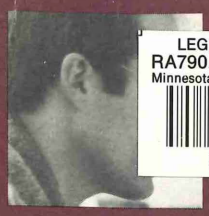
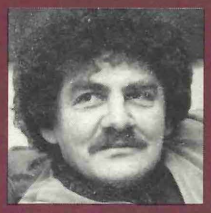


MANDATE FOR ACTION

Recommendations
of the Governor's
Mental Health Commission
February 3, 1986



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The photographs shown on the cover and repeated throughout the text are meant to represent the people of Minnesota.

Preparation by:
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February 3, 1986

Recommendations of the Governor's Mental Health Commission

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THE CONTEXT

"We can't expect those most affected to be the sole champions of this cause. It is the responsibility of all of us to address this situation. I am announcing today a means for beginning this discussion . . . ."

— Governor Rudy Perpich

The Governor's Commission on Mental Health

On June 14, 1985, Governor Rudy Perpich announced formation of the Governor's Commission on Mental Health and a list of specific issues to be addressed by the Commission including:

- the needs of the people;
- state planning functions;
- prevention efforts;
- appropriate ways to deliver mental health services;
- the structure of the existing delivery system;
- the level of funding and how funding is directed;
- the provision of community support programs across the state;
- a consolidated funding approach; and
- minimum statewide service standards for all counties and all providers of service.

In announcing the Commission, the Governor identified a number of facts which must be faced which affect the delivery of mental health services in Minnesota:

- mental illness is an increasing public problem which is aggravated by unemployment, layoffs, and economic uncertainty;
- it is also a reality that there are many other problems demanding the state's attention; and
- obtaining funds for mental health services has never been easy.

Governor Perpich appointed the members of the Commission on August 16, 1985, bringing together representatives of state hospitals, mental health centers, county social services, county government, advocates and members of the legal profession. Under the direction of Norma Schleppegrell, chair, the Commission first met on September 5, 1985.

Between September and November, the Commission structured its effort around working groups assigned to deal with specific issue areas:

- policies and strategies;
- needs of people and services;
- planning and delivery of services;
- quality assurance and standards;
- funding; and
- next steps.

By the end of November 1985, the recommendations of the working groups had been reviewed by the Commission and priorities established for the future.

Definitions and the Needs of People with Mental Health Problems

The Governor's Commission was formed to look at every aspect of mental illness, but especially issues related to mental health services and policy. Two preliminary questions must be addressed in order to set the context for the Commission's work and recommendations—What is mental illness? What are the needs of people with mental illness?

These questions are not easily answered. First, a precise definition of mental illness is illusive. Second, most investigations of "the needs of people with mental illness" focus on the services required or being offered to meet needs, not the fundamental needs of the individuals.

Definitions

The American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (third edition) is clear on the definitional problem—"there is no satisfactory definition that specifies the precise boundaries for the concept of 'mental disorder' " (p. 5). The APA was able, however, to develop a definition that influenced its decisions to include certain conditions in the manual and exclude others.

> . . . a mental disorder is conceptualized as a clinically significant behavioral or psychologic syndrome or pattern that occurs in an individual, and that typically is associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychologic or biologic dysfunction, and that the disturbance is not only the relationship between the individual and society. When the disturbance is limited to a conflict between an individual and society this may represent social deviance . . . but is not by itself a mental disorder.
> (p. 363)

Clinically significant mental disorders affect an individual's ability to function in important areas of daily living. Because of disruptions or distortions of emotional or cognitive mental processes, the person may have an increased difficulty dealing with personal relationships, living arrangements, work, recreation, mobility within the environment, and achieving a reasonable level of productivity.

The people who are of concern to the Governor's Commission on Mental Health are Minnesotans who have a mental/psychiatric disorder which is clinically definable and who experience disruption in their abilities to function in daily life.

In order to identify people who are in need of special mental health services in the population, a definition of "person with mental illness" is necessary. Current definitions of mental illness require, in addition to descriptions of the individual's behavior, specifying co-existent medical illnesses, the degree and severity of psychosocial stressors, and recognition of the highest level of functioning attained by the individual in the past. A mental illness may be a limited experience (acute) or of long duration (chronic), but "the real difference between acute and chronic is not the length of the illness, but whether deterioration occurs in family, work and social relationships" (Janecek, 1985, p. 2).

Needs

The surveys conducted in Minnesota to date have not focused on the needs of individuals but have described services. There are several basic needs including:

Like all Minnesotans, people with mental illness need food, clothing, shelter, medical or health services, transportation, education, recreation, and a secure income. The lack of one or more of these supports, in fact, may aggravate or stimulate the mental health problems experienced by the individual. "Also, like every other person, chronically disabled adults need a personal support system consisting of other people who care about them as unique individuals" (NIMH, 1976, pp. 3-4).

People who are chronically mentally ill are usually able to learn and develop skills, friendships, and interests which are compatible with independent living in a community. These individuals tend to be shy, avoid social contact with others, and do not show aggressiveness or dangerousness. The cruel paradox is that they respond to consistent and supportive relationships which are often denied them due to their lack of assertiveness and the social stigma attributed to mental illness.

The use of such phrases as "mentally ill" should not obscure the basic fact that these are individuals with a whole array of positive attributes and abilities. Although mental health problems are clearly important, it is also important to recognize the strengths of the individual and his/ her right to be respected and appreciated. **"Indeed, one of the most serious obstacles to more rewarding lives for these people is the stigmatization and devaluation which occurs, both in organized service settings and in society at large" (NIMH 1976, pp. 1-2).**

As Governor Perpich said, "We can't expect those most affected to be the sole champions of this cause." In fact, people with mental illness are often at a significant disadvantage in terms of the political processes which so affect their lives—decisions about services and budgets. They often lack the skills to represent their interests effectively. The stigma attached to "mental illness" deters many individuals and families from engaging in public advocacy. People with significant mental health problems are commonly blamed for their plight, and the diagnosis itself often throws into doubt their capacity to function reliably or make sound judgments in areas unrelated to their condition (Mechanic, 1985, pp. 78-79).

The Governor's Commission on Mental Health is concerned with the following list of special needs which may apply in whole or part and in varying degrees to individuals with mental illness. There are several special needs including:

A comprehensive evaluation of strengths and weaknesses, and an opportunity to participate in setting goals and developing a plan for appropriate services;

Appropriate and continuing medical, psychiatric, or psychological treatment as necessary, including periodic review and regulation of medication;

A place to go or a person to call for help in dealing with acute behavioral, emotional, or physical distress;

Training in "coping skills" to assist in tasks of daily living, and when appropriate, assistance in performing these tasks;

Dependable, available resources to provide assistance as needed or when crises arise, who will protect the person from exploitation, represent the person as necessary, and espouse the person's cause in dealing with the system;

Opportunities for validation of personal worth, for being appreciated and valued as a human being;

A residential setting [a place to live] which provides emotional support, practical assistance in daily living, and which resembles other community living arrangements as much as possible [in a family or a household composed of people of one's own choosing];

Assistance to family and significant others in relation to any difficulties they may experience as a result of the person's mental illness;

The Governor's Commission on Mental Health, in 1985, draws one conclusion after examining these recommendations and the current state of affairs—these issues are still current.

Assistance to neighbors or employers in coping appropriately with any unusual, annoying, or disturbing aspects of the person's behavior;

Vocational guidance, training, and assistance in securing and holding an appropriate job;

Provisions of work or other useful daily activities for those individuals who are currently incapable of holding a regular job;

Assistance in taking advantage of entitlements as citizens or residents of their respective communities; and

A clearly defined, accessible, and workable grievance procedure (NIMH, 1976, p. 4).

We must never forget, however, that the basic needs of people with mental health problems are the same as for all people. In meeting their special needs, we must also pay close attention to their ordinary needs.

A History of Studies and Commissions

The history of mental health services in Minnesota has not only involved a series of policy and service initiatives, it is also marked by numerous reports and recommendations. Since 1951, 21 separate efforts have focused on issues facing mental health services and people with mental health problems. Each has taken a different perspective on a different set of issues, but together they constitute an impressive body of recommendations, most of which have not been implemented.

Some of the major themes linking these reports together are as follows:

Advocacy and Rights:
The rights of people with mental health problems should be expanded and enforced. Special efforts should be made to reach out to individuals who are members of minority groups. The capacity to oversee the system should be created. (1971, 1978, 1979, 1983)

Coordination and Leadership:
To address the needs of people with mental illness, it is necessary to exercise leadership and coordinate the efforts of several state agencies. (1971, 1975, 1978, 1979, 1985)

Services:
All residents of Minnesota should have access to a comprehensive array of appropriate quality services. (1956, 1963, 1965, 1971, 1977, 1978, 1979, 1985)

Services should be available to those groups of people who are least well-served at the current time—people with chronic mental illness, members of minority groups, and people with sensory impairments. (1978, 1979)

State Hospitals:
There is an ongoing need for specialized programs, outpatient services, and more comprehensive treatment approaches. (1951, 1952, 1965, 1971, 1979, 1983, 1985)

Personnel and Training:
Efforts should be directed at: a) providing a training program for personnel in the field of mental illness, b) stimulating training by providing incentives, c) developing volunteer capabilities, d) providing technical assistance and consultation support to service providers, and e) the development and implementation of a public education program. (1951, 1963, 1965, 1971, 1978, 1979, 1983)

An Information Base:
A data base and information system needs to be developed to assist in the identification of people in need, to gain access to technical and financial assistance, to provide an information clearinghouse, and to document needs and the availability of services. (1971, 1977, 1978, 1979, 1980, 1985)

Funding:
Funding levels should be increased. Disincentives which stand in the way of receiving appropriate care should be removed. (1956, 1963, 1965, 1978, 1979, 1985a, 1985b)

Research:
Funds for research should be provided with an emphasis on effective management and treatment approaches. (1951, 1961, 1977, 1978, 1983)

This summary is, however, far from a complete picture of the more than 100 recommendations put forward in the last three decades related to a range of issues.

THE FINDINGS

PART TWO

Introduction

The Governor's Commission on Mental Health focused its attention on five major issue areas:

1. policy direction and mission;
2. the needs of people with mental health problems;
3. planning and delivery of mental health services;
4. quality assurance and standards; and
5. funding.

There is in fact no goal, direction, or mission that draws together the array of mental health services, policies, and funding mechanisms in the state.

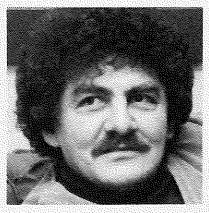
Within each area, the Commission reviewed the current state of affairs in mental health services in Minnesota and extensive information on alternatives to pursue in order to address current issues.

In addition to its own expertise and published reports in Minnesota, the Commission relied greatly on information and analyses presented to it by individuals invited to present their views at Commission and working group meetings.

Issue 1: Policy Direction, Mission, and Rights

Two themes were of primary interest to the Commission in this area—the direction of mental health services, and the rights of people with mental health problems.

Policy:
As with numerous other investigations and reports, the Governor's Commission concluded that the system of mental health services in Minnesota can only be described as a nonsystem. One of the defining characteristics of a system is that a series of parts (in this case, services, policies, and funding) work together as a whole to perform a vital function or achieve a goal.



The idea that a sense of mission is required to build a system is certainly not new in Minnesota. There are, for instance, clear statements of direction in terms of mental retardation and chemical dependency programs:

> It is the policy of the state of Minnesota to provide a coordinated approach to the supervision, protection, and habilitation of its mentally retarded citizens. In furtherance of this policy, sections 252A.01 to 252A.21 are enacted to authorize the Commissioner of Human Services . . . to protect such mentally retarded persons from violation of their human and civil rights by assuring that such individuals receive the full range of needed social, financial, residential, and habilitative services to which they are lawfully entitled.

It is hereby declared to be the public policy of this state that the interests of society are best served by providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services . . . treatment shall include a continuum of services available for a person leaving a program of treatment.

SUCH STATEMENTS DO NOT EXIST IN STATE STATUTE WITH REFERENCE TO SERVICES FOR PEOPLE WITH MENTAL ILLNESS.

It is the conclusion of the commission that these mission statements are not sufficient to guide and stimulate the development and operation of a mental health service system which is responsive to the needs of Minnesota's citizens and the communities in which they live.

The Commission is aware, however, that Mission Statements do exist within the Department of Human Services and its mental health division. The statements provided to the Commission by the Department are as follows:

> The Department of Human Services . . . is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to help them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.
>
> . . . the purpose [of the mental health division] is to encourage, ensure, or provide opportunities for every person in Minnesota to grow in his/her abilities to get along with others, in ways that are satisfying to him/her, and acceptable to those around him/her.

In addition to the Mission Statements provided to the Commission, the Department of Human Services has also included a mission statement in its January 1985 *Report to the Legislature Regarding Rules 36, 12, and 14.*

> The mission of the Department of Human Services through all the programs, authority, and resources under its aegis is to prevent, ameliorate, and minimize dependency of persons on others due to chemical abuse, or emotional, developmental and/or physical disabilities.

At the current time, there is a considerable discrepancy between the rights of people with mental illness, the recognition of those rights in state statute, and the protection of those rights in practice.

As an overall statement of commitment, the Department reaffirms its belief that the mental health "system" in Minnesota must ensure that an adequate array of mental health services are available to all those in need, based on the following criteria:

- be reasonably accessible to all;
- meet at least minimum health, fire safety and program standards;
- be appropriate to an individual's diagnosis and condition;
- be delivered in the least intrusive manner, in the least restrictive environment possible, and be free of abuse; and
- contribute to the progress of the individual toward self-determination and independent living.

Rights

The federal Mental Health Systems Act included a patients' bill of rights which was recommended to states for their adoption in statute. Section 501 recommended the following rights:

- treatment and least restriction of liberty;
- individual treatment plan;
- planning participation;
- explanation of treatment;
- right to refuse treatment;
- nonparticipation in experimentation;
- freedom from restraint or seclusion;
- humane treatment environment;
- confidentiality of records;
- access to records;
- right to converse in private;
- reasonable access to telephone, mail and visitors;
- information regarding rights;
- assert grievances;
- fair grievance procedure;
- access to an advocate;
- referral upon discharge;
- other civil rights;
- confidentiality of records on discharge;
- no reprisals for assertion of rights;
- rights of facilities;
- access by legal representative;
- posted notice of rights; and
- substitute judgment (guardian).

In a recent review of state statutes to determine the extent to which these rights have been accepted in states (Lyon, Levine, & Zusman, 1982), it was determined that Minnesota had substantially complied in nine areas, partially complied in six areas, and had not complied or contradicted the recommendations in nine areas. According to this review, several states such as Alaska, Arkansas, California, Connecticut, Georgia, Hawaii, Illinois, Kansas, Missouri, Montana, New Jersey, New York, Ohio, and Wisconsin exceed Minnesota in statutory protection of rights.

Issue 2: The Needs of People with Mental Illness

The Commission is not aware of any study in Minnesota which documents the individual needs of all people with mental illness. There have been a number of investigations into some of the characteristics of people with needs, such as Rule 14 and Rule 36 facilities; the services they are receiving; and the services which are required in order to respond to their needs. Two recent studies illustrate the current state of our knowledge in these areas.

Study of Services to Mentally Ill People, Minnesota Department of Human Services
This 1984 study collected current information on the services provided by counties under the Community Social Services Act (CSSA) to people with mental illness, and the views of counties regarding the accessibility, adequacy and quality of those services. Its recommendations focus on the range of services which should be designated as the "minimum capability" available within a county to respond to the needs of people with mental illness.

The study indicates that counties are providing an array of services to people with mental illness, and that many essential services are either not available in all counties, or not available to the extent that they are needed.

The major areas of services identified as needed are as follows:

- ***Housing:*** More supportive living arrangements, adult foster care, halfway houses, board and lodging, Rule 36 facilities, semi-independent living programs, apartment living, and food and clothing.
- ***Employment:*** Employment programs, training, job placement and sheltered workshop alternatives.
- ***Case Management:*** Including more county social workers who have smaller caseloads.
- ***Patient Followup and Aftercare.***
- ***Crisis Care/Emergency Services:*** Including critical care capabilities and crisis homes.
- ***Transportation:*** Especially in rural areas.
- ***Day Treatment Programs.***
- ***Social and Recreational Activities.***
- ***Prevention and Education Services.***
- ***Services for Special Populations:*** Including people with dual diagnoses (mental illness and mental retardation, chemical dependency, or physical disability), children and adolescents, elderly persons in nursing homes, people with mental illness who are homeless, and ethnic populations.

The following services were identified by 75 percent or more of the counties involved in the study as "essential for mentally ill persons" and were then recommended by the Department to be included in the description of minimal capability:

- adult protection;
- child protection;
- assessment;
- case management;
- emergency services/24-hour emergency service;
- prepetition screening;
- assistance in meeting basic human needs;
- outpatient services;
- community residential services;
- diagnosis; and
- inpatient psychiatric services.

The fundamental fact, however, is that we have little comprehensive information about the actual needs of Minnesotans with mental illness.

Consumer Survey of Mental Health Services in Minnesota, Mental Health Advocates Coalition of Minnesota, Inc.
In 1984, the Coalition surveyed consumers of mental health services and their families across the state. The survey addressed three issues—availability, accessibility, and quality of services. It is important to note that the consumers involved in the study had already, in some way, been connected with the mental health system or the Coalition.

Among people who are involved in services or the coalition, less than half think they have adequate access to services.

The major findings of the study were reported under four headings:

Access to Mental Health Services (N = 812):

48 percent reported having adequate access;

42 percent reported having no access; and

10 percent reported being unaware of services accessible to them.

Approximately one in five individuals think they are restricted in their access to hospitalization.

Inpatient Services (N = 788):

78 percent reported having adequate access;

14 percent reported having no access to a hospital; and

8 percent reported being unaware of the availability of a hospital.

Information:

54 percent reported adequate information about mental illness (N = 710);

47 percent reported adequate information about ways to cope (N = 693); and

51 percent reported adequate information about services available (N = 686).

One half of the respondents do not have basic information about the illness, how to cope, nor services available.

The services which allow people to live close to home and family; reduce hospitalization; and are cost effective are seen as inaccessible to many people who may require such services.

Outpatient and Community Services:

Outpatient Services:
60 percent report access (N = 790);

Housing/Residential:
40 percent report access (N = 734);

Vocational/Rehabilitation:
37 percent report access (N = 763); and

Respite Care:
24 percent report access (N = 519).

Issue 3: Planning and Delivery of Services

Concerns and Issues
Based on the experiences of members of the Governor's Commission, the material it reviewed, the presentations it heard, and the issues repeatedly identified in other reports, the Commission is concerned about the planning and delivery of mental health services.

State Hospitals
Currently, six of the eight state hospitals, and the Minnesota Security Hospital serve people with mental illness. Before the deinstitutionalization movement of the 1960s and 1970s, there were over 10,000 beds in the state hospital system for people with mental illness. Today, there are fewer than 1,300 beds. In FY '85, the average daily census was 1,197 persons (with mental illness), and this is expected to rise to 1,251 in FY86 (Nagel, 1985, p. 6).

There has been a significant decline in the institutionalization of citizens with mental illness in state hospitals.

Nursing Homes
Many elderly persons with mental illness have been moved into nursing homes, because federal Medicaid funds are available. From 1978, the number of persons (medicaid funded) with mental illness in nursing homes has increased from 6,281 to 9,948 in 1982. The Department of Human Services reports 15,200 people with mental illness now living in nursing homes (Department of Human Services, 1985, p. 12). This number (15,200) represents all types of funding in all nursing homes including state-operated.

Conversely, there has been a dramatic increase in the number of elderly persons with mental illness in nursing homes. These individuals do not necessarily receive any mental health care.

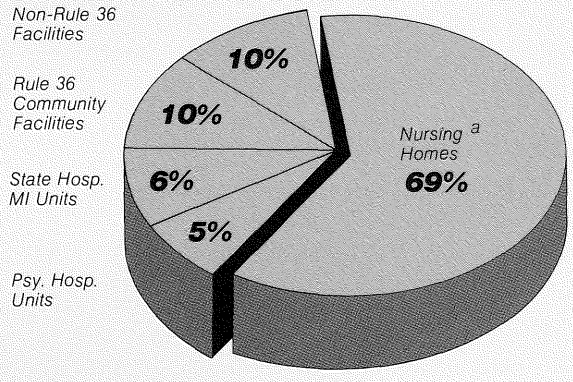
There has been a dramatic increase in community residential programs and the state's involvement in funding and setting standards. Their distribution, however, is limited.

Community Residential Programs
Licensed residential programs for people with mental illness began to grow after the Minnesota Legislative Auditor's report (1981) which examined facilities for people with mental illness. The group homes are now under the licensure requirements of Rule 36. Excluding state hospital beds for people with mental illness which are also licensed under Rule 36, there were 1,918 beds licensed or in the process of being licensed under Rule 36, involving a total of 81 facilities as of January 1986.

Rule 12 is the funding mechanism for grants to counties to help pay for services required by Rule 36. In FY '86, Rule 12 grants funded 75 facilities with a capacity of 1,676 beds. In total, 29 counties received Rule 12 grants.

Current estimates from the Department of Human Services are that the total number of persons with mental illness in Minnesota's 300 to 350 residential facilities is approximately 22,000 at any specific time. The distribution of those people among the different types of facilities is as follows:

Mental Illness Facilities and Approximate Residents 22,000



Source: Department of Human Services, 1985, p. 12.

[a]Includes over 1,000 people under age 65 years.

Additionally, according to the Department of Human Services approximately 4,000 to 5,000 Minnesotans have mental health needs appropriate for placement in a Rule 36 facility, a semi-independent living arrangement, or a supportive living residence (Department of Human Services, 1985, p. 12). These alternatives are not available to meet the projected need.

Community Support Programs
Community support programs offer day programs, case management, outpatient treatment, and other support programs for people with mental illness in Minnesota. Rule 14 establishes standards and serves as the funding mechanism for grants to counties to fund community support projects. During FY '84, 32 projects were funded, serving 2,750 clients. Funding was provided to 36 counties.

Under the umbrella of the Community Social Services Act (CSSA), a variety of services are offered to people with mental health problems.

Community Mental Health Centers
Virtually all community mental health centers in Minnesota were organized under the Community Mental Health Center Act passed by the 1957 Minnesota Legislature. The passage of P.L. 88-164, Title II in 1963, which authorized establishment of community mental health centers had a limited impact in Minnesota. Only seven facilities in the state ever qualified for support under this Act. Community mental health centers pioneered noninstitutional care throughout the state of Minnesota. In 1985, there were 39 mental health center and county program boards listed in the directory maintained by the mental health division. The funding of such facilities is not consistent throughout the state, and the programs offered by centers differ significantly.

General Hospital Psychiatric Care
In FY '84, 6054 patients were covered under Medical Assistance and General Assistance Medical Care for general hospital psychiatric care. The Minnesota Department of Health reports 1,100 licensed beds in community hospitals for psychiatric care. Funding for this service comes from both private and public sources. In the past, Medical Assistance and General Assistance Medical Care funding for general hospital psychiatric treatment has been based on a per case prospective payment. Since Fall 1985, a four category DRG system exists for community-based psychiatric hospital reimbursement. The Department of Human Services has subcontracted quality assurance activities and utilization review to Blue Cross/Blue Shield of Minnesota for the past two years. Olson (1985) cited several problems in the mental health area including: (a) poor or nonexistent discharge planning, (b) poor or nonexistent physician involvement, and (c) a lack of crisis intervention and seclusion areas within facilities, which would prevent the need to transfer people to inpatient care.

Other Outpatient Services
Rule 29 governs eligibility for insurance reimbursement for outpatient mental health clinics. The Department of Human Services listed 62 Rule 29 centers in 1983. Most Rule 29 clinics receive a mix of reimbursement from both public and private sources. There has been no attempt to describe the people served by these clinics and the quality of services received.

The Commission reached several conclusions about the organization of the service system and its outcomes:

Mental health services are provided by the private sector through health insurance and health maintenance organizations and a public sector. The public sector includes the Medicare and Medicaid programs, the state hospitals and county administered programs through the Community Social Services Act. Public sector systems also include employment and government assistance programs in order to satisfy basic human needs. The public funding involves three levels of government, federal, state, and county.

- These sectors and levels of government are not a well-integrated system. To the extent that a system exists, it is not well-understood by those within it or those intended to be served by it.
- A change in one part of the system affects the other sectors and/or levels of government. There is little coordination related to these impacts. Examples of such changes include new mandates, changes in funding levels, and changes in insurance coverage.
- There are inconsistencies among the three sectors and levels of government in terms of regulations, uniformity, and flexibility.
- Responsibility is not well-identified or fixed within either the sectors or the levels of government.
- Leadership is often cited as a problem. As with responsibility, it must exist in all sectors and at all levels of government.

There has been a dramatic increase in the availability of community support programs in the state, but their distribution is limited.

Very little is known or required to be known about outpatient services in contrast to inpatient psychiatric services.

Most of the state seems to have access to the services of a community mental health center. However, the range and nature of services offered by them vary considerably and their funding is not uniform.

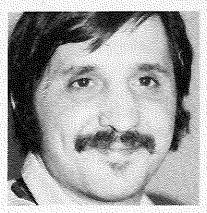
In answer to the governor's question about why community support programs are not provided statewide, there are two reasons: (1) lack of long-term funding, and (2) fiscal disincentives to counties.

Mental health is a field in which there are so many goals and so few agreed upon priorities that progress toward any goal requires sustained effort across years.

— Leighton, 1984 —

- There is no unified philosophy, set of goals or policy driving the mental health system. In addition, there appear to be two competing philosophies—a welfare philosophy which implies providing a minimum level of services to all who are eligible, and a health/wellness philosophy which implies providing a level of service that matches the needs of all the people.
- An array of services does exist in the state, but not in all parts or in all types of service. Access to services remains a problem. Access is an issue at a number of levels—the existence of a service, its availability, transportation or distance, physical access, adaptation/accommodation for people with sensory impairments, ability to pay, and fear of stigmatization by professionals.
- There is no ongoing, integrated method of ensuring accountability in all sectors and levels of government. There is a significant lack of information on the services available to and received by individuals, as well as the outcomes achieved by those services. This puts public officials at a critical disadvantage.
- Funding remains a problem in terms of stability and level of funding, and incentives and disincentives for certain programs and services.

In other words, the "system" is, to a significant extent, divided, inconsistent, uncoordinated, undirected, unaccountable, and without a unified direction. While some information exists about the availability and use of services, very little is known about the bottom line—how effective the system is in responding to the needs of the people it is intended to serve and support.



Issue 4: Quality Assurance and Standards

The Commission examined a wide range of issues related to standards and ensuring quality in the system—rights, case management, consumer input, grievance procedures, standards and licensing, and quality assurance. Much of the information gathered has already been reviewed in other sections of this report. This is quite appropriate since issues of quality and quality assurance should and do emerge in all aspects of the mental health service system.

Issues and Concerns

Rights

According to the Minnesota Mental Health Law Project, major discrepancies between current Minnesota statutes and the patients' bill of rights contained in federal law include four areas:

1. rights of outpatients;
2. rights to appropriate care and related services;
3. fair grievance procedures; and
4. access to advocacy.

In addition to these discrepancies, no clear statements of rights exist for minors or with respect to families. There are no mechanisms for ensuring accountability and evaluating the extent to which rights are, in fact, respected.

Case Management

A study conducted in Hennepin County demonstrated that case management services are effective—quality of life increases, days in hospital decrease, and hospitals are used more appropriately.

It is also clear that case management is more effective when case loads are manageable. Finally, unless agencies are in some way accountable to case managers for delivering the needed services to individuals, case managers cannot be sufficiently effective.

A cornerstone of vigorous case management systems is the individual service plan. To be effective, individual service plans must: (1) be individualized, (2) support the least restrictive/most enhancing environment, (3) contain measurable outcomes, and (4) be client-centered. To be useful for both planning and quality assurance, individual service plans must be used in CSSA planning efforts.

The current case management system, however, needs additional support such as a clear definition, standards, outcome measures, training, interagency agreements, and the ability to develop needed services.

Consumer Input

The consumers of services are the fundamental reason for the existence of services, yet their views about the service and their satisfaction with it are rarely solicited on a systematic basis.

Standards and Licensing

The Commission is concerned about a number of characteristics related to standards and licensing, including the following:

- funding without standards;
- standards which are not implemented;
- inactive quality review processes;
- unlicensed facilities;
- incongruity of effort between the Departments of Human Services and Health; and
- conflict between and among rules with no attempt to consolidate them underway.

Quality Assurance

There is no comprehensive quality assurance system in place related to the mental health service system in Minnesota. There are discrete parts of quality assurance such as accreditation, utilization review, Vulnerable Adults Act, Patient Bill of Rights, and licensing in existence. To build a comprehensive system, the Commission recognizes that a number of essential features are required:

Three basic components of a quality assurance system must be in place—standards, mechanisms to monitor, and the ability to take corrective action when standards are not being met.

Quality assurance must involve the systematic incorporation of the results of monitoring and evaluation efforts into the management and planning processes of programs and government agencies. If they are not, individual situations are likely to go uncorrected, or the causes of such situations are likely to go unattended.

Standards must emphasize three different elements—outcomes (the results, change or benefits for the client); process (the performance of the agency); and inputs (the human and material resources dedicated). If the system is to be responsive to individuals, much more emphasis is required on outcomes and processes.

Monitoring cannot rely on the traditional and formal practices of licensing and accreditation alone. It must be an ongoing process, related to individuals, and involving a number of perspectives, including the perspective of the consumer of the service.

For the purposes of developing quality assurance mechanisms, it is important to recognized that "quality assurance" is an activity usually conducted by management to assess the status of quality in a service, to track that status over time, and to recommend ways to improve the correspondence between standards and performance.

Quality outcomes for people with mental illness are improved with case management, consumer input, treatment standards, quality assurance mechanisms, and structures to protect rights.

A History of Minnesota's Mental Health Services

The history of policy and services within Minnesota's mental health system has involved developments at the state and federal levels, and in terms of both the state hospital system and community programs. These developments have not occurred within an overall plan. The language used is out of date but reflects the terms appearing in state statutes:

Psychiatric disorders have been estimated at 150 per 1,000 people in the U.S. (Weissman, Myers, & Harding, 1978).

1866 Minnesota Hospital for the Insane established at St. Peter. Training School called House of Refuge established in St. Paul for boys and girls.

1879 Hospital for the Insane opened at Rochester.

1890 Fergus Falls Hospital for the Insane opened.

Fergus Falls State Hospital, Fergus, MN Ca. 1913
Photo: St. Paul Dispatch-Pioneer Press

1900 State Asylums for the Insane opened at Anoka and Hastings.

The prevalence of chronic mental illness in U.S. households is approximately 9 per 1,000 or over 1 million people in the U.S. (Ashbaugh, Leaf, Manderscheid, & Eaton, 1983).

1911 The Asylum for the Dangerously Insane opened on the St. Peter Hospital campus (Later this became the Minnesota Security Hospital.)

1917 Willmar State Hospital admits patients with mental illness.

1938 Moose Lake Hospital for the Insane opened.

1946 Congress passed the National Mental Health Act, involving the federal government in support of mental health services and research, and the training of mental health professionals.[a]

1949 Minnesota's Mental Health Policy Act became law, setting forth measures of service in the care and treatment of people with mental illness as goals for the state, and providing increased financial support for services.

1950 Sandstone State Hospital for the Insane established (later converted to a federal prison in 1959).

1950s Introduction of psychotropic medications contributed significantly to the management of symptoms experienced by persons with mental illness, thereby making it possible to live in the community.

First Minnesota "Insane Asylum" St. Peter, MN Ca. 1868

1957 The Community Mental Health Services Act was enacted by the Minnesota Legislature, authorizing the Commissioner of Public Welfare to make grants to local communities and nonprofit corporations to establish and operate local mental health programs. Local programs were to include prevention, information and education, consultation, outpatient diagnosis, and treatment and rehabilitative services.

1961 The federal Joint Commission on Mental Illness and Health released findings of its six-year study *(Action on Mental Health)* and cited humanitarian, clinical, and economic reasons for a move to community treatment.[a]

1963 The federal Mental Retardation Facilities and Community Mental Health Centers Construction Act (P.L. 88-164) passed, provided federal funding for community mental health centers.[a]

1963 Medicare and Medicaid legislation passed, allowing states to receive federal funding for some costs incurred by persons with mental illness.[a]

1963 State residential treatment center for emotionally disturbed children opened at Lino Lakes.

1968 Revision of the Minnesota Hospitalization and Commitment Act made involuntary hospitalizations less common and increased the need for community-based alternatives.

1971 *Wyatt v. Stickney*, 325 F. Supp. 781 (N.D., Ala., 1971) one of several federal court decisions establishing right to treatment and least restrictive alternative.[a]

Hastings Hospital, Womens Cottage #1, 1904

Photos from the collection of the Minnesota Historical Society

1971 Brainerd Regional Human Service Center opened to serve persons with mental illness.

1973 Right to treatment in state hospitals established in Minnesota law.

1973 Patient's Bill of Rights Act enacted. Revised in subsequent years.

1976 Rule 36, first promulgated in 1974 established rules governing licensure of all residential facilities housing five or more adult mentally ill persons, began to be implemented. Only 7 of the 100 existing facilities, however, were licensed by 1981 because there was no funding source.

1976 Public Welfare Licensing Act enacted for protection of residents.

1977 The General Accounting Office issues a report urging more federal intervention in mental health, *Returning the Mentally Ill to the Community: Government Needs to Do More.*[a]

1978 Hastings State Hospital closed. Legislature approved the construction of a new 165-bed security hospital on the St. Peter campus.

1978 Minnesota received NIMH funding for a pilot community support program in Hennepin County.

1979 The Minnesota Legislature approves state funding for community support programs (Rule 14) for projects beginning in 1981.

1979 The Community Social Services Act (CSSA), passed by the Minnesota Legislature, establishing a system of planning, and providing community social services administered by county boards under the supervision of the Commissioner of Public Welfare. Counties were required to assess the needs of and provide services to "emotionally disturbed children and adolescents, and chronically and acutely mentally ill persons who are unable to provide for their own needs or to independently engage in ordinary community activities."

State Hospital, Rochester, MN 1918

Dormitory Ward, Hastings State Hospital, Hastings, MN Photo: C. J. Hibbard, Mpls., MN

1980 *Vickerman et al. v. Peterson et al.*, Civ 4-78-153, D. Minn. increased support for the principles of "least restrictive alternative" and the "right to treatment" in Minnesota.

1980 The U.S. Department of Health and Human Services Steering Committee on the Chronically Mentally Ill issues, *Toward a National Plan for the Chronically Mentally Ill.*

1980 The federal Mental Health Systems Act (MHSA) passed and included a recommended patients' bill of rights. While most of the Act was repealed in 1981, the rights section was retained. The section providing for grants for protection and advocacy was repealed.[a]

1981 Funding provided for Rule 36 facilities.

1981 Vulnerable Adults Act enacted.

1982 Revised Rule 36 became effective, establishing levels of programming and staff ratios, emphasizing individual treatment plans; requiring sound administrative practices; establishing residents' rights; and requiring compliance with standards.

1982 The Minnesota Commitment Act of 1982 was passed, providing for informal institutionalization by consent, involuntary emergency institutionalization, and involuntary commitment by civil judicial procedures. It also provided for the rights of persons hospitalized; requires prepetition screening and commitment hearings and procedures in conformance with due process; provides for commitment for determinate periods of time, and for provisional discharges and partial institutionalization.

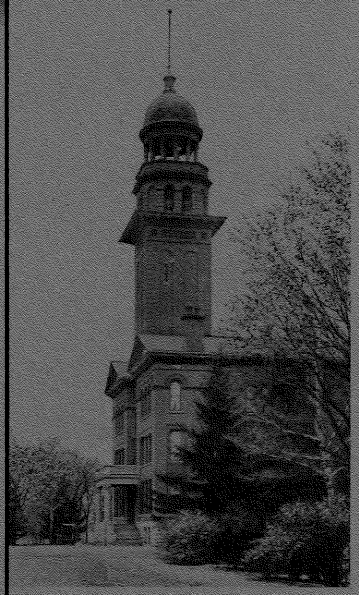
1982 Rochester State Hospital closed.

1985 Senator Lowell Weicker issues a report and holds three days of hearings on institutional care for persons with mental disabilities. A national protection and advocacy system for persons with mental illness is proposed by Senator Weicker as a result of this report.[a]

1985 Senator Edward Kennedy introduces three mental health bills to establish a special program for housing (S. 1743), to require states to develop, establish, and implement comprehensive mental health plans (S. 1744), and to amend the Social Security Act to provide case management and home and community-based services.[a]

1985 Minnesota State Hospitals change names to Regional Treatment Centers, Regional Centers, or Human Service Centers.

In 1983, the Minnesota Department of Human Services estimated 30,000 chronically mentally ill people lived in Minnesota.



Entrance to State Hospital, Rochester, MN Ca. 1910 (postcard)

[a]Federal action.

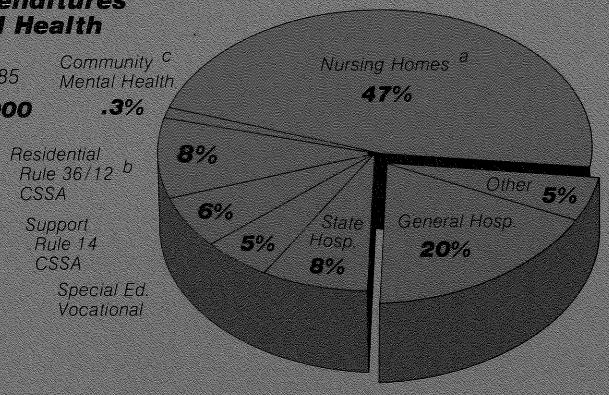
Hundreds of millions of dollars are spent on mental health services in Minnesota, but we do not have systematic information about: (1) Precisely how much is spent on services for persons with mental illness, (2) who is receiving services, (3) what services are received and to what effect, and (4) who pays for services.

Issue 5: Funding

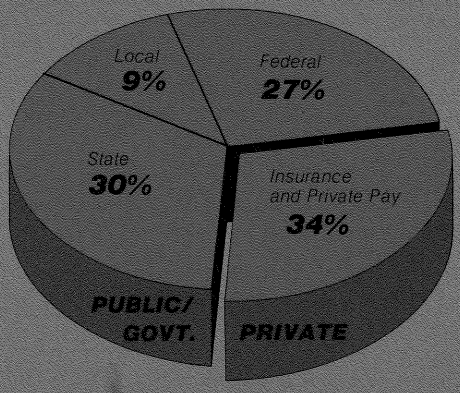
Minnesota's mental health system not only relies on funding for its existence, it is distinctively shaped by the sources of funding, eligibility criteria, amounts available, and requirements for accountability. If the service system can be described as a nonsystem, a major reason for this is the funding nonsystem.

In a report prepared for the Commission, total expenditures for mental illness services in Minnesota were identified for the major program areas (Nagel, 1985).

Total Expenditures for Mental Health Services
Minnesota FY85
$565,250,000



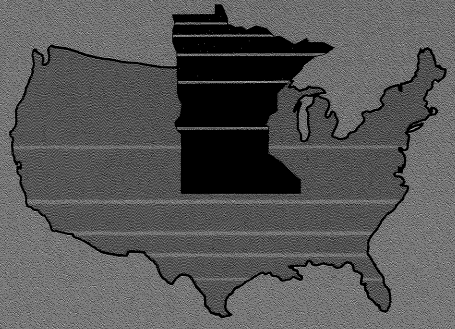
Funding Sources for Mental Illness Services
Minnesota FY85
$565,300,000



[a]Includes people over age 65 who may have a psychiatric diagnosis. These funds are for nursing home care and not mental health services.

[b]Rule 36 funds include room and board.

[c]Does not represent the total sources of funding, only federal block grant.



Source: National Institute of Mental Health in *Funding Sources and Expenditures of State Mental Health Agencies: Revenue/ Expenditure Study Results: Fiscal Year 1983.* Washington, DC: 1983).

The current funding arrangements are far from systematic. The most systematic results, however, appear to be: (1) to require people with mental illness to "follow the dollars" rather than the dollars following the person in order to purchase the required services; and (2) to favor the placement of individuals in more restrictive, but not necessarily more effective, environments.

Current funding arrangements restrict the types of treatment people can receive, and the types of settings in which they can receive treatment. For instance:

- The "best" funding arrangement for elderly persons with mental health problems is in nursing homes. The cost to counties is lower (5 percent).
- In comparing the costs to counties of placement in a Rule 36 community facility versus a state hospital, the cost to the county is often lower for a state hospital placement.
- The CSSA requirement for at least 50 percent county funding makes less restrictive options—halfway houses, extended care, crisis homes—more expensive, less attractive options.
- Federal Title XIX dollars are not available for residential care of persons with mental illness between the ages of 21 and 65.
- Private insurance coverage for outpatient mental health services is limited.

The absence of a vigorous case management and individual service planning approach, and of uniform placement criteria, increase the risk that services will be offered based on "the costs to the unit of government making the placement" rather than the needs of people.

A full array of services is neither in place nor funded.

Minnesota's Status on Expenditures for Mental Health Services
Compared to other states:

12th *State Mental Health Agency per capita Expenditures for Community-Based Programs*

15th *State Mental Health Agency Expenditures for Community-Based Programs*

16th *Total State Mental Health Agency Expenditures*

17th *Total State Mental Health Agency per capita Expenditures*

23rd *State Mental Health Agency Expenditures for State Hospitals*

33rd *State Mental Health Agency per capita Expenditures for State Hospitals*

Positive Trends

While the Commission is concerned about these issues and the fact that they have been outstanding for a number of years, it is also aware that there are a number of positive trends in the state. Members of the Commission offered the following statements about such trends:

"I am very happy with the development of community support projects outside the metropolitan area. Another positive sign is the beginning of the development of group homes outside the metro area. A good trend is the increasing emphasis on the rights of patients. Further, we are seeing more emphasis on outpatient care."

— Jerry Lovrien

"Hennepin County is progressive and willing to fund programs. Others from around the country are amazed that a county is funding a professional crisis center."

— Zigfrids Stelmachers

"The most positive thing I can cite is the increased availability of Community Support Program services. Consortiums funded by the McKnight Foundation have brought people together, and as a result, a systems advocacy capacity has developed. In Anoka, there is the highly successful Independent Living Program. It is down-to-earth and provides training in practical, day-to-day living skills. As a result, hospital stays have been greatly reduced, and we have seen a strong retention of former patients in their homes."

— Rebecca Fink

"The concern and motivation [for change] are already in place. Community Mental Health Centers are located throughout the state. As a result of our counties being part of a Service Board, people have "one stop shopping"; referrals are all internal. The structure is in place. It is well-distributed. It provides good access."

— Duane Shimpach

"Minnesota, at this time, does have a great number of people committed to quality. There are some highly qualified staff who, while frustrated, are anxious to provide quality care."

— Tom Bounds

"Overwhelmingly successful are the community support programs treating people with chronic mental illness. The problem is that community support programs do not exist in all counties. The data show a good reduction in calls for emergency medical care and law enforcement. The programs are successful because they provide training in everyday skills and they coordinate recreation, socialization, family outreach, and outpatient care."

"Another positive observation is that some of the counties, such as Hennepin and St. Louis, have taken their role in mental health care very seriously."

— Miller Friesen

"The Range and Northland mental health centers are very good examples of programs that work. They have developed programs that are meaningful to Indians and their outreach to those communities is commendable."

— Norby Blake

"One of the best things happening in the state is the movement of families to organize on behalf of their relatives.

"The increase in community support funding is a good thing and can help renew the emphasis on mental health centers on the care of people who are chronically mentally ill. People are recognizing that more needs to be done for people who are chronically mentally ill."

— Gail Jackson

PART THREE

THE FUTURE

Introduction

Based on its understanding of the current situation in Minnesota's mental health system, in terms of policy, services and needs, the Governor's Commission on Mental Health is convinced that three types of steps must be taken:

1. The state of Minnesota must make a commitment to mental health services that are responsive, efficient and effective in meeting the needs and rights of our citizens with mental illness.
2. Services, authority and funding must be organized in ways that are consistent with meeting this commitment.
3. Standards and quality assurance mechanisms must be in place to ensure that the commitment is met.

The recommendations of the Commission are organized and presented according to these three themes—**commitment, organizing to meet the commitment, and ensuring that the commitment is met.**

The recommendations also relate to two timelines—the immediate future and the near future. The immediate future means during 1986. The near future refers to 1987 and after.

Finally, the Commission has identified four top priority recommendations:

1. The adoption of a Mission Statement in state statute.
2. The extension of the Bill of Rights to outpatient mental health services in state statute.
3. The creation in state government of a visible, responsible, and committed focal point of administrative and professional leadership.
4. The continuation of a Governor's Commission on Mental Health to monitor and advocate the implementation of the recommendations contained in this report.

The Commitment

Goals

To ensure the planned development of a comprehensive community mental health service system that:

- respects the rights of people with mental illness;
- responds to their needs and the needs of their families;
- ensures services are provided in the least restrictive environment most appropriate to the person's needs; and
- ensures that people with mental illness problems are able or enabled to belong to our communities, and participate in and contribute to them.

To increase the appropriateness, availability, and accessibility of programs, services, and supports to people with actual or potential mental health problems, their families, and others who are significantly involved in their lives (such as students and workers, employers and educators, friends, and others).

Recommendations for the Immediate and Near Future

A Commitment to Excellence

In the immediate future, the Governor should make a commitment to excellence in the treatment of mental illness and the prevention of mental health problems in Minnesota.

Consistent with the position statement from the National Council of Community Mental Health Centers, "excellence" should be defined as the achievement of the following goals for individuals and by the mental health services system:

- **Restoration:** restore people with mental illness to a previously held higher level of functioning;
- **Stabilization:** stabilize individuals with mental illness;
- **Prevention:** prevent the development and deepening of mental illness;
- **Support and Assistance:** support and assist individuals in resolving emotional problems which impede their functioning;
- **Promotion of Functioning:** promote higher and more satisfying levels of emotional functioning; and
- **Promotion of Mental Health:** promote sound mental health.

Consistent with the needs of people with mental illness, "excellence" should also be defined as the achievement of quality outcomes for individuals and by the system, not merely compliance with minimally adequate standards.

A Mandated Mission
In the immediate future, the Commission's Mission Statement for Minnesota's mental health system should be adopted as follows:

The State of Minnesota is committed to the creation, operation, and maintenance of a comprehensive mental health service system that is both unified and accountable. This system will:

1. empower consumers to control their lives as fully as possible and recognize their rights to do so;
2. provide services which respond to the needs of people with mental illness in the least restrictive environment and aimed at:
   - relieving acute distress experienced by individuals,
   - enhancing individual capacities, and
   - maintaining the strengths and abilities of the individual;
3. be monitored continuously against state of the art program standards and quality of life measures to ensure that the services provided are effective, efficient, and appropriate; and
4. be measured against the goals of:
   - increased independence,
   - reduced chronicity,
   - increased safety, and
   - reduced abuse.

In the near future, the Governor should ask the Legislature to place an appropriately worded Mission Statement in state statute.

A Commitment to Rights
In the immediate future, the following steps should be taken with respect to the rights of people with mental illness and their families:

- the extension of relevant sections of the Bill of Rights to outpatient mental health services; and
- the development and implementation of methods to ensure accountability in the protection of rights.
- the development and adoption of a Bill of Rights for families of people with mental health problems;
- the clarification of the applicability of the Bill of Rights to minors;

A Commitment to Transforming the System
In the near future, the Governor should direct the executive branch to take whatever steps are necessary to transform the current "nonsystem" of mental health services in Minnesota to an effective, efficient and appropriate system of services.

The label of mental illness is almost universally regarded as a negative attribute.

— Rabkin, 1979 —

Organizing to Meet the Commitment

Goals

To develop, maintain and enforce statewide planning and evaluation efforts that promote the efficient, effective, and appropriate delivery of mental health services in Minnesota.

To allocate, manage, and monitor the use of state financial resources in ways that are directed at the development and maintenance of appropriate care, treatment, support, and habilitation programs for persons with mental illness, and in ways that are consistent with standards of service quality.

Recommendations for the Immediate and Near Future

A Point of Responsibility
In the immediate future, the Governor should create a focal point in state government of visible, responsible, and committed leadership for a system of mental health services.

This focal point can be accomplished in several ways:

- create a mental health authority in the Department of Human Services under its own deputy commissioner; or
- create a mental health authority in the Department of Health under its own deputy commissioner; or
- the creation by the Legislature of a separate Department of Mental Health in state government.

The Commission endorses the creation of a Department of Mental Health under the leadership of a mental health professional.

Responsibility for Overseeing Implementation
In the immediate future, the Governor's Commission on Mental Health should be continued to oversee, monitor, and advocate the implementation of these recommendations.

Funding for Planning
In the immediate future, the state agencies responsible for mental health care and services, in collaboration with the State Planning Agency, should seek federal funding to engage in planning efforts consistent with the realization of the Mission Statement.

A Range of Services
In the near future, the services position statement of the National Council of Community Mental Health Centers should be adopted by the Legislature as the basis for defining, planning, developing, and supporting a system of services for community mental health care. Such a system would include the following components:

- Nonresidential:
- Outpatient,
- Twenty-four hour emergency services,
- Partial hospitalization and day treatment,
- Consultation,
- Prevention/Education,
- Screening and Assessment, and
- Community Support Services;
- Twenty-four hour community-based, non-hospital residential care:
- Short-term intensive treatment, and
- Structured residential support;
- Community-based hospital care:
- Short-term inpatient treatment, and
- Long-term inpatient treatment.

The definition of services should be converted to appropriate legislative language and include a clear definition of case management.

Equitable, Adequate, and Accessible Services
In the immediate future, a mental health services equity approach similar to Massachusetts should be adopted in order to achieve a more even distribution of services within areas of the state and an adequate level of services.

Appropriate Funding and Benefits
In the immediate future, the objectives of funding allocations should include:

- localized authority and responsibility for placement decisions;
- promotion of quality services; and
- accessibility of a minimum level and range of services statewide without regard for county of responsibility.

In the immediate future, funding should be provided in such a way as to promote access to an array of mental health services which are capable of achieving quality outcomes, not merely minimally adequate standards.[a]

In the immediate future, legislation should be developed which would expand outpatient mental health group policies and subscriber contracts benefits beyond $600 per year based on an individual assessment and treatment plan. To remove the current discrimination against individuals who require outpatient services beyond $600 per year, a needs assessment based on: (1) the severity of stress on the individual, (2) the level of function impairment experienced by the individual, and (3) the likelihood of attaining treatment goals shall be provided.

In the immediate future, legislation should be introduced to allow payment for hospital inpatient psychiatric services on a per diem basis, rather than on the basis of Diagnosis Related Groupings.

In the near future, reimbursement for hospital-based outpatient services should be expanded. Standards should be developed for outpatient treatment to promote continuity of care and individualized treatment.

In the near future, community-support programs (Rule 14) should be funded in all counties.

In the near future, funding for mental health services should be based on the person's needs and be directed to the actual provision of needed services. Existing funding arrangement should be maintained for a transitional period to assure continuity; but thereafter, funding should be tied to the individual and a plan of service.

In the near future, counties should ensure payment to service providers for services obtained, and utilize all available revenue sources.

In the near future, SSI/SSDI applications by or on behalf of Minnesota residents who may qualify because of mental disabilities should be made a priority and supported by all levels of state and local government and by private providers.

In the near future, services currently funded by the McKnight Foundation should be reviewed in order to allow inclusion of projects under public funding.

In the near future, community services should be fully funded, and the state share of mental health service funding be increased to 75 percent (actual), and fiscal disincentives be identified and removed.

Checks and Balances
In the near future, the functions of providing, regulating, and evaluating mental health programs should be separated to better assure a checks and balances approach.

Innovation and Excellence
In the immediate future, the development of innovations and application of models of excellence should be encouraged and supported through technical assistance and increased awareness.

An Indian Mental Health Program Office
In the near future, an Indian Mental Health Program Office should be created and employ Indian staff, utilizing existing staff complement positions and available funding.

Prevention and Outreach
In the immediate future, prevention services and outreach programs related to mental health should be available to Minnesotans of all ages.

Research
In the immediate future, basic research in the causes of mental illness and effective treatment should be supported at both the federal and state levels.

Information Systems
In the near future, a statewide information system for publicly funded mental health services should be implemented. The system should be client-based, ongoing, protective of confidentiality and privacy, using simple data collection techniques, capable of tracking or following clients within the public mental health system, and integrated with current data systems.

[a]"Access" has several meanings including availability of services, transportation or distance, physical accessibility, and accommodations for sensory impairments.

"The biggest need is for the public to accept and understand mental illness. Would that those with a mental illness would enjoy the same public acceptance that the alcoholic does."

— Concerned and interested citizen —

Ensuring the Commitment Is Met

Goals

To implement accepted principles for the provision of mental health services and maintain statewide standards (at both minimum and excellence levels) for the care, treatment, rehabilitation, and support of people with mental illness.

Recommendations for the Immediate Future and Near Future

Review and Consolidate Standards
In the immediate future, the Governor should request the State Planning Agency to reconvene the Department of Human Services and Minnesota Department of Health work group to continue the process of unifying licensing, seeking consistency in licensing and regulating, and seeking consolidation in the number of rules, and to then begin implementing changes.

Standards with Quality Content
In the near future, the content of standards should be consistent with the following characteristics of the system:

- services will be based, when feasible, on research findings;
- services will be based on clinical needs and delivered in a manner consistent with and sensitive to the cultural and ethnic backgrounds of the population to be served;
- services will be accessible to all age groups and treatment plans should reflect the special needs of the age group being served;
- services will be in the best, most appropriate, least restrictive setting available [or capable of being made available].
- services will be delivered in a manner which provides for accountability;
- services will be provided by individuals who are qualified by training and/or experience as determined by appropriate credentialing authorities.
- services will interact and coordinate with other organizations that impact on the delivery of community mental health care.
- an identified continuum of service will be provided within a designated geographic area.
- counties will identify individual needs and the state will identify special population and/or low incidence needs.

In the near future, greater emphasis should be placed on developing standards related to quality outcomes for individuals.

Monitor Compliance with Standards
In the near future, consumers should be sampled in all sectors of the service system on a regular basis to assess their opinions and satisfaction.

In the near future, state law governing appeals procedures should be amended to include client suspensions, discharges, and quality issues in violation of established standards of quality care.

Did You Know?

Independence Station, started in 1977, serves an average of 40 people at any one time, serving between 90 and 100 over the course of a year. People who successfully complete the program, about 25% typically, do so in 8 to 12 months. The goal of the program is independent living, a by-product of which is reducing hospitalization. Virtually all patients are on public assistance, either medical assistance or general assistance medical care. Roughly half have schizophrenia; another 25% have manic depression, and the rest miscellaneous personality disorders. Most are in their 20s and 30s. For some of the patients, treatment serves to rehabilitate them to a level of independence they at one time had. For a greater number, the treatment provides them with first-time skills. The typical patient has been hospitalized several times, has a spotty work history, and has not graduated from high school.

Treatment at Independence Station assumes that every person has the potential to "make it." The emphasis is positive, not a problem-orientation; the program emphasizes successes and the positive progress that a patient makes. "A lot of energy goes into acknowledgement for health." We try to role model healthy behavior. We work with Goodwill, the Voluntary Action Center, and others so that we can have the people working either at a paid job or at a voluntary service. We coordinate our work with other providers, many of whom are on the Advisory Board.

The Community Living Project was established to fill the gap between day treatment and independent living. We provide counseling, personal advocacy and agency advocacy and other forms of outreach to people going through the transition from day treatment to independent living.

Our program is one that recognizes dual disabilities; some patients have chemical dependency problems, a significant number in fact. It doesn't serve them well to treat their mental illness, but not their chemical dependency, so we provide chemical dependency treatment as well.

In an effort to provide a continuum of care, the Duluth Community Support Program has three main components: Independence Station, a day-treatment center; Community Living Project, an outreach project for people in their homes; and Harmony Club, a 20-year-old program that maintains support groups for people that have returned to the community, are living independently, but who need the ongoing support of a group with problems similar to their own.

—Solem, 1985—

The outpatient psychiatric program at Carondolet-St. Mary's Hospital (Minneapolis) is an especially successful, integrated, client-centered treatment service, combining a number of aspects:

- Two case managers serve a population of 100 persons suffering with chronic mental illness. The nurse case managers strive to integrate the treatment plan, linking families, the psychiatric and other physicians, social workers, and (often) Rule 36 facilities for a practical and effective treatment plan for the patient. The nurses accept drop-ins, phone calls during the week, and arrange crisis intervention when appropriate.

- Because most patients are on some form of public assistance and receive benefits concerning their housing and basic human needs, county social workers and families are considered an integral part of the support system. Staff at Rule 36 facilities and board and care homes are requested to meet with client, nurse case manager and supervising psychiatrists at intervals.

- Goals are highly individualized to the patient; sometimes they are maintenance-oriented, and at other times striving to establish improvement in basic living skills. Patient responsibility is emphasized and supported. Treatment goals are "concrete and common sense." The program is thus a "no fault" experience for the client. Compliance with the program is high because the patient-client agrees to and participates in the treatment decisions as much as is possible.

- The program is cost-effective. Hospital stays are reduced in length, the frequency of hospitalizations is reduced. Outpatient care is the primary therapy and not viewed as a followup or aftercare to hospitalization. The hospital inpatient service is used as a backup to the outpatient treatment system.

— Beecher, 1986 —

Did You Know?

"In the community support program we suggest that first of all the funds follow the client so that he or she does not become a political pawn in the hands of the county or state.
Adequate housing should be available throughout the state, both group and individual, supervised and unsupervised living situations. In group living situations adequate funds must be available to the clients to provide some sense of dignity.
Forty dollars a month for all personal needs, giving of gifts, etc., hardly provides much freedom of choice or feeling of value. In order to have a sense of dignity, a person needs to feel needed; therefore, every effort must be made to find jobs, both paid and volunteer. Job Service, vocational rehabilitation and all other work-related organizations must be made aware of and responsive to the special needs of the mentally ill."

— Parents —

The national-award-winning Range Mental Health Center CSP was started in the early 1970s as a multi-agency team approach. The program establishes a network of care for people who are chronically mentally ill, incorporating social services, vocational rehabilitation, sheltered workshops, hospital and day treatment. Representatives from the agencies meet regularly to discuss patient treatments and to appoint case managers. Since 1978, some 800 patients have passed through the program, out of a total service area population of 95,000. The program has been especially successful at training workers at public agencies in identifying people who are mentally ill. The CSP provides numerous in-service training sessions with the agencies, at the nearby nursing schools, with Rule 36 facilities, and with Indian workers. Thus, referrals come from Welfare, HUD, DVR, and others. Also, because the CSP is well-known in the community, there are more self- and family referrals.

— Schleppegrell, 1986 —

The Wilderness Therapy Project began in 1984 and has enabled about 25 people, many of whom are on major psychotropic treatment, to go on weekend campouts or day-long canoe trips into the BWCA. Many of the clients responded well to the independence and the sense of accomplishment that the trip provided; their personal hygiene and grooming improved and self-esteem was noticeably heightened. The project is privately funded by the Fitzgerald Brothers Foundation, Boca Raton, Florida.

— Schleppegrell, 1986 —

"The clubhouse concept in Vail Place is the missing link needed to stop the revolving door phenomena. During the first ten years of illness, my son experienced 25 hospitalizations. Since becoming a member of Vail Place ten years ago, my son maintains himself in the community because expectations are more realistic, he is treated as an equal, and there is freedom from the pressure of the next step or next move."

— A parent —

In 1980, mental illness was the third most expensive class of disorders accounting for more than 20 billion dollars of health care expenditures. Only circulatory disorders including heart disease, stroke, and hypertension, and all disorders of the digestive system were more costly in the aggregate.

— Janecek, 1985 —

Between January, 1983 and June, 1985, the Minneapolis Star and Tribune published 84 articles covering mental illness.

40% legal issues
20% licensing controversies, disability payments, outpatient services
15% criminal conduct
10% victimization of patients by therapists
10% indepth explanation of depression and schizophrenia
5% profile of people with mental illness.

— Moore, 1985 —

Senior Peer Counseling began at the University of Minnesota in 1978 with a demonstration grant from NIMH. As of January 1985, approximately 550 peer counselors have been trained. Senior Peer Counselors are older volunteers trained to serve as paraprofessional counselors to their peers. In addition, they often serve as a link to help older people use professional mental health services in their communities.

— Board on Aging, 1985 —

Over the last 35 years there have been over 150 studies examining attitudes toward mental illness. The public consistently demonstrates rejecting attitudes toward people with mental illness.

— Rabkin, 1980 —

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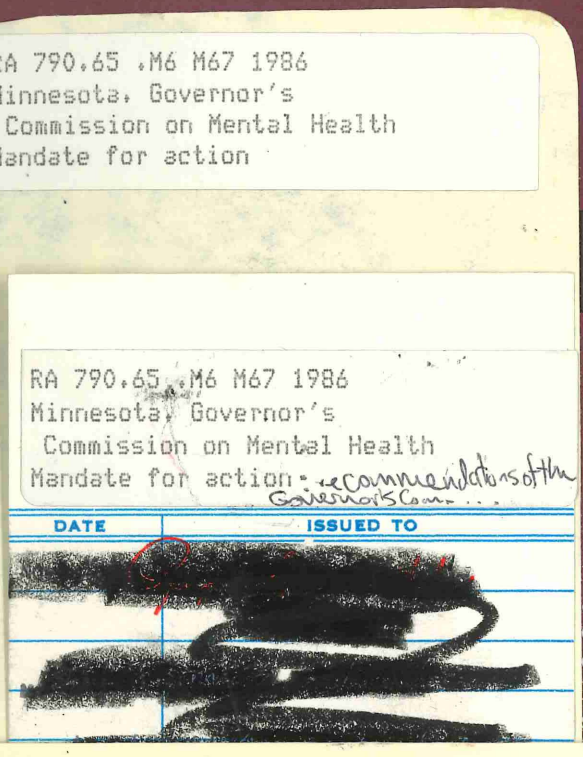

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