
FISCAL YEARS 1969-73

STATE HOSPITAL	FY 1969	FY 1970	FY1971	FY 1972	FY 1973
ANOKA					
Expenditures	$3,601,707.00	$4,080,125.00	$4,402,779.00	$3,940,130.00	$4,012,878.00
Per Capita Cost	6,398.00	8,607.00	10,005.00	8,932.00	9,508.00
BRAINERD					
Expenditures	$4,239,192.00	$4,981,080.00	$5,609,696.00	$6,079,735.00	$6,443,738.00
Per Capita Cost	3,518.00	4,726.00	5,685.00	6,587.00	7,501.00
CAMBRIDGE					
Expenditures	$5,693,334.00	$6,265,941.00	$6,589,314.00	$6,493,308.00	$6,541,490.00
Per Capita Cost	4,211.05	5,161.40	6,216.34	6,770.92	7,468.13
FARIBAULT					
Expenditures	$8,045,830.00	$8,884,635.00	$9,155,809.00	$9,553,577.00	$10,195,505.00
Per Capita Cost	4,033.25	5,069.85	5,730.50	6,190.40	7,066.40
FERGUS FALLS					
Expenditures	$3,933,437.00	$4,253,951.00	$4,401,468.00	$4,529,808.00	$4,566,547.00
Per Capita Cost	6,233.66	7,359.78	7,804.03	7,933.12	8,169.14
HASTINGS					
Expenditures	$2,804,749.00	$2,788,088.00	$2,829,426.00	$2,660,384.00	$2,669,650.00
Per Capita Cost	7,419.94	7,317.82	8,297.44	9,400.65	10,764.71
MOOSE LAKE					
Expenditures	$2,918,398.00	$3,216,005.00	$3,350,720.00	$3,262,244.00	$3,281,282.00
Per Capita Cost	4,435.26	5,212.33	6,298.35	7,314.45	7,812.58
ROCHESTER					
Expenditures	$3,919,519.00	$4,425,086.00	$4,715,517.00	$4,977,657.00	$5,396,658.00
Per Capita Cost	6,259.75	6,891.20	7,143.05	7,657.70	8,719.85
ST. PETER & MINNESOTA SECURITY HOSPITAL					
Expenditures	$5,271,179.00	$5,839,368.00	$6,073,903.00	$6,067,046.00	$6,212,178.00
Per Capita Cost	7,689.54	7,522.05	7,508.66	7,828.45	8,628.03
WILLMAR					
Expenditures	$2,993,952.00	$3,169,036.00	$3,290,282.00	$3,439,826.00	$3,888,374.00
Per Capita	4,448.00	5,153.00	5,682.00	6,311.00	7,406.00
TOTAL EXPENDITURES	$43,421,297.00	$47,903,315.00	$54,079,702.00	$51,003,715.00	$53,208,300.00
TOTAL PER CAPITA COST	54,646.48	63,020.43	70,370.37	74,925.69	83,043.84
AVERAGE PER CAPITA	5,464.65	6,302.04	7,037.04	7,492.60	8,304.40

Information obtained from Department of Public Welfare: 1973 State Institutions Informational Brochure.

It is anticipated that program budgeting will be implemented next year. At the present time, it is difficult to identify specific amounts of funds for each program area.

c. Cost of Care for Emotionally Disturbed Children: In 1971, the Legislature appropriated funds for cost of care for emotionally disturbed children and for mentally retarded children under 18 years of age. In 1973, the Legislature appropriated funds for cost of care for the emotionally disturbed children and the mentally retarded children. However, in the 1973 legislation, the state funding level for these two groups changed. The funding for emotionally disturbed children remained at a 50% level and the funding for mentally retarded children increased the state share to a 70% level.

This funding is paid to county welfare departments as a reimbursement for payment to the residential treatment centers for care of emotionally disturbed children. The parents pay 10% of cost or a maximum of $60 per month and the county and state funds pay the remainder of the cost on a 50-50 basis.

The appropriation for cost of care for emotionally disturbed children in the 1973-75 biennium is $1.2 million.

d. Research: The state appropriation for research in fiscal year '73-'74 is $200,000.00. These funds have primarily been used in the state hospitals, and do include costs for salaries and office expenses.

e. Minnesota Supplemental Aid: In addition to paying for community-based psychiatric, medical, and nursing care for individuals disabled by mental illness, the government will continue to provide financial support to help meet the costs of shelter, food, and clothing for such individuals. Income maintenance for the disabled (and for the indigent elderly, as well) will continue with the state administered system of welfare payments. In 1974, the Minnesota Legislature provided a supplemental appropriation. This program takes the place of the former federal-state programs of public assistance payments to people who are disabled or elderly. The supplemental funding permits that the state funds can be used in addition to the basic monthly cash SSI ($146 per month) payments from the federal government, so that the current income levels for the disabled and aged are maintained. Where clients are not eligible for disability or old age benefits, they may be eligible for general relief.

It is expected that the federal regulations relating to the use of SSI will be publicized in March, 1975 and subject to the regulations determinations will be made more specifically regarding this source of funding.

3. County Funding: Under the Minnesota Community Mental Health Centers Act, counties may levy up to two mills for support of community mental health centers. Local funds (including but not limited to county tax dollars) are usually matched on a 50-50 basis with state funds appropriated for community mental health programs.

County funds are used in cost of care for emotionally disturbed children as described above. County funds are also used to pay for temporary hospitalization as required under the Minnesota Hospitalization and Commitment Act.

County dollars also participate in the funding formula as identified above for Title XIX, AFDC, categorical assistance to aged, blind and disabled.

4. Private Insurance Coverage: Coverage for the costs of mental illness by health insurance companies is much broader and more extensive than it was 15 or 20 years ago and the situation seems to be improving. Most private health insurance organizations offer some coverage for mental disorders but generally to a lesser extent than general illness.[3]

If you take a look at the trend, however, we can be a bit optimistic. Back in 1951, not a single Blue Cross plan provided any benefit whatsoever for inhospital treatment of mental illness. So we have progressed from no mental health programs under any Blue Cross plan in 1951 to 100% participation, at least at some level in 1970. The majority of plans offer some coverage even in their most widely held contracts.

Legislation should be recommended to mandate coverage in all private insurance policies for services in a community mental health center or with a private practitioner; the inpatient care for mental illness in general hospitals should be the same basis as physical illness; the partial hospitalization/ residential care should be covered by insurance for intensive day or night treatment if available; the 24 hour residential care that is non-hospital based and is an approved program should also be provided health coverage.

5. Multiple Funding: Other public human service systems, in addition to the Department of Public Welfare, already assume some of the costs of support and services for mentally ill.

a. The Department of Education, particularly Special Education and Vocational Rehabilitation, provide support services for mental health. This utilizes both federal and state educational and vocational rehabilitation funds.

b. Department of Corrections provides funds for supportive mental health services to many of the MI/BD group who are within the correctional system.

c. Public health nursing agencies are important in the mental health supportive services system and provide direct service to many of the MI/BD population. It is generally accepted that approximately 50% of the public health nursing caseload have emotional difficulties.

6. Private Philanthropy, Fees and Foundations: Frequently, private donations are made. United Way, other foundation grants and/or philanthropic gifts are made to providers of service.

[3] Reed, Louis, Meyers, Evelyn, Scheidemendel, Patricia, Health Insurance and Psychiatric Care (Washington: American Psychiatric Association, 1972), p. 45.

B. Proposed Funding

There are some key questions that must be considered regarding funding:

1.) Will there be continued expansion of state funds above and beyond cost of living increases that can be expected during the coming years?
2.) Will federal funds be available for construction and operation of community services?
3.) To what extent will third party payments become a source of mental health revenues?

Basic to these questions, of course, is the problem of how much it will cost to operate a state-wide network of comprehensive community mental health services.

There will always be a portion of the population who are intermittently or chronically disabled by mental illness. Changes can be produced in the severity and duration of the disability. However, it would be naive to contend that the problem of mental illness will disappear.

State funds will continue to finance a major portion of the costs associated with services to the mentally ill, particularly long-term care. Third party payments are increasingly paying for the acute inpatient and outpatient care, and federal funds are assuming part of the living costs for the aged and the totally disabled. Again, however, state funds will be required to meet the many program costs for which alternative funds are not available.

The Department of Public Welfare must remain concerned and involved with insuring the comprehensive clinical and support services are available to the mentally ill. The department may or may not directly administer all relevant services in the future. The Legislature must establish a policy on deinstitutionalization which will indicate and give direction for future efforts and resources of the state to be directed toward the development and implementation of a community-based comprehensive program for mental health. The state appropriations for community mental health centers and state hospitals are identified in Table VIII-4. The trend of the funding community mental health centers and state hospitals reflects a gradual increase in both, which could be considered maintenance and cost of living increase.

Resources are needed for long term care regardless whether the provider is the state hospital or some community based facility. The residential and treatment needs of the MI/BD population are distributed and range from 24-hour supervision and care to facilities that feature an increase in patient-self-help and less responsibility for the individual by the facility. Partial support/treatment programs do not provide round-the-clock care. Therefore, they are less expensive.

Starting of funding should not be contingent upon the completion of the area plan but rather should be started at once and should be accompanied by continuous planning. There is a need for expanded funding during the transitional phase of gearing up the local resources.

TABLE VIII - 4

APPROPRIATIONS FOR STATE INSTITUTIONS AND
COMMUNITY MENTAL HEALTH CENTERS

Fiscal Year	General Budget for 10 State Institutions	State Appropriations for 25 Community Mental Health Centers
1969-70	$43,421,297.00	$3,000,000.00
1970-71	$47,903,315.00	$3,500,000.00
1971-72	$54,079,702.00	$4,000,000.00*
1972-73	$51,003,715.00	$4,500,000.00*
1973-74	$53,208,300.00	$5,200,000.00
1974-75		$5,500,000.00*

*Separate appropriations made for community-based chemical dependency programs not included in figures.

State Institution figures obtained from Department of Public Welfare: 1973 State Informational Brochure.

The apparent skewed system of funding, which costs the county approximately $10 per month for a patient in the state hospital should be equalized so the billing is the same regardless if the patient is placed in the community or state hospital. The current practice grossly discriminates against utilization of community resources, while the actual cost of care and treatment might be quite comparable.

Evaluation of the cost of the services must be made. Currently, funding is not provided and it is difficult to project what it will cost to fund community programs.

C. Closing of Institutions

Consideration has been given to the closing of state hospitals and questions have been raised regarding what it would cost to provide care and treatment for the individuals who are currently in the state hospitals.

The Research and Evaluation Office of the Department of Public Welfare identified that 62% of the current MI population in the state hospitals were placeable. Of this placeable group (1216 individuals), 37% could be placed in halfway houses, 37% could be placed in board and care homes, 21% in nursing homes and 5% could return to their own home.

The Research and Evaluation Office in conjunction with staff in state hospitals, identified that the MI population (consisting of 1961 individuals who were physically present on the hospital unit, on extended visits and short visits) 62% or 1216 individuals were placeable. The cost projections are reflected in the Comprehensive Plan.

D. Funding of Community based Comprehensive Mental Health Program

The cost projections identified in the Comprehensive Plan identifies the estimated projections for cost to provide care and treatment or population that is currently hospitalized in state hospitals.

A per capita projection would also be difficult to make with the lack of information regarding the population. Reportedly in 1958, a per capita base was set at approximately fifty cents per capita, per county and with the state matching this amounted to approximately one dollar per capita. That amount was established to provide a very limited program and was in an era prior to our current inflationary level.

Cost estimates for the development and maintenance of the community based system are difficult to present. The MI/BD population is poorly defined due to absence of data and reporting. The current funding pattern is limited and diverse. The single unified mental health system will provide a means by which the various factors could be brought together.

The emphasis and direction of area community mental health planning and clear designation of responsibility and accountability should produce more firm data in the next year. The implementation of the licensing Rule #36 will assist in locating the various resources and the needs of these resources to provide appropriate and quality care and treatment.

Additional funding will be needed to assist in meeting the funding gap that will be occurring as a result of the termination of federal grants. Table VIII-1 reflects this information. Some of the programs have been rather successful in obtaining third party payment, particularly for the inpatient component of service. The third party payment does not offset the total amount nor does it provide coverage for some of the direct services and for the indirect services. Efforts are being made to expand our community based mental health system and attention should be given so that the progress that has been made is not lost.

CHAPTER IX

RIGHTS

A. Definition

"Rights" are defined as "just claims". They are of value to the extent to which you can present and enforce your claim. There is no limit to rights or just claims - new ones keep appearing such as the recent ones relating to housing, jobs, sexual orientation, abortion, etc. These rights are all derived from the constitution and represent an interpretation of that document in relation to a rather specific action.

B. Rights of MI/BD Persons

The mentally ill have traditionally lacked rights because they have lacked the means to have their claims heard, and when they were heard interpretations of the constitution as applied to the mentally ill often differed markedly from how the constitution was interpreted to apply to other citizens. The mentally ill were often assumed to be incapable of making decisions or judgments in their own best interests, so someone else had to make these decisions for the patient's own good.

Recently, many of these assumptions have been questioned. Many groups have crusaded for more rights for the mentally ill, but we need to take a complete fresh look at the area of rights of the mentally ill. We have usually started from the fact that the mentally ill in institutions have been deprived of many of their rights in practice, and equally important, have been powerless to challenge or appeal these actions by institution staff members and others. We have then proceeded to fight to get certain rights restored, and have prepared lists of these restored rights: the right to send and receive mail; have visitors; make and receive phone calls, etc. We have also provided machinery (review boards and advocates) to ensure these rights are not denied and to assist the patient to challenge adverse decisions and actions.

This would be analogous to listing all the rights of the people in the Constitution and assuming they do not have any rights not listed. The Constitution takes quite the opposite approach. Amendment IX states: "The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people." Amendment X further states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states, or to the people."

The mentally ill, especially those in our institutions, need to be assured that they have all the rights and powers of any other citizen, except where by due process of law, they have been deprived of particular rights. Furthermore, in such instances, they have equal protection of the law to appeal any decision abridging their rights. We should then list those rights which are denied by law as a result of commitment as mentally ill, for instance. In an ambiguous situation, the individual would get the benefit of the doubt since

it would be assumed that he has the right until he has been legally deprived of it. Furthermore, the person must be informed of his right to challenge or appeal the deprivation of a right in his/her specific case.

The first step is one of informing people about their rights. There is a tendency for people in new or strange situations to allow the people in charge to do with them pretty much as they wish without serious question. Persons often don't realize that they don't have to go along with all the rules which the people in charge frequently establish for their own convenience.

Obviously, the people in charge usually prefer that people don't question their rules so the tendency is to avoid telling them that they have this right.

Written materials have been prepared to help to inform patients, but these are given to them at a time when they may be very upset or preoccupied. See Appendix F. Probably the best way is to have an advocate sit down with the person and discuss these matters in a manner which matches the individuals level of comprehension, and encourage the person to ask questions, and to contact the advocate at any time. Here again it can be seen that the mechanism is as important as the right itself. A right without readily available and effective means to ensure it is empty. Actions of agencies, hospitals, judges, psychiatrists, etc., must be challenged when they deprive a mentally ill person of any right which others can exercise.

One function of research procedure is the protection of clients. There are specific standards for protecting rights of patients, confidentiality of records, individual privacy and informed consents for participation in a study. See Appendix G for Draft Research Policies and Procedures.

The DPW has established several mechanisms to assist the mentally ill challenge such actions: the Consumer Concerns Division, hospital review boards and hospital advocates.

C. Existing Provisions for Protection of Patients' Rights

1. Consumer Concerns Division:

The Commissioner of Public Welfare has established a Consumer Concerns Division within the Comprehensive Program Bureau. The division is independent of the service arm of the system. The purpose of the Consumer Concerns Division is to assist the client to achieve equality with the service arm's staff, justice in seeking redress of their grievances and participation in policy development.

Human service systems typically are organized to meet clientele needs as these needs are defined by the professional staff of the system. Physician's see primarily medical needs; social workers see human and environmental relationship needs; employment counselors see vocational needs; teachers see educational needs, etc. The team concept is designed to ensure a comprehensive assessment of the clients' needs, but no team covers all areas (for instance, few have attorneys or clergymen on them), and rare is the team that accepts the client's view and priorities of his own needs, and recognizes the client's right in final decisions concerning his needs and what will be

done about meeting them. Therefore, it is essential to emphasize the client's need and right to be heard, to be paid attention to, and allowed and encouraged to make his own decisions even when professionals disagree with a particular decision. The client's needs and rights to be heard and listened to before organization decisions are made must also be emphasized. This does not mean that clients should run the system. It does mean that client's views should be sought, respected, and given equal weight to those of others. When differences in views occur, negotiation, persuasion, and compromise where appropriate should prevail. The client also needs the assistance of special staff in the negotiating, persuading and compromise processes.

Objectives of the Consumer Concerns Division are to respond immediately to the client's contact with the Consumer Concerns Division; (usually the client has been referred to several persons before being referred to them); assist the client in getting a fair hearing and a just resolution to their problem; assist the department to utilize the information about the system from the consumer contacts, in prevention of abuses, problems, unmet needs and complaints, by proposing changes in policies, procedures, services and programs which give more recognition to consumer concerns, values, rights and points of view.

2. Hospital Review Boards:

The Hospital Review Board is required under the Minnesota Hospitalization and Commitment Act, 253A.16. See Appendix B.

The Commissioner appoints three or more persons to review the admission and retention of patients in state mental hospitals. One of these persons must be qualified in the diagnosis of mental illness, one person must be learned in the law, and the third person is a lay person.

The principle role of the Review Board is to assure protection of the patient's legal rights. The Board reviews the admission and retention of patients at each state hospital. If, in the opinion of the Board, there are significant legal irregularities, these facts are communicated promptly to the Commissioner. Policy Bulletin #26 defines the role of the Review Board. See Appendix H.

3. Hospital Advocates:

Each state hospital has an advocate for patients. This position ranges from part time to full time in the different hospitals. The advocate is administratively responsible to the Chief Executive Officer of the state hospital. The primary purpose of the advocate position is to be a resource to patients and inform them of their rights and to be alert in observing situations in which the patients' rights are being violated, particularly those rights of patients as identified in the Minnesota Hospitalization and Commitment Act. See Appendix B, note particularly 253A.05 and 253A.17. Patients' rights are disbursed throughout the Commitment Act.

4. Humane Practices Committee:

The Humane Practices Committee was started by Dr. David Vail in April, 1965 and has continued over the years. Each state hospital has a Humane Practices Committee and there is a state level Humane Practices Committee. The state Humane Practices Committee has broad representation. The committee started in state hospitals and focused on concerns of state hospitals.

The Humane Practices Committee focuses on a review of practices of the service provider and makes suggestions for policy changes and procedural changes to provide better human practices to the consumers of the services. The Mentally Ill, Mentally Retarded and Chemical Dependency population have primarily received their attention.

The activities of this Committee has had influence on legislation in regard to proposing legislative changes, particularly in the Commitment Act, and has had impact on the level of appropriations for state hospitals. They have reviewed and made known the conditions and needs of state hospitals.

The long range plan has given serious consideration to becoming involved with other populations served by the "DPW system" in addition to the MI/MR-CD. The short range plan is to extend the involvement of the county welfare departments and community mental health centers with particular attention to the MI/MR-CD populations.

D. Facilities Must Safeguard Patients' Rights

Each facility and or agency must have written policies and procedures designed to enhance the dignity of all patients and to protect their rights as human beings.

This includes but is not limited to the development of procedures to inform all patients/clients of their legal and human rights. There should be documentation that these procedures are implemented.

To list all rights of humans would be exhaustive. However, as the MI/BD population has been deprived of their rights over the years the following are presented as minimal requirements.

1. Image of Facility's Reflection on Patient:

To enhance the well-being and protect the self-esteem and dignity of patients and families, steps must be taken to disseminate appropriate information within the community and to meet and maintain adequate liaison with community groups or individuals. This is to be done to prevent or resolve any situations that might put patients at the risk of misunderstanding, embarrassment or discrimination.

2. Communication:

There must be procedures to protect the patients' rights and privacy with respect to facility visitors. There must be provision for communicating with persons outside of the program. That is, minimally the patients must be allowed to have phone conversations with family and friends and to send and receive mail.

3. Participate in Treatment Plan:

Patients and families must be allowed to participate in plans for treatment. The formulations based upon assessment, and the goals and expectations of the treatment plan must be explained in terms that the patient and family can understand.

Every effort shall be made to safeguard the legal and civil rights, and to make certain that patients are kept informed of their rights, including the right to legal counsel and all other requirements of due process.

4. Clinical Record:

A facility or agency is responsible for safeguarding the information in the patients record. This includes protection against loss, defacement, tampering or use by unauthorized persons. The facility or agency is responsible to protect the confidentiality of clinical information and communications among staff members and patients. Except as required by law, the written consent of the patient, family or other legally responsible parties is required for the release of clinical record information. Records may be removed from the facility's jurisdiction and safekeeping only as required by policy of facility or as required by law.

5. Restraints and Seclusion:

Historically physical and chemical restraints and seclusion have been used in providing services to the mentally ill. These modes of restraining should be used only in extreme cases to protect the patient from injuring himself or others, and when all other alternatives have been exhausted. This should also be documented. A written order and justification should be in the patient clinical record.

Risks associated with the use of any drugs and or procedures must be fully explained to patients in terms that he can understand. In event the patient is unable to exercise sound judgement, the risk of the potentially hazardous drugs and procedures must be explained to family members having the legal right to consent. The decision as to whether or not the patient is able to exercise sound judgement rests with the clinical staff and must be documented. Potentially hazardous drugs and procedures shall be administered in accordance with current accepted professional practice.

6. Responding to Patients:

There should be written policies and procedures for reviewing and responding to patients communications, e.g. opinions, recommendations, and grievances, in a way that will preserve and foster the therapeutic aspects of conflict resolution and problem solving. The written policies should also delineate the means by which patients are familiarized with these procedures.

CHAPTER X

RECOMMENDATIONS

This Chapter presents the recommendations for the comprehensive mental health program plan. Each recommendation is made more specific in the designated action steps relating to the state and area levels. The recommendations are based upon the goal of developing a single unified comprehensive mental health system in the state, that provides a continuum of quality treatment and services, that is accessible and available to the residents of the state.

Area Boards/Community Mental Health Programs must be required to provide the continuum of comprehensive mental health services. This full range of services in the continuum must be available and accessible to the residents of the area. It follows that there must be sufficient funding to achieve this.

There must be an identified responsible fundamental unit, the area community mental health program which is assigned the responsibility for the planning and implementation of mental health services for the residents of the specific geographic area. The area size must be sufficiently large to provide the economic and population base that permits a mental health continuum to be implemented and maintained. The area size should not be so large as to interfere with planning and integration of a single unified system. Federal studies have resulted in recommendations of catchment area size to accommodate 75,000 to 200,000 population. The experience in Minnesota has not contraindicated these recommendations for size. Funding and staffing resources must be adequate in number and excellence to enable the provision of quality programming.

The state hospital programs must be converted into specialized mental health facilities that support the community based mental health programs. Social services provided to the MI/BD population by the County Social Service Departments must also be coordinated with the comprehensive mental health program. The recommendations are as follows:

1. There must be a single, unified designated organization responsible for mental health program planning, implementation, monitoring, evaluating, funding and administration. Designated responsibility and authority is necessary so that there can be accountability.

a. The provision for and administration of all mental health services and programs within and/or under the authority of the Commissioner should be unified.

Recommended Action: Assessment of intra-departmental organization

Target Date: Soon as possible

b. The state must develop policies that will help to implement the legislative mandates. These policies must relate to the purpose of the programs and be monitored consistently and amended as necessary.

Recommended Action: Mental Health Advisory Committee be established for ongoing review of mental health plan, policies and procedures.

Target Date: Tentatively July, 1975

c. There must be legally designated geographic areas, service delivery/catchment areas, consistent with the governor's economic regions or multiples thereof, that are the fundamental units within which comprehensive mental services shall be planned and provided. The area community mental health program should be a statutorily designated organization for mental health planning and service provisions.

Recommended Action: Legislation should be updated to more clearly state the responsibilities relating to catchment area concept. Include in revision of Minnesota Community Mental Health Services Act as indicated in Recommendation #2.

Target Date: Tentatively July, 1977

d. Areas must have a required base population that is of sufficient size and economic base so that comprehensive mental health program can be economically and feasibly carried out.

Recommended Action: Include in revision of Minnesota Community Mental Health Service Act as indicated in Recommendation #2.

Target Date: Tentatively July, 1977

e. The area level mental health program which is comprised of the array of service elements identified in the continuum (Chapter V), must be integrated. Integrated means a coordinated comprehensive mental health service delivery system, which provides ready access for the residents of the area. Integration can be achieved by colaborative efforts.

Recommended Action: Implementation at local area level

Target Date: Ongoing

f. A report should be made by the Department of Public Welfare to the Governor and Legislature at least biannually, regarding the comprehensive mental health program.

Recommended Action: The Department should make a separate report to the Governor and Legislature.

Target Date: Next legislative session, 1975-76

2. The establishment of a state comprehensive mental health program must be based on statute. The legislation must be mandatory rather than permissive and should provide a tax base levy allocated specifically and directly for this purpose.

a. State funding participation should be geared to equalizing the maintenance of quality programs throughout the state.

b. Funding must be increased to expedite the provision of a quality continuum of services in each area.

c. The local tax funds and other sources of revenue must participate in the provision of the continuum of services.

Recommended Action: Updating of Community Mental Health Services Act should include a., b., c. above.

Target Date: Tentatively July, 1977

d. The state must establish policies and regulations regarding fees for service that will make services fiscally accessible to all individuals and that no one will be denied services because of lack of income or amount of income. Fee schedules must be approved by the Commissioner of Welfare.

e. A fee policy must be developed that relates to all reimbursement mechanisms and must be consistently applied.

Recommended Action: For d. and e. above - Revision of existing fee policy

Target Date: Tentatively December, 1975

3. There must be a plan for service both at the state and area level. The Comprehensive Plan is developed, implemented, maintained, and evaluated by an ongoing process which includes assessing, evaluation, planning, implementation. This process is repeated in the course of adapting to assure desired refinements. The Plan must include the continuum of care as described in Chapter V and must be designed to meet the needs of the MI/BD population.

a. The mental health program division shall maintain, and evaluate the state comprehensive mental health plan. The plan must include provision for the continuum of mental health services.

b. The area community mental health program shall develop, maintain and evaluate the comprehensive mental health plan for the area. The plan must include provision for the continuum of mental health services.

c. The area comprehensive mental health plan shall be complementary to and an extension of the state comprehensive mental health plan. Encouragement will be given to innovation and local decision making based upon a foundation of high standards and excellence of personnel and a program which has breadth and scope of specialized services and programs.

d. State hospital programs must be converted into specialized mental health facilities that support the community based mental health programs. These programs must not be competitive with the development of community-based programs. Admissions to state hospitals should be processed through the area CMH Program in conjunction with county welfare departments.

e. County social services provided to the MI/BD population must be coordinated as a support system for the community comprehensive mental health system.

Recommended Action: Departmental policies to require coordination of a., b., c., d., and e. above.

Target Date: Tentatively July, 1976

f. The lines of authority and the scope and limitations of responsibilities of each facility, board, committee and/or official involved in the delivery system for mental health must be clearly spelled out.

Recommended Action: Should be included in legislative revision of Minnesota Community Mental Health Services Act.

Target Date: Tentatively, 1977

g. State guidelines for the area comprehensive mental health plan must be developed with assurance of participation and input from the area community mental health program, consumers and other appropriate sources.

Recommended Action: Include in development of Standards for Community Mental Health Programs

Target Date: Tentatively, 1976

4. The mental health system must be integrated with other service providers and state department. Linkages must be delineated with Departments of Health, Education and Corrections, the judicial system and welfare service providers. These linkages must be related to the specialized service needs of the MI/BD population.

a. State Department of Welfare should develop agreements with the Department of Education, particularly Special Education and Vocational Rehabilitation; Department of Corrections; Department of Health regarding their respective roles in providing their services to the MI/BD population so the services provided by each department can be integrated and complementary in meeting the service needs of the MI/BD population.

Recommended Action: Develop an agreement with Department of Education (Special Education and Vocational Rehabilitation)

Target Date: Tentatively July, 1976

b. State departments should periodically review their roles. Presumably, these roles change from time to time and various services should be added, dropped or merged. This should be included in the report to the Governor and Legislature.

Recommended Action: Develop agreement with Health Department

Target Date: Tentatively July, 1976

c. The area community mental health program should develop agreements with local school districts and cooperatives, vocational rehabilitation agencies, community corrections services, community health services, local county social service departments, courts, and probation offices, etc., regarding their specialized services to the MI/BD population so that services can be coordinated and complementary to the specialized mental health services.

Recommended Action: Develop agreements

Target Date: Tentatively July, 1976

d. Area community mental health programs and the various local agencies should periodically review their roles. The description and/or agreements should be included in the annual plan submitted to the state and subsequently transmitted in the legislative report.

Recommended Action: Ongoing with report to DPW

Target Date: Tentatively, 1976

5. The phase out or closure of state hospitals must relate to the community preparedness and the provision of alternative local services rather than be based on hospital closure per se.

a. All admissions to state hospitals shouls be screened by the community mental health program so there is clear understanding of the nature of the problems for which the individual is being admitted, determination of alternative resources and to facilitate the understanding of types of resources that need to be developed. This supplements county welfare departments taking of social history, assessment of financial needs and screening activities.

Recommended Action: Legislation desireable but not necessary. Clarify existing legislation.

Target Date: Tentatively, 1976

b. Hospital closure should lead to placement of patients in community facilities, in so far as possible, rather than their transfer to other state hospitals.

Recommended Action: Funding community and developing community resources draft legislation

Target Date: Tentatively, 1977

c. Review and standard setting procedures should be established which assure that each area provides clients with alternative community services that are equal to, or superior to, services in institutions and are based on individual client needs.

Recommended Action: Development of standards and rules and appropriation to support alternative services

Target Date: Tentatively July, 1977

d. Redistribution of previously allocated institutional resources, as a consequence of hospital closure must be equitable and based on a statewide assessment of relative need, rather than related to geographic or political considerations alone.

Recommended Action: Draft legislation for development of resources, role change or plase out of institutions

Target Date: Tentatively July, 1977

e. Maximum possible employment continuity and opportunities for transfer of current institutional personnel must be an integral part of deinstitutionalization.

Recommended Action: Draft legislation relating to employment of State Hospital personnel

Target Date: Tentatively, 1977

f. Area eligibility for reallocated institutional resources should be contingent upon the area demonstrating its clinical and administrative capacity to provide alternatives to state hospitalizations.

Recommended Action: Development of policy and regulation

Target Date: Tentatively, 1977

6. Mental health services should endeavor to maximize all federal funding mechanisms.

a. Maintain cooperative relationship with the federal mental health agencies, meet the intent and goal of the national programs, as well as meet the regulations and requirements.

Recommended Action: Department policies incorporate above direction

Target Date: Ongoing

b. Maximize the available grants in the areas and the state hospitals to facilitate and improve treatment of patients in the trasitional phase and to insure improved treatment is continued as an ongoing process.

Recommended Action: Utilize grants to extent available

Target Date: Ongoing

c. The state should develop linkages with Veterans Administration mental health resources. Agreements should be developed at state and area levels to encourage joint projects and research.

Recommended Action: Establish relationship and develop agreements

Target Date: Ongoing

d. State and area levels should develop agreements for service delivery with CHAMPUS. Areas should participate in projects and research efforts with CHAMPUS.

Recommended Action: Establish relationship and develop agreements

Target Date: Ongoing

e. State mental health program division should develop relationships with other Federal departments as appropriate.

Recommended Action: Establish and maintain relationships

Target Date: Ongoing

f. Mental Health Services should be included as eligible services under Medicare, Medicaid to the degree possible. Area community mental health services should utilize these funding resources to the degree possible.

Recommended Action: Include MH services in Title XIX plan

Target Date: Current

g. Reimbursement for services through state and federal funding mechanisms should be centralized to ensure cost effectiveness and equalization of criteria.

Recommended Action: Centralization of payments

Target Date: Tentatively July, 1975

h. Through the utilization of existing federal resources, particularly those which are forms of insurance (Medicare, Medicaid, V.A. and CHAMPUS), the state has an opportunity to help shape the forthcoming National Health Insurance.

Recommended Action: Utilization or resources, appropriate input into Federal agencies

Target Date: Current

7. The continuum of services must be developed in each area for the MI/BD and the special target groups of children and youth, aging, and the MI/BD offender.

a. The area program director's office is responsible for the development of the area plan to provide the continuum mental health services.

Recommended Action: Development of area plan and state plan with legislative appropriation to implement needed services

Target Date: Tentatively, 1976

b. Determination of need for services is basic to the planning for services and must be based upon relevant information regarding the population of the area.

Recommended Action: Assessment of service needs

Target Date: Tentatively July, 1976

c. Each element of the continuum of services must be available to the residents of the area. Free movement from one element to another must be guaranteed.

Recommended Action: State appropriation and local funding to provide for development of continuum.

Target Date: Would take approximately three years to get services in place.

d. Services provided by State Hospitals should be supportive to the community-based mental health program.

Recommended Action: Legislation desirable to establish intent

Target Date: July 1, 1976

e. The state Department of Welfare must assist the area community mental health program in linking existing resources.

Recommended Action: Development of policies and regulations

Target Date: Tentatively, 1976

f. The state may need to see to the development of highly specialized programs which are more feasible for multi-area population groups. If such services are necessary, the state must assure adequate subsidy.

Recommended Action: Draft legislation for specialized programs

Target Date: Tentatively, 1977

3. Mental health staff must be adequate in number and have the education, training and qualifications necessary to have the capacity to fulfill the responsibilities assigned.

a. State mental health staff should be multi-disciplinary with expertise in mental health. The state staff must be sufficient in numbers and have the necessary mental health training and expertise to provide the program direction, establish policies, provide technical assistance and consultation, to establish guidelines and standards for mental health services and programs.

Recommended Action: Legislative appropriation

Target Date: Tentatively, 1976

b. The state should provide needed educational resources to the area in regard to clinical care, administration, fiscal management, and for interpretation and implementation of various policies and directives.

Recommended Action: Legislative appropriation needed

Target Date: Tentatively, 1976

c. There must be direct communication from the state mental health program division to the area community mental health program.

Recommended Action: Establish linkage

Target Date: Ongoing

d. The area mental health director must have expertise in mental health and administration. He should be a mental health professional.

Recommended Action: Maintain policy of DPW Rule 28

Target Date: Ongoing

e. Area community mental health staff must have expertise in mental health and must be comprised in multi-disciplines and assure the provision of multi-treatment modalities.

Recommended Action: Maintain policy of DPW Rule 28 and include in standards

Target Date: Ongoing

f. The area community mental health director must be responsible and accountable for planning, developing, and the provisions for professional treatment and care. There must be flexibility that will permit realignment of resources in response to changing programmatic requirements.

Recommended Action: Include in above recommended legislative revision of Minnesota Community Mental Health Service Act

Target Date: Tentatively July 1, 1977

g. Each area must have a written in-service education plan that reflects the service needs of the area.

Recommended Action: Include in state regulation or standards. In-service Education Plan to be developed by local Community Mental Health Program.

Target Date: Tentatively July, 1976

9. Standards must be developed for various elements of the continuum of mental health services and for the area community mental health program.

a. Standards must be developed for the area community mental health programs. Representatives of community mental health programs must be included in the development of standards.

Recommended Action: Develop standards

Target Date: Tentatively January 1, 1976

b. Standards must be compatible with federal regulations and requirements and other recognized established standards, such as JCAH standards.

Recommended Action: Develop standards

Target Date: Tentatively January 1, 1976

c. Standards including licensing rules, must require individual active treatment plans for patients and require documentation of implementation of the treatment plan.

Recommended Action: Active treatment plans be required in standards

Target Date: Current

d. The development and revision of licensing rules for mental health services must have active participation of the mental health program division, and provide for participation of representatives of Community Mental Health Programs, service providers, consumers and other appropriate resources.

Recommended Action: Develop licensing rule and revision of existing rules

Target Date: Current

e. Assessment of need for mental health services for which licensing is sought must be at the area level. The area community mental health program should make recommendations to the Commissioner of Welfare. This local assessment must have major input from other local agencies, organizations and consumers.

Recommended Action: Need determination

Target Date: With implementation of MH Licensing - 1975

f. The mental health program division must participate in the review of license applications, both new and renewal, for all mental health services.

Recommended Action: Mental Health Program Division involved in review of license application

Target Date: Tentatively, 1975

10. An accountability system must be established that is capable of measuring not only if an activity is performed, but also to assist in making qualitative and quantitative judgments as to the effectiveness, adequacy, and efficiency of performance. Cost benefits and cost effectiveness procedures must be developed for all components of the mental health system.

a. A system of data collection must be established that will provide information regarding the number and characteristics of the MI/BD population that are being served. This must include type of service provided, service provider and effects of the service.

Recommended Action: Establish data collection system

Target Date: Tentatively January 1, 1976

b. Data must be collected that will provide information regarding the individuals who are in need of service and not obtaining services.

Recommended Action: Establish data collection system

Target Date: Tentatively January 1, 1976

c. Demographic data must be utilized to compare the population served with the population of the area.

Recommended Action: Establish data collection system

Target Date: Tentatively January 1, 1976

d. Data collected must contain information that is relevant for mental health planning.

Recommended Action: Establish data collection system

Target Date: Tentatively January 1, 1976

e. The state should have agreements with the Departments of Health, Education and Corrections regarding the services they provide to the MI/BD population.

Recommended Action: Written agreements

Target Date: Tentatively July 1, 1976

f. Data must be provided by County Social Service Agencies regarding the MI/BD population they provide social services and those individuals who have high risk potential for MI/BD disabilities.

Recommended Action: Data collection

Target Date: Tentatively July 1, 1976

g. Data must be provided by state hospitals regarding the MI/BD population which they serve.

Recommended Action: Data collection

Target Date: Tentatively January 1, 1976

h. Area community mental health programs must collaborate with the local service providers who serve the MI/BD population to obtain relevant data about the MI/BD population that may be served elsewhere.

Recommended Action: Provide data and information

Target Date: Tentatively January 1, 1976

i. Mechanisms must be developed for measuring the performance of each element of the mental health service system including the state level. These mechanisms should provide information needed at every level to permit an objective review to determine whether or not responsibilities are being carried out.

Recommended Action: Provide data and information

Target Date: Tentatively January 1, 1977

j. Each component of service system must be able to ensure that those responsible to them are effectively carrying out their duties.

Recommended Action: Provide data and information

Target Date: Tentatively January 1, 1977

k. The state and area community M.H. program should be able to identify activities performed in each area and assist in making qualitative and quantitative judgments as to effectiveness, adequacy, efficiency of performance.

Recommended Action: Provide date and information

Target Date: Tentatively January 1, 1976

l. Cost benefits and cost effectiveness procedures must be developed for all components of the mental health system.

Recommended Action: Collection and assessment

Target Date: Tentatively January 1, 1977

m. Utilization review mechanisms should be developed by each service provider.

Recommended Action: Develop utilization review mechanism

Target Date: Tentatively July 1, 1978

n. There should be rapid feedback of data from state to area community M.H. programs.

Recommended Action: Data collection and feedback

Target Date: Tentatively July 1, 1977

11. Research efforts should be expanded.

a. Efforts to involve community mental health programs should continue and should be supported.

Recommended Action: Legislative appropriation to support research and evaluation efforts. Continue efforts of Research and Evaluation Office in their involvement with community mental health programs, as well as state hospitals.

Target Date: State appropriation next biennium. Ongoing involvement with programs.

12. Consultation and education services must focus to have impact on the mental health problems of the catchment area.

a. Area community mental health programs must provide consultative and educational services (including preventive programs) for at least: health personnel (professional and allied); law enforcement and correctional agencies (state and local); public welfare and social service agencies; health service delivery agencies (including health maintenance organizations and private deliverers of health services); educational institutions (public and private nurseries, elementary and secondary schools, institutions of higher education, head start programs and schools within residential facilities); clergy and residential rehabilitation service providers.

Recommended Action: Include above provisions in policies and regulations. Legislative appropriation to support expanded consultation and education services.

Target Date: Current and 1977 legislative CMH center appropriations.

b. Consultation and educational services provided to other agencies should be charged to the administrative costs of the respective agency.

Recommended Action: Include in policies and regulations

Target Date: Tentatively July, 1976

c. Consultation should be interchanged between DPW and the community program and between DPW and other departments as appropriate.

Recommended Action: Interchange of consultation in the area of expertise

Target Date: Ongoing

d. There must be continuing education and training for mental health specialists and other professionals in the community.

Recommended Action: Continue in-service education

Target Date: Current

e. Mental health education must be provided to volunteers who participate in a variety of community service programs including Board members and advisory group members for mental health programs.

Recommended Action: Include in standards and regulations

Target Date: Ongoing

f. Mental health education must be mandatory for lay members of the governing board of the area community mental health program.

Recommended Action: Include in Regulations and Standards

Target Date: Ongoing

g. Consultation and education must be coordinated and goal-oriented with an identifiable administrative structure. C & E goals must be consonant with and facilitative of the overall objectives of the comprehensive mental health program and must be consistent with the treatment goals of the program and relevant to the mental health problems of the area.

Recommended Action: Include in Standards and Regulations

Target Date: Ongoing

13. The existing mechanisms, to ensure and protect rights of patients, within the Department (Consumer Concerns Division, Review Boards, Hospital Advocates and Humane Practices Committee) should be strengthened. These mechanisms must be provided the opportunity for freedom of action so advocacy functions and services are not impaired.

a. This should be incorporated in all mental health legislation.

Recommended Action: Legislation as required

Target Date: Ongoing

14. Each mental health service provider must have written policies and procedures to protect patients' rights.

a. These policies and procedures are to be incorporated in the review for licensing.

b. Such policies and procedures should constitute a requirement for any mental health program application.

c. Guidelines and standards should be established for such policies and procedures.

Recommended Action: For a., b., c. above - Development of rules, regulations and standards. Licensing assessment must include review for policies and procedures to protect patients' rights.

Target Date: Ongoing

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APPENDIX A

STATUTORY BASE FOR COMMISSIONER'S AUTHORITIES AND RESPONSIBILITIES

The Minnesota statutory base for the Commissioner's authorities and responsibilities relating to mental health are provided in this brief overview and statute citation.

1. 620 Grants from the United States:

This statute provides that all funds received by various types of categorical assistance must be used solely for the purpose that the federal grant was made. This law indicates what benefits of the Federal Social Security Act are to be utilized.

2. 245.75 Federal Grants for Indians:

This Act authorizes the Commissioner to enter into contractual agreements with the Federal Departments of Health, Education and Welfare, the Department of Interior and Bureau of Indian Affairs for the purpose of receiving federal funds for the welfare and relief of the Minnesota Indians.

3. 245.04 Transfer of Powers and Duties:

Powers and duties prior to 1953 assigned to the Director and the Division of Social Welfare and the Director and the Division of Public Institutions were transferred to the Commissioner of Public Welfare. The Commissioner of Public Welfare is designated the "State Agency" as defined by the Social Security Act of the United States.

4. 246.01 Powers and Duties

This Act provides that the Commissioner may be guardian of both the person and the estate of the retarded or epileptic persons. The Commissioner shall have exclusive power for administration and management of the state's schools and hospitals for the mentally retarded, epileptic, mentally ill, deaf, inebriate and the deaf and blind. This Act also authorizes the Commissioner to accept, in behalf of the state, gifts, donations and personal property for the use and benefit of inmates of the public institutions under his control. This statute designates the Commissioner as a "State Agency" as defined by the Social Security Act of the United States and the laws of Minnesota for all purposes relating to mental health and mental hygiene.

5. 246.017 Medical Policy Directional Committee on Mental Health:

The Commissioner is directed to devise, install and operate an adequate system of records and statistics. Patient records and medical record forms and the manner of their use must be uniform throughout all hospitals for the mentally ill. The Commissioner is also directed to establish a Medical Policy Directional Committee. This committee is to advise the Commissioner regarding all phases

of professional standards including patient care, training of personnel, management practices, establishment of treatment programs, obtaining adequate staff, establishment of medical and statistical records and operation of practices so that they may be compatible with professional requirements. This committee shall also advise the Commissioner in the approval and guidance of research projects and distribution of research funds. A Medical Director shall be appointed to assist the Commissioner in establishing and maintaining the best possible practices in all mental institutions.

6. 246.06 Reports to the Governor and Legislature:

The Commissioner is required to report to the Governor and Legislature on November 15 of even number years regarding the preceding biennium. The Commissioner shall make other reports to the Governor, as required or as the Commissioner may deem necessary, relating to the conditions and needs of the institutions.

7. 246.234 Reciprocal Exchange of Mentally Ill Persons:

The Commissioner is authorized to enter into reciprocal agreements with other states through duly authorized authorities regarding mutual exchange, return and transportation of mentally ill and mentally retarded individuals who are within the confines of the state, but have legal residence or settlement in another state.

8. 256.01 Commissioner of Public Welfare: Powers, Duties:

The powers previously invested in the State Board of Control are transferred to the Commissioner of Welfare. The Commissioner is designated as the "State Agency" as defined by the Federal Social Security Act and the laws of this state. This statute provides for the administration and supervision of all forms of public assistance, administration and supervision of all child welfare activities, to act as the agent of and cooperate with the federal government in matters relating to the Social Security Act, including the promulgation of rules and regulations regarding medical care benefits to all recipients of public assistance and to establish county, regional or state-wide schedules for the maximum fees and charges, which may be paid by county welfare boards for medical and other health care and supplies under the categorical aid programs.

9. 246.14 Transfer of Patients to other State Institutions

The Commissioner may transfer patients under his care and custody to other institutions.

10. 245.70 Mentally Ill and Mentally Retarded Federal Aid:

The Commissioner of Public Welfare is designated as the "State Agency" to establish and administer a state-wide plan for construction, equipment maintenance, and operation of any facility for the care, treatment, diagnosis, or rehabilitation of MR or MI, which are or may be required by conditions under any federal law. The Commissioner is authorized and directed to receive, administer and expend funds that may be available under any federal law or from any other source public, private or for such purposes.

11. 245.71 Conditions to Federal Aid for Mentally Ill and MR:

This section spells out in more detail the authorities that are delegated to the Commissioner under 245.70.

12. 393.07 Powers and Duties, Public Child Welfare Program:

The Public Child Welfare Program is supervised by the Commissioner of Public Welfare and administered by the county welfare board in accordance with the law, and with rules and regulations of the Commissioner. The purposes of the Public Child Welfare Program is to assure protection for and financial assistance to children who are confronted with social, physical or emotional problems requiring such protection and assistance. The duties of the county welfare boards shall be performed in accordance with the standards, rules and regulations that are promulgated by the Commissioner of Public Welfare, in order to achieve the purposes of this Act and to comply with the requirements of the Federal Social Security Act.

13. 245.51 Interstate Compact on Mental Health:

The Commissioner of Public Welfare is designated as a compact administrator. This Act provides that Minnesota may legally join with other states in an interstate compact of mental health. The purpose of the Act is to permit individuals to receive proper and expeditious treatment of mental illness and mental deficiency by cooperative action between the states. This Act provides a legal base for care and treatment of mentally ill and mentally retarded, regardless of state residency, and designates the Commissioner as the state's agent responsible for the institutionalization or other appropriate care and treatment of MI and MR under a system that recognizes the paramount importance of the patient's welfare.

14. 246.013 - 246.014 Mentally Ill, Care, Treatment, Examinations and Services:

This Act provides that within the limits of appropriation, the Commissioner is directed to maintain standards in the care and treatment of the mentally ill. These standards include provisions relating to food and food service, staff, both professional and lay staff, requires that the staff be trained in the diagnosis, care and treatment of mentally ill, physical illness, as well as qualified staff such as chaplains, occupational and recreational therapy, and other creative activity staff. The care and treatment must be consistent with modern methods of treatment. Separate facilities must be provided for persons with communicable diseases. The accommodations for patients must be comfortable and attractive with adequate furnishings. The same standards are to be applied for diagnoses, care and treatment for MI, the mentally retarded, chemically dependent persons and the psychopathic personalities. The staff is to be specifically trained in psychiatry and related fields. The Commissioner is directed to establish and provide facilities and equipment for research and study.

15. 245.61 - 245.69 Minnesota Community Mental Health Act:

This Act authorizes the Commissioner to make grants to community mental health boards. The Act also identifies purposes and expectations of those community mental health boards. Provision is made for rules and regulations to be established by the Commissioner regarding the community programs. There are to be specific standards for qualifications of personnel and the quality of professional service, and for in-service training and educational programs for the personnel. The Commissioner is directed to establish a fee schedule so that no individual will be denied service and to regulate fee schedules for consultation and diagnostic services. The Commissioner is also directed to employ qualified personnel and to provide consultative staff to the communities. Programs are to be reviewed and evaluated.

16. 245.691 Lakeland Area Program Board; Community Mental Health Program:

This 1971 amendment to 245.691 provides for the establishment and funding for small group homes for the care and rehabilitation of mentally ill, mentally retarded and juvenile delinquents. This amendment also allows the Commissioner to permit personnel of Fergus Falls State Hospital to assist in developing and carrying out the program. This establishes a precedent and offers guidance for the Commissioner to link community mental health program and the state hospital in the programming and services to the MI/BD population. In summary, this Act authorizes the Commissioner to fund programs, set quality mental health standards for these services and the staff at the local level and the state level, requires need assessment, coordination, planning and evaluation at both local and state level.

17. 253A.01 Minnesota Hospitalization and Commitment Act:

This Act provides for informal hospitalization by consent for mentally ill persons, emergency hospitalization of mentally ill persons, patient's right to communicate, medical examinations of the persons admitted, judicial commitment, commitment to an agency of the federal government such as the VA Hospital, provides for transportation for an individual who is to be placed in a hospital, provides for places of temporary hospitalization, provides for release of the individual before commitment, provides for release after commitment, provides for transfer by the Commissioner to other institutions under the Commissioner's jurisdiction, provides for discharge, provides for the establishment of review boards by the Commissioner for each state hospital. The review board reviews the admission and the retention of patients at each state hospital. The Act also provides for the rights of patients. The Act provides that there be judicial determination of mental competency separate from the need for hospitalization.

18. 252.27 Cost of Boarding Care Outside Home or Institution:

This Act provides for up to 50% state reimbursement to the county for cost of care for emotionally disturbed children up to the age of 18 years. The amount of county participation in the cost is subject to regulation established by the Commissioner of Public Welfare.

19. 245.78 Licensing of Day Care and Residential Facilities and Services:

The Commissioner shall establish rules, regulations and guidelines for the licensing and operating of day care and residential facilities and services for the MI.

The responsibilities and authorities of the Commissioner of Public Welfare are broad and provide the basis for the development of a comprehensive mental health plan for the State of Minnesota. The statutes require multi-disciplinary professional mental health staff in institutions and in community mental health programs.

APPENDIX B

AN ACT
RELATING TO THE HOSPITALIZATION AND COMMITMENT OF CERTAIN PERSONS; PROVIDING FOR CERTAIN PENALTIES; REPEALING MINNESOTA STATUTES 1965, SECTIONS 246.10, 246.101, 253.11, 253.12, 253.18, AND 525.749 to 525.79.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. (253A.01) MINNESOTA HOSPITALIZATION AND COMMITMENT ACT: CITATION. Sections 253A.01 to 253A.21 may be cited as the Minnesota hospitalization and commitment act.

Sec. 2. (253A.02) DEFINITION. Subdivision 1. For the purposes of sections 253A.01 to 253A. 21 the terms defined in this section have the meanings given them.

Subd. 2. "Patient" means any person who qualifies for hospitalization under sections 253A.01 to 253A.21.

Subd. 3. "Mentally ill person" means any person diagnosed as having a psychiatric or other disorder which substantially impairs his mental health and as being in need of treatment or supervision. For the purpose of involuntary commitment of a person as mentally ill it is necessary for the court to find: (a) that the person is a mentally ill person, and (b) that involuntary hospitalization is necessary for the welfare of the person or the protection of society as defined in section 253A.07, subdivision 17, clause (a).

Subd. 4. "Inebriate person" means any person determined as being incapable of managing himself or his affairs by reason of the habitual and excessive use of intoxicating liquors, narcotics, or other drugs. For the purpose of involuntary commitment of a person as inebriate it is necessary for the court to find: (a) that the person is an inebriate person, and (b) that involuntary hospitalization is necessary for the welfare of the person or the protection of society as defined in section 253A.07, subdivision 17, clause (d).

Subd. 5. "Mentally deficient person" means any person other than a mentally ill person, so mentally defective as to require treatment or supervision for his own or the public welfare.

Subd. 6. "Examiner" means a licensed physician especially qualified in the diagnosis of mental illness, except that where no licensed physician so qualified is available any licensed physician or certified consulting psychologist may be designated.

Subd. 7. "Licensed physician" means a person licensed under the laws of Minnesota to practice medicine or a medical officer of the government of the United States while in Minnesota in performance of his official duties.

Subd 8. "Hospital" means a public or private hospital, community mental health center, or other institution or part thereof equipped to provide care and treatment for mentally ill, mentally deficient or inebriate persons.

Subd. 9. "Head of the hospital" means the physician or medical superintendent charged with overall responsibility for the professional program of care and treatment of a hospital or such other members of the medical staff as may be designated by him.

Subd. 10. "Hospital administrator" means any person designated as the administrative head of a hospital or his designees.

Subd. 11. "Superintendent" means the superintendent of a hospital or such members of the medical staff as he may designate.

Subd. 12. "Commissioner" means the commissioner of public welfare or his designees.

Subd. 13. "Emergency treatment" means the treatment of a patient under the provisions of section 253A.04 of this act which is necessary to protect the patient or others from immediate harm prior to the hearing.

Subd. 14. "Interested person" means an interested responsible adult, including but not limited to a public official, the legal guardian, spouse, parent, legal counsel, adult child, or next of kin of a person allegedly mentally ill, mentally deficient, or inebriate.

Subd. 15. "Peace Officer" means a sheriff, or municipal or other local police officer, or a state highway patrol officer when engaged in the authorized duties of his office.

Subd. 16. "Health officer" means a licensed physician, certified consulting psychologist, psychiatric social worker, or psychiatric or public health nurse.

Subd. 17. "A person dangerous to the public" means a person who is mentally ill or mentally deficient and whose conduct might reasonably be expected to produce a clear and present danger of injury to others.

Subd. 18. "Certified consulting psychologist" means a person as defined by Section 148.81, Subdivision 2.

Subd. 19. "Committing Court" means probate court.

Subd. 20. "Drug dependent person" means any inebriate person or any person incapable of managing himself or his affairs or unable to function physically or mentally in an effective manner because of the use of a psychological or physiological dependency producing drug including alcohol.

Sec. 3 (253A.03) INFORMAL HOSPITALIZATION BY CONSENT; VOLUNTARY HOSPITALIZATION FOR INEBRIATE PERSONS. Subdivision 1. Any person may, if he so requests and the head of the hospital consents, be admitted to a hospital as an informal patient for observation, evaluation, diagnosis, care, and treatment, without making formal written application. Such person shall not be admitted to the hospital if he objects thereto and shall be free to leave the hospital within 12 hours of his request unless held under another provision of Sections 253A.01 to 253A.21.

Subd. 2. Any person desiring to receive care and treatment at a public hospital as a drug dependent person may be admitted to such hospital upon his application, in such manner and upon such conditions as the commissioner of public welfare may determine. If such person requests to leave the hospital, such request shall be submitted in writing to the head of the hospital. If such person in writing demands his release, the head of the hospital may detain such person for three days, exclusive of Sundays and legal holidays, after the date of such demand for release. If the head of the hospital deems such release not to be for the best interest of such person, his family, or the public, he shall petition for the commitment of such person as provided in Section 253A.04, subdivision 3.

Sec. 4. (253A.04) EMERGENCY HOSPITALIZATION OF MENTALLY ILL PERSONS. Subdivision 1. Any person may be admitted or held for emergency care and treatment in a hospital with the consent of the head of the hospital upon a written statement by any licensed physician that he has examined the person not more than 15 days prior to the person's admission, that he is of the opinion, for stated reasons, that the person is mentally ill or inebriate and is in imminent danger of causing injury to himself or others if not immediately restrained, and that an order of the court cannot be obtained in time to prevent such anticipated injury. Such physician's statement shall be sufficient authority for a peace or health officer to transport a patient to a hospital.

Subd. 2. A peace or health officer may take a person into custody and transport him to a licensed physician or hospital if such officer has reason to believe that such person is mentally ill and in imminent danger of injuring himself or others if not immediately restrained. Application for admission of such person to a hospital shall be made by the peace or health officer and the application shall contain a statement given by the peace or health officer stating the circumstances under which such person was taken into custody and the reasons therefor. Such person may be admitted to a hospital for emergency care and treatment persuant to this subdivision with the consent of the head of the hospital if a written statement is made by the medical officer on duty at the hospital that after preliminary examination the person has symptoms of a mental illness and appears to be in imminent danger of harming himself or others.

A peace or health officer or a person working under such officer's supervision, may take a person who is intoxicated in public into custody and transport him to a licensed hospital, mental health center facility or a person on the staff of a state licensed or approved program equipped to treat drug dependent persons. Provided, if such person is not endangering himself or any other person or property the peace or health officer may transport the person to his home.

Application for admission of an intoxicated person to a hospital, mental health center or other state licensed or approved program equipped to treat drug dependent persons shall be made by the peace or health officer, or a person working under such officer's supervision taking such person into custody and the application shall contain a statement given by the peace or health officer stating the circumstances under which such person was taken into custody and the reasons therefor. Such person may be admitted to a program or facility specified in this provision for emergency care and treatment with the consent of the institution program director or head of the facility.

Subd. 3. Any person hospitalized pursuant to this section may be held up to 72 hours after admission, exclusive of Saturdays, Sundays, and legal holidays, unless a petition for the commitment of such person has been filed in the probate court of the county of residence or of the county wherein such hospital is located. If the head of the hospital deems such discharge not to be for the best interest of the person, his family, or the public and no other petition has been filed, he shall prior to the expiration of 72 hours after admission, exclusive of Saturdays, Sundays, and legal holidays, file a petition for the commitment of such person. Upon the filing of a petition, the court may order the detention of the person until determination of the matter. Upon motion of such hospitalized person the venue of the petition shall be changed to the probate court of the county of the person's residence, if he be a resident of the state of Minnesota.

Subd. 4. Any person admitted pursuant to this section shall be transferred to the informal status provided by section 3 upon his request in writing and with the consent of the head of the hospital.

Sec. 5 (253A.05) PATIENT'S RIGHT TO COMMUNICATION AND NOTICE THEREOF. Subdivision.1. From the time of his admission any patient admitted under the provisions of section 3 or section 4 may communicate by all reasonable means with a reasonable number of persons at reasonable hours of the day and night, and may consult privately with an attorney, personal physician and at least one member of his family.

Subd. 2. Any patient admitted under the provisions of section 3 shall be informed in writing prior to admission of his right to object to admission, of his right to leave the hospital as provided in section 3 subject to other provisions of this act, and of his right to communicate as specified in subdivision 1.

Subd. 3. Any patient admitted under the provisions of section 4, subdivisions 1 and 2, shall be informed of his right to communicate as specified in subdivision 1, and of his right to discharge and change of venue under section 4, subdivision 3.

Subd. 4. The head of the hospital, hospital administrator, or superintendent shall assist any patient in making and presenting written requests for discharge and change of venue.

Sec. 6. (253A.06) MEDICAL EXAMINATION OF PERSONS ADMITTED OTHER THAN BY JUDICIAL PROCEDURES. Subdivision 1. The head of a hospital shall arrange to have every patient hospitalized pursuant to section 3 or 4 examined by an examiner forthwith, but in no event more than 48 hours following the date of admission.

Subd. 2. At the end of such period any patient admitted pursuant to section 4 shall be discharged if an examination has not been held or if upon examination the examiner fails to notify the head of the hospital in writing that in his opinion the patient is apparently mentally ill and in need of care, treatment, and evaluation.

Sec. 7. (253A.07) JUDICIAL COMMITMENT. Subdivision 1. Any interested person may file in the probate court of the county of the proposed patient's settlement or presence a petition for commitment of a proposed patient,setting forth the name and address of the proposed patient, the name and address of his nearest relatives, and the reasons for the petition. Such petition shall be accompanied either by a written statement by a licensed physician stating that he has examined the proposed patient and is of the opinion that the proposed patient may be mentally ill, mentally deficient, or inebriate, and should be hospitalized, or by a written statement by the petitioner that, after reasonable effort, the petitioner has been unable to obtain an examination by a licensed physician or that an examination could not be performed. Before filing, a copy of the petition shall be delivered by the petitioner to the county welfare department.

Subd. 2. After the filing of the petition the probate court shall appoint two examiners, at least one of whom shall be a licensed physician. If the proposed patient is alleged to be mentally deficient one of the two examiners shall be skilled in the ascertainment of mental deficiency. If the proposed patient is alleged to be drug dependent and if at least one examiner qualified in the field of alcohol and drug abuse cannot be obtained, the court shall appoint a single examiner plus one additional person qualified in the field of alcohol and drug abuse. The final report submitted to the court shall contain all pertinent information and comments preferred by such qualified person. The court shall issue such orders as may be necessary to provide for the examination of the proposed patient which will be conducted prior to the hearing. The examination shall be held at a hospital, a public health facility, the home of the proposed patient, or such

other suitable place as the court shall determine is not likely to have a harmful effect on the health of the proposed patient. No persons shall be present during the examination unless authorized by the examiner. The court may require the examiners to file with the court, prior to the hearing two copies of their report as to the condition of the proposed patient and his need for hospitalization, which report, if filed, shall be available to counsel.

Subd. 3. The court may direct a health or peace officer or any other person to take the proposed patient into custody and transport him to a public hospital, private hospital consenting to receive him, public health facility, or other institution, for observation, evaluation, diagnosis, emergency treatment, care, and if necessary, confinement. The order of the court may be executed on any day and at any time thereof, by the use of all necessary means including the breaking open of any place in which the proposed patient is located and the imposition of necessary restraint upon the person of such proposed patient. Unless otherwise ordered by the court, a peace officer taking the proposed patient into custody pursuant to this subdivision shall not be in uniform and shall not use a motor vehicle visibly marked as a police vehicle.

Subd. 4. From the time of his admission any patient admitted under the provisions of this section may communicate by all reasonable means with a reasonable number of persons at reasonable hours of the day and night, and may consult privately with an attorney, at least one member of his family, and with a personal physician. Such patient shall be informed in writing at the time of his admission of his right to communicate as herein specified and of his right to a hearing as provided in subdivision 8 of this section.

Subd. 5. If the proposed patient has no settlement in this state, the commissioner shall be notified by the court of the proceedings.

Subd. 6. Notice of the filing of the petition and the order for examination shall be given to the proposed patient, his counsel, one interested person other than the proposed patient's counsel and the petitioner, and such other persons as the court directs. Notice shall be served personally on the proposed patient and unless otherwise ordered by the court such notice shall be served on the proposed patient by a non-uniformed person. The contents of all documents served shall be read to the proposed patient. If the court has reason to believe that notice would be likely to be injurious to the proposed patient, notice to the proposed patient may be omitted if a guardian ad litem is appointed by the probate court for receipt of such notice. Such guardian shall represent the proposed patient throughout the action of the petition.

Subd. 7. The probate court shall direct the county welfare department to make an investigation into the financial circumstances, family relationships, residence, social history, and background of such patient and make a report thereof in writing to be filed with the court for the use and guidance of the head of the hospital to which such person may be committed. The court may require that such report be filed prior to the commitment hearing.

Subd. 8. The court shall fix a time and place for the hearing which shall be held within 14 days from the date of the filing of the petition. For good cause shown, the court may extend the time of hearing up to an additional 30 days. When any proposed patient has not had a hearing on a petition filed for his commitment within 14 days from the date of filing of said petition, or within the extended time, the proceedings shall be dismissed. The proposed patient, or the head of a hospital or other institution in which the patient is held, may demand in writing at any time that the hearing be held immediately. Unless the hearing is thereafter held within five days of the date of such demand, exclusive of Saturdays, Sundays and legal holidays, the petition shall be automatically discharged if the patient is being held in a hospital or other institution pursuant to court order. For good cause shown, the court may extend the time of hearing on demand up to an additional 10 days.

Subd. 9. The proposed patient, his counsel, one interested person other than his counsel, the petitioner, and such other persons as the court directs shall be given at least five days' notice by the court that a hearing will be held and at least two days' notice of the time and date of the hearing, unless notice is waived by patient's counsel. The commissioner shall be given ten days' notice by mail of a commitment hearing of a person alleged to be mentally deficient unless such notice is expressly waived by the commissioner.

Subd. 10. The proposed patient, the petitioner, and all other persons to whom notice has been given pursuant to subdivision 9 may attend the hearing and, except for the patient's legal counsel, may testify. The court shall notify such persons of their right to attend the hearing and to testify.

Subd. 11. The proposed patient and the petitioner may present and cross-examine witnesses, including examiners, at the hearing and the court may in its discretion receive the testimony of any other person.

Subd. 12. Subject to the proposed patient's right to attend the hearing, the court in its discretion may permit the proposed patient to be absent from the hearing if the person conducting the hearing shall have observed and consulted with the proposed patient prior to the hearing. The court may exclude from the hearing any person not necessary for the conduct of the proceedings except those persons to whom notice was given pursuant to subdivision 9 and any other persons requested to be present by the proposed

patient. At the time of the hearing the patient shall not be so under the influence or so suffer the effects of drugs, medication, or other treatment as to be hampered in preparing for or participating in the proceedings. When in the opinion of the licensed physician attending the patient the discontinuance of drugs, medication, or other treatment is not in the best interest of the patient, the court at the time of the hearing, shall be presented a record of all drugs, medication or other treatment which the patient has received during the 48 hours immediately prior to the hearing.

Subd. 13. The hearing shall be conducted in a manner consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the mental health of the proposed patient. If the proposed patient is to be present, the hearing may be held at a hospital, a public health facility, the proposed patient's residence, or such other suitable and appropriate place as the court may determine. In all such proceedings the court shall keep accurate minutes containing, among other appropriate materials, notations of appearances at the hearing, including witnesses, of motions made and the disposition thereof, and of all waivers of rights made by the parties. The court shall have taken and preserved an accurate stenographic record or tape recording of the proceedings. The court shall not be bound by the evidence presented by the examiners but shall make its determination upon the entire record pursuant to the rules of evidence. In all cases the court shall find the facts specifically, state separately its conclusions of law thereon, and direct the entry of an appropriate judgment, Where commitment is ordered under the provisions of subdivision 17(a) of this section, the findings of fact and conclusions of law shall specifically include the proposed patient's conduct which is a basis for determining that each of the requisites of subdivision 17(a) is met, including less restrictive alternatives to commitment considered and rejected by the court and the reasons for rejecting each alternative.

Subd. 14. The court shall hear any relevant testimony and shall receive all relevant evidence which may be offered at the hearing.

Subd. 15. In all such proceedings the county attorney may appear and represent the petitioner, or shall appear and represent the petitioner upon the request of the judge of probate court or the petitioner. The petitioner shall be notified of his right to request that the county attorney appear. The proposed patient shall be afforded an opportunity to be represented by counsel, and if neither the proposed patient nor others provide counsel, the court at the time the examiners or licensed physicians are appointed shall appoint counsel to represent the proposed patient. Counsel shall consult with the proposed patient prior to the hearing and shall be given adequate time to prepare therefor. Counsel shall have the full right of subpoena.

Subd. 16. If, upon completion of the hearing and consideration of the record, the court finds that the proposed patient is not mentally ill, mentally deficient, or an inebriate, it shall terminate the proceedings, dismiss the application, and discharge the proposed patient forthwith.

Subd. 17. If, upon completion of the hearing and consideration of the record which shall be made pursuant to the rules of evidence, the court finds the proposed patient is:

(a) A mentally ill person and (1) that the evidence of the proposed patient's conduct clearly shows that his customary self-control, judgment, and discretion in the conduct of his affairs and social relations is lessened to such an extent that hospitalization is necessary for his own welfare or the protection of society; that is, that the evidence of his conduct clearly shows: (i) that he has attempted to or threatened to take his own life or attempted to seriously physically harm himself or others; or (ii) that he has failed to protect himself from exploitation from others; or (iii) that he has failed to care for his own needs for food, clothing, shelter, safety or medical care; and (2) after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petition, out-patient care, informal or voluntary hospitalization in a private or public facility, appointment of a guardian, or release before commitment as provided for in Minnesota Statutes, Section 253A.12, and finds no suitable alternative to involuntary hospitalization, the court shall commit such patient to a public hospital or a private hospital consenting to receive him subject to a mandatory review by the head of the hospital within 60 days from the date of the order as hereinafter provided;

(b) Mentally deficient, the court shall appoint the commissioner guardian of the person of the proposed patient and commit him to the care and custody of the commissioner.

(c) A mentally ill person determined to be in need of commitment in accordance with clauses (a) (1) and (2) above, and a person who is dangerous to the public, the court shall commit such patient to a public hospital or a private hospital consenting to receive him, subject to a mandatory review by the head of the hospital within 60 days from the date of the order as hereinafter provided;

(d) An inebriate person, and that commitment to a hospital is necessary for the welfare of the patient or the protection of society, the court shall commit such patient to a public hospital or a private hospital consenting to receive the person, subject to a mandatory review by the head of the hospital within 60 days from the date of the order as hereinafter provided.

Subd. 18. Upon commitment of a mentally deficient patient under subdivision 17, clause (b), the commissioner may place such patient in an appropriate home, hospital, or institution, or exercise general supervision over him anywhere in the state outside of any institution through any county welfare board or other appropriate agency authorized by the commissioner.

Subd. 19. Whenever a person is committed under subdivision 17, clause (a) or (c), the court shall issue a warrant in duplicate, committing the patient to the custody of the head of the designated hospital for the care of the mentally ill or inebriate persons, and the patient shall be transported to the institution as provided in section 253A.09.

Subd. 20. Upon delivery of a patient committed under subdivision 17, clause (a) or (c), to the hospital to which he is committed, the head of the hospital shall retain the duplicate warrant, and endorse his receipt upon the original warrant, which shall be filed in the court of commitment. After such delivery the patient shall be under the control and custody of the head of the designated hospital.

Subd. 21. A copy of the petition for commitment, a copy of the court's findings of fact and conclusions of law, a copy of the court order committing the patient, a copy of the report of the medical examiners, and a copy of the social service report shall be transmitted within 14 days to the head of the hospital receiving such person, or in the case of a mentally deficient patient, to the commissioner.

Subd. 22. The court shall determine the nature and extent of the patient's property and the nature and extent of the property of the persons upon whom liability for such patient's care and support is imposed by law. One copy of such findings shall be filed with the court and another copy shall be transmitted to the commissioner.

Subd. 23. Whenever a patient is committed under subdivision 17, clause (a) or (c), for a 60 day period, he shall be held at the hospital during such period for observation, evaluation, diagnosis, treatment, and care. Every patient admitted to a hospital under such clause shall be examined by at least one examiner as soon as practicable after admission. Within 60 days from the date of the commitment order the head of the hospital shall file a written statement with the court issuing said order, and a copy thereof with the commissioner and the patient's attorney, setting forth findings as to the condition of the patient; a diagnosis of the patient; whether the patient is in need of further care and treatment; whether such care and treatment, if any, must be provided in a hospital and if so what type; whether the patient must be committed to a hospital ; and whether the patient is dangerous to the public.

Subd. 24. If no written statement is filed within 60 days or if the written statement describes the patient as not in need of further institutional care and treatment, the proceedings shall be terminated by the court and the patient shall be discharged from the hospital unless the patient is committed as mentally ill and dangerous to the public or as a psychopathic personality, in which case a further hearing shall be held by the committing court within 14 days after the court's receipt of such statement and the committing court shall then make the final determination.

Subd. 25. If the written statement describes the patient as being in need of further institutional care and treatment, the court shall consider such finding in making its final determination, and the court may order hospitalization of the proposed patient for an indeterminate period. A copy of the final order for commitment shall be forwarded to the head of the proper hospital.

Subd. 26. If, in the case of a person committed under subdivision 17, clause (c), the statement describes the patient as mentally ill but not dangerous to the public, the patient shall not be committed for an indeterminate period as dangerous to the public except following a hearing as provided for in this section. If the statement describes the patient as mentally ill and dangerous to the public, the court may order hospitalization of the patient for an indeterminate period. Upon the patient's request the court shall conduct a hearing as provided by this section before final determination.

Subd. 27. At any time prior to the expiration of the 60 day period a patient who has not been committed as mentally ill and dangerous to the public or as a psychopathic personality may be transferred to informal status upon his application in writing with the consent of the head of the hospital. Upon such transfer the head of the hospital shall immediately notify the court in writing and upon receipt of the same the court shall terminate the proceedings.

Subd. 28. During the 60 day period a patient who has not been committed as mentally ill and dangerous to the public or as a psychopathic personality may be placed on provisional discharge as provided in section 253A.15, but unless such discharge is made absolute before the end of the 60 day period the patient shall remain subject to the same laws, rules, and regulations as other patients committed under sections 253A.01 to 253A.21.

Subd. 29. Patients or other responsible persons are required to pay the necessary hospital charges for patients committed or transferred to private hospitals or institutions.

Subd. 30. When, pursuant to an order of a state or federal district court, a defendant in a criminal proceeding is examined in the probate court, the probate court shall transmit its findings and return the defendant to such district court unless otherwise ordered. A duplicate of the findings shall be filed in the probate court, but there shall be no petition, property report, or commitment unless otherwise ordered.

Sec. 8. (253A.08) COMMITMENT TO AN AGENCY OF THE UNITED STATES. Subdivision 1. If the patient is entitled to care by the veterans administration or other agency of the United States in this state, the commitment warrant shall be in triplicate, committing the patient to the joint custody of the head of the hospital or the superintendent of the proper state institution and the institution of the veterans administration or other federal agency. If the veterans administration or other federal agency is unable or unwilling to receive the patient at the time of commitment, the patient may subsequently be transferred to it upon its request.

Subd. 2. Any person, when admitted to an institution of the veterans administration or other federal agency within or without this state, shall be subject to the rules and regulations of the veterans administration or other federal agency except that nothing in this section shall deprive any such person of rights secured to patients of state mental hospitals by section 253A.16.

Subd. 3. The chief officer of any institution operated by the veterans administration or other agency of the United States to which any person is admitted shall with respect to such person be vested with the same powers as the heads of hospitals for mental diseases within this state with respect to admission, retention of custody, transfer, parole, release or discharge.

Subd. 4. The judgment or order of commitment by a court of competent jurisdiction of another state or the District of Columbia, committing a person to the veterans administration or other agency of the United States for care or treatment, shall have the same force and effect as to the committed person while in this state as in the jurisdiction in which is situated the court entering the judgment or making the order. Consent is hereby given to the application of the law of the committing state or district in respect to the authority of the chief officer of any facility of the veterans administration, or of any institution operated in this

state by any other agency of the United States, to retain custody of, transfer, parole, release, or discharge the committed person.

Subd. 5. Upon receipt of a certificate of the veterans administration or such other agency of the United States that facilities are available for the care or treatment of any person heretofore committed to any hospital for the mentally ill or other institution for the care or treatment of persons similarly afflicted and that such person is eligible for care or treatment, the head of the hospital or institution may cause the transfer of such person to the veterans administration or other agency of the United States for care or treatment. Upon affecting such transfer, the committing court or proper officer thereof shall be notified thereof by the transferring agency. No person shall be transferred to the veterans administration or other agency of the United States if he be confined pursuant to conviction of any felony or misdemeanor or if he has been acquitted of the charge solely on the ground of insanity, unless prior to transfer the court or other authority originally committing such person shall enter an order for such transfer after appropriate motion and hearing.

Written notice of the transfer shall be given to the patient's spouse or parent, or if non be known, to some other interested person.

Any person transferred as provided in this section shall be deemed to be committed to the veterans administration or other agency of the United States pursuant to the original commitment.

Sec. 9. (253A.09) TRANSPORTATION. Subdivision 1. Whenever an individual is about to be placed in a hospital or public health facility under the terms of this act, the court may by order:

(a) Upon the request of an interested person, authorize the county welfare department to arrange for the individual's transportation to the hospital with appropriate medical or nursing attendants, and by such means as may be suitable for the individual's condition. The person making the request shall be liable for the cost of such transportation.

(b) Authorize county welfare department or public health facility personnel to transport the individual to the designated facility if the head of the welfare department or health facility has advised the court that such personnel are available for the purpose.

(c) Authorize an interested or any other responsible person to transport the individual to the designated facility.

(d) Authorize a peace officer to transport the individual to the hospital or public health facility. Unless otherwise ordered by the court, the peace officer shall not be in uniform and shall use a motor vehicle not visibly marked as a police vehicle.

Subd. 2. In addition to the persons ordered by the court to transport the patient, the patient may be accompanied by one or more interested persons.

Subd. 3. Whenever a patient being committed under this act requests a change of venue as provided in this act, or whenever a hearing is to be held for adjudication of a patient's status pursuant to section 19 of this act, the transportation of said patient to the hearing shall be provided by the commissioner.

Sec. 10. (253A.10) PLACES OF TEMPORARY HOSPITALIZATION. Subdivision 1. Except when ordered by the court, no person apprehended, detained, or hospitalized as mentally ill, mentally deficient, or inebriate under any provision of this act shall be confined in jail or in any penal or correctional institution.

Subd. 2. Each county or a group of counties or other political subdivisions shall at the expense of the county or participating counties or political subdivisions maintain or provide by contract a facility for hospitalization of persons held temporarily for observation, evaluation, diagnosis, treatment, and care while awaiting a hearing under the terms of sections 253A.01 to 253A.21, and when such hospitalization is provided at a state hospital the commissioner shall charge the responsible county, and shall be paid, at a rate based on the commissioner's determination of the average per capita cost of all maintenance, treatment and expense, other than that paid from the Minnesota state building fund, for persons hospitalized pursuant to section 253A.04, subdivision 2 and section 253A.07, subdivision 3 at all of the state hospitals for the mentally ill during the fiscal year previous to the period for which billing is being made.

Subd. 3. A facility may consist of all or a portion of a hospital, licensed nursing home, licensed foster home, or other facility, but shall not be part of a facility used primarily for the detention of individuals charged with or convicted of penal offenses.

Subd. 4. The county welfare board shall take such reasonable measures, including provision for medical treatment, as may be necessary to assure proper care and treatment of a person temporarily detained pursuant to this section.

Sec. 11. (253A.11) NOTICE OF ADMISSION TO HOSPITAL. Whenever a patient has been admitted to a hospital of public health facility under the provisions of sections 253A.04 and 253A.07, the hospital or public health facility shall notify forthwith the patient's spouse or parent, if the patient was not admitted upon the petition of the spouse or parent, and the county of the patient's legal settlement if said county may bear a portion of the cost of hospitalization. If the patient was admitted upon the petition of a spouse or parent the head of the hospital or public health facility

shall notify an interested person other than the petitioner.

Sec. 12. (253A.12) RELEASE BEFORE COMMITMENT. Subdivision 1. After the commitment hearing and before a commitment order has been issued, the court may release a proposed patient to the custody of any individual upon such conditions guaranteeing the care and treatment of such patient; but no person against whom a criminal proceeding is pending shall be so released.

Subd. 2. The court, on its own motion or upon the petition of any person, and after a hearing upon such notice as it directs, may revoke any such release and commitment the proposed patient in such manner as provided in this act.

Sec. 13. (253A.13) RELEASE AFTER COMMITMENT. Subdivision 1. Any patient committed as mentally deficient to the guardianship of the commissioner may be released to any person by the commissioner upon such conditions guaranteeing the necessary care and treatment of such patient as the commissioner may prescribe.

Subd. 2. Each patient so released is subject to supervision and return to custody until unconditionally discharged. The releasing authority may request the patient to return to the hospital or to such other hospital or public health facility as consents to receive him. Public health personnel, welfare personnel, or a peace officer of the county where the patient is located, if so requested, may return the patient to the place from which he was released or to such other hospital or public health facility as consents to receive him. The releasing authority may inform the probate court of such revocation of release and the court may direct a health or peace officer in the county where the patient is located to return him to the place from which he was released or to such other hospital or public health facility as consents to receive him. The expense of returning the patient, unless paid by the patient or his relatives, shall be paid by the commissioner.

Sec. 14. (253A.14) TRANSFER. Subdivision 1. The commissioner may transfer any patient who is committed by probate court as mentally ill, mentally deficient, or inebriate from one state hospital or institution to any other hospital or other institution under his jurisdiction which is capable of providing such patient proper care and treatment, unless such patient was found by the committing court to be dangerous to the public or to have a psychopathic personality. Whenever a patient is transferred from one hospital to another written notice shall be given to the probate court if the patient was committed under sections 253A.01 to 253A.21, and to his parent or spouse or, if none be known, to an interested person, and the county welfare board.

Subd. 2. Persons who have been found by the committing court to be dangerous to the public or a psychopathic personality shall not be transferred out of the Minnesota Security Hospital unless it appears to the satisfaction of the commissioner, after a hearing before and a recommendation by the special review board, appointed and acting under and pursuant to section 253A.16 that such transfer is appropriate. The probate court and the county attorney of the

county of commitment and the patient and his attorney shall be given notice by the commissioner at least 14 days prior to the hearing of the time and place of the hearing before such special review board.

Sec. 15. (253A.15) DISCHARGE. Subdivision 1. The head of a hospital shall discharge any patient admitted as mentally ill or inebriate when certified by him to be no longer in need of institutional care and treatment, unless such patient was charged with or convicted of a criminal offense, or was found by the committing court to be dangerous to the public or to have a psychopathic personality. In the case of committed patients, other than those committed as mentally ill and dangerous to the public or as a psychopathic personality the head of the hospital may provisionally discharge any such patient; that is, discharge him from the hospital without discharging his commitment. Where such patient was charged with or convicted of a criminal offense, he shall not be discharged except upon order of a court of competent jurisdiction. In cases where the patient was charged with, or convicted of, a criminal offense the hospital shall notify the court that the patient is no longer in need of institutional care and treatment and the court shall order appropriate disposition of the patient.

Subd. 2. (a) Where such patient was found by the committing court to be dangerous to the public or to have a psychopathic personality, such patient shall not be discharged or provisionally discharged except upon order of the commissioner and no such discharge or provisional discharge shall be ordered by the commissioner unless he is satisfied that the patient is capable of making an acceptable adjustment in society and unless the commissioner has received a favorable recommendation to that effect by a majority of the special review board appointed and acting under section 253A.16. A petition for an order of discharge or provisional discharge shall be filed with the commissioner and may be filed by the patient or by the head of the hospital. The special review board shall be convened by the commissioner at reasonable intervals and shall hold a hearing on each petition for discharge or provisional discharge prior to making any recommendation thereon. The probate court and county attorney of the county of commitment, and the petitioner and his attorney, if any, shall each be given written notice by the commissioner of the time and place of the hearing before the special review board at least 14 days prior to the date of such hearing and may appear before the special review board and such persons shall also be given written notice of the making of any such order by the commissioner and a copy of the same within five days after the making and entry of such order, the notice and copy thereof to be furnished by registered mail with return receipt. No order by the commissioner for the discharge or provisional discharge of a patient shall be made effective sooner than 30 days after the making and entry of such order.

(b) There shall be established by the supreme court an appeal panel composed of three probate judges and two alternate probate judges, all of whom shall be appointed from among the acting probate

judges of the state by the chief justice of the supreme court for terms of one year each. Only three judges need hear any case. One of the regular three judges so appointed shall be designated as the chief judge of the appeal panel and that judge is hereby vested with power and authority to fix the time and place of all hearings before the panel, issue all notices, subpoena witnesses, appoint counsel for the patient, if necessary, and generally to supervise and direct the operation of the appeal panel. The chief judge shall designate any other judge or any alternate judge to act as chief judge in any case where such chief judge is unable to act and with the same powers and authority. No judge appointed to the appeal panel shall take part in the consideration of any case in which that judge committed the patient in the probate court. The chief justice of the supreme court shall determine the compensation of the judges serving on the appeal panel, such compensation to be in addition to their ordinary compensation as probate judges, and all compensation and expenses of the appeal panel shall be borne by the department of public welfare.

(c) The patient or the county attorney of the county from which the patient was committed aggrieved by the action of the commissioner under clause (a) of this subdivision, may petition for a rehearing and reconsideration of the case before the appeal panel. Such petition shall be filed with the supreme court within 30 days after the making and entry of the order of the commissioner. The supreme court shall notify the head of the hospital in which the patient is confined and refer the petition to the chief judge of the appeal panel. Written notice by mail shall be given to the patient, the county attorney of the county of commitment, the commissioner, the head of the hospital in which the patient is confined, and such persons as the chief judge may designate, of the t me and place of the hearing on such petition. Such notice is to be given not less than 14 days prior to the date of such hearing, which hearing shall be within 45 days of the filing of the petition. Any person may oppose the petition. The appeal panel may appoint examiners, and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all such proceedings. The patient and the county attorney of the committing county shall be entitled to be present and to cross-examine all witnesses. A majority of the appeal panel shall make and enter such orders as they may deem just and equitable and the order of the appeal panel shall supersede all orders of the commissioner in such cases.

(d) In all proceedings before the appeal panel the patient shall be afforded an opportunity to be represented by counsel, and if neither the patient or others provide counsel the chief judge of the appeal panel shall appoint counsel to represent the patient. The compensation of such appointed counsel shall be determined by the chief judge and the expense thereof shall be borne and paid by the department of public welfare.

(e) The filing with the supreme court of a petition under clause (c) of this subdivision shall immediately suspend the operation of any order for discharge, provisional discharge or release from custody of the patient and said patient shall not thereafter be discharged or released in any manner except upon order of a majority of the appeal panel.

(f) A party aggrieved by an order of the appeal panel may appeal from such decision to the supreme court in the same manner as other appeals in civil actions.

Subd. 3. Except as otherwise authorized by this act, no person with respect to whom proceedings for judicial hospitalization have been commenced shall be released or discharged prior to commitment unless so ordered by the probate court.

Subd. 4. The head of the hospital shall review the facts relating to the activity of a patient on provisional discharge within one year from the date when provisional discharge commenced and unless such patient is readmitted to a hospital within such one year period or unless the period of provisional discharge is extended by the head of the hospital, the provisional discharge shall become absolute and operate to discharge such patient.

Subd. 5. If, while on provisional discharge or extended provisional discharge, a patient is discharged as provided in this section the discharge shall be absolute.

Subd. 6. Notice of the expiration of the one year period or of the extended period shall be given by the head of the hospital to the committing court, the commissioner, and the county welfare board.

Subd. 7. The head of a hospital, upon revoking a provisional discharge or if a patient is absent without authorization, may request the patient to return to the hospital voluntarily, and when necessary may request public health personnel, welfare personnel, or a peace officer to return the patient to the hospital from which he was released or to such other hospital or public health facility as consents to receive him. Public health personnel, welfare personnel, or a peace officer so requested may return the patient to the hospital or to such other hospital or public health facility as consents to receive him. The head of the hospital may inform the committing probate court of such revocation or absence and the court shall direct a health or peace officer in the county where the patient is located to return such patient to the hospital or to such other hospital or public health facility as consents to receive him for further care and treatment in such manner as provided in this act.

The expense of returning the patient to a hospital shall be paid by the commissioner unless paid by the patient or his relatives.

Subd. 8. The head of a hospital may place any patient hospitalized pursuant to this act on a status of partial hospitalization. Such status shall allow the patient to be absent from the hospital for certain fixed periods of time. Such patient shall be placed on such status in a state hospital under such terms and conditions as are established by the commissioner. The head of the hospital may terminate such status at any time.

Subd. 9. When a committed patient is discharged, provisionally discharged, transferred to another hospital, released, or partially hospitalized, or when he dies, is absent without authorization, or is returned, the hospital having custody of the patient shall file notice thereof in the court of commitment.

Subd. 10. The hospital administrator shall make such arrangements at the expense of the state as may be necessary to insure that no patient is discharged, provisionally discharged, or released without suitable clothing. The head of a public hospital shall, if necessary, provide such patient with a sufficient sum of money to secure transportation home, or to another destination of his choice, if such destination is located within a reasonable distance of the hospital, which sum shall be paid out of the current expense fund of the hospital or institution.

Subd. 11. The head of any hospital, upon the provisional discharge, partial hospitalization, or release of any patient hospitalized under sections 253A.01 to 253A.21, shall notify the welfare board and in the event the patient is a drug dependent person the community mental health center of the county of such patient's residence before the patient is to leave the hospital, and and the welfare board shall thereupon notify the patient's family. Whenever possible said notice shall be given at least one week before the patient is to leave the hospital. The commissioner shall provide by regulation the procedure and methods whereby such patient shall be helped to receive all public assistance benefits provided by state or federal law.

Subd. 12. Prior to the date of discharge, provisional discharge, partial hospitalization, or release of any patient hospitalized under this act, the county welfare board of the county of such patient's residence, in cooperation with the head of the hospital where the patient is hospitalized, the director of the community health center service of said area, and the patient's physician, if notified pursuant to subdivision 13, shall establish a continuing plan for after-care services for such patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and such other aid as the patient shall need. It shall be the duty of such welfare board to supervise and assist such patient in finding employment, suitable shelter, and adequate

medical and psychiatric treatment, and to aid in his readjustment to the community.

Subd. 13. In establishing such plan for after-care services the county welfare board shall engage in such consultation with persons or agencies, including any public health nurse and vocational rehabilitation personnel, as is necessary to insure adequate planning for after-care services.

Subd. 14. The head of the hospital shall notify the physician of any patient hospitalized pursuant to this act at the time of such patient's discharge, provisional discharge, partial hospitalization, or release, unless such patient shall object to such notice.

Subd. 15. A patient who has been hospitalized under this act may at any time after discharge, provisional discharge, partial hospitalization, or release, apply to the head of any public hospital within whose district he resides for treatment. If the head of the hospital determines that the applicant requires such service he may provide, under the medical supervision of a physician in the hospital, such services related to mental illness as are required for the mental health of such applicant. Such service shall be provided in state hospitals under terms and conditions established by the commissioner.

Subd. 16. Any person may apply to the head of any public hospital within whose district he resides for treatment. If his condition warrants he may be enrolled as an outpatient and receive treatment during such enrollment while under medical supervision of a hospital physician. Such service shall be provided in state hospitals under terms and conditions established by the commissioner.

Subd. 17. The application prescribed in subdivision 15 may be made by any person 18 years of age or older, or on behalf of a person under the age of 18 years by his parent, guardian, or custodian, or on behalf of a person 18 years of age or older by his guardian or custodian.

Sec. 16. (253A.16) REVIEW BOARD. Subdivision 1. There shall be established by the commissioner for each state hospital a review board of three or more persons to review the admission and retention of patients in state mental hospitals. One of such persons shall be qualified in the diagnosis of mental illness or mental deficiency and one of such persons shall be learned in the law.

Subd. 2. Each state hospital shall be visited by the review board at least once every six months. Each patient in the hospital who so requests shall have the right to appear before the review board during such visit. A patient may at any time request the right to appear before the review board. Upon receiving such

request the head of the hospital shall notify the commissioner who shall set a time and date for the patient's appearance before the review board.

Subd. 3. The head of the state hospital shall notify each patient at the time of admission by a simple written statement of the patient's right to appear before the review board and the next date when the board will visit the hospital. A request to appear before the board does not have to be in writing. Any employee of the hospital receiving such a request to appear before the board shall notify the head of the hospital of such request.

Subd. 4. The board shall review the admission and retention of patients at each state mental hospital. The board may examine the records of all patients admitted and may examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement in a mental hospital. The board shall report its findings to the commissioner. The board may also receive reports from patients and interested persons, including but not limited to hospital employees, on conditions affecting the humane and dignified care of patients and the board may examine the circumstances thereof in the manner described in this subdivision.

Subd. 5. There shall be established by the commissioner one special review board for mentally ill and dangerous and psychopathic personalities, of three members, all of whom shall be experienced in the field of mental illness. One member of the special review board shall be a physician qualified in the diagnosis of mental illness or mental deficiency, one member shall be an attorney and no member shall be connected with the department of public welfare. This special review board shall meet at least every six months and be otherwise on call of the commissioner and shall hear and consider all petitions for transfer out of the Minnesota Security Hospital, discharge or provisional discharge filed under and pursuant to sections 253A.14 and 253A.15, and make recommendations to the commissioner concerning the same.

Subd. 6. Each member of the review board and the special review board shall receive as compensation the sum of $50 per day or any portion thereof spent in discharge of his official duties. In addition to the compensation so provided, each member of the review board and the special review board shall be reimbursed for all expenses paid or incurred by him in the performance of his official duties.

Sec. 17. (253A.17) RIGHTS OF PATIENTS. Subdivision 1. Restraints shall not be applied to a patient unless the head of the hospital or a member of the medical staff determines that they are necessary for the safety of the patient or others. Each use of a restraint and reason therefor shall be made part of the clinical

record of the patient under the signature of the head of the hospital or a member of the medical staff.

Subd. 2. Any patient may correspond by sealed mail or otherwise, freely without censorship, with the governor, the commissioner, the court, and any official agency, and may communicate without censorship by sealed mail or any other means with his physician and one or more attorneys.

Subd. 3. Any patient of a state hospital or institution may select a correspondent outside the institution with whom he may freely correspond without censorship. The head of the hospital shall register the name and postoffice address of every such correspondent. Within three days after such selection by a patient the head of the hospital shall notify the correspondent thereof and, in case of his refusal to act, shall notify the patient, who may select another. Each correspondent shall endorse his name and address upon all envelopes sent to such patient.

Subd. 4. Such patient shall be furnished with necessary paper and stamped envelopes for such correspondence, and with a postal card addressed to himself, having a form of receipt for the letter on the reverse side, to be enclosed therein. Such letter and postal card, when enveloped, sealed, directed, and delivered to the head of the hospital or an assistant physician, shall be mailed forthwith without being opened or read. Every letter received from such correspondent shall be delivered to the patient unopened. The facts in reference to such correspondence shall be at once entered in the register.

Subd. 5. The correspondence rights enumerated in subdivisions 2, 3 and 4 may be restricted by the head of the hospital if he determines that the medical welfare of the patient so requires. Such determination may be reviewed by the commissioner. Any mail or other communication which is not delivered to the patient for whom it is intended shall be immediately returned to the sender. Any limitation imposed by the head of the hospital on the exercise of a patient's correspondence rights and the reason for such limitation shall be made a part of the clinical record of the patient.

Subd. 6. Subject to the general rules of the hospital and subject to the determination by the head of the hospital that it is necessary for the medical welfare of the patient to impose restrictions, every patient shall be entitled to receive visitors. The patient's personal physician, spiritual advisor and attorney shall be permitted to visit the patient at all reasonable times and the patient shall not be denied the right to continue the practice of his religion in accordance with its tenets during his confinement.

Subd. 7. The head of a hospital shall have the physical and mental condition of every patient assessed as frequently as necessary, but not less often than annually.

Subd. 8. The head of a state hospital shall obtain consent of a surgical operation necessary to save the life, health, eyesight, hearing, or a limb of any patient, from the proper relatives or guardian. If such persons cannot be found after diligent search, or in the case of an emergency, the head of the hospital, upon being notified of the pertinent medical facts, may give such consent. The commissioner shall be notified forthwith of such emergency operation. When in the opinion of the head of a hospital having custody of the patient, a patient who has not been adjudged legally incompetent has sufficient capacity to make a responsible decision, the patient's consent shall be obtained before such surgery. In such cases the patient's consent shall be determinative and no other consent is necessary; provided, however, that in the case of a minor, consent shall also be obtained from his parent, guardian, or custodian. No person who consents to the performance of a surgical operation pursuant to the provisions of this subdivision shall be civilly or criminally liable for the performance or the manner of performing such operation. No person who acts within the scope of the authority conferred by such consent in the course of discharging his official duties shall be civilly or criminally liable for the performance of such operation, but this act shall not affect any liability which he may incur as a consequence of the manner in which such operation is performed.

Subd. 9. Every person hospitalized or otherwise receiving services under this act shall be entitled to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further custody, institutionalization, or other services unnecessary. To this end the head of the hospital shall devise or cause to be devised for such person so hospitalized a written program plan which shall describe in behavioral terms the case problems, and the precise goals, including the expected period of time for hospitalization, and the specific measures to be employed in the solution or easement of said problems. Each plan shall be reviewed at not less than quarterly intervals to determine progress toward the goals, and to modify the program plan as necessary. The program plan shall be devised and reviewed in each instance with the appropriate county welfare department, and with the patient. The hospital record shall attest to the program plan review. If the county welfare department or the patient does not so participate in the planning and review, the hospital record shall include reasons for non-participation and the plans for future involvement.

The department of public welfare shall monitor the aforementioned program plan and review process to insure compliance with the provisions of this subdivision.

Sec. 18. (253A.18) INCOMPETENCY. Subdivision 1. Except as otherwise provided in this act, and in Minnesota Statutes, Sections 246.15 and 246.16, no person by reason of commitment, hospitalization, or treatment pursuant to this act shall be deprived of any legal right, including but not limited to the right to dispose of property, sue and be sued, execute instruments,

make purchases, enter into contractual relationships, vote, and hold a driver's license. Commitment, hospitalization, or treatment of any patient pursuant to this act is not a judicial determination of legal incompetency except to the extent provided in section 17, subdivision 8.

Subd. 2. Proceedings for determination of legal incompetency and the appointment of a guardian for a person subject to hospitalization under this act may be commenced before, during, or after commitment proceedings have been instituted and may be conducted jointly with such commitment proceedings. The court shall notify the head of the hospital to whom the patient is committed of a finding that the patient is incompetent.

Subd. 3. Where the person to be committed is a minor or owns property of value and it appears to the court that such person is not competent to manage his estate, the court shall appoint a guardian of such person's estate, either general or special as otherwise provided by law.

Sec. 19. (253A.19) JUDICIAL DETERMINATION OF MENTAL COMPETENCY AND NEED FOR HOSPITALIZATION. Subdivision 1. Any interested person may petition the court of commitment or the court to which venue has been transferred for an order adjudicating that a patient is not now in need of continued hospitalization or for an order adjudicating that an individual is not now mentally ill, mentally deficient, or inebriate, or for an order restoring a patient to legal incapacity, or for such other order as the court may deem just and equitable.

Subd. 2. Upon the filing of the petition the court shall fix the time and place of the hearing thereof, ten days' notice of which shall be given to the county attorney and to the commissioner, if he did not file the petition. Notice shall be given to the patient, his legal counsel, the head of the hospital in which the patient resides, and such other persons and in such manner as the court directs. Any person may oppose the petition.

Subd. 3. The court may appoint two examiners if the patient is alleged to be mentally ill; otherwise the court may appoint one licensed physician and in addition thereto may appoint a person skilled in the ascertainment of mental deficiency to examine the patient.

Subd. 4. The patient and the petitioner shall be entitled to be present and cross-examine witnesses including any licensed physician and examiners. The court shall hear any relevant testimony and shall receive all relevant evidence which may be offered at the hearing.

Subd. 5. Upon proof of the allegations of the petition, the court shall enter an order adjudicating that the patient is not now in need of continued hospitalization and upon proper proof thereof shall order that an individual is not now mentally ill, mentally deficient, or inebriate, or may restore the patient to legal capacity, or may enter such other order as the court may deem equitable and just.

Subd. 6. The county attorney shall attend the hearing and shall oppose the restoration of the patient in the probate court and in the appellate courts, if he deems it for the best interest of the public.

Subd. 7. A copy of said order shall be mailed to the head of the hospital where the patient was last confined. The head of the hospital, upon receipt thereof, shall then comply with such order.

Subd. 8. The attorney general shall represent the commissioner in such proceedings.

Subd. 9. In all such proceedings the patient shall be afforded an opportunity to be represented by counsel, and if neither the patient nor others provide counsel the court shall appoint counsel to represent the patient.

Sec. 20. (253A.20) COSTS OF HEARINGS. Subdivision 1. In each proceeding under this act the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each examiner a reasonable sum for his services and for travel; to persons, including county welfare or public health personnel, conveying the patient to the place of detention, disbursements for the travel, board and lodging of the patient and of themselves and their authorized assistants; and to the patient's counsel, when appointed by the court, a reasonable sum for travel and for each day or portion thereof actually employed in court or actually consumed in preparing for the hearing. Upon such order the county auditor shall issue a warrant on the county treasurer for payment of the amounts allowed.

Subd. 2. When the settlement of the patient is found to be in another county, the court shall transmit to the county auditor a statement of the expenses of the taking into custody, confinement, examination, commitment, conveyance to the place of detention, and rehearing. The auditor shall transmit the statement to the auditor of the county of the patient's settlement and this claim shall be paid as other claims against the county. If the auditor to whom this claim is transmitted denies the claim, he shall transmit it, together with his objections thereto, to the commissioner, who shall determine the question of settlement and certify his findings to each auditor. If the claim is not paid within 30 days after such certification, an action may be maintained thereon in the district court of the claimant county.

Subd. 3. Whenever venue of a proceeding has been transferred under this act the costs of such proceedings shall be reimbursed to the county of the patient's settlement by the state.

Sec. 21. (253A.21) GENERAL PROVISIONS. Subdivision 1. Any person who willfully makes, joins in, or advises the making of any false petition or report, or knowingly or willfully makes any false representation for the purpose of causing such petition or report to be made or for the purpose of causing an individual to be improperly hospitalized under this act, is guilty of a gross misdemeanor and may be punished by imprisonment in the state prison for not more than one year or by a fine of not more than $500. The attorney general or his designees shall conduct any prosecution for the violation of this section.

Subd. 2. All persons acting in good faith, upon either actual knowledge or information thought by them to be reliable, who act pursuant to any provision of this chapter or who procedurally or physically assist in the hospitalization of any individual, pursuant to this act, are not subject to any civil or criminal liability under this act. Any medical privilege otherwise existing between patient and physician is waived as to any physician who provides information with respect to a patient pursuant to any provision of this chapter.

Subd. 3. Nothing in this act shall be construed to abridge the right of any person to the writ of habeas corpus.

Subd. 4. The court commissioner may act for the probate judge upon a petition for the commitment of a patient when the probate judge is unable to act.

Subd. 5. The commissioner or any other aggrieved party may appeal to the district court from any order entered under sections 253A.01 to 253A.21 in the manner prescribed in Minnesota Statutes, Section 487.39.

Upon perfection of the appeal, the return shall be filed forthwith. The district court shall give the appeal preference over every other proceeding therein. Such appeal shall not suspend the operation of the order appealed from until the appeal is determined, unless otherwise ordered by the district court.

Notwithstanding any contrary provision in Minnesota Statutes, Section 487.39, an appeal may be taken from the determination of a district court judge to the supreme court without leave of the supreme court in cases in which the district court upholds an order committing a person under Minnesota Statutes, Section 253A.07, Subdivision 17 or an order denying a petition under section 253A.19.

Subd. 6. The commissioner shall establish such rules and regulations not inconsistent with the provisions of this act as he may find to be necessary for the proper and efficient administration thereof and shall prescribe the form of applications, records, reports, and medical certificates required by this act and the information to be contained therein.

Subd. 7. This act applies to any conduct, transaction, or proceeding within its terms which occurs after the effective date of this act; provided, however, that a proceeding for the commitment of a person to a hospital commenced before the effective date of this act is governed by the law existing at the time the proceeding was commenced, and unless such proceedings are terminated within 12 months after the effective date of this act, they shall thereafter be governed by the provisions of this act.

Subd. 8. For purposes of taking an appeal or petition for habeas corpus or for a judicial determination of mental competency or need for hospitalization, transcripts of commitment proceedings, or portions thereof, shall be made available to the parties upon written application to the court. Upon a showing by a party that he is unable to pay the cost of such transcripts or portions thereof they shall be made available at no expense to such party.

Sec. 22. REPEALER. Minnesota Statutes 1965, Sections 246.10, 246.101, 253.11 253.12, 253.18, 525.749, 525.75, 525.751, 525.752, 525.753, 525.754, 525.76, 525.761, 525.762, 525.763, 525.77, 525.78, and 525.79, are repealed.

Sec. 23. EFFECTIVE DATE. The effective date of this act shall be January 1, 1968.

Approved May 22, 1967.

AN ACT
RELATING TO THE HOSPITALIZATION AND COMMITMENT OF CERTAIN PERSONS: CONTAINING CERTAIN AMENDMENTS INCIDENT TO A BILL FOR AN ACT TO BE CITED AS THE MINNESOTA HOSPITALIZATION AND COMMITMENT ACT; AMENDING MINNESOTA STATUTES 1965, SECTIONS 171.04, 201.15, 246.013, 246.014, AND 246.14.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1965, Section 171.04, is amended to read:

171.04. HOSPITALIZATION AND COMMITMENT; CORRECTION BILL; PERSONS NOT ELIGIBLE FOR DRIVER'S LICENSES. The department shall not issue a driver's license hereunder:

(1) To any person who is under the age of 16 years; nor, after January 1, 1967, to any person under 18 years unless such person shall have successfully completed a course in driver education, including both classroom and behind the wheel instruction, approved by the state department of education, except when such person has completed a course of driver education in another state or has a previously issued valid license from another state or country; nor to any person under 18 years unless the application of a license is approved by either parent when both reside in the same household as the minor applicant, otherwise the parent having custody or with whom the minor is living in the event there is no court order for custody, or guardian having the custody of such minor, or in the event a person under the age of 18 has no living father, mother or guardian, the license shall not be issued to such person unless his application therefor is approved by his employer. Behind the wheel driver education courses offered in any public school shall be open for enrollment to persons between the ages of 15 and 18 years residing in the school district or attending school therein. Any public school offering behind the wheel driver education courses may charge an enrollment fee for the behind the wheel driver education course which shall not exceed the actual cost thereof to the public school and the school district. The approval required herein shall contain a verification of the age of the applicant;

(2) To any person whose license has been suspended during the period of suspension except that a suspended license may be reinstated during the period or suspension upon the licensee furnishing proof of financial responsibility in the same manner as provided in the safety responsibility act;

(3) To any person whose license has been revoked except upon furnishing proof of financial responsibility in the same manner as provided in the safety responsibility act and if otherwise qualified;

(4) To any person who is an habitual drunkard as determined by competent authority or is addicted to the use of narcotic drugs;

(5) To any person who has been adjudged legally incompetent by reason of mental illness, mental deficiency, or inebriation, and has not been restored to capacity, unless the department is satisfied that such person is competent to operate a motor vehicle with safety to persons or property;

(6) To any person who is required by this chapter to take an examination, unless such person shall have successfully passed such examination;

(7) To any person who is required under the provisions of the safety responsibility laws of this state to deposit proof of financial responsibility and who has not deposited such proof;

(8) To any person when the commissioner has good cause to believe that the operation of a motor vehicle on the highways by such person would be inimical to public safety or welfare;

(9) To any person when, in the opinion of the commissioner, such person is afflicted with or suffering from such physical or mental disability or disease as will affect such person in a manner to prevent him from exercising reasonable and ordinary control over a motor vehicle while operating the same upon the highways; nor to a person who is unable to read and understand official signs regulating, warning, and directing traffic.

Sec. 2. Minnesota Statutes 1965, Section 201.15, is amended to read:

201.15. PROBATE JUDGE, REPORT GUARDIANSHIPS AND COMMITMENTS. The judge of probate in each county in the state shall report monthly to each commissioner in his county the name, age and address of each person 18 years of age, or over, residing in such municipality, who has, during the month preceding the date of the report, been placed under a guardianship of the person, and each such person under guardianship of the person transferred to the jurisdiction of the probate court, or restored to capacity, and each person, 18 years of age, or over, adjudged legally incompetent by reason of mental illness, mental deficiency, or inebriation, or as a psychopathic personality, and each such person restored to capacity by the court. Upon receipt of such report, the commissioner shall examine the original and duplicate registration files; and, if such examination discloses that any of the persons named in such report as being under guardianship of the person, or as

adjudged incompetent or a psychopathic personality, is registered, the commissioner shall remove the registration cards of such persons from the active files; and upon notice from the judge of probate of a restoration to capacity, the commissioner shall then process the person's registration card in the same manner as if no guardianship or adjudication has occurred.

Sec. 3. Minnesota Statutes 1965, Section 246.013, is amended to read:

246.013. MENTALLY ILL, CARE, TREATMENT, EXAMINATION. Within the limits of the appropriations for the commissioner of public welfare, he is directed, in the performance of the duties imposed upon him by the laws of this state, to bring to the measure prescribed by section 246.012, the care and treatment of the mentally ill as speedily as is possible, and to thereafter, subject to the paramount authority of the legislature with respect to appropriations, maintain said standards in the care and treatment of the mentally ill.

Sec. 4. Minnesota Statutes 1965, Section 246.014, is amended to read:

246.014. SERVICES. The measure of services established and prescribed by section 246.012, are:

(1) There shall be served in state hospitals a single standard of food for patients and employees alike, which is nutritious and palatable together with special diets as prescribed by the medical staff thereof. There shall be a chief dietitian in the department of public welfare and at least one dietitian at each state hospital. There shall be adequate staff and equipment for processing, preparation, distribution and serving of food.

(2) There shall be a staff of persons, professional and lay, sufficient in number, trained in the diagnosis, care and treatment of the mentally ill, physical illness, and including religious and spiritual counsel through qualified chaplains (who shall be in the unclassified service) adequate to take advantage of and put into practice modern methods of psychiatry, medicine and related fields.

(3) There shall be a staff and facilities to provide occupational and recreational therapy, entertainment and other creative activities as are consistent with modern methods of treatment and well being.

(4) There shall be in each state hospital for the care and treatment of the mentally ill facilities for the segregation and treatment of patients who have communicable disease.

(5) The commissioner of public welfare shall provide modern and adequate psychiatric social case work service.

(6) The commissioner of public welfare shall make every effort to improve the accommodations for patients so that the same shall be comfortable and attractive with adequate furnishings, clothing, and supplies.

(7) The commissioner of public welfare shall establish training programs for the training of personnel and may require the participation of personnel in such programs. Within the limits of the appropriations available he may establish professional training programs in the forms of educational stipends for positions for which there is a scarcity of applicants.

(8) There shall be a separate hospital for the diagnosis, care and treatment of the mentally ill who have tuberculosis which shall conform to the standards established for the diagnosis, care and treatment of physical disease. Pending construction of such separate hospital, one of the present state hospitals, or so much thereof as may be necessary, shall be set apart for the diagnosis, care and treatment of the mentally ill who have turberculosis and shall be staffed and equipped to meet the accepted requirements of modern medicine for the care and treatment of persons afflicted with tuberculosis.

(9) The standards herein established shall be adapted and applied to the diagnosis, care and treatment of inebriate persons and mentally deficient persons who come within those terms in the laws relating to the hospitalization and commitment of such persons and of persons who are psychopathic personalities within the definition thereof in Minnesota Statutes 1945, Section 526.09.

(10) The commissioner of public welfare shall establish a program of detection, diagnosis, and treatment of mentally and nervously ill persons and persons described in paragraph (9), and within the limits of appropriations may establish clinics and staff the same with persons specially trained in psychiatry and related fields.

(11) The director of civil service and the civil service commission may reclassify employees of the mental institutions from time to time, and assign classifications to such salary brackets as will adequately compensate personnel and reasonably assure a continuity of adequate staff.

(12) In addition to the chaplaincy services, provided in (2), the commissioner of public welfare shall open said institutions to ministers of the Gospel to the end that religious and spiritual counsel and services are made available to the patients therein, and shall cooperate with all ministers of the Gospel in making said

patients available for religious and spiritual counsel, and shall provide such ministers of the Gospel with meals and accommodations.

(13) Within the limits of the appropriations therefor, the commissioner of public welfare shall establish and provide facilities and equipment for research and study in the field of modern hospital management, the causes of mental and related illness and the treatment, diagnosis and care of the mentally ill and funds provided therefore may be used to make available services, abilities and advice of leaders in these and related field, and may provide them with meals and accommodations and compensate them for traveling expenses and services.

Sec. 5. Minnesota Statutes 1965, Section 246.14, is amended to read:

246.14. TRANSFERS OF PATIENTS TO OTHER STATE INSTITUTIONS. The commissioner of public welfare may use available space in any institution under his jurisdiction, or in any institution under the jurisdiction of another department or agency of the state in which space is proferred him, by executive or legislative action, for the care and custody of persons, patients, or inmates of the institutions under his exclusive control for whom other, more suitable, space is not available. All laws relating to the commitment and care of such persons who may be so committed and institutionalized shall be applicable to such persons.

Sec. 6. The effective date of this act shall be January 1, 1968.

Approved May 24, 1967.

APPENDIX C

A. COMMUNITY MENTAL HEALTH SERVICES

245.61 COMMISSIONER OF PUBLIC WELFARE MAY MAKE GRANTS FOR LOCAL MENTAL HEALTH PROGRAMS. The commissioner of public welfare is hereby authorized to make grants to assist cities, counties, towns, villages or any combinations thereof, or non-profit corporations in the establishment and operation of local mental health programs to provide the following services: (a) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, alcoholism, and other psychiatric disabilities; (b) informational and educational services to the general public, and lay and professional groups; (c) consultative services to schools, courts, and health and welfare agencies, both public and private; (d) out-patient diagnostic and treatment services; (e) rehabilitative services for patients suffering from mental or emotional disorders, mental retardation, alcoholism, and other psychiatric conditions particularly those who have received prior treatment in an in-patient facility; (f) detoxification and alcoholism evaluation and service facilities.

245.62 COMMUNITY MENTAL HEALTH PROGRAM: TAX LEVY. Any city, county, town or village, or any combination thereof, of over 50,000 population, and upon consent of the commissioner of public welfare, any city, county, town or village or combination thereof with less than 50,000 population, may establish a community mental health services program and may establish clinics and staff same with persons specially trained in psychiatry and related fields. Such programs and clinics may be administered by a city, county, town, village or non-profit corporation or a community mental health board established pursuant to sections 245.61 to 245.69.

In order to provide the necessary funds to establish and operate a mental health services program and to establish and maintain a clinic, the governing body of any city, county, town or village may levy annually upon all taxable property in such city, county, town or village, a special tax in excess of any statutory or charter limitation but such levy shall not exceed two mills. The governing body of any city, town, county or village may make such a levy, where necessary, separate from the general levy and at any time of the year. Nothing contained herein shall in any way preclude the use of funds available for this purpose under any existing statute or charter provision relating to cities, towns, counties or villages.

245.63 ASSISTANCE OR GRANT. Any city, county, town, village, non-profit corporation or community mental health board administering a mental health services program may apply for the assistance provided by sections 245.61 to 245.69 by submitting annually to the commissioner of public welfare its plan and budget for the next fiscal year together with the recommendations of the community mental health board thereon. No programs shall be eligible for a grant hereunder unless its plan and budget have been approved by the commissioner.

245.64 FUNDS ALLOCATED. At the beginning of each fiscal year the commissioner of public welfare shall allocate available funds to the mental health programs for disbursement during the fiscal year in accordance with such approved plans and budgets. The commissioner shall, from time to time during the fiscal year, review the budgets and expenditures of the various programs and if funds are not needed for a program to which they were allocated, he may, after reasonable notice and opportunity for hearing, withdraw such funds as are unencumbered and reallocate them to other programs. He may withdraw funds from any program which is not being administered in accordance with its approved plan and budget.

245.65 LIMITATION ON GRANTS. Subdivision 1. Except as hereinafter provided, grants for any program shall not exceed 50 percent of the total expenditures for (a) salaries, (b) contract facilities and services, (c) operation, maintenance, rental and service costs, (d) per diem and travel expense of members of community mental health boards, (e) mortgage or other financial costs specifically approved by the commissioner of public welfare for buildings and facilities constructed under the auspices of community mental health centers construction programs sponsored by the government of the United States, (f) mortgage or other financial costs specifically approved by the commissioner of public welfare for buildings and facilities which are not constructed under the auspices of community mental health centers construction programs sponsored by the government of the United States, providing such grants do not exceed 25 percent of total construction costs, and (g) other expenditures specifically approved and authorized by the commissioner of public welfare. Where any county served by a program hereunder has an assessed valuation of real and personal property of less than $13,000,000 and the required total mill levy for all costs, including administrative costs, for all forms of public assistance exceeds by 50 percent or more the average required mill levy for such costs in all counties of the state, and the levy is insufficient to pay the county's share of such costs, grants hereunder, attributable to such county's proportionate share of the total expenditures based on the ratio of such county's population to the total population of the area served by the program, may exceed 50 percent of the total expenditures but shall not exceed 75 percent of the total expenditure for the mental health program of such county. No grants shall be made for capital expenditures, except as herein provided. Grants may be made for expenditures for mental health services whether provided by operation of a local facility or through contract with other public or private agencies.

Subd. 2. Where local funds from any source other than the department of public welfare are being used to finance community mental health services prior to the effective date of sections 245.61 to 245.69 such funds shall not be used for matching state funds hereunder except that such local funds may be used for matching state funds for expansion of the existing services if such existing and expanded services conform to the provisions of sections 245.61 to 245.69.

Subd. 3. Existing local out-patient psychiatric clinic services now 100 percent state supported shall continue to receive such support until local funds are secured to provide 50 percent of such support but in no event beyond four years from the effective date hereof. Nothing in sections 245.61 to 245.69 shall be construed to limit the power of the commissioner of public welfare to establish clinics pursuant to section 246.014 (10).

245.66 COMMUNITY MENTAL HEALTH BOARDS. Every city, county, town, or village, or combination thereof establishing a community mental health services program shall, before it may come within the provisions of section 245.61 to 245.69 establish a community mental health board. When a combination of four or less of such political subdivisions establish such a program the board shall consist of nine members. When a combination of five or six of such political subdivisions establish such a program the board shall consist of at least nine members but not more than twelve members at the option of the selection committee. When seven or more of such political subdivisions establish such a program the board shall consist of at least nine members but not more than fifteen members at the option of the selecting committee. When any city, town, or village singly establishes such a program, such board shall be appointed by the chief executive officer of such city or village or the chairman of the governing body of such county or town. When a non-profit corporation is the administrator of such a program not established by a city, county,

town or village, such corporation shall select a community mental health board which shall be representative of the groups herein enumerated, but the number of members need not be nine. When any combination of the political subdivision herein enumerated establishes a community mental health services program, the chief executive officer of of each participating city or village and the chairman of the governing body of each participating county or town shall appoint two members to a selecting committee which shall select the members of the board. Membership of the community mental health boards shall be representative of local health departments, medical societies, county welfare boards, hospital boards, lay associations concerned with mental health, labor, agriculture, business, civic and professional groups and the general public. Nothing in this section shall be construed to preclude the appointment to the community mental health board of individuals who are also members of a board of county commissioners so long as the mental health board retains the representative character indicated above.

245.67 MEMBERS OF COMMUNITY MENTAL HEALTH BOARDS; TERMS, VACANCIES, REMOVAL. Except for boards appointed by non-profit corporations, the term of office of each member of the community mental health board shall be for three years measured from the first day of the year of appointment except that of the members first appointed, one-third shall be appointed for a term of one year, one-third for a term of two years, and one-third for a term of three years if there is a nine, twelve, or fifteen member board. Any remaining members first appointed shall serve the three year term. Vacancies shall be filled for the unexpired term in the same manner as original appointments. Any member of a board may be removed by the appointing authority for neglect of duty, misconduct, or malfeasance in office, after being given a written statement of charges and an opportunity to be heard thereon.

245.68 DUTIES OF COMMUNITY MENTAL HEALTH BOARDS. Subject to the provisions of this section and the rules and regulations of the commissioner of public welfare, each community mental health board shall:

(a) Facilitate and implement programs in mental health, mental retardation and inebriacy so as to assure delivery of services;

(b) Review and evaluate community mental health service provided pursuant to sections 245.61 to 245.69, and report thereon to the commissioner of public welfare, the administrator of the program, and, when indicated, the public, together with recommendations for additional services and facilities;

(c) Recruit and promote local financial support for the program from private sources such as community chests, business, industrial and private foundations, voluntary agencies and other lawful sources, and promote public support for municipal and county appropriations;

(d) Promote, arrange and implement working agreements with other social service agencies, both public and private, and with other educational and judicial agencies;

(e) Advise the administrator of the community mental health program on the adoption and implementation of policies to stimulate effective community relations;

(f). Review the annual plan and budget and make recommendations thereon; and

(g) When so determined by the authority establishing the program, act as the administrator of the program;

(h) Approve applications for grants made pursuant to section 2 of this act;

(i) Establish and operate a detoxification center;

(j) Encourage and assist innovative private treatment programs.

(k) Provide services for drug dependent persons.

(l) Appoint advisory committees in at least the areas of mental health, mental retardation and inebriacy. A committee shall consist of residents of the area served who are interested and knowledgeable in the area governed by such committee. These advisory committees shall report regularly to the board.

A. COMMUNITY MENTAL HEALTH SERVICES

245.69 ADDITIONAL DUTIES OF COMMISSIONER OF PUBLIC WELFARE. In addition to the powers and duties conferred upon him by law the commissioner of public welfare shall:

(a) Promulgate rules and regulations governing eligibility of community mental health programs to receive state grants, prescribing standards for qualification of personnel and quality of professional service and for in-service training and educational leave programs for personnel, governing eligibility for service so that no person will be denied service on the basis of race, color or creed, or inability to pay, providing for establishment, subject to the approval of the commissioner, of fee schedules which shall be based upon ability to pay and the guiding principle of which shall be that no one can afford to pay for his own treatment at the rate customarily charged in private practice shall be treated in the community mental health services clinic except as hereinafter provided, regulating fees for consultation and diagnostic services which services may be provided to anyone without regard to his financial status when referred by the courts, schools, or health or welfare agencies whether public or private, and such other rules and regulations as he deems necessary to carry out the purposes of sections 245.61 to 245.69.

(b) Review and evaluate local programs and the performace of administrative and psychiatric personnel and make recommendations thereon to community mental health boards and program administrators;

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

(d) Employ qualified personnel, including a director of community mental health services, under the supervision of the medical director to implement sections 245.61 to 245.69.

245.69 LAKELAND AREA PROGRAM BOARD; COMMUNITY MENTAL HEALTH PROGRAM. Subdivision 1. In order to better ascertain the effectiveness of caring for the mentally ill, mentally retarded, and juvenile delinquents in a small home-personalized environment as opposed to institutional care, the counties of Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, and Wilkin may, as a pilot program establish not more than ten group homes, nor more than two of which shall be located in any one of the above enumerated counties, for the care and rehabilitation of the mentally ill, mentally retarded, and juvenile delinquents.

Subd. 2. The homes authorized under this section shall be subject to the provisions of the Community Mental Health Act (Minnesota Statutes 1967, Sections 245.61 to 245.69), and the provisions of this section.

Subd. 3. Not more than ten patients shall be cared for in any group home established under this section. Minnesota Statutes 1967, Sections 144.50 to 144.58, are not applicable to group homes established by this section.

Subd. 4. The Lakeland Area Program Board established by the counties enumerated in Subdivision 1 of this section under Minnesota Statutes 1967, Section 244.66, is designated as the regional agency to receive grants for the purposes of this section from the commissioner of public welfare, subject to the limitations of Minnesota Statutes 1967, Section 245.65. No grants may be made under this section for the costs of construction or remodeling of any building. The commissioner of public welfare is authorized to make reasonable rules not inconsistent with the provisions of this section.

Subd. 5. The commissioner of public welfare may permit personnel of the Fergus Falls State Hospital to assist in developing and carrying out the programs authorized by this section.

A. COMMUNITY MENTAL HEALTH SERVICES

Sec. 2 There is hereby appropriated the sum of $75,000 for the commissioner of public welfare to be expended for the purposes of this act. Sums appropriated under this section shall be in addition to the regular appropriation for the purposes of the Community Mental Health Act.

NOTE: THIS COPY OF THE MINNESOTA COMMUNITY MENTAL HEALTH ACT DOES NOT INCLUDE THE MORE AMENDMENTS.

APPENDIX D

MENTAL HEALTH PLAN

This ranking of needs is based upon the premise that social dysfunction correlates highly with emotional instability. Where social dysfunction occurs the mechanisms to cope with daily living are sharply reduced or severly taxed. Marginal adjustment becomes more characteristic. It is, therefore, appropriate to utilize indicators of social dysfunction as a means of measuring the need priorities of geographical areas for mental health services.

The factors which we have selected as being most likely to reflect the prevalence of social disruption in the community are:

a. The dependency ration- the ratio of that part of a community's population who are under 15 years of age and over 65 years of age to the rest of the populations.

b. The percentage of aged persons (65 years and older) in the population.

c. The proportion of non-white population.

d. The divorce rate per 1,000 population.

e. The violent death (accidents, homicides, and suicides) rate per 1,000 population.

f. The unemployment rate per 1,000 population.

g. The educational level (median) of the population who are 25 years and older.

h. The child mortality rate (persons under 15 years) per 1,000 population.

i. The median buying income level of the population.

j. The rate of children in foster care per 1,000 population.

k. The estimated inebriacy rate in the population according to a rule* which is currently used by the Minnesota Commission on Alcoholism.

l. The rate per 1,000 population of persons on concurrent categorical aid.

m. The rate per 1,000 population of persons on AFDC.

n. The rate per 1,000 population of persons on OAA and MA.

o. The rate per 1,000 population of persons on AD and AB.

*Estimate = 66/1000 of 75 percent of the adult (15 years and over population.)

(These figures were obtained from the 1970 Census Bureau Report; 1969 Minnesota State Plan; Minnesota Vital Statistics - 1970; Preliminary 1971 Work Force, Unemployment and Unemployment Rate by County prepared by the Minnesota Department of Manpower Services; and the 1971 Fiscal Year reports from the Minnesota Department of Public Welfare; and are tabulated in Tables 1 through 19.)

The indicators include 'non-white population' per 1,000 population; and 'child mortality rate'; 'violent deaths per 1,000 population'; and, 'inebriacy estimates' since these also relate to the inference of social disruption.

Indicators such as 'admissions to MI hospitals per 1,000 population'; and, 'children receiving special education services per 1,000 population' are not included here because of the possible confusability of their meaning. That is, if a community has a relatively large number of admissions per 1,000 population, it is difficult to logically distinguish whether this would reflect a higher actual need or simply that members of the population at risk are more apt to be institutionalized if they live in that particular community. Other communities with relatively low institutionalization rates may actually be reflecting a philosophy for maintaining members of high risk population in the community.

Children receiving special education services is not included because this statistic may simply be indicative of the availability of special education services more than anything else.

For each of the indicators listed above, each of the areas has been ranked from 1 to 25. A rank of 1 reflects the most observed rate per thousand and a rank of 25 the least observed rate per thousand. The reason for ordering the comparative indices of need in this manner is to yield the highest numerical value for the areas reflecting the most prevelance in the population with respect to any of the 'need' indicators. (see attached tables) Since we have no way of knowing which of the indicators are more or less suggestive of need than others, we assigned equal values to each. However, the indicators were grouped according to the likelihood that they would reflect need for services to children and adults combined).

CHILD
RANKINS OF COMPARATIVE NEEDS
BY
SOCIAL DYSFUNCTION

AREA	DEPENDENCY	AD & AB	AFDC	FOSTER CARE	DIVORCE	RACE	VIOLENT DEATHS	CHILD MORT.
Anoka	12	25	8	25	10	10	22	23
Carver-Scott	4	20	18	10	21	20	18	17
Central	9	13	22	17	23	15	9	9
Dakota	13	24	15	13	21	13	25	24
Duluth	21	11	5	6	24	5	14	5
Five County	3	9	7	7	12	7	8	8
Hennepin	25	15	2	9	1	3	3	15
Hiawatha Valley	19	19	24	20	16	23	12	18
Lakeland	18	8	13	18	15	9	16	1
Minnesota Valley	24	18	11	8	13	7	19	19
Mower County	20	21	12	24	7	24	15	10
Northern Pines	2	2	9	11	17	18	6	12
Northland	1	3	6	2	5	24	13	11
Northwestern	6	4	10	16	19	8	10	3
Ramsey	23	12	1	3	2	2	4	16
Range	22	10	4	5	3	6	1	22
Sioux Trails	17	16	5	19	20	22	5	6
Southern	15	17	16	4	14	16	21	21

Southwestern	8	6	20	23	24	21	17	13
Upper Mississippi	11	1	3	1	8	1	2	4
Washington	5	3	14	12	6	11	24	25
Washington	5	3	14	12	6	11	24	25
West Central	10	7	19	14	22	25	7	2
Western	7	5	17	21	25	14	20	7
Youngdahl	14	22	23	22	18	19	23	10
Zumbro Valley	16	14	21	15	9	12	11	14

ADULT AND CHILD
RANKINGS OF COMPARATIVE NEEDS BY AREA

AREA	Dep	65+	Con Aid	AD AB	OAA MA	AF DC	Fst Cre	Div	Rce	Vlt Dth	Cld Mrt	Buy Inc	Un-emp	Edu-cat	Ineb.
Anoka	12	25	25	25	20	8	25	10	10	22	23	19	20.5	22.5	24
Carver-Scott	4	22	18.5	20	13	18	10	21	20	22	17	14	9	6.5	14.5
Central	9	20	14	13	11	22	17	23	15	9	9	9	6	6.5	5.5
Dakota	13	24	24	24	25	15	13	21	13	25	24	22	20.5	21	26.5
Duluth	21	16	10	11	3	5	6	4	5	14	5	18	11	24.5	3
Five County	3	4	6	9	6	7	7	12	7	8	8	7	4	2.5	8.5
Hennepin	25	2	20	15	9	2	9	1	3	3	15	25	20.5	24.5	16.5
Hiawatha Valley	19	11	16	19	16	24	20	16	26	12	18	13	8	12	18.5
Lakeland	18	9	5	8	8	13	18	15	9	16	1	6	10	13	4
Minnesota Valley	24	15	12	18	12	11	8	13	17	19	19	16	16	16	20.5
Mower County	20	18	15	21	18	12	24	7	24	15	20	23	15	17.5	1
Northern Pines	2	6	2	22	5	9	11	17	18	6	12	2	5	9.5	11
Northland	1	1	4	3	7	6	2	5	4	13	11	5	3	15	5.5
Northwestern	6	2	3	4	4	10	16	19	8	10	3	10	2	2.5	14.5
Ramsey	23	19	17	12	17	1	3	2	2	4	16	24	20.5	22.5	10
Range	22	14	11	10	2	4	5	3	6	1	22	20	7	19	7
Sioux Trails	17	12	21	16	23	25	19	20	22	5	6	11	17	1	20
Southern	15	10	13	17	15	16	4	14	16	21	21	12	18	14	12.5
Southwestern	8	7	8	6	24	20	23	24	21	17	13	8	25	6.5	8.5
Upper Mississippi	11	5	1	1	1	3	1	8	1	2	4	1	1	6.5	18.5
Washington	5	23	22	23	22	14	12	6	11	24	25	21	20.5	20	25
West Central	10	3	7	7	10	19	14	22	25	7	2	4	12	9.5	2.5
Western	7	8	9	5	19	17	21	25	14	20	7	3	13	2.5	12.5
Youngdahl	14	13	23	22	21	23	22	18	19	23	10	15	14	11	22.5
Zumbro Valley	61	17	18.5	14	14	21	15	9	12	11	14	17	24	17.5	21

ADULT

RANKINGS FOR COMPARATIVE NEEDS

AREA	Dep	65+	AD AB	OAA MA	Con Aid	Div	Rce	Vlt Dth	Buy Inc	Un-emp	Edu-cat	Ineb.
Anoka	12	25	25	20	25	10	10	22	19		20.5	24
Carver-Scott	4	22	20	13	18.5	21	20	18	14	9	6.5	14.5
Central	9	20	13	11	14	23	15	9	9	6	6.5	6.0
Dakota	13	24	24	25	24	11	13	25	22	20.5	21	16.5
Duluth	21	16	11	3	10	4	5	14	18	11	24.5	3
Five County	3	4	9	6	6	12	7	8	7	4	2.5	8.5
Hennepin	25	21	15	9	20	1	3	3	25	20.5	24.5	16.5
Hiawatha Valley	19	11	19	16	16	16	23	12	13	8	12	18.5
Lakeland	18		8	8	5	15	9	16	6	10	3	4
Minnesota Valley	24	15	18	12	12	13	17	19	16	16	16	22.5
Mower County	20	18	21	18	15	7	24	15	23	15	17.5	1
Northern Pines	2	6	2	5	2	17	18	6	2	5	9.5	11
Northland	1	1	3	7	4	5	4	13	5	3	15	5.5
Northwestern	6		4	4	3	19	8	10	10	2	2.5	14.5
Ramsey	23	19	12	17		2	2	4	24	20.5	22.5	10
Range	22	14	10	2	11	3	6	1	20	7	19.0	7
Sioux Trails	17	12	16	23	21	20	22	5	11	12	1	20
Southern	15	10	17	15	13	14	16	21	12	18	14	12.5
Southwestern	8	7	6	24	8	24	21	17	8	25	6.5	8.5
Upper Mississippi	11	5	1	1	1	8	1	2	1	1	6.5	18.5
Washington	5	23	23	22	22	6	11	24	21	20.5	20	25
West Central	10	3	7	10	7	22	25	7	4	12	9.5	2
Western	7	8	9	19	9	25	14	20	3	13	2.5	8.5
Youngdahl	14	13	22	21	23	18	19	23	15	14	11	22.5
Zumbro Valley	16	17	14	14	8.5	9	12	11	17	24	7.5	21

Table 6

DEPENDENCY RATIO

Area	Total Population	Ages 15-64	0-14 and 65 & over	Rate per 1000	Rank
Anoka	154,556	88,728	65,828	739.6	11.5
Carver-Scott	60,733	33,767	26,966	793.1	5
Central	173,518	98,203	75,315	768.5	8
Dakota	139,808	80,486	59,322	741.5	11
Duluth	170,641	101,385	69,256	685.7	20
Five County	76,351	42,227	34,124	812.5	3
Hennepin	960,080	596,711	363,369	608.7	24
Hiawatha Valley	79,189	46,077	33,112	719.8	18
Lakeland	185,376	107,571	77,805	720.4	17
Minnesota Valley	73,654	45,333	28,321	629.4	23
Mower County	43,783	25,786	17,997	692.2	19
Northern Pines	96,301	52,954	43,347	522.3	25
Northland	64,064	34,076	29,988	282.0	2
Northwestern	88,648	49,701	38,947	778.9	6
Ramsey	476,255	287,754	188,501	654.5	22
Range	94,898	56,719	38,179	669.8	21
Sioux Trails	106,864	61,912	44,952	725.0	16
Southern	58,960	34,079	24,881	731.8	13
Southwestern	76,584	43,313	33,271	773.7	7
Upper Mississippi	77,848	44,565	33,283	739.6	11.5
Washington	82,948	46,411	36,537	794.3	4
West Central	145,550	82,540	63,010	759.2	10
Western	79,366	44,846	34,520	767.1	9
Youngdahl	98,213	57,294	41,919	735.4	14
Zumbro Valley	140,783	81,432	59,351	732.7	15
TOTALS	3,804,971		1,562,101		

Table 7

PERSONS 65 AND OVER

Area	Total Population	Persons 65 and Over	Rate Per 1000	Rank
Anoka	154,556	4,655	30.01	25
Carver-Scott	60,733	5,403	88.57	22
Central	173,518	17,160	98.62	20
Dakota	139,808	7,254	51.81	24
Duluth	170,641	19,328	113.03	16
Five County	76,351	10,957	144.17	4
Hennepin	960,080	92,953	96.83	21
Hiawatha Valley	79,189	10,454	132.33	11
Lakeland	185,376	25,166	136.03	9
Minnesota Valley	73,654	8,354	112.89	15
Mower County	43,783	4,814	109.41	18
Northern Pines	96,301	13,612	141.79	6
Northland	64,064	10,894	170.22	1
Northwestern	88,648	12,969	145.72	2
Ramsey	476,255	48,386	101.65	19
Range	94,898	11,212	118.02	14
Sioux Trails	106,864	13,880	129.72	12
Southern	58,960	7,818	132.51	10
Southwestern	76,584	10,688	138.81	7
Upper Mississippi	77,848	11,109	142.42	5
Washington	82,948	4,795	57.77	23
West Central	145,550	20,990	143.77	3
Western	79,366	10,963	138.77	8
Youngdahl	98,213	12,719	129.79	13
Zumbro Valley	140,783	15,799	112.05	17
TOTALS	3,804,971	412,332		

Table 8

CONCURRENTLY RECEIVING CATEGORICAL AID

Area	Total Population	Population Over 19	Concurrently Receiving Categorical Aid	Rate per 1000	Rank
Anoka	154,556	79,957	228	2.85	25
Carver-Scott	60,733	33,674	273	9.10	18.5
Central	173,518	95,646	1,001	10.01	15
Dakota	139,808	75,940	236	2.95	24
Duluth	170,641	103,439	1,286	12.86	11
Five County	76,351	46,283	824	16.48	7
Hennepin	960,080	599,830	5,346	8.91	20
Hiawatha Valley	79,189	47,794	472	9.44	17
Lakeland	185,376	112,105	2,078	18.89	6
Minnesota Valley	73,654	44,458	434	10.85	13
Mower County	43,783	25,928	290	9.67	16
Northern Pines	96,301	56,924	1,372	22.87	3
Northland	64,064	38,179	868	21.70	5
Northwestern	88,648	53,931	1,124	22.48	4
Ramsey	476,255	290,520	2,681	9.25	18
Range	94,898	58,170	697	11.62	12
Sioux Trails	106,864	65,196	595	8.50	21
Southern	58,960	36,228	412	10.30	14
Southwestern	76,584	46,283	687	13.74	9
Upper Mississippi	77,848	47,461	1,207	24.14	6
Washington	82,948	43,906	322	8.05	24
West Central	145,550	89,746	1,389	15.43	8
Western	79,366	47,279	670	13.40	10
Youngdahl	98,213	58,441	444	7.40	23
Zumbro Valley	140,783	84,477	728	9.10	18.5
TOTALS	3,804,971	2,280,795	25,664		

Table 9

AID TO THE DISABLED
AND
AID TO THE BLIND

Area	Total Population	Total Under 65	AD and AB	Rate per 1000	Rank
Anoka	154,556	149,901	161	1.07	25
Carver-Scott	60,733	55,330	181	3.02	20
Central	173,518	156,358	688	4.30	13
Dakota	139,808	132,554	230	1.77	24
Duluth	170,641	151,313	801	5.34	11
Five County	76,351	65,394	425	6.07	9
Hennepin	960,080	867,127	3,578	4.11	15
Hiawatha Valley	79,189	68,735	251	3.59	19
Lakeland	185,376	160,210	988	6.18	8
Minnesota Valley	73,654	65,300	262	3.74	18
Mower County	43,783	38,969	108	2.70	21
Northern Pines	96,301	82,689	792	9.90	2
Northland	64,064	53,170	472	9.44	3
Northwestern	88,648	75,679	716	8.95	4
Ramsey	476,255	427,869	2,082	4.84	12
Range	94,898	83,686	477	5.96	10
Sioux Trails	106,864	92,984	367	4.08	16
Southern	58,960	51,142	201	4.02	17
Southwestern	76,584	65,896	493	7.04	6
Upper Mississippi	77,848	66,739	835	11.93	1
Washington	82,948	78,153	196	2.45	23
West Central	145,550	124,560	802	6.68	7
Western	79,366	68,403	536	7.66	5
Youngdahl	98,213	86,494	231	2.57	22
Zumbro Valley	140,783	124,984	498	4.15	14
TOTALS	3,804,971	3,393,639	16,371		

Table 10

OLD AGE ASSISTANCE
AND
MEDICAL ASSISTANCE

Area	Total Population	Total 65 & Over	OAA And MA	Rate per 1000	Rank
Anoka	154,056	4,655	350	70.00	20
Carver-Scott	60,733	5,403	417	83.40	13
Central	173,518	17,160	1,464	86.12	11
Dakota	139,808	7,254	326	46.57	25
Duluth	170,641	19,328	2,555	134.47	3
Five County	76,351	10,957	1,334	121.27	6
Hennepin	960,080	92,953	9,469	101.82	9
Hiawatha Valley	79,189	10,454	808	80.80	16
Lakeland	185,376	25,166	2,773	110.92	8
Minnesota Valley	73,654	8,354	676	84.50	12
Mower County	43,783	4,814	389	77.80	18
Northern Pines	96,301	13,612	1,763	125.93	5
Northland	64,064	10,894	1,274	115.82	7
Northwestern	88,648	12,969	1,471	133.92	4
Ramsey	476,255	48,386	3,838	79.96	17
Range	94,898	11,212	1,495	135.91	2
Sioux Trails	106,864	13,880	860	61.43	23
Southern	58,960	7,818	652	81.50	15
Southwestern	76,584	10,688	670	60.91	24
Upper Mississippi	77,848	11,109	1,627	147.91	1
Washington	82,948	4,795	340	68.00	22
West Central	145,550	20,990	1,912	91.05	10
Western	79,366	10,963	848	77.09	19
Youngdahl	98.213	12,719	891	68.54	21
Zumbro Valley	140,783	15,799	1,306	81.63	14
TOTALS	3,804,971	412,332	39,508		

Table 11

AID TO FAMILIES WITH DEPENDENT CHILDREN

Area	Total Population	Total 19 & Under	Average Number AFDC Children	Rate per 1000	Rank
Anoka	154,556	74,599	2,635	37.64	8
Carver-Scott	60,733	27,059	686	22.87	18
Central	173,518	77,872	1,532	19.15	22
Dakota	139,808	63,868	1,650	27.50	15
Duluth	170,641	67,202	3,533	50.47	5
Five County	76,351	30,068	1,217	40.57	7
Hennepin	960,080	360,250	29,303	81.40	2
Hiawatha Valley	79,189	31,395	555	18.50	24
Lakeland	185,376	73,271	2,033	29.04	13
Minnesota Valley	73,654	29,196	916	30.53	11
Mower County	43,783	17,855	606	30.30	12
Northern Pines	96,301	39,377	1,477	36.93	9
Northland	64,064	25,885	1,470	49.00	6
Northwestern	88,648	34,717	1,004	33.47	10
Ramsey	476,255	185,735	15,507	81.62	1
Range	94,898	36,728	2,147	53.68	4
Sioux Trails	106,864	41,668	720	18.00	25
Southern	58,960	22,732	505	25.25	16
Southwestern	76,584	30,301	630	21.00	20
Upper Mississippi	77,848	30,387	2,069	68.97	3
Washington	82,948	39,042	1,110	27.75	14
West Central	145,550	55,804	1,321	22.02	19
Western	79,366	32,087	704	23.47	17
Youngdahl	98,213	39,772	746	18.65	23
Zumbro Valley	140,783	56,306	1,227	20.45	21
TOTALS	3,804,971	1,523,176	75,303		

Table 12

CHILDREN IN FOSTER CARE

Area	Total Population	Total 19 & Under	Children in Foster Care	Rate per 1000	Rank
Anoka	154,556	74,599	27	.39	25
Carver-Scott	60,733	27,059	59	1.97	10
Central	173,518	77,872	76	.95	17
Dakota	139,808	63,868	79	1.32	13
Duluth	170,641	67,202	185	2.64	6
Five County	76,351	30,068	72	2.40	7
Hennepin	960,080	360,250	780	2.17	9
Hiawatha Valley	79,189	31,395	24	.80	20
Lakeland	185,376	73,271	65	.93	18
Minnesota Valley	73,654	29,196	67	2.23	8
Mower County	43,783	17,855	9	.45	24
Northern Pines	96,301	39,377	71	1.78	11
Northland	64.064	25,885	112	3.73	2
Northwestern	88,648	34,717	29	.97	16
Ramsey	476,255	185,735	658	3.46	3
Range	94,898	36,728	106	2.65	5
Sioux Trails	106,864	41,668	36	.90	19
Southern	58,960	22,732	61	3.05	4
Southwestern	76,584	30,301	20	.67	23
Upper Mississippi	77,848	30,387	166	5.53	1
Washington	82,948	39,042	63	1.58	12
West Central	145,550	55,804	72	1.20	14
Western	79,366	32,087	23	.77	21
Youngdahl	98,213	39,772	29	.73	22
Zumbro Valley	140,783	56,306	66	1.10	15
TOTALS	3.804,971	1,523,176	2,955		

Table 13

DIVORCES

Area	Total Population	Number of Divorces	Rate per 1000	Rank
Anoka	154,556	2,063	13.75	10
Carver-Scott	60,733	512	8.53	21
Central	173,518	1,382	8.13	23
Dakota	139,808	1,847	13.19	11
Duluth	170,641	3,373	19.84	4
Five County	76,351	936	11.70	12
Hennepin	960,080	26,384	27.48	1
Hiawatha Valley	79,189	854	10.68	16
Lakeland	185,376	2,045	10.76	15
Minnesota Valley	73,654	780	11.14	13
Mower County	43,783	608	15.20	7
Northern Pines	96,301	1,066	10.66	17
Northland	64,064	1,001	16.68	5
Northwestern	88,648	888	9.87	19
Ramsey	476,255	12,163	25.34	2
Range	94,898	1,938	21.53	3
Sioux Trails	106,864	997	9.06	20
Southern	58,960	654	10.90	14
Southwestern	76,584	588	7.35	24
Upper Mississippi	77,848	1,182	14.78	8
Washington	82,948	1,221	15.26	6
West Central	145,550	1,274	8.49	22
Western	79,366	544	6.80	25
Youngdahl	98,213	1,045	10.45	18
Zumbro Valley	140,783	2,006	14.33	9
TOTALS	3,804,971	67,351		

Table 14

RACE

Area	Total Population	Total White Population	Total Non-White Population	Rate Non-White Population Per 1000	Rank
Anoka	154,556	153,420	1,136	7.32	10
Carver-Scott	60,733	60,544	189	3.09	20
Central Minnesota	173,518	172,659	859	4.93	15
Dakota	139,808	139,038	770	5.50	13
Duluth	170,641	168,211	2,430	14.20	5
Five County	76,351	75,350	1,001	13.17	7
Hennepin	960,080	928,507	31,573	32.88	3
Hiawatha Valley	79,189	79,003	186	2.35	23
Lakeland	185,376	183,431	1,945	10.51	9
Minnesota Valley	73,654	73,387	267	3.60	17
Mower County	43,783	43,693	90	2.04	24
Northern Pines	96,301	95,977	324	3.38	18
Northland	64,064	62,796	1,268	19.80	4
Northwestern	88,648	87,602	1,046	11.75	8
Ramsey	476,255	460,454	15,801	33.19	2
Range	94,898	93,640	1,258	13.24	6
Sioux Trails	106,864	106,610	254	2.37	22
Southern Minnesota	58,960	58,705	255	4.32	16
Southwestern	76,584	76,360	224	2.90	21
Upper Mississippi	77,848	72,408	5,440	69.74	1
Washington	82,948	82,350	598	7.20	11
West Central	145,550	145,274	276	1.89	25
Western	79,366	78,953	413	5.22	14
Youngdahl	98,213	97,884	329	3.35	19
Zumbro Valley	140,783	139,782	1,001	7.10	12
TOTALS	3,804,971	3,736,038	68,933		

Table 15

VIOLENT DEATHS

Area	Total Population	Violent Deaths	Rate Per 1000	Rank
Anoka	154,556	88	5.67	22
Carver Scott	60,733	43	7.04	18
Central	173,518	140	8.04	9
Dakota	139,808	53	3.78	25
Duluth	170,641	130	7.60	14
Five County	76,351	63	8.28	8
Hennepin	960,080	1,044	10.80	3
Hiawatha Valley	78,189	62	7.84	12
Lakeland	185,376	135	7.29	16
Minnesota Valley	73,654	50	6.76	19
Mower County	43,783	33	7.50	15
Northern Pines	96,301	85	8.85	6
Northland	64,064	49	7.65	13
Northwestern	88,648	72	8.00	10
Ramsey	476,255	478	10.00	4
Range	94,864	207	21.78	1
Sioux Trails	106,864	96	8.97	5
Southern	58,960	39	6.61	21
Southwestern	76,584	55	7.14	17
Upper Mississippi	77,484	92	11.70	2
Washington	82,948	44	5.30	24
West Central	145,550	127	8.69	7
Western	79,366	53	6.70	20
Youngdahl	98,213	55	5.61	23
Zumbro Valley	140,783	111	7.87	11
TOTALS	3,804,971	3,404		

Table 16

CHILD MORTALITY

Area	Total Population	Child Mortality	Rate Per 1000	Rank
Anoka	154,556	71	4.6	23
Carver-Scott	60,733	58	9.5	17
Central	173,518	308	17.7	9
Dakota	139,808	45	3.2	24
Duluth	170,641	453	26.5	5
Five County	76,351	155	20.4	8
Hennepin	960,080	1,133	11.8	15
Hiawatha Valley	78,189	74	9.4	18
Lakeland	185,376	796	43.0	1
Minnesota Valley	73,654	63	8.5	19
Mower County	43,783	33	7.5	20
Northern Pines	96,301	140	14.6	12
Northland	64,064	108	16.8	11
Northwestern	88,648	298	33.5	3
Ramsey	476,255	50	9.6	16
Range	94,864	457	5.3	22
Sioux Trails	106,864	282	26.4	6
Southern	58,960	44	7.4	21
Southwestern	76,584	109	14.2	13
Upper Mississippi	77,484	229	29.3	4
Washington	82,948	25	3.0	25
West Central	145,550	587	40.2	2
Western	79,366	194	24.5	7
Youngdahl	98,213	166	16.9	10
Zumbro Valley	140,783	176	12.5	14
TOTALS	3,804,971	6,054		

Table 17

MEDIAN BUYING INCOME

Area	Total Population	Buying Income	Rank
Anoka	154,556	$2,986.	19
Carver-Scott	60,733	$2,461.	14
Central	173,518	$2,171.	9
Dakota	139,808	$3,137.	22
Duluth	170,641	$2,823.	18
Five County	76,351	$2,125.	7
Hennepin	960,080	$3,565.	25
Hiawatha Valley	79,189	$2,413.	13
Lakeland	185,376	$2,121.	6
Minnesota Valley	73,654	$2,574.	16
Mower County	43,783	$3,175.	23
Northern Pines	96,301	$1,929.	2
Northland	64,064	$2,117.	5
Northwestern	88,648	$2,228.	10
Ramsey	476,255	$3,224.	24
Range	94,898	$2,993.	20
Sioux Trails	106,864	$2,345.	11
Southern	58,960	$2,396.	12
Southwestern	76,584	$2,170.	8
Upper Mississippi	77,848	$1,728.	1
Washington	82,948	$3,069.	21
West Central	145,550	$2,063.	4
Western	79,366	$1,987.	3
Youngdahl	98,213	$2,544.	15
Zumbro Valley	140,783	$2,749.	17
TOTALS	3,804,971		

Table 18

UNEMPLOYMENT

Area	Total Population	Work Force	Unemployed	Rate per 1000	Rank
Anoka	154,556	78,520	3,564	45.11	20.5
Carver-Scott	60,733	20,878	1,336	63.62	9
Central Minnesota	173,518	62,264	4,906	79.13	6
Dakota	139,808	61,070	2,772	45.44	20.5
Duluth	170,641	65,290	3,826	58.86	11
Five County	76,351	30,510	2,806	90.52	4
Hennepin	960,080	462,370	20,988	45.43	20.5
Hiawatha Valley	79,189	32,386	2,081	65.03	8
Lakeland	185,376	75,759	4,808	63.26	10
Minnesota Valley	73,654	30,727	1,554	50.13	16
Mower County	43,783	20,038	1,052	52.60	15
Northern Pines	96,301	37,477	3,257	88.03	5
Northland	64,064	25,447	2,445	97.80	3
Northwestern	88,640	39,519	3,828	95.70	2
Ramsey	476,255	226,820	10,296	45.36	20.5
Range	94,898	45,167	3,105	69.00	7
Sioux Trails	106,864	47,203	2,287	48.66	17
Southern	58,960	26,616	1,238	45.85	18
Southwestern	76,584	31,857	1,334	41.69	25
Upper Mississippi	77,848	32,048	3,269	102.16	1
Washington	82,948	43,620	1,980	45.00	20.5
West Central	145,550	67,187	3,789	56.55	12
Western	79,366	33,437	1,839	55.73	13
Youngdahl	98,213	41,738	2,258	53.76	14
Zumbro Valley	140,783	64,839	2,789	42.91	24
TOTALS	3,804,791	1,702,787	93,407		

Table 19

MEDIAN EDUCATION LEVEL

Area	Total Population	Population 25 & Over	Median Education	Rate Per 1000	Rank
Anoka	154,556	68,729	11.8	443.41	22.5
Carver-Scott	60,733	29,714	8.9	487.11	10.5
Central	173,518	80,690	8.9	463.74	10.5
Dakota	139,808	66,356	11.5	473.97	21
Duluth	170,641	92,027	12.1	538.17	24.5
Five County	76,351	42,517	8.8	559.43	2.5
Hennepin	960,080	507,304	12.1	528.44	24.5
Hiawatha Valley	79,189	41,273	9.4	522.44	12
Lakeland	185,376	99,999	9.5	540.54	13
Minnesota Valley	73,654	35,638	10.4	481.59	16
Mower County	43,783	23,677	10.7	538.11	17.5
Northern Pines	96,301	52,279	9.0	544.57	9.5
Northland	64,064	35,136	9.8	549.00	15
Northwestern	88,648	49,434	8.8	555.44	2.5
Ramsey	476,255	246,465	11.8	517.78	22.5
Range	94,898	51,584	11.0	542.99	19
Sioux Trails	106,964	63,115	8.3	589.86	23.5
Southern	58,960	32,770	9.7	555.42	14
Southwestern	76,584	42,472	8.9	551.58	6.5
Upper Mississippi	77,848	42,096	8.9	539.69	6.5
Washington	82,948	39,230	11.3	472.65	20
West Central	145,550	82,594	9.0	565.71	9.5
Western	79,366	43,298	8.8	548.08	2.5
Youngdahl	98,213	51,020	9.3	520.61	11
Zumbro Valley	140,783	75,013	10.7	532.01	17.5
TOTALS	3,804,971	1,994,430			

Lower rank number indicates less education

APPENDIX E

TO: Minnesota Association of Mental Health Programs

FROM: Policy Committee- MAMHP- (Ed Schnettler, Chairman, Roy Anderson, Vince Mehmel, Tom Olson, Gary Selvy)

SUBJECT: Final Draft - Policy Statement - Area Program Responsibility in Human Service Caretaker System

DATE: 2/14/74

I. Preamble:

The wide range of human needs and complexity of human problems requires a varied human service delivery system with highly qualified staff providing services to meet those human needs. Each caretaker group must have a clearly delineated area of responsibility and defined service program. Particular caretakers must have authority for planning, coordination and development of specific aspects of the human service delivery system.

The area Mental Health, Mental Retardation and Addiction program is committed to the development of a coordinated and cooperative human service delivery system. The authority for this program is based on Minnesota Statutes 1972, Section 245.61 to 245.69 and Section 245.692 and Chapter 572.

The following outlines the baseline program and service requirements for Area Programs as specified in Minnesota Statutes. It requires the Area Board to provide a comprehensive service for the three disability groups of mentally ill, mentally retarded and chemically dependent by directly administrating such programs and services as specified in these statutes, contracting for these services, or in other ways insuring their delivery. Services and programs not included in the above statutes would be provided only after an area wide planning and coordinating body, DPW or County Board delegates such responsibility to an Area Board.

II. Service Requirements:

Chapter 245.61Minnesota Statutes give the Commissioner of Public Welfare authority to make grants for the operation of local mental health programs "to provide the following services."

A. "Collaborative and Cooperative services with public health and other groups for purposes of prevention of mental illness, mental retardation, alcoholism and other psychiatric disabilities."

1. Area Board Responsibility:

a. Requires the Area Board to serve as the coordinating and convening agency of community caretakers for the development of preventative programs for mental illness, retardation, addiction and other psychiatric disabilities.

b. Requires the Area Board to develop programs for prevention of mental illness, retardation, addiction and other psychiatric disabilities.

1. Primary prevention programs - programs addressed to adverse influences of society.

2. Secondary prevention-programs designed for early detection and intervention - such as crises intervention, early case finding.
3. Tertiary prevention - programs for follow up and rehabilitation of the above disability groups.

2. Suggestions for Implementation:

a. Assign responsibility for developing and evaluating collaborative and cooperative services to statutorily required advisory committees on Mental Health, Mental Retardation and Chemical Dependency.
b. Convene area coordinating committee for mental illness, mental retardation, addiction and other psychiatric disorders. This committee could help plan, develop and evaluate area programs for prevention.
c. Coordinating committee could review and recommend preventative services to appropriate caretaker groups and Boards.
d. Prevention programs of Area Board should include early identification programs, crises intervention, high risk group programs, educational and research programs.

B. "Informational and educational services to the general public and lay and professional groups."

1. Area Board Responsibility:

a. Requires Area Board to provide educational programs and services to promote mental health and prevent mental illness, retardation, addiction and other psychiatric disabilities.
b. Requires Area Board to provide educational programs to assist the general public in its understanding of above disability groups.
c. Requires Area Board to provide educational programs for lay and professional groups on matters concerning mental illness, retardation, addiction and other psychiatric disabilities.

2. Suggestions for Implementation:

a. Educational program to increase visibility, identifiability, and accessibility of all mental health, mental retardation and chemical dependency programs for area residents.
b. Dissemination and distribution of relevant mental health information and knowledge.
c. Goal oriented educational service with identified objectives and specific target populations.
d. Extending expertise of Center staff to other caretaker groups and at the same time drawing from their expertise for improvement of Center program.
e. Establish Area library and other informational materials on mental illness, retardation, addiction and other psychiatric disabilities.
f. Assign staff responsibility for development of educational programs.
g. Provide workshops for voluntary associations and professional groups.

C. "Consultative services to schools, courts, and health and welfare agencies, both public and private."

1. Area Board Responsibility:

a. Requires Area Board to provide mental health assistance, by qualified personnel, to other community caretakers.
b. Requires Area Board to provide consultative assistance to particular public and private groups.

2. Suggestions for Implementation:

a. Provide collaborative consultation with community caretakers to help them deal more effectively with particular clients- (Case consultation).
b. Provide program consultation on the planning and development of mental health related programs and services-(Program consultation).
c. Develop expertise in special areas, such as children's problems, to assist center staff and other caretakers.
d. Include this service as part of outreach program.

D. "Out-patient diagnostic and treatment services."

1. Area Board Responsibility:

a. Requires Area Board to provide the necessary therapies for persons with mental illness, retardation, addiction and other psychiatric disabilities.
b. Requires Area Board to provide varied therapy programs such as crises intervention services, emergency service, on-going treatment programs, etc.
c. Requires Area Board to provide diagnostic service to all area residents and other community caretakers.

2. Suggestions for Implementation:

a Provide varied goal oriented services to general groups and specific services for special need groups.
b. Provide out-patient diagnostic and treatment services as appropriate to meet the needs of area residents.
c. Provide a staff with different treatment methods so as to meet the varied needs of people in service area.
d. Provide primarily short term care services.
e. Provide direct services at different points in the catchment area to improve accessibility of the service.
f. Provide Day Treatment program along with other treatment modalities.
g. Provide 24 hour emergency service.
h. Coordinate above services with in-patient program to provide continuity of care.

E. "Rehabilitative services for patients suffering from mental or emotional disorders, mental retardation, alcoholism and other psychiatric conditions particularly those who have received prior treatment in an in-patient facility."

1. Area Board Responsibility:

   a. Requires Area Board to provide direct service program for post-hospital patients.
   b. Requires Area Board to develop treatment services beyond those described above to meet the specific needs of persons with more chronic or deep rooted disturbances.

2. Suggestions for Implementation:

   a. Provide specialized service programs designed to assist and rehabilitate the more seriously ill patient.
   b. Develop programs in addition to traditional direct service programs - such as group home and sheltered work setting.
   c. Develop Day Treatment and Day Care programs.
   d. Provide follow-up drug clinic.
   e. Coordinate efforts with County Welfare Departments and other caretakers who most often also concern themselves with this type patient.
   f. Provide liaison with residential prgrams, county welfare staff and other caretakers to assist in appropriate planning for this type of patient.

F. "Detoxification and alcoholism evaluation and service facilities."

1. Area Board Responsibility:

   a. Requires Area Board to provide detoxification service facility and program as specified also in Section 245.61 Minnesota Statute.
   b. Requires Area Board to provide evaluation and treatment program for addiction problems.

2. Suggestions for Implementation:

   a. Provide directly or by contract a sub-acute detoxification facility and program.
   b. Provide or coordinate with existing hospitals to provide acute detoxification programs.
   c. Provide direct therapy or service program for addicted persons, in addition to detoxification service, based on individual need.
   d. Provide educational and consultative services concerning addiction problems.

G. "Staff Requirements and Qualifications."

1. Minimum staff qualifications for Area Program will be established by the Commissioner of Public Welfare.

2. The responsibilities assigned to Area Programs requires a highly qualified staff representing a variety of professions. The Area Board is responsible for providing staff meeting minimum State requirements and of such quality and special expertise as to meet the needs of its programs and services.

3. Professional staff will include specialists in the area of mental illness, mental retardation, addiction and other psychiatric problems.

4. Staff will be of sufficient number to carry out program responsibilities of Area Boards.

5. Staff and volunteers will be provided with inservice training programs and appropriate supervision to assure a quality service to those in need.

6. All staff will be expected, through training or educational programs, to continue their professional development. This is essential to meet changing needs of people and programs.

III. Duties of Community Mental Health Boards:

Minnesota Statute Section 245.68 provides that "Subject to provision of this section and the rules and regulations of the Commission of Public Welfare, each community mental health Board shall:"

A. "Facilitate and implement programs in mental health, mental retardation and inebriacy so as to assure delivery of services."

1. Area Board Responsibility:

a. Requires Area Board to either implement, operate or assist in establishment of programs in mental health, mental retardation and inebriacy and other psychiatric disorders.
b. Requires Area Board to assure delivery of appropriate services for these disability groups.
c. Requires Area Board to be responsible for planning coordination of programs and services in area of mental health, mental retardation and inebriacy or addiction problems and other psychiatric disorders.

2. Suggestions for Implementation:

a. Establish area coordinating committee for planning and coordination of program services in mental health, mental retardation and inebriacy.
b. Assist in development of programs and services and support other caretakers, public and private, in development of programs and services.
c. Administer and develop programs and services which Area Board feels appropriate to assure adequate program in mental health, mental retardation and inebriacy.
d. Assume responsibility for planning and coordination of program and service for mental health, retardation and inebriacy.

B. "Review and Evaluate Community Mental Health Service provided pursuant to Section 245.61 to 245.69, and report thereon to the Commission of Public Welfare, the administrator of the program, and when indicated, the public, together with recommendations for additional services and facilities."

1. Area Board Responsibility:

a. Requires Area Board to review and evaluate community mental health programs provided pursuant to this act.

b. Requires Area Board to provide evaluation reports and recommendations to Commissioner of Public Welfare, program administrators and general public.

2. Suggestions for Implementation:

a. Develop ongoing review procedures - requires ongoing evaluation.
b. Assign responsibility to advisory committee to assist in the review, evaluation and recommendation requirment.
c. Requires program director to provide specific reports and program evaluation to enable Area Board to fulfill its responsibilities in this section.

C. "Recruit and promote local financial support for the program from private sources, such as community chests, industrial and private foundations, volunteer agencies and other lawful sources, and promote public support for municipal and county appropriations:"

1. Area Board Responsibility:

a. Requires Area Board to seek out and promote multi-source funding for programs and services for mental health, mental retardation, inebriacy and other psychiatric disorders.
b. Requires Area Board to promote the development of third party payment systems.
c. Requires the Area Board to publicly support and promote appropriations made for programs and services for mental health, mental retardation, inebriacy and other psychiatric disabilities by county boards and other public bodies.

2. Suggestions for Implementation:

a. Establish a finance committee for the Area Board with broad representation, and assign it responsibility for 1. a,b,c, above.
b. Promote and support legislation granting "qualified agency" certification for third party payment programs, rather than individual professional certification for third party payment programs.

D. "Promote, arrange, and implement working agreements with other social service agencies, both public and private, and with other educational and judicial agencies."

1. Area Board Responsibility:

a. Requires Area Board to coordinate its programs and services with other community caretakers, both public and private.
b. Requires Area Boards to develop specific working agreements with social service agencies, both public and private, and educational and judicial agencies.
c. Requires Area Board to take the lead in the development of these working agreements in the area of mental health, mental retardation, inebriacy and other psychiatric disorders.

2. Suggestions for Implementation:

a. Assign area Program Director responsibility for developing proposed working agreements with social service, educational and judicial agencies, both public and private.
b. Use the area coordinating committee to assist in the development and implementation of these working agreements.

E. "Advise the administrator of the community mental health program of the adoption and implementation of policies to stimulate effective community relations."

1. Area Board Responsibility:

a. Assign the responsibility for community and public realtions to area Program Director.
b. Assist Program Director in the implementation of policies that will promote effective community relations.

2. Suggestions for Implementation:

a. Require Program Director develop specific program for community relations and public relations.

F. "Review the annual plan and budget and make recommendations thereon."

1. Area Board Responsibility:

a. Requires Area Board to review all plans and budgets for community mental health, mental retardation, inebriacy and other psychiatric disorder programs developed pursuant to this act.
b. Where the Area Board is the administrator of the program that Board is required to approve both the annual plan and the budget before submittal to funding sources.

2. Suggestions for Implementation:

a. Require the Program Director to develop an annual plan and budget for mental health, mental retardation and inebriacy programs and services.
b. Seek input from appropriate coordinating committees, advisory committees, etc., on the annual plan and budget.

G. "When so determined by the authority establishing the program, act as the administrator of the program."

1. Area Board Responsibility:

a. Requires the Area Board to administer all or parts of the community mental health, mental retardation, inebriacy and other psychiatric disability programs.
b. Retains responsibility for review and evaluation of programs and services for mental health, mental retardation, inebriacy and other psychiatric disabilities developed pursuant to this act.

2. Suggestions for Implementation:

a. When it is determined that Area Board will directly administer a program, it shall assign administrative responsibilities to the Program Director, along with the required reports, evaluating procedures, etc., for responsible administration of the program.
b. When Area Board is administrator of the program it shall provide mechanism for review and evaluation of programs of mental illness, mental retardation and inebriacy developed pursuant to this act.

H. "Approve applications for grants made pursuant to Section 2 of this Act."

1. Area Board Responsibility:

a. Requires the Area Board to pass on grant requests as specified in Minnesota Statutes Chapter 245.693, Section 2, as a preliminary to grants being made by the Community Programs Division and Chemical Dependency Division of the Department of Public Welfare.

2. Suggestions for Implementation:

a. Refer such requests for review to the Area Board's Advisory Committee on Addiction Problems.
b. Area Board is to review the recommendations of the Advisory Committee and pass along recommendations to the State Planning Agency.

I. "Establish and operate a Detoxification Center."

1. Area Board Responsibility:

a. Requires the Area Board to establish and operate or contract for a Detoxification program.

2. Suggestions for Implementation:

a. Directly administer and operate a Detoxification Center.
b. Contract the Detoxification Center services, but provide program supervision and maintain program responsibility for the Center.
c. The Program Director shall be responsible for carrying out the above.

J. "Encourage and assist innovative private treatment programs."

1. Area Board Responsibility:

a. Requires Area Board to both encourage and assist in the private sector of services and programs for mental health, mental retardation, inebriacy and other psychiatric disorders.

b. Requires coordination between the private and public sector of programs and services for mental health, mental retardation, inebriacy and other psychiatric disorders.

2. Suggestions for Implementation:

a. Establish liaison with the private caretakers in mental health, mental retardation, inebriacy and other psychiatric disorders.
b. Look to the private caretakers as alternatives to public programs where there is any indication that this could provide equal or better care.
c. Encourage the development of the private sector so as to provide alternative treatment programs in mental health, mental retardation, inebriacy and other psychiatric disorders.
d. Contract with private caretakers for treatment programs when indicated.

K. "Provide service for drug dependent persons."

1. Area Board Responsibility

a. Requires Area Board to provide a service program for drug dependent persons.
b. Requires Board to either provide the service directly or contract for this service.
c. Requires Area Board to coordinate, plan, and assist in the development of services for drug dependent persons.

2. Suggestions for Implementation:

a. Develop programs and services for drug dependent people.
b. Assign program and planning responsibilities to area Program Director and hence for their services.
c. Use the addiction advisory committee to assist in the planning, development and evaluation of programs, services and drug dependent people.

L. "Appoint advisory committees in at least the areas of mental health, mental retardation, and inebriacy."

1. Area Board Responsibility:

a. Requires Area Board to establish three (3) separate advisory committees, representing mental health, mental retardation, and inebriacy.
b. Require the Area Board to have representative and knowledgeable membership on these committees, which members have specific interest and concern for the problem area his committee represents.
c. Requires the Area Board to use these committees and to see out regular reports from these committees.

2. Suggestions for Implementation:

a. Establish specific assignments for each committee, but not limit the committee to these assignments.
b. Require Program Director to assign a staff person to assist each committee in its work.
c. Provide for regular liaison between each committee and the Area Board.
d. Use the committee for program and service planning and evaluation.
e. Act on each of the specific recommendations of the advisory committee.

IV. Duties of Area Board under Minnesota Statutes Chapter 572, Section 7 and 8 "The Commissioner of Public Welfare shall designate the community mental health boards to:"

A. "Coordinate all alcohol and other drug abuse services conducted by local agencies."

1. Area Board Responsibility

a. Requires area boards to coordinate alcohol and drug abuse services conducted by agencies within its catchment area.

2. Suggestion for Implementation

a. Utilize area board's advisory committee on addiction problems to study, review, and evaluate local programs for alcohol and drug abuse.
b. Require Area Program Director to establish liaison with other community caretakers.

B. "Review all proposed agreements, contracts, plans, and programs in relation to alcohol and other drug abuse proposed by any such local agencies for funding from any local, state or federal governmental sources."

1. Area Board Responsibility:

a. Requires Area Boards to establish a review mechanism for any agreements, contracts, plans or programs developed by local agencies related to alcohol or drugs in which local, state, or federal governmental monies are requested.

2. Suggestion for Implementation:

a. Develop area plan from which base the Area Board can better review requests for local, state, federal governmental funds.
b. Establish combined subcommittee of Area Board and Addiction Advisory Committee to serve as review board and act in advisory capacity to Area Board.
c. Assign review responsibility for this section to Area Program Director with input from Coordinator of Addiction Program.

C. "Department of Public Welfare may make grants to community mental health boards for comprehensive programs for prevention, care, and treatment of alcohol and drug abuse.

1. Area Board Responsibility:

a. Gives Area Board authority to develop comprehensive alcohol and drug abuse programs.
b. Gives the Area Board authority to establish direct and indirect service programs for treatment of alcohol and drug abuse programs.
c. Gives Area Board authority to contract for service elements of the comprehensive alcohol and drug abuse program.

2. Suggestion for Program Implementation:

a. Develop comprehensive area plan for alcohol and drug abuse program.
b. Evaluate feasibility of establishing appropriate programs and services establishing priority for same.
c. Evaluate which services already are provided by other community caretakers - arrange appropriate contracts for same when indicated.
d. Utilize area board staff and facilities for program of preventative care and treatment where it appears the needs of person with alcohol and drug abuse problems are thereby best served.
e. Utilize advisory committee on addiction problems to assist in program development, planning, and review.

D. "Every community mental health board shall provide a detoxification program for drug dependent persons within its area."

1. Area Board Responsibility:

a. Requires Area Board to provide a detoxification program directly or by contract for alcohol or drug dependent persons in its area.
b. Requires development of social rehabilitation program to facilitate access to care and treatment by detoxifying and evaluating individuals and by providing an entrance into the comprehensive program.
c. Requires Area Board to tie in its detoxification program with the comprehensive alcohol and durg abuse program.

2. Suggestion for Implementation.

a. Directly provide program for detoxification and social rehabilitation program.
b. Contract for and coordinate detoxification program.
c. Develop system to insure that detoxification program is part of the continuum of care provided in the comprehensive alcohol and drug abuse program.
d. Provide means to evaluate services provided.
e. Utilize addiction advisory committee in planning and implementation of detoxification program.

E. Section 13 provides that a person publicly intoxicated may be brought by a peace or health officer to a hospital or mental health facility equipped to treat drug dependent persons with consent or the program director or head of the facility.

1. Area Board Responsibility:

   a. Requires Area Board to develop mechanism to provide care under this section.
   b. Requires Area Board to coordinate services under this section with other community caretakers.

APPENDIX F- 1

October, 1973
Minnesota Department of Public Welfare
Consumer Concerns Division

Information About
MENTALLY ILL Persons In State Hospitals

Introduction

The following material describes the various categories in which persons generally referred to as "mentally ill" may fit into in state hospitals. Other documents will describe in detail what it means in terms of rights and hospital procedures, to be in any one of these categories.

In addition to general rights that apply to all persons, there are legally required procedures for admission and discharge which differ depending on the type of admission or status a particular patient or resident may be in. The various types of admission or hospital status are described below.

Types of Admission or Status of Mentally Ill Persons in State Hospitals

I. Informal. A person may be admitted at his own request and with the approval of the head of the hospital - as an "informal" patient or resident, or he may be admitted as an "emergency", "hold order", or "committed" patient or resident and transfer to "informal" status at his request with the approval of the head of the hospital.

An "Informal" patient or resident is one who is in the hospital by his own choice whether he originally entered by his own choice or not.

II. Emergency. A person may be admitted as an "emergency" patient or resident, or an informal patient or resident may be transferred to "emergency" status by the head of the hospital.

An "emergency" patient or resident is one who needs immediate involuntary care and treatment because it is believed he will cause injury to himself or others and there is not sufficient time to go to a court and obtain an order from the judge to have the person hospitalized.

III. Hold Order. If there is time to go to court (a probate court or the probate division of a county court) a person who believes someone should be hospitalized against his will because he is mentally ill, must fill out a form called a "petition". A petition is a request that the court hold a hearing to determine whether or not a person should be hospitalized against his will; that is, committed. After the judge receives the petition, he may decide to have the person apprehended and placed in a hospital temporarily, under a so-called "hold order", until the hearing is held.

A "hold order" patient or resident is one who is being held in a hospital against his will, temporarily, under a probate court order while awaiting a hearing on a petition that he be committed. A person may be admitted as a "hold order" patient or resident or he might start out as an "informal" or "emergency" patient or resident and become a "hold order" patient if someone requests the probate court that he be committed and the judge decides to order the person held in a hospital against his will until the commitment hearing.

IV. Committed. A commitment is a court order which restricts a person's liberty in some way. There are several types of commitments depending on the kind of court that issues the commitment order, and the particular law under which a person is committed. There are two types of courts which commit persons to state mental institutions or facilities: probate courts (in all but Hennepin and Ramsey Counties, these are now probate divisions of county courts) and district courts.

A. Probate Court Commitments. Probate court commitments in the area of mental illness occur because someone believes someone else is Mentally ill, mentally ill and dangerous, or unable to control his behavior in sexual matters (psychopathic personality), and that the person is unwilling or unable to seek help for himself or remain under care long enough to get the help he needs. If a person believes that the other one should get help whether he wants it or not, he may file a petition in probate court requesting that the judge hold a hearing to determine whether it is necessary to force the person to get help against his will. If the judge determines that it is necessary for the person to get treatment against his will, he will commit the person to the head of a hospital for a period not to exceed 60 days.

In committing a person to the head of the hospital, the judge has the person transported to a hospital. The head of the hospital is required to admit the person and keep him under treatment until the head of the hospital determines he no longer needs hospitalization, At that time, the head of the hospital may discharge the person or in the case of mentally ill and dangerous, or psychopathic personality commitments, he may request the commissioner that he discharge the person upon the recommendation of a special review board.

In order for the period of hospitalization to exceed 60 days, the head of the hospital must recommend in a report to the court 45 days after commitment, that the person be committed for an indeterminate period. The court may or may not accept the hospital recommendation.

B. District Court Commitments. There are three types of district court commitments to state mental institutions. They all involve persons who have been charged with or convicted of committing a crime.

1. Incompetent to Stand Trial
First there are those persons who are charged with committing a crime, but who are found by the court before or during the trial to be so mentally ill that they can't get a fair trial

because they can't help themselves and their attorneys in their defense. The district court must commit such persons to a state hospital as "incompetent to stand trial." The hospital must provide safekeeping and treatment for such persons until they are certified to be competent to stand trial.

2. Not Guilty by Reason of Mental Illness

Secondly, there are those persons who are charged with a crime and are found to be not guilty because the person was mentally ill at the time the crime was committed. When the verdict in a criminal matter is that the person is not guilty by reason of mental illness, the court must commit the person to a state hospital until he is released by the court upon the recommendation of the head of the hospital.

3. Sex Offender

If a person is convicted of certain specific crimes referred to as "sex crimes", the court must have the person examined by experts in order to determine if the person needs specialized treatment for any mental or physical problems he may have. If the results of the examination and the report to the court indicate that the person needs specialized treatment, the court may either place the person on probation for outpatient treatment or commit him to the commissioner of public welfare for specialized treatment in whatever setting the commissioner thinks best. If the examination and report to the court indicate that the person does not need specialized treatment, the court must sentence the person in whatever manner the law requires.

October, 1973
Minnesota Department of Public Welfare
Consumer Concerns Division

Information About

INFORMAL HOSPITALIZATION in State Hospitals

Informal Admission

1. You have a right to object to admission
2. You may leave the hospital.
3. You may communicate with others.

Persons Considering Requesting Admission as an Informal Patient Should Know:

1. You must request admission. You may change your mind and refuse to be admitted.

2. The hospital staff will want to know enough about you to decide whether in their opinion, hospitalization is indicated.

3. This might require temporary hospitalization in order to obtain the necessary information.

4. You may be discharged when the hospital believes you no longer need or can no longer benefit from hospitalization. This would be discussed with you before a decision is made.

5. You may request to leave the hospital at any time.

6. The hospital has a legal right to hold you as an informal patient for a maximum of 12 hours after you request to leave.

7. During the 12 hours immediately following your request to leave the hospital may change your status to that of an "emergency" patient and hold you against your will for up to 72 hours longer if:

   a) they believe you will cause injury to yourself or others; and
   b) if there is not sufficient time to go to court, file a petition, and have the judge issue an order to hold you against your will.

8. If there is sufficient time during the 12 hour period to file a petition in probate court and get the judge to issue a "hold order", the hospital may initiate such action if they believe it would not be in the best interest of yourself, your family or the public for you to be released from the hospital. Under the court hold order, you may be held in the hospital until the date of your court hearing. This could be two weeks or more. (See the Information material on "Hold Order")

9. If you are admitted to the hospital as an"informal" patient, certain persons and agencies will be notified of your admission:
   a. your spouse, parent or other interest person; b.the county welfare department of your county of residence;c.the state DPW

INFORMAL HOSPITALIZATION

10. If you are admitted as an "informal" patient you have the following rights:

1. Right to Communicate

   a. Visits at reasonable hours with a reasonable number of persons.

   b. Meet privately with an attorney, a physicican and at least one family member.

   c. Correspond freely and without censorship. The mail may not be opened. Any limiation must be noted in your record.

2. Right to Medical Care

   a. Examination with 48 hours of admission.

   b. Physical and mental exam at least once annually.

   c. No operation can be performed without your permission unless you are a minor or have been judged incompetent.

3. Right to Continued Legal Rights

   a. You retain all legal rights, except:

   b. The hospital may hold and manage any of your money and personal property which comes into its hands.

4. Right to see the Review Board to make complaints about admission and retention.

5. Right to Treatment.

   a. The hospital must formulate and record a specific plan of treatment and the goals of treatment, including the expected period of time for hospitalization.

   b. You should be involved in formulating and reviewing the treatment plan.

6. You may not be restrained unless a physician decides it's necessary to protect you or others.

7. Right to practice a religion.

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October, 1973
Minnesota Department of Public Welfare
Consumer Concerns Division

Information About

EMERGENCY HOSPITALIZATION in State Hospitals

The purpose of "emergency" hospitalization is to protect you from yourself when it appears that you are about to injure yourself or someone else, and there isn't time to get an order from a court to restrain you. Emergency hospitalization in which you can participate can be drawn up.

A licensed physician or a peace or health officer should have signed a written statement that he has examined you not more than 15 days prior to your admission to the hospital and that he is of the opinion that you are mentally ill or inebriate and in eminent danger of causing injury to yourself or others and that a court order could not be obtained in time to prevent such anticipated injury.

This admission was with the consent of the head of the hospital.

Upon your request in writing and with the consent of the medical director you may be transferred to Informal Status.

During the 72 hour period (not counting Saturdays, Sundays and legal holidays) in which you may be held against your will as an emergency patient, the hospital staff or someone else may initiate action to have a petition filed in probate court and may request that the judge issue a "hold order" so that the hospital could continue to hold you, as a "hold order" patient until the time of the probate court hearing.

As an "emergency" patient you have a right to the following:

1. a physical and mental examination from a licensed physician especially qualified in the diagnosis of mental illness;

2. discharge from the hospital if such examination is not conducted within 48 hours of your admission;

3. discharge within 48 hours of your admission if the examiner finds that you are not mentally ill and in need of hospitalization;

4. discharge if the examiner does not notify the head of the hospital if he finds that you are apparently mentally ill and in need of care, treatment, and evaluation;

5. communicate by all reasonable means with a reasonable number of persons, and may consult privately with your attorney, your personal physician and at least one member of your family. If a petition for commitment has been filed you also have a right to have the court hearing in your home county, if different from the county wherein you are hospitalized.

ATTACHMENT A

STATEMENT OF PATIENT'S RIGHTS UPON RETURN TO HOSPITAL

Your provisional discharge has been revoked. While you may become eligible for provisional, final, or outright discharge in the future, for the present time you must remain in the hospital.

You have a number of rights which are related to your return from provisional discharge and they are listed here for your information.

(a) A copy of the Report and recommendation which states the reasons for your revocation must be provided to you within 48 hours;

(b) A person known as a Patient's Counsel will be appointed within 24 hours to assist and counsel with you as to what you can do about your return to the Hospital; including requesting a different Patient's Counsel.

(c) You may contest your return to the hospital, either informally through the hospital advocate, Review Board or Consumer Concerns Division, or by requesting that a hearing be held. The form upon which such request must be made can be obtained from your Patient's Counsel or the Hospital. You will suffer no penalty or adverse treatment as the result of requesting such a hearing.

(d) You will receive a notice of the time, date, and place of the hearing at least five days before the day of the hearing. The hearing will be within 10 days of the date of your request.

(e) Prior to the hearing you are entitled to receive a list of the persons who will testify in support of the need for your return to the hospital. You may examine your medical records. You may have witnesses of your own present at the hearing provided you make a written request to the Hearing Examiner at least three days in advance of the hearing. Witness fees for your witnesses will be paid by the State if you cannot afford to pay them.

(f) Your hearing will be conducted by a Hearing Examiner appointed by the Commissioner of the Department of Public Welfare.

(g) At the hearing the person(s) who filed the Report seeking to have your provisional discharge revoked will be required to appear and explain her/his reasons for making such a recommendation. Other witnesses and evidence may be called and offered to support the recommendation with which you disagree. You may cross-examine all of these witnesses and contest the evidence or have your counsel do it for you.

(h) At the hearing you may call your own witnesses and offer evidence. Naturally, the other side can cross-examine your witnesses and contest your evidence.

(i) It is up to those persons who seek to have you returned to the hospital to establish that one of the following three grounds for revocation is present in your case:

1. The patient has continued to not comply with the treatment plan, and the treatment needs of the patient require rehospitalization.

2. The patient is exhibiting extreme forms of behavior symptomatic of mental illness for which treatment in the hospital is required.

3. There is an emergency caused in part by the mental illness of the patient such that the patient is in imminent danger of causing injury to her/himself or others if not immediately restrained.

Furthermore, consideration of community alternatives to the hospital must be given.

(j) The Hearing Examiner will make a decision at the end of the hearing and the propriety of your return to the hospital will only be upheld upon a showing of clear and convincing evidence. If such evidence is not present then you will be released as if your provisional discharge had never been interrupted.

(k) If you disagree with the Hearing Examiner's decision you may appeal to the Commissioner of Public Welfare and if you disagree with her decision you may appeal into the District Court.

If you have any questions or concerns please confer with your counsel. She/he is assigned to give you the assistance needed in order that you can pursue your rights.

Read and received this date.

Dated: _____ Patient's Signature _____

Presented and explained to the patient this date.

Dated: _____ Patient Counsel's Signature _____

Patient's counsel has contacted me and has explained my right and I am aware of my right to a hearing to contest my revocation, and I hereby waive my right to contest my revocation at a hearing.

Dated: _____ Patient's Signature _____

Appendix G

POLICY DRAFT: RESEARCH POLICIES AND PROCEDURES

The following research policies and procedures are effective immediately, and supersede all previous documents on subjects contained herein.

APPLICABILITY: These policies and procedures apply to all state hospitals, DPW units on state hospital campuses, mental health centers, county welfare departments, and other agencies under the direct supervision of control of the Department of Public Welfare. These procedures also apply to any research project in any agency (public or private) which directly involves clients for which the Department of Public Welfare retains responsibility, as in a contractual relationship.

These procedures apply to generalizable research projects and programs (including clinical, administrative, socio-epidemiological, and basic research), to evaluative research (use of scientific methods for the purpose of evaluating a program), and to experimental evaluative systems. They do not apply to non-experimental, on-going systems of evaluation which are or may be established on a routine basis. (For more detailed definitions see Definition of Terms in Mental Health, Alcohol Abuse, Drug Abuse, and Mental Retardation, prepared under contract from NIMH by SREB and SRCMHC, June 1973.)

II. GENERAL PRINCIPLES:

A. Intent: The intent of these procedures is to maximally decentralize responsibility to the local level while establishing clear lines of responsibility and accountability. In essence, the local agency is responsible for encouraging high priority research which meets adequate technical standards, for coordination, reporting and clearing research projects and programs in accordance with these procedures.

B. Priorities: It is recognized that it is often difficult to predict impact of a specific research program or study, and that some of the most significant advances have come from studies which initially offered little promise or were of little interest to anyone but the individual researcher. It is recognized, too, that one element of a successful and practical research program is a climate where creativity and the instinct for the serendipitous payoff can contribute with relative freedom from trammels.

It is also recognized that there are side benefits from the process of cooperation with other agencies and educational institutions, even if the specific project may itself be of limited value to the DPW system. For example, better and broader agency relationships may be fostered, or constructive educational experiences may be provided for students or academic staff.

However, in instances where DPW funds or DPW resources are involved, it is also desirable and necessary to recognize a system of priorities setting a general direction which reflects the needs and goals of the sponsoring organization. Without such priorities there can be no systematic progress and no clear understanding of the criteria by which allocation of public funds are made. For the Department of Public Welfare these priorities are as follows:

First priority: Operations research. That is, goal-oriented, problem-solving research having some organic and clearly evident relationships to improved performance of the DPW system and its component parts. Examples are evaluation of outcome of DPW programs, follow up studies, effects of administrative or legislative actions, ward conditions and attitudes, assessment of agency and community variables which affect planning.

Second priority: Those projects or programs in which the state has an interest and which are clearly related to the aims and functions of DPW, but where the application of results are likely to be less immediate than first priority research. Examples are studies to further the general understanding of a particular disability or client group, or methods to improve the diagnosis or identification of such groups.

Third priority: Those projects or programs which have a more indirect or less immediate relationship to the aims of the state program, but which are of primary concern to the individual agency or investigator because of their particular interest in the method or area of study, because of the potential contribution to scientific knowledge or technology, or because of its potential for leading into studies of first or second priority.

This category of research is supportable by public funds, but to a more limited degree than the first two categories. Investigators or agencies interested in pursuing third priority projects are encouraged to do so provided that such activity does not displace higher priority research and evaluation and to the extent that satisfactory support may be found outside of state funds.

III. RESPONSIBILITIES:

A. Agency administration: State law assigns to the Medical Policy Directional Committee on Mental Health (MPDCMH) advisory responsibility for research (traditionally, "mental health" research), and departmental policy requires Central Office awareness of agency involvement in research activities of any type. As stated in II A above, however, it is intended that decentralization of research responsibilities occurs to the maximum extent possible provided there is also a clearly identified system of accountability.

Therefore, each agency engaging in research as defined above must designate the specific person or persons responsible for that research and responsible for compliance with these research policies and procedures. Larger agencies, or agencies with a substantial volume of research, may designate a local Research Committee to oversee all research activities, as is required for state institutions. Smaller agencies having a lesser volume of research may prefer to designate an individual to assume responsibilities for all such projects or programs that might occur in that agency. Smaller agencies having only occasional projects may prefer to designate a separate responsible agency person for each project.

1. Local Research Committee for state institutions: the Chief Executive Officer of each such facility, in consultation with the Medical Director, will appoint a Research Committee which will be responsible for all research activities within or originating from that facility, and to which research responsibilities can be delegated from the Department of Public Welfare. In addition, a written hospital procedure, regulation, or policy statement should be prepared which establishes its Research Committee, defines its membership, and outlines its function and method of operation. An informational copy of the procedural statement and the names and titles of current members, as well as any changes as they occur, will be submitted to the Director, Office of Research and Evaluation (ORE).

To assume responsibility for the substantial amounts of research in the typical institution, some of which may involve resident participation, the composition and operation of the local committee is of considerable importance. Although its specific membership is likely to vary from one location to another, it should include at least the following:

a. One or more persons skilled in experimental design, statistical methods, evaluation techniques, interpretation of research findings, and scientific ethics, as these matters apply to research with humans.

b. One or more members of the treatment or training staff who are sufficiently familiar with the programs of the hospital to be able to assess the effect of any given proposal on such programs, such as the medical director or his designee, and/or one or more clinical department heads, and/or the institution program coordinator.

d. A member of the administrative staff, such as the Chief Executive Officer or his designee, who can provide information and assistance concerning costs, administrative arrangements, etc.

d. The chairperson of the institution Humane Practices Committee (or his designee) and/or the agency Advocate.

e. At least one non-staff community member to represent consumers or citizens concerned with the disability groups or types of clients who may be involved in research projects or programs.

f. For discussion of specific proposals, appropriate invited representatives of departments, units, and/or wards which would be involved if the project were approved (these need not necessarily be voting members of the Committee).

B. Local Research Committee, or other designated responsible person designated by local agency: In general, the responsibilities include the following:

1. Maintain appropriate standards of scientific rigor, relevance, and concern for human rights and dignity.

2. Review, evaluate, and approve all research proposals, including "pilot studies", which employ agency personnel or property, or which involves patients, residents, or clients. This assumes familiarity with relevant federal, state and other research guidelines.

3. Stimulate, assist, and further research and evaluation in its agency or region, with emphasis on First Priority projects (see II B).

4. Decide which agency activities are research and therefore under the jurisdiction of the Research Committee or designated person.

5. Observe research clearance and reporting procedures as described below.

IV. PROCEDURES: (see enclosure for flow chart)

A. Proposed research projects or programs will be submitted by the investigator(s) to the local Research Committee, if there is one, or otherwise to other designated responsible agency personnel. The proposal should include the following information plus any other comments or data considered relevant by the applicant or agency (other outlines or another sequence may be used as long as the necessary information is included:

Specific aims: a concise statement of the aims or purpose of the proposed work; a clear formulation of any hypotheses to be tested, or questions which will be answered by the project or program.

Significance: why the project is relevant; why the results would be important to clients, agency, department, legislature, Minnesota citizens, or others (any or all of these, as appropriate); what activities, policies, or plans should be influenced by the results, and in what way.

Relevant background information: a very brief summary of relevant background -- what is already known about the question to be studied, with major references cited; how the study relates to present knowledge.

If medication is used as part of the study, its properties and action must be briefly described, including possible side effects; its FDA status must also be stated.

Method: concise explanation of project design, with a listing of the procedures in sequence. If clients are involved, the nature of their participation, method and criteria for their inclusion or exclusion, criteria for dropping clients from the study; who will carry out each procedure, who will complete rating scales or other measurements, how the results will be analyzed. If the proposal is a drug study where a drug company provides the design or analyzes the results, this should be stated and their methods described. Copies of rating scales, check lists, etc. should be included if others may not be generally familiar with them.

If human subjects are involved, describe methods to protect their rights, privacy, and confidentiality, and (where applicable) what provisions will be made for informed consent.

B. Informed consent: Legally effective informed consent, in writing, must be obtained for participation by clients in research procedures which are not ordinarily part of the usual treatment armamentarium or which may cause exposure to the possiblity of physical or psychological injury or discomfort. Informed consent must be obtained from the client, or if there is a question of the client's ability to understand or to give consent that is truly voluntary, from his legally authorized representative (though not over the client's objections). Copies of the forms to be used will be included with each proposal in which client participation is anticipated.

The basic elements of an informed consent are as follows:

1. An explanation of the procedures and their purposes, including identification of any procedures which are experimental.

2. Description of any discomforts, risks, or side effects which might reasonably be expected.

3. Description of any benefits which might reasonably be expected.

4. An offer to answer any inquiries about the procedures before or during the study.

5. Instruction that the person may withdraw his consent and discontinue participation at any time without prejudice.

The form and procedure for obtaining informed consent may be modified only if the local Review Committee can establish that the physical or psychological risk or discomfort to any subject is minimal, that use of the standard procedure and form would invalidate very important objectives, and that there are no reasonable alternatives for attaining these objectives. Any proposal for the use of such modified procedures must be described in the research proposal, with the specific reasons for the modification, and must receive prior clearance from the Office of Research and Evaluation as well as the local Research Committee.

C. Confidentiality, access to records, and contacts with ex-clients by persons not connected to the agency or otherwise not normally having access to the records or the clients:

Since access to clients' records (file research or surveys) and follow-up or other contacts with former clients or their relatives have the potential for violation of confidentiality, privacy, or safety of records, attention to these factors must be an integral part of the approval process for each research project or program. In both instances the local Research Committee must (1) determine the extent and nature of the risk, if any, to confidentiality and privacy, (2) decide whether the value of the specific proposal and its results justifies the amount of risk, (3) determine reasonable procedures for the project to minimize the risk (such as where the agency records may be viewed), (4) make certain that the investigator understands the principles and local requirements for safeguarding confidentiality, privacy, and the safety of records, and (5) make a judgment that the specific investigator will responsibly adhere to those principles and local requirements.

Consistent with the above process, the following procedures have been established for research involving former DPW clients or their records.

1. Use of clients' records: The basic principle as stated by DHEW is as follows: "Except as otherwise provided by law, information ... acquired in connection with (a research) activity ..., which information refers to or can be identified with a particular subject may not be disclosed except ... with the consent of the subject or his legally authorized representative ...." (Federal Register, Vol. 39, No. 105, Part II, May 30, 1974 "DHEW Protection of Human Subjects")

   In studies or surveys where the investigator needs to use any part of a client's records, the local Research Committee will obtain a signed statement, applicable to the specific project, attesting to the investigator's understanding of the need and principles of confidentiality and of the local procedures for safeguarding the record and the information therein. Copies of this signed statement will be included in the copies of the locally approved proposals when they are forwarded to this office by the local Research Committee. In effect, therefore, the signed statement is a representation that the local Research Committee vouches for the integrity and understanding of the investigator concerning confidentiality.

2. In-person interviewing or examination of former clients, relatives, or others (follow-up): Follow-up is one of the weakest links in the evaluation chain because of its technical difficulties and high cost. Nevertheless, good follow-up is of cardinal importance in determining program effectiveness, and such efforts should be encouraged. However, followup by persons outside the agency who would not otherwise be doing it also raises questions of invasion of privacy which can be answered only by adhering to the principles of informed consent.

   For projects whose merit, in the judgment of the local Research Committee, justifies the proposed interaction with the former client or others, the agency will therefore take the following additional steps:

   a. From the total list of potential subjects, select (in accordance with the provisions of the project) the names and addresses of those who will be contacted, in such a way that there is protection of the confidentiality of records of those not ultimately selected.

   b. Send to the prospective subject and/or his legally authorized representative an informed consent form which is consistent with the requirements of section B above ("Informed Consent") and which describes the purpose of the project, the nature of the interview, the person conducting the interview, provisions taken to ensure confidentiality, and requesting signed permission for the interview or other procedures to take place.

   Obtaining informed consent in this manner may in some instances place a greater burden upon the Research Committee and the agency. The extent of the burden in a given case will have to be considered in the process of approval and negotiation between the Research Committee and the outside investigator.

D. Each copy of the proposal should be accompanied by a face sheet "Application for Research Grant or Clearance" (DPW 453); if a grant is requested, "Proposed Budget" (DPW 454) should also be included. When the local Research Committee or agency has approved a project, it will submit four copies of the proposal, face sheet, and (where appropriate) the "Proposed Budget" to the Director, DPW Office of Research and Evaluation (ORE).

E. The Director of ORE will determine whether the proposal may be immediately cleared (or cleared with modifications), or whether it should be referred to the Medical Policy Directional Committee on Mental Health (as for example if the proposal is medical in nature, if it involves clients, staff or other resources in such a way to raise a policy question, and if it is in the area of "mental health"), or to other persons.

   1. The Director of ORE will consult when appropriate with other relevant personnel such as the departmental Medical Director of any of the assistant commissioners.

   2. If the Director of ORE, in consultation with the DPW Medical Director, determines that the proposal should be reviewed by MPDCMH, copies of the proposal will be forwarded to MPDCMH members and to the DPW

Medical Director for discussion at their next meeting. In such instances, the originator of the proposal and the Director of ORE will ordinarily be expected to attend the MPDCMH in order to answer questions about the proposal.

3. Each proposal will be cleared as soon as possible after receipt; if the local Research Committee or agency receives no questions or other communications within fifteen working days after the post-marked date, the proposal may be considered cleared and the project may be started.

F. Cooperative projects involving several facilities: Where an investigator from outside the DPW system proposes a project which would involve several facilities in the same way, the investigator may submit the proposal directly to the Director of ORE for general clearance. If approved in principle by ORE and if necessary by MPDCMH and others, ORE will send copies of the proposal, together with an endorsement, to the local Research Committee or responsible person. The local Research Committee or responsible person will then review the proposal and decide whether to approve, disapprove, or set other conditions for the project for the specific local agency. The decision of the local agency will then be communicated to ORE.

G. Projects to be funded from non-state sources (for example, private individuals or foundations; NIMH):

1. If the project does not involve clients for which DPW is responsible, and does not involve the use of state money, personnel, or other resources, it is sufficient to submit a simple statement of intent, with a brief description of the anticipated project or a copy of the grant request. This information is submitted to the Director of ORE for informational purposes only unless it includes violations of departmental or state policy, in which case the Director of ORE will so notify the agency within fifteen working days.

2. If the project involves clients for which the state is responsible, or significant use of agency funds, personnel, or other resources, the agency will follow the same procedures as for any other project except that the investigator is encouraged to avoid duplication of effort by submitting the same project descriptions required by the fund-granting agency (provided the information requested in IV A is included in the description or in an attachment).

3. In both instances described above the project should be included in the annual report (IV H 2 b). When the project is completed, copies of final reports and publications will be submitted to the Director of ORE as for other projects.

H. Reports:

1. Investigator:

a. Will submit to the local Research Committee or responsible person a final report for each completed project, with a summary or abstract of not more than 300 words which describes the project in non-technical language and which emphasizes the main findings

and conclusions, and implications or applications. A copy of any report sent to a drug company or other non-DPW agency will be sent to the local Committee if that report is different from the final report.

b. Will notify the agency of any publication resulting from the project, submitting reprints or copies of the article.

c. May be asked by the agency to provide progress reports at given intervals.

2. Local Research Committee or responsible person:

a. Will keep ORE informed of the status of each cleared project, i.e., will notify ORE of the following:

(1) Any significant changes being considered for the project.

(2) Any project cancellation or termination, with reasons.

(3) Completion of project, with five copies of final report and abstract.

(4) Publication of report, with reprints or copies if different from final report.

b. Will prepare an annual report; twelve copies of this report will be submitted to ORE by January 20th of each year for the preceding calendar year.

The annual report will include:

(1) For each project completed during the reporting year: a summary or abstract of not more than 300 words which describes the project in non-technical language and which emphasizes the main findings, conclusions, and implications or applications (this abstract may be the same as that submitted with the final report -- see H 1 a above).

(2) For each project initiated or on-going during the reporting year but not yet completed: a summary or abstract of not more than 300 words which describes the project in non-technical language, which emphasizes the purpose and expected benefit of the project, and which indicates the status of the project and/or expected date of completion.

(3) For projects initiated but cancelled or terminated without completion: a brief summary or abstract which describes the project as in (2) above and the reasons for termination.

(4) A listing of current members of the local Research Committee, or (for agencies not having a Research Committee but designating a staff member responsible for research on an on-going basis) responsible agency person.

(5) Optional: comments or suggestions about problems experienced in initiating or carrying out research in the agency, and suggestions for improving these procedures or the quality and relevance of research.

(6) The annual progress report will include all research projects in which the agency was involved during the reporting period. Reference to the individual projects should include the project number designated by ORE at the time of clearance.

The annual progress report should also include those projects which were not formally cleared (projects not under the jurisdiction of clearance procedures at the time, projects which began as minor local surveys but which turned out to have more significance than anticipated, etc.). The annual progress report should accurately reflect the amount and nature of the research effort of the reporting agency.

c. Local agencies making application for state grants for research under these provisions will submit to ORE by April 1 of each year twelve copies of its budget requests for the following fiscal year.

d. Agencies which have received research grants from ORE are reminded that such funds are allocated from a small revolving fund account appropriated by the legislature on a biennial basis. This means that unspent money from the first fiscal year of the biennium is carried over in the DPW research account to the second year of the biennium; unspent money from the second fiscal year is returned to the state's general revenue fund. State fiscal policies require certain accounting procedures at the end of each fiscal year so the above can be carried out. For those agencies receiving research grants this means:

(1) Before the end of the first fiscal year of the biennium (by April 1) it is necessary to report to ORE (a) the amount of unspent research money which is likely to accrue by the end of that fiscal year, and the purposes for which it was originally allocated and (b) whether it is requested that the amount is to be continued into the next fiscal year for the purposes originally intended, or whether it should revert to the DPW research account for redistribution for research purposes.

(2) Before the end of the second fiscal year of the biennium (also by April 1), it is necessary, as for the first year, to report to ORE the amount of unspent research money which is likely to accrue by the end of the fiscal year, and the purposes for which it was allocated. This unspent money will revert to the general revenue fund unless otherwise encumbered.

3. Office of Research and Evaluation:

   a. Will submit to MPDCMH, DPW Executive Staff, and other relevant persons an annual progress report on projects cleared under these provisions.

   b. Will distribute final reports of individual projects as indicated or requested to MPDCMH, Executive Staff and other relevant persons.

   c. As appropriate, will resolve research problems or questions at the local level (definition of projects to be cleared locally or through ORE, operation of Research Committee, or other consultation).