DEINSTITUTIONALIZATION OF MENTALLY ILL PEOPLE

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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February 1986

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State of Minnesota

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STATE OF MINNESOTA
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JAMES R. NOBLES, LEGISLATIVE AUDITOR

February 6, 1986

Senator Randolph W. Peterson, Chairman
Legislative Audit Commission

Dear Senator Peterson:

In June 1985, the Legislative Audit Commission directed the Program Evaluation Division to study the deinstitutionalization of mentally ill and mentally retarded people from state hospitals to community programs.

We are issuing two reports from this study. This report examines the transition of mentally ill people from state hospitals to community care. The other report analyzes how state hospital programs for mentally retarded people have changed as a result of litigation and other forces.

Unfortunately, top management in the Department of Human Services seemed uninterested in our study and was less than cooperative. We did, nevertheless, receive considerable help from other people in the department and particularly from staff at the state hospitals. We also appreciate the assistance provided by county social service directors throughout the state.

This report was written by Deborah N. Fine and Susan T. Job. Allan Baumgarten was project manager for the study, and Kathleen Vanderwall assisted in the research.

Sincerely yours,

James R. Nobles
Legislative Auditor

Roger A. Brooks
Deputy Legislative Auditor
for Program Evaluation

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EXECUTIVE SUMMARY

Although state hospital populations have declined dramatically over the last 30 years, Minnesota's state hospitals still serve about 2,500 mentally ill persons each year. Many of the patients are chronically ill people who enter the hospitals during a crisis in their illness, remain for a few months, and return to the community until the cycle begins again. In our study, we asked:

- Are county case managers and others adequately involved in preparing state hospital patients for discharge?
- Do patients receive adequate community support when they leave the hospital?

To answer these questions, we interviewed people from metropolitan and outstate counties, advocacy groups, state hospitals, and the Departments of Human Services and Health. We studied records for a representative sample of patients released from state hospitals in 1984. We surveyed counties to learn about their caseloads and analyzed the distribution of state grants for community residential and support services.

The role of state hospitals is different now than it was 30 years ago when public institutions served large numbers of people on a long-term basis. The primary role of state hospitals today is to provide crisis care for people experiencing acute episodes of mental illness. Each state hospital mental illness program has a clear identity, and the differences among the programs reflect the type and availability of mental illness treatment services in the surrounding communities. Despite efforts to shift the focus of care for mentally ill people away from institutions and into the community, Minnesota's state hospitals continue to play an important role in providing care for mentally ill people.

A. PATIENT CHARACTERISTICS

Mentally ill patients discharged from state hospitals in 1984 were relatively young: nearly 70 percent of the patients in our sample were under

40 years old. About two-thirds of the patients had previously been admitted to community hospitals for psychiatric care, and about one-third were admitted to state institutions directly from inpatient psychiatric treatment in community hospitals. Almost 42 percent entered the hospital voluntarily, while about 23 percent were committed by the courts. The most common diagnosis was schizophrenia, a chronic mental disorder.

For most patients, the visit we examined was only one in a series of many visits to state hospitals:

- About two-thirds of all patients had been admitted to a state hospital at least once in the past for mental illness treatment.
- About 21 percent of the patients were readmitted to state hospitals within 90 days of the visit we examined.

Readmission rates are high because of the nature of the illnesses, gaps in discharge planning, and limited participation by county case managers and others in planning follow-up care in the community. Our analysis shows a serious breakdown in the system of care for chronic mentally ill people.

B. COUNTY INVOLVEMENT WITH STATE HOSPITAL PATIENTS

Discharge planning is an important part of inpatient treatment because it links patients with critical resources to help in the transition back to the community. We examined patients' discharge plans to determine the level of county participation in discharge planning, and asked whether counties are equally involved with voluntary and committed patients. We also surveyed counties to find out how many mentally ill clients are served by case workers in each county.

The Minnesota Commitment Act of 1982 requires counties to participate in discharge planning for all state hospital patients regardless of their admission status. However, we found that:

- More than one-third of all patients left the hospital without a county case manager having participated in discharge planning.
- County staff were not involved in discharge planning for ten percent of committed patients and for 41.2 percent of voluntary patients.

We were not surprised to find gaps in county case management for state hospital patients. While mental health professionals generally recommend 30 to 40 clients per case worker, our survey of county caseloads for mentally ill people showed that case workers generally carry higher caseloads.

- According to our analysis, the statewide median is one full-time county case worker for 48 clients.

C. COMMUNITY SUPPORT SERVICES

We think that the absence of social service support is particularly significant in light of the fact that:

- Fifty-six percent of all patients were discharged from state hospitals with medication. However, the discharge plans for half of these patients did not designate a person or agency to monitor the use of medication after the patient returned to the community.

- Only 15 percent went to residential facilities licensed to serve mentally ill people, and 23 percent went to other group living arrangements not licensed to serve mentally ill people.

- About one-third of the patients went home, in most cases without specific arrangements for community follow-up services. Furthermore, only 26 percent of the patients had a family member participating in discharge planning.

During our study, we learned about gaps in the availability of residential programs and community support services for mentally ill people. The Department of Human Services administers two grant programs to help mentally ill people remain in their own communities. The Rule 12 grant program provides funding for bringing Rule 36 adult residential facilities up to state program licensing standards. The Rule 14 grant program funds community support projects enabling chronic mentally ill persons to remain at home. In analyzing these programs, we found that:

- The Department of Human Services has awarded a high proportion of Rule 12 and Rule 14 grants to the metropolitan area. This has resulted in an over-concentration of services in one region of the state.

About 64 percent of all beds funded by Rule 12 are concentrated in six metropolitan counties which contain about 50 percent of the state's population. In 57 counties, mentally ill persons must travel considerable distances to the nearest residential facility with a Rule 36 program license. Five of the seven metropolitan counties have received Rule 14 community support grants, but less than one-fifth of the outstate counties have been recipients. We believe that the awards should be distributed more evenly throughout the state in order for mentally ill people to remain and function in their own communities.

D. RECOMMENDATIONS

Our research was not intended to document gaps in case management and community support services in particular counties. However, our work does suggest that problems exist and that they affect the frequency and number of readmissions to state hospitals. Therefore, we recommend that:

- The Department of Human Services should establish regional priorities to ensure equitable distribution of Rule 36 facilities and should consider these priorities in awarding Rule 12 grants.

- The Legislature should place a high priority on increasing funds for the Rule 14 grant program in the next biennium. It should dedicate half of the increase to innovative case management projects. The other half should be earmarked for new community support projects in outstate communities without ready access to such services.

Because we also found significant gaps and variations in discharge planning at state hospitals, we also recommend that:

- The Department of Human Services should develop minimum system-wide standards for the content of discharge plans and should establish consistent recordkeeping procedures for discharge planning and patient follow-up at all hospitals.

- The hospitals and counties should focus discharge planning on community support services and residential programs that enable patients to remain in the community. The Department of Human Services should document gaps and target Rule 12 and 14 grants to areas where needed services are not available.

We recognize that the department and individual state hospitals do not have the power to enforce Commitment Act provisions requiring county involvement in state hospital discharge planning. However, we do think that the Department of Human Services should play a leadership role in solving this problem. Therefore, we recommend that:

- The Legislature should direct the Department of Human Services to establish a task force made up of state, county, and community representatives to recommend ways of improving the coordination of discharge planning between state hospitals and counties. The task force should consider changes in law and hospital procedure.

We believe that major changes in public attitudes will be required before the state can adequately fulfill its responsiblities to mentally ill people. This report focuses on practical changes in the state hospital discharge process which should result in improved hospital and community services for all mentally ill people.

INTRODUCTION

Until the 1950's, the state was the primary provider of care to mentally ill persons in Minnesota. Since then, the number of persons living in state-operated institutions has declined dramatically. In 1985, Minnesota's state hospitals served about 2,500 mentally ill persons. Many of these patients were chronically ill people who entered the hospital during a crisis in their illness, remained for a few months, and returned to the community until the cycle began again.

In June 1985, the Legislative Audit Commission directed the Program Evaluation Division to study the deinstitutionalization of mentally ill and mentally retarded people from Minnesota's state hospitals. In this study, we focused on the transition of mentally ill people from state-operated hospitals to community-based programs. We asked:

- What is the current role of state hospitals in serving mentally ill persons?
- Are hospitals and counties effectively working together to prepare patients for discharge?
- Do patients receive adequate community support when they leave the hospital?

In order to answer these questions, we visited each of the six state hospitals with mental illness programs. We reviewed the files of a representative sample of patients who were discharged from the hospitals in 1984. We interviewed state hospital staff and observed the programs in order to understand the role of each hospital within the region it serves. We also surveyed counties to learn about case management services for mentally ill people, and interviewed social service directors and staff in both the metropolitan and outstate counties. In addition, we met with legislators, advocates, and staff of the Departments of Human Services and Health.

Chapter 1 presents an overview of the state hospital system and traces the development of mental illness programs. In Chapter 2, we review the state's administration of two grant programs designed to enable mentally ill persons to remain in their own communities. In this chapter we also

report the data which we collected from 87 counties on case management services for mentally ill people.

Chapter 3 presents our analysis of data from a representative sample of patient files. In this chapter we report demographic information about mentally ill patients, and we discuss our findings regarding hospital and county roles during patient admission, discharge, and readmission. Chapter 4 includes our conclusions and recommendations for improving the coordination of services between state hospitals and counties.

AN OVERVIEW OF STATE HOSPITALS

Chapter 1

A. HISTORY OF STATE HOSPITALS IN MINNESOTA

The first state hospital for mentally ill people in Minnesota opened at St. Peter in 1866. In 1881, a school for mentally retarded people was established in Faribault.[1] These hospitals were the result of a national social reform movement which linked the therapeutic concept of *asylum* with the good of society. Social reformers advocated isolating mentally ill and mentally retarded people from the rest of society, preferably in peaceful rural settings. There, they could receive treatment and shelter from abuse and exploitation, while, at the same time, society would be protected from them.

Minnesota's system of state hospitals grew rapidly. The state hospitals were the primary providers of services to mentally disabled people until the late 1950s. At that time, a new group of social reformers successfully argued for *normalization*: that disabled people should live where they have the best opportunity to lead normal lives. The reformers further argued that community settings, rather than state hospitals, would provide the *least restrictive environment* for most people. This led to *deinstitutionalization*, a broader reform, with two main thrusts: creating a full range of new community services, and reducing the population of state institutions.

Federal and state governments passed laws to encourage the development of community services, and to reduce state hospital populations. In 1960, Minnesota's state hospitals had a population of about 15,400, as Table 1.1 shows.[2] By 1970, the number was down by nearly a half, to approximately

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[1] In this report, we refer to the system of state institutions which serve handicapped persons as *state hospitals*. In tables and figures, hospitals are generally identified by the city in which they are located.

[2] Throughout the report, all references to years are to state fiscal years, which are the twelve months beginning on July 1 and ending on June 30 of the following year.

TABLE 1.1

MINNESOTA STATE HOSPITAL POPULATION, ALL DISABILITY GROUPS
1960 - 1985

Year	Anoka	Brainerd	Cambridge	Faribault	Fergus Falls	Hastings	Moose Lake	Rochester	St. Peter	Minnesota Security Hospital	Willmar	Total
1960	1,085	147	2,001	3,096	1,852	940	1,108	1,642	2,111	239	1,233	15,454
1970	476	1,205	1,245	1,757	594	381	631	676	634	142	615	8,356
1980	362	543	527	807	550	--[a]	457	457	368	203	575	4,849
1985	313	424	459	668	470	--	435	--[b]	378	219	537	3,903

Sources: Department of Human Services, Fact Book: State Hospitals and Nursing Homes, 1974 and 1983, for 1960-1980; Department of Human Services, "In-Residence State Hospital Daily Census for FY 1985," for 1985.

[a]Hastings State Hospital closed in 1978.
[b]Rochester State Hospital closed in 1982.

8,400. In 1980, the population in state hospitals was 4,849, and in 1985, it was 3,903.

Between 1960 and 1980, significant changes also occurred in the population of various disability groups throughout the system, and in individual hospitals. For instance, mental illness programs were historically larger than the others. However, by the late 1960s, the number of mentally ill patients had fallen below the number of mentally retarded residents. During the 1960s and 1970s, the number of patients treated for chemical dependency increased steadily.

The Department of Human Services responded by establishing a "regional" system of mental retardation programs. As new space became available due to reductions in the mentally ill population, mental retardation programs were added at hospitals which had previously served only mentally ill or chemically dependent patients. Some people argue that this evolution has been beneficial in allowing the hospitals to provide a full range of services to all disability groups in different regions of the state. Others, however, contend that the actions were primarily designed to *save* hospitals whose mental illness programs and populations were steadily shrinking.

At present, Minnesota operates eight state hospitals for persons with mental illness, mental retardation, and chemical dependency. Minnesota is one of the few states whose state institutions serve more than one disability group on individual campuses. As Figure 1.1 indicates, six of the eight hospitals serve more than one disability group. In 1985, mentally ill patients made up about 32 percent of the state hospital population, mentally retarded residents were about 53 percent of the total, and chemically dependent patients were about 15 percent of the total.

The total budget for state hospitals in 1985 was about $146.4 million. More than two-thirds ($107.1 million) was paid for by the Medical Assistance program. Those costs are shared 52 percent, federal; 43 percent, state; and 4.5 percent, county. About 11 percent was recovered from Medicare, private insurance, charges to patients, and charges to counties. The rest was a direct state appropriation.[3]

In 1985, expenditures and staff complement for state hospital mental retardation programs were larger than for the other two programs. This is because mental retardation programs are the largest and the most staff intensive. In contrast, patients in mental illness and chemical dependency programs require less direct care but need proportionally more professional contact.

In 1985, about 29 percent of all state hospital expenditures were for programs serving mentally ill persons, 12 percent were for chemical dependency programs, and close to 60 percent were for mental retardation programs. As shown in Table 1.2, 18 percent of all state hospital staff were

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[3]Data provided by the Minnesota Department of Human Services, Reimbursement Division.

assigned to programs for mentally ill persons, six percent were employed in chemical dependency programs, and 49 percent worked in programs for mentally retarded residents. The remaining 28 percent of state hospital employees were general support staff serving all three disability groups.

FIGURE 1.1

MINNESOTA'S STATE HOSPITAL PROGRAMS

Hospital	Year Opened	Groups Served[a]	Special Programs
1. Anoka Metro Regional Treatment Center	1900	MI,CD	
2. Brainerd Regional Human Services Center	1958	MI,MR,CD	Minnesota Learning Center for adolescents who are mentally retarded or emotionally disturbed
3. Cambridge Regional Human Services Center	1925	MR	
4. Faribault Regional Center	1881	MR	Skilled Nursing Facility for medically fragile residents
5. Fergus Falls Regional Treatment Center	1890	MI,MR,CD	
6. Moose Lake Regional Treatment Center	1938	MI,MR,CD	Psycho-Geriatric Unit
7. St. Peter Regional Treatment Center	1866	MI,MR,CD	Minnesota Security Hospital; Services for hearing impaired
8. Willmar Regional Treatment Center	1912	MI,MR,CD	Adolescent psychiatric unit

[a]MI = Mentally Ill
MR = Mentally Retarded
CD = Chemically Dependent

TABLE 1.2

1985 STAFF COMPLEMENT IN STATE HOSPITALS

Hospital	Mental Retardation	Mental Illness	Chemical Dependency	General Support	Total
Anoka	--	176.50	37.56	164.60	378.66
Brainerd[a]	416.73	40.00	25.29	204.70	686.72
Cambridge	557.73	--	--	239.17	796.90
Faribault	850.98	--	--	242.20	1,093.18
Fergus Falls	290.32	86.00	87.31	159.25	622.88
Moose Lake	140.03	129.00	101.42	141.90	512.35
St. Peter[b]	207.77	310.00	30.55	162.40	712.72
Willmar	180.89	222.42	48.87	191.40	643.58
TOTAL	2,644.45	963.92	331.00	1,505.62	5,444.99

Source: Department of Human Services, Financial Management Division, "State Hospitals and Nursing Homes Staff Allocation Plan," July 1, 1985.

[a]Includes Minnesota Learning Center.
[b]Includes Minnesota Security Hospital.

B. NATIONAL TRENDS IN STATE HOSPITAL MENTAL ILLNESS PROGRAMS

During the second half of the nineteenth century, state mental hospitals were established throughout the country to provide long-term custodial care for three general types of patients: indigent elderly people; chronic mentally ill younger people; and individuals whose mental illness symptoms were related to physical disabilities or diseases, such as syphilis.[4]

In the mid-1950s, state mental hospitals reached a peak population of 550,000 patients. Then, serious questions emerged about the quality of care in state hospitals and the negative effects of isolating people in institutions for long periods. These two factors, combined with the availability of new *psychotropic* drugs for treating mental illness created pressure to reduce the numbers of patients in state hospitals.

[4]Gerald N. Grob, "Historical Origins of Deinstitutionalization," in *New Directions For Mental Health Services: Deinstitutionalization*, no. 17, by L. Bachrach, ed. San Francisco: Jossey Bass, March 1983.

In addition to challenging the traditional role of state hospitals, the new *deinstitutionalization* movement also stimulated the development of community treatment resources. The first important federal support for deinstitutionalization was the Community Mental Health Centers Act of 1963, which provided funds for constructing commmunity treatment facilities. The creation of the Medicare and Medical Assistance programs in 1965 provided a new payment source for nursing home care and community inpatient treatment of elderly, disabled, and low-income mentally ill persons. This federal legislation brought two immediate results: a sharp decline in state hospital populations, which began in the late 1950s and continues to the present; and a significant increase in public expenditures at all levels of government for community treatment of mental illness.

Thus, between 1955 and 1975, the number of mentally ill people in state hospitals nationwide decreased from 559,000 in 1955 to 193,000 in 1975, as stays were shortened and many elderly patients were discharged to nursing homes. During this period, the number of short-term admissions to state hospitals more than doubled, with about two-thirds being readmissions.[5]

At the same time, community-based residential and outpatient services began to develop with federal, state, and local support. First, the new community mental health centers diverted some patients from state hospitals and served as a referral and follow-up point for others. Second, after passage of Medicare and Medical Assistance, general hospitals began to increase the size of their psychiatric units to serve patients whose care was federally reimbursable.

Finally, during this period, many states passed laws to protect the rights of mentally ill people during commitment proceedings and involuntary hospitalization. These new laws required consideration of community services as an alternative to institutionalization. They also made it more difficult to commit persons, and made it virtually impossible to commit patients for long periods of time.

C. THE DEVELOPMENT OF STATE HOSPITAL MENTAL ILLNESS PROGRAMS IN MINNESOTA

In Minnesota, the development of services for mentally ill people has generally followed national patterns. As Figure 1.2 and Table 1.3 indicate, three state mental hospitals served almost 3,600 patients at the turn of the century. By 1930, there were seven hospitals, and the total population had more than doubled.

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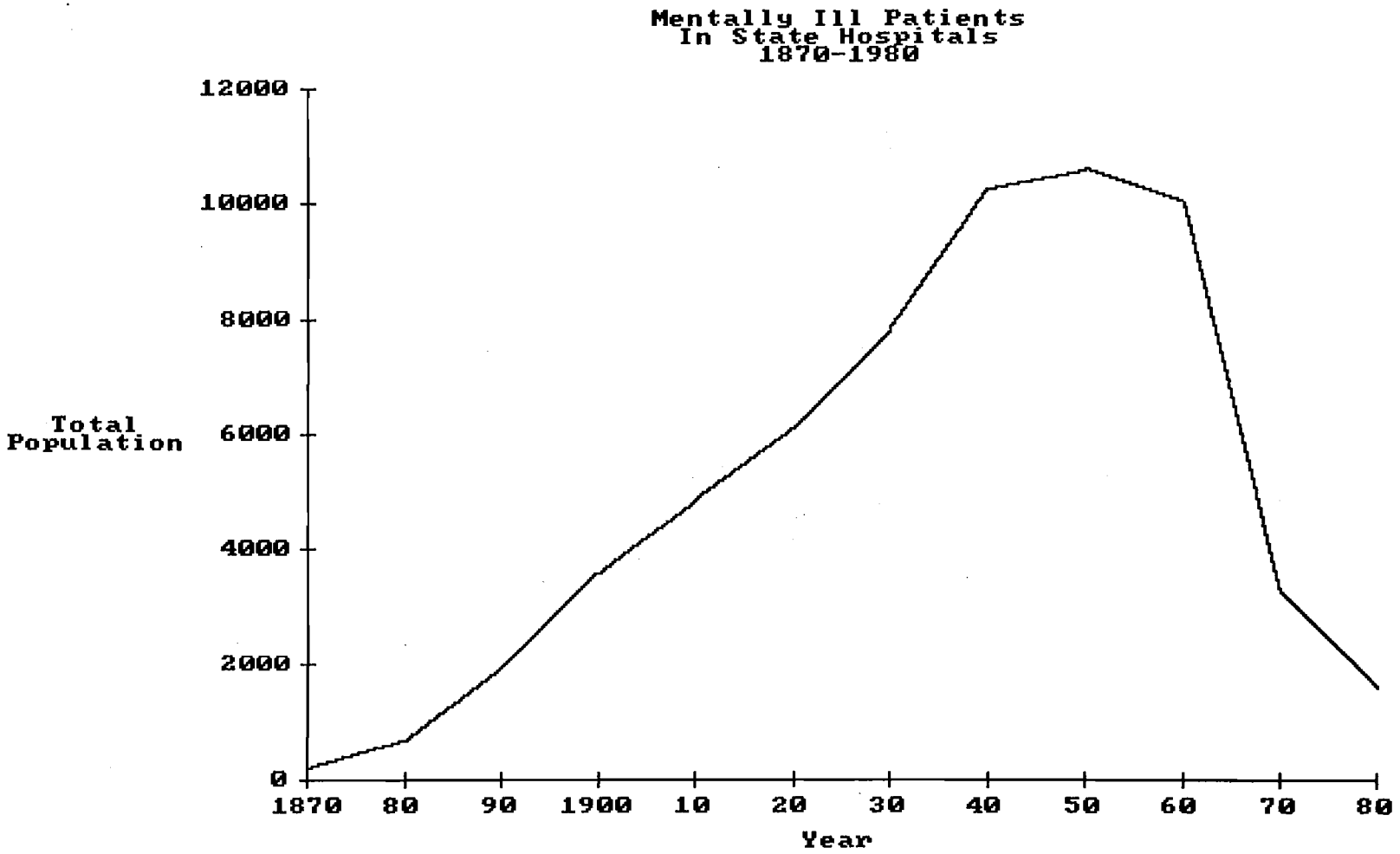
[5]Howard H. Goldman, "The Demography of Deinstitutionalization," in *New Directions For Mental Health Services: Deinstitutionalization*, no. 17, by L. Bachrach, ed. San Francisco: Jossey Bass, March 1983.

FIGURE 1.2



Sources: Department of Human Services, "Monthly Statistical Report, Minnesota State Institutions," July 1962, for 1870-1950; Department of Human Services, Fact Book: State Hospitals and Nursing Homes, for various years for 1960-1980; Department of Human Services, "In-Residence State Hospital Daily Census, FY 1985," for 1985.

TABLE 1.3

CENSUS OF MENTALLY ILL PERSONS IN STATE HOSPITALS

1870 - 1950

Year	Total	Anoka	Fergus Falls	Hastings	Moose Lake	Rochester	St. Peter	Minnesota Security Hospital	Willmar
1870	206						206[e]		
1880	679					112[d]	567		
1890	1,951		79[b]			967	905		
1900	3,589	114[a]	1,306	111[a]		1,122	936		
1910	4,861	475	1,662	477		1,222	1,025		
1920	6,092	860	1,496	894		1,276	1,223	73[f]	270[g]
1930	7,816	1,051	1,637	1,048		1,398	1,598	148	936
1940	10,236	1,435	1,829	1,100	760[c]	1,472	1,947	249	1,444
1950	10,578	1,010	1,994	1,009	1,115	1,669	2,117	243	1,421

Source: Department of Human Services, "Monthly Statistical Report, Minnesota State Institutions," July 1962.

[a] Anoka State Hospital and Hastings State Hospital opened in 1900.
[b] Fergus Falls State Hospital opened in 1890.
[c] Moose Lake State Hospital opened in 1938.
[d] Rochester State Hospital established in 1879.
[e] Minnesota Hospital for the Insane opened in 1867 at St. Peter.
[f] St. Peter State Hospital added the Asylum for the Dangerously Insane in 1911.
[g] Mentally ill patients were first admitted to Willmar State Hospital in 1917.

In 1955, the state system reached a peak size of 11,500 patients.[6] Two years later, the Legislature passed the Community Mental Health Services Act, which pre-dated federal legislative efforts to support community-based care of mentally ill people. The act authorized state grants for community mental health programs.

State hospital populations began to decline by 1960 and dropped sharply throughout the following decade. As Table 1.4 shows, the population of mentally ill people in state hospitals dropped from 10,012 in 1960 to 3,223 in 1970, a decline of about 68 percent. During the same period, the number of licensed nursing home beds increased from 11,308 to 30,341.[7] This is consistent with nationwide evidence that many elderly patients were discharged from state hospitals to nursing homes.

In 1967, the Legislature passed the Hospitalization and Commitment Act. The law made long-term commitment more difficult and encouraged consideration of non-institutional treatment alternatives as part of the commitment process. By 1985, the average daily population of the state hospitals was down to 1,235. During 1985, Minnesota's state hospitals served about 2,500 mentally ill patients. Expenditures for mental illness programs in state hospitals totaled $47.6 million.[8]

Figure 1.3 shows the location of state hospitals with mental illness programs. As shown in the figure, the state is divided into six *catchment* areas, and patients generally receive care at the hospital which is in their service area. However, there are three special programs which serve mentally ill persons from the entire state. These are the Minnesota Security Hospital at St. Peter, the psycho-geriatric unit at Moose Lake, and the adolescent unit at Willmar.

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[6]Office of the Legislative Auditor, *Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill*. St. Paul: Office of the Legislative Auditor, February 1981.

[7]Data provided by the Minnesota Department of Health, Health Resources Division.

[8]Data provided by the Minnesota Department of Human Services, Reimbursement Division.

TABLE 1.4

CENSUS OF MENTALLY ILL PERSONS IN STATE HOSPITALS

1960 - 1985

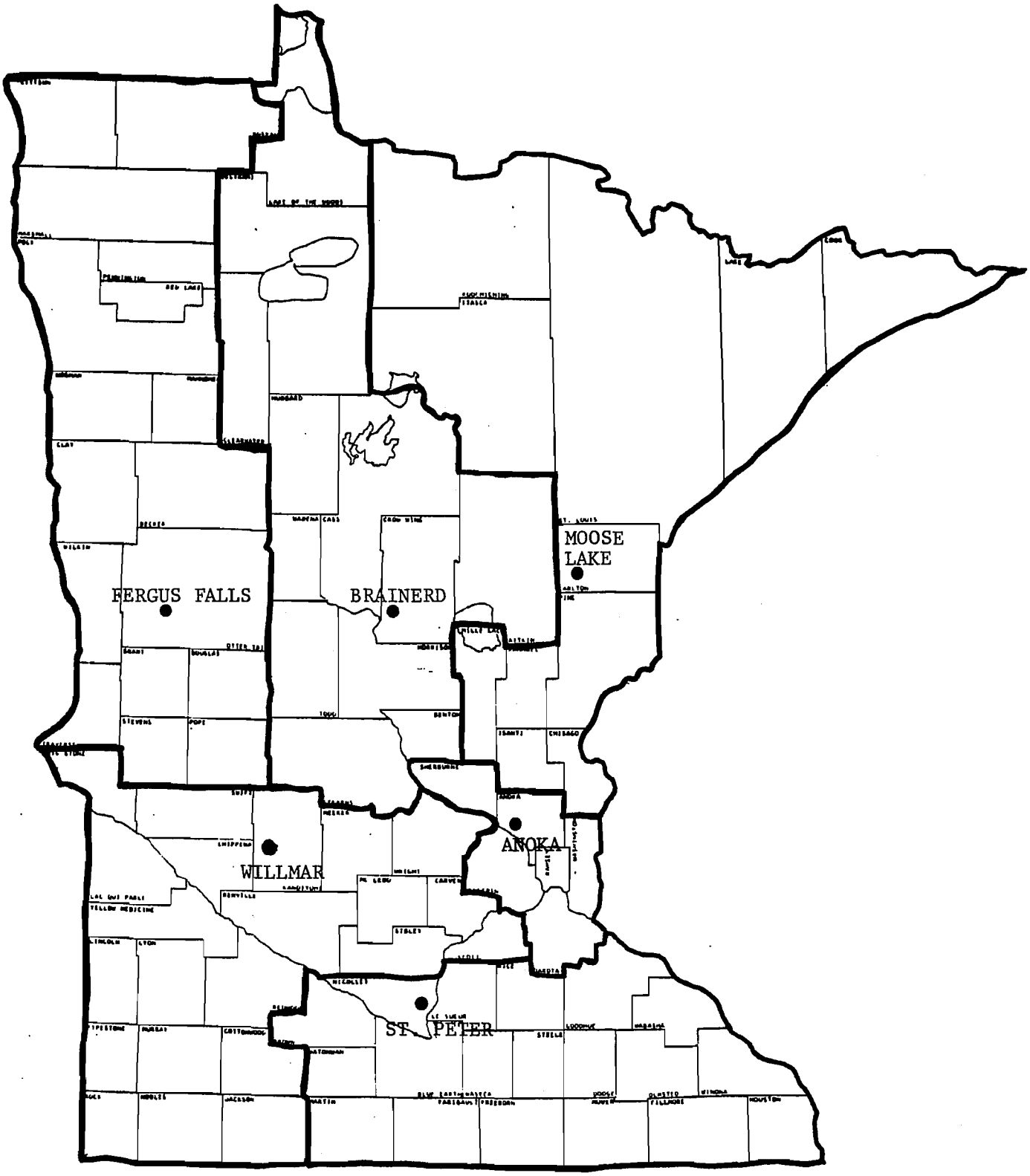
Year	Total	Anoka	Brainerd	Fergus Falls	Hastings	Moose Lake	Rochester	St. Peter	Minnesota Security Hospital	Willmar
1960	10,012	1,085		1,852	940	1,108	1,642	2,111	239	1,035
1962	8,709	995		1,729	786	962	1,421	1,848	244	724
1964	7,272	910		1,389	676	847	1,095	1,588	201	566
1966	6,005	771		1,159	589	799	736	1,235	150	566
1968	4,450	599		777	349	717	640	688	138	542
1970	3,223	476		431	275	541	662	295	142	401
1972	2,380	335	58[a]	221	168	297	573	256	114	358
1974	1,950	274	50	141	144	226	451	207	106	351
1976	1,618	255	49	133	103	184	308	158	108	320
1978	1,543	248	67	131	42[b]	155	267	150	167	316
1980	1,524	280	60	129		150	253	136	203	313
1982	1,336	228	74	113		163	104[c]	159	189	306
1984	1,231	237	65	98		169		156	210	296
1985	1,235	234	57	104		171		160	219	290

Source: Department of Human Services, Fact Book: State Hospitals and Nursing Homes, various years, for 1960-1984; Department of Human Services, "In-Residence State Hospital Daily Census, FY 1985," for 1985.

[a]Program for mentally ill people opened at Brainerd State Hospital in 1971.
[b]Hastings State Hospital closed in 1978.
[c]Rochester State Hospital closed in 1982.

FIGURE 1.3

MINNESOTA'S STATE HOSPITALS



COMMUNITY PROGRAMS

Chapter 2

A. STATE GRANT PROGRAMS FOR COMMUNITY SERVICES

Since 1979, the state has established two grant programs to help mentally ill persons remain in their own communities. This section describes the programs and examines how state funds have been distributed among the counties.

1. THE RULE 12 GRANT PROGRAM

In June 1981, the Legislature authorized the Department of Human Services to administer a grant program which would bring residential facilities for adult mentally ill persons up to state licensing standards. These facilities are commonly referred to as Rule 36 facilities, after the applicable Department of Human Services licensing rule.[1] The grant program, known as Rule 12, established a funding mechanism to ensure that previously unlicensed facilities could comply with the standards of Rule 36.[2]

County boards apply to the Department of Human Services for Rule 12 funds by providing a budget and program plan for each eligible facility. Awards are based on compliance with the rule, the reasonableness of projected costs, and the availability of funds. Payments are made to the counties on a quarterly basis, and are adjusted to reflect actual direct service expenditures. The state grant cannot exceed 75 percent of the total new costs, and may only be used to pay for direct program services required by Rule 36. The 25 percent county match may be used for non-direct service costs required by Rule 36, such as costs for administration, renovation, and equipment.

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[1]Minnesota Rules, Parts 9520.0500-.0690.

[2]Minnesota Rules, Parts 9535.2000-.3000.

In 1984 and 1985, 2,126 beds were available in 86 licensed Rule 36 facilities throughout the state.[3] During 1984, Rule 12 grants funded program costs for about one-half of these beds. In 1985, the Department of Human Services awarded grants to fund an additional 524 beds in 22 facilities, bringing the total to 1,541 beds. Room and board costs are separate, and are usually paid by General Assistance, Social Security, or Minnesota Supplemental Aid. The department reports that the average daily room and board rate was $17.62 in 1985. Program costs averaged $19.67 per day.

Since 1982, the Legislature has appropriated $35.0 million for the Rule 12 grant program, of which $33.5 million dollars will be awarded to the counties by 1987.[4] We found that:

- Almost 58 percent of these funds, $19.4 million, have been allocated to Hennepin and Ramsey Counties, with the remaining $14.1 million distributed among other counties.

- Less than one-third of Minnesota's counties are currently receiving funds through the Rule 12 grant program.

As shown in Table 2.1, five counties had Rule 12 funded facilities during 1982. In 1983 and 1984, 13 counties received funds. As appropriations have increased, the department has expanded the program to more outstate counties. In 1985, 13 outstate counties received grants for the first time.[5] Still, two-thirds of the counties in the state have not received any funds through the grant program.

The department's flexibility in distributing grants has been limited in two ways. First, existing facilities, many of which were in Hennepin and Ramsey Counties, benefited from a statutory preference during the first two years of the program. Second, while the department may encourage the development of new facilities outstate, counties must acknowledge the need and agree to provide matching funds.

The Department of Human Services reported that counties which do not have their own Rule 36 facilities contract for services from facilities in

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[3]This includes three Rule 36 facilities which were under development during 1984, and 19 facilities which applied for Rule 36 licenses before September 1985.

[4]Almost half of the remaining $1.9 million was returned to the state's general fund. This sum was originally appropriated to upgrade existing Rule 36 facilities, but some counties subsequently decided to replace old facilities with new ones. The balance was used to help reduce a deficit in the state's budget, to cover legal fees associated with the Vickerman decree, and to help establish a new facility for mentally ill persons who have hearing impairments.

[5]This includes a joint venture between Stearns and Benton Counties.

TABLE 2.1

RULE 12 AWARDS
(By County)

County	1982	1983	1984	1985	1986[a]	1987[a]	Total By County
Anoka	$ 0	$ 0	$ 0	$ 43,052	$ 101,728	$ 178,092	$ 322,872
Blue Earth	$ 0	$ 0	$ 0	$ 0	$ 30,012	$ 72,028	$ 102,040
Brown	0	0	0	79,133	88,002	85,969	253,104
Carlton	0	62,638	65,735	88,622	102,600	91,227	410,822
Crow Wing	0	0	0	56,410	38,852	153,493	248,755
Dakota	0	34,858	44,650	67,547	71,312	76,556	294,923
Douglas	0	33,018	71,319	79,761	80,559	81,364	346,021
Freeborn	0	0	0	138,276	140,213	139,343	417,832
Hennepin	214,097	1,345,085	1,663,808	2,149,720	2,872,279	3,090,475	11,335,464
Itasca	0	0	0	1,127	77,296	122,232	200,655
Kandiyohi	27,804	81,356	191,005	317,256	395,229	384,604	1,397,254
Meeker	0	0	0	51,007	146,396	146,405	343,808
Morrison	0	0	0	48,531	129,072	126,874	304,477
Mower	0	0	0	58,387	88,493	89,399	236,279
Olmsted	63,851	268,050	306,928	322,275	378,115	385,391	1,724,610
Otter Tail	0	40,612	102,504	107,629	108,705	109,792	469,243
Pennington	0	0	0	33,005	67,068	101,195	201,268
Pine	0	0	0	53,680	75,612	73,641	202,933
Polk	0	15,210	95,431	100,203	105,905	102,217	418,966
Ramsey	300,846	1,076,982	1,316,990	1,503,753	1,849,265	1,975,426	8,023,262
Rock	0	0	0	48,748	57,292	57,865	163,905
St. Louis	0	312,300	435,971	457,770	520,382	511,714	2,238,137
Stearns-Benton	0	0	0	8,906	87,184	90,996	187,086
Steele	0	58,991	126,150	131,215	137,558	146,121	600,035
Stevens	0	51,485	84,421	114,309	164,990	170,504	585,709
Wadena	0	0	0	51,485	111,606	150,581	313,672
Washington	0	0	0	54,908	149,856	152,803	357,567
Winona	111,671	315,575	368,362	358,962	350,421	323,233	1,828,224
TOTAL AWARDS	$718,269	$3,696,160	$4,873,274	$6,525,677	$8,526,002	$9,189,539	$33,528,921

Source: Memoranda from Department of Human Services, Mental Health Program Division, September 4, 1985; February 4, 1986.

[a]Note that some grants in 1986 and 1987 have been set aside for anticipated needs, or have been awarded on a tentative basis, pending the development of a formal plan by the county.

other counties. This means that mentally ill persons in 57 counties cannot be served in their own communities and must travel long distances to the nearest Rule 36 facility. For example, residents of Yellow Medicine County must travel to Kandiyohi or Brown Counties, and residents of Roseau County must go to Pennington or St. Louis County. While we agree that Rule 36 facilities are not needed in each county, we do believe that the department should consider geographic location and need when allocating Rule 12 funds.

We found that the distribution of Rule 12 funded beds does not reflect the distribution of population between the metropolitan and outstate areas. Table 2.2 shows that in 1985, 63.6 percent of Rule 12 funded beds were located in the six counties served by the state hospital at Anoka, with the remaining beds distributed among the 81 counties served by the other state hospitals. In contrast, the state's population is almost evenly split, with one half of the population residing in the metropolitan area served by the state hospital at Anoka, and the other half of the population residing in the outstate areas served by the other five state hospitals.

We recommend:

- The Department of Human Services should establish regional priorities to ensure more even distribution of Rule 36 facilities, and should consider these when awarding Rule 12 grants.

TABLE 2.2

1985 DISTRIBUTION OF RULE 12 BEDS
(By Hospital Catchment Area)

State Hospital Catchment Area	Total Number of Rule 36 Beds	Number of Rule 12 Funded Beds	Percentage of Rule 12 Funded Beds	Percentage of State's Population
Anoka	1,493	980	63.6%	47.7%
Brainerd	43	43	2.8	5.7
Fergus Falls	103	103	6.7	7.5
Moose Lake	199	177	11.5	10.2
St. Peter	170	122	7.9	14.9
Willmar	118	116	7.5	14.1
TOTAL	2,126	1,541	100.0%	100.0%

Source: Program Evaluation Division analysis of Department of Human Services report, "Status of Current and Pending Mental Health Residential Programs in Minnesota," September 1985.

2. THE RULE 14 GRANT PROGRAM

The Community Social Services Act of 1979 included a $2.0 million appropriation for a new grant program to fund projects which would enable chronic mentally ill persons to remain and function in their own communities.[6] Department of Human Services Rule 14 describes the types of programs which are eligible for the grant, explains how funds are allocated to counties, and details the purposes for which these funds may be used.

In order to be eligible for funding, a program must provide direct service to chronic mentally ill persons in the areas of: day treatment, case management, vocational training or employment, socialization and recreation, residential programming, or crisis intervention. County boards may request funds for contracted services, or for services provided directly by the county. By rule, the grant may be used to fund new or expanded projects, but not for existing services. Ten percent of a project's total budget must be matched with local funds.

Since 1980, the Legislature has appropriated $18.5 million for the Rule 14 grant program. During the first year of the program, 20 counties applied for and received grants, although the programs actually served 39 counties through cooperative ventures. As shown in Table 2.3, the same 20 counties continued to receive funding in each of the following years, although other counties applied for grants. The Legislature increased the Rule 14 appropriation for the 1985-87 biennium by $1.2 million, with $400,000 earmarked for new demonstration projects. This increase will enable new counties which have not received funds in the past to compete for grants.

The Department of Human Services reported that between 1980 and 1984, over 5,000 clients from 55 counties have received services in Rule 14 programs.[7] Based on department estimates, this was about 17 percent of the state's chronic mentally ill adult population. The department also reported that over the years, the number of new clients has decreased, while the number of repeat clients has increased. During 1984, almost 1,000 new clients participated in Rule 14 programs, while 300 repeat clients received additional services. Almost one-half of all Rule 14 funds awarded during that year were used for direct services such as day treatment, counseling and therapy, or for indirect services, which included consultation and education.

We looked at Rule 14 awards by county to determine how funds have been distributed throughout the state. We found:

- Five of the seven metropolitan counties have received grants, but less than one-fifth of the outstate counties have been recipients.

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[6]Minnesota Rules, Parts 9535.0100-.1600

[7]Minnesota Department of Human Services, *Report to the Legislature: Rules 36, 12 and 14 for Adult Mentally Ill Persons.* St. Paul: Mental Health Division, January 1985.

TABLE 2.3

RULE 14 AWARDS
(By County)

County	1980-1981	1982	1983	1984	1985	1986	1987	Total By County
Anoka	$ 104,400	$ 113,944	$ 124,149	$ 130,407	$ 138,070	$ 151,857	$ 167,078	$ 929,905
Beltrami	105,000	102,856	104,000	109,200	114,660	126,541	137,563	799,820
Blue Earth	46,958	51,232	58,011	53,000	55,650	65,678	70,765	401,294
Carlton	22,500	25,747	29,025	37,880	41,668	43,126	44,635	244,581
Cass	48,109	53,861	55,327	54,822	57,803	59,826	61,920	391,668
Dakota	110,000	114,691	120,760	143,298	153,502	158,875	184,435	985,561
Goodhue	56,400	61,532	64,640	62,841	65,763	68,065	70,447	449,688
Hennepin	525,707	635,019	602,381	622,550	646,897	617,805	676,843	4,327,202
Kandiyohi	107,134	123,429	129,600	136,080	142,884	165,741	176,061	980,929
Lake	22,500	25,747	29,060	29,400	32,300	33,400	34,600	207,007
Morrison	50,000	58,680	66,597	69,927	68,840	86,529	100,855	501,428
Mower	72,695	79,324	82,297	89,775	93,946	107,234	118,657	643,928
Nobles	84,472	124,412	128,078	124,770	132,005	135,878	140,634	870,249
Olmsted	43,823	78,292	108,506	124,965	138,261	162,081	175,983	831,911
Polk	90,163	108,535	114,619	116,191	121,956	125,625	130,022	807,111
Ramsey	245,485	327,196	309,899	321,815	338,124	440,193	505,972	2,488,684
St. Louis	200,000	240,899	271,571	285,150	299,408	309,887	330,733	1,937,648
Sherburne	27,733	30,235	32,221	33,510	35,185	24,415	27,411	210,710
Washington	14,408	31,835	31,799	37,603	39,955	48,353	54,800	258,753
Winona	22,513	33,750	46,695	57,338	62,770	78,092	84,741	385,899
Wright[a]	0	0	0	0	0	18,208	18,845	37,053
TOTAL AWARDS	$2,000,000	$2,421,216[b]	$2,509,235	$2,640,522	$2,779,647	$3,027,409	$3,313,000	$18,691,029

Source: Memorandum from Department of Human Services, Mental Health Program Division, September 4, 1985.

[a]Until 1986, Wright County received its award jointly with Sherburne County.

[b]The 1982 appropriation was originally for $2,522,100, however, the Legislature later reduced this amount by over $100,000 due to a deficit in the state's budget.

By rule, the department allocates funds according to the distribution of population, with one-half the funds awarded to the seven metropolitan counties and one-half awarded to the outstate counties. While the department has allocated funds according to these regional priorities, we are concerned that only 15 of the 80 eligible counties in the outstate area have received a grant. This means that mentally ill people in other counties must leave their communities to receive services funded through Rule 14 grants.

State funding is necessary to encourage counties to establish community support services. Therefore, we recommend:

- The Legislature should place a high priority on increasing funds for the Rule 14 grant program in the next biennium. Half of the increase should be dedicated for new community support projects in areas without ready access to these services.

3. CONCLUSIONS

During our interviews with mental health professionals we learned that mentally ill persons sometimes prefer to live in metropolitan areas where they are able to maintain their anonymity, and where a broader range of social services are available to them. However, others want to remain in their own communities, close to their families and familiar support services. We are concerned by the large proportion of state grants awarded to metro-area counties, particularly Hennepin and Ramsey.

We believe that this pattern of funding has increased the concentration of services in the metropolitan area, at the expense of outstate areas which could benefit from these programs. It is essential that services be developed more evenly throughout the state in order for mentally ill persons to remain and function in their own communities.

B. COUNTY CASE MANAGEMENT

In Minnesota, counties are responsible for arranging appropriate services for chronic and acutely mentally ill persons who are unable to care for their own needs.[8] Case management in most counties is provided directly through the county social service agency, although some counties contract with, or operate, the local mental health center which offers this service.

In recent years, the role of the county case manager has gained increased importance. The purpose of case management is to establish and maintain links between clients and appropriate community resources, including vocational, medical, psychological, residential, and recreational ser-

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[8]Minn. Stat. §256E.03, subd. 2.

vices. Staffing for case management varies considerably among counties, partly because the state does not impose standards for staffing and caseloads. In our interviews with county social service directors, we learned that case management staff may range from a number of social workers, case aides, and pre-petition screeners who work exclusively with mentally ill persons, to a single person who divides his time among the mentally ill, mentally retarded, and chemically dependent residents of the county.

We surveyed all county social service directors in the state to determine how staff and caseload size vary among the 87 counties.[9] We asked:

- How many mentally ill persons are currently receiving case manager services?
- Do counties allocate adequate staff time for case management?
- Does caseload size vary among counties? Are caseload sizes appropriate?

1. CLIENTS

Counties reported a total of 7,538 mentally ill persons currently receiving services from case managers. Eighty-five percent of these clients have had direct contact with their case manager within the last three months.

We found that counties differ significantly in the number of mentally ill persons they serve. As shown in Table 2.4, the number of persons reported to be receiving case manager services ranged from a low of four clients in Mahnomen County, to a high of 1,500 persons in Hennepin County. However, the number of clients served in a county does not necessarily reflect the county's population. For example, both Scott and Swift Counties reported that they are each serving 30 clients, but the population of Scott County is more than four times larger than the population of Swift County. Similarly, Goodhue and Kandiyohi Counties have almost identical populations, yet the former reports serving 59 mentally ill clients, while the latter reports serving 100 persons.

In our follow-up discussions with county social service directors, we learned that some of these variations may be due to differences in the way counties define mentally ill persons. Some counties report only persons with a primary diagnosis of mental illness, while others include persons with short-term mental health problems. These variations may indicate basic differences in how counties identify persons in need of services.

2. COUNTY CASE MANAGERS

We also found that case management resources are allocated differently in each county. Responses to our survey show that 156.57 full-time equiva-

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[9]Appendix A contains a copy of the survey questionnaire.

TABLE 2.4

MENTALLY ILL CLIENTS SERVED
(Compared with County Population)

County	1984 Estimated Population	MI Clients Served	MI Clients Per 1000	County	1984 Estimated Population	MI Clients Served	MI Clients Per 1000	County	1984 Estimated Population	MI Clients Served	MI Clients Per 1000
Aitkin	13,428	12	0.9	Hubbard	15,424	16	1.0	Polk	34,520	39	1.1
Anoka	210,889	185	0.9	Isanti	25,618	20	0.8	Pope	11,957	15	1.3
Becker	31,354	46	1.5	Itasca	44,573	100	2.2	Ramsey	456,022	1,150	2.5
Beltrami	33,465	71	2.1	Jackson	13,569	78	5.7	Red Lake	5,239	5	1.0
Benton	26,704	25	0.9	Kanabec	12,403	5	0.4	Redwood	18,853	37	2.0
Big Stone	8,008	16	2.0	Kandiyohi	39,708	100	2.5	Renville	19,620	57	2.9
Blue Earth	52,964	777	14.7	Kittson	6,846	5	0.7	Rice	47,247	25	0.5
Brown	28,469	80	2.8	Koochiching	16,867	21	1.2	Rock	10,738	8	0.7
Carlton	28,575	44	1.5	Lac Qui Parle	10,409	24	2.3	Roseau	13,324	25	1.9
Carver	39,890	72	1.8	Lake	11,913	9	0.8	St. Louis	212,214	475	2.2
Cass	21,368	55	2.6	Lake of Woods	3,901	28	7.2	Scott	49,671	30	0.6
Chippewa	15,105	23	1.5	Le Sueur	23,471	40	1.7	Sherburne	33,603	40	1.2
Chisago	27,926	15	0.5	Lincoln/Lyon				Sibley	15,655	15	1.0
Clay	49,865	28	0.6	Murray	45,391	121	2.7	Stearns	114,585	87	0.8
Clearwater	9,156	24	2.6	McLeod	30,233	55	1.8	Steele	30,527	25	0.8
Cook	4,321	32	7.4	Mahnomen	5,614	4	0.7	Stevens	11,288	35	3.1
Cottonwood	13,948	17	1.2	Marshall	12,775	9	0.7	Swift	12,746	30	2.4
Crow Wing	42,535	117	2.8	Meeker	21,065	50	2.4	Todd	25,973	16	0.6
Dakota	211,927	176	0.8	Mille Lacs	18,507	19	1.0	Traverse	5,343	8	1.5
Dodge	15,184	25	1.6	Morrison	30,019	38	1.3	Wabasha	19,359	10	0.5
Douglas	29,802	60	2.0	Mower	39,624	35	0.9	Wadena	13,935	10	0.7
Faribault/Martin/				Nicollet	28,064	35	1.2	Waseca	18,659	34	1.8
Watonwan	55,485	237	4.3	Nobles	21,908	36	1.6	Washington	123,071	103	0.8
Fillmore	21,708	48	2.2	Norman	9,472	25	2.6	Wilkin	8,337	7	0.8
Freeborn	35,275	65	1.8	Olmsted	96,816	197	2.0	Winona	46,853	96	2.0
Goodhue	39,674	59	1.5	Otter Tail	55,132	111	2.0	Wright	62,496	49	0.8
Grant	7,282	9	1.2	Pennington	14,041	30	2.1	Yellow Medicine	12,974	20	1.5
Hennepin	947,786	1,500	1.6	Pine	20,742	24	1.2				
Houston	19,067	28	1.5	Pipestone	11,400	6	0.5	STATE TOTAL	4,161,464	7,538	
								COUNTY MEDIAN			1.5

Sources: Program Evaluation Division analysis of responses by 87 counties to a survey of case management for mentally ill persons, December 1985; 1984 population estimates from State Demographer's Office, State Planning Agency.

lent staff persons are providing case management services to mentally ill clients in 87 counties. This includes 141 social workers and 15 case aides.[10]

As shown in Table 2.5, 49 counties have less than one full-time equivalent person assigned to work with mentally ill persons. Staff size ranges from .03 full-time equivalent social workers in Cottonwood County, to almost 30 full-time equivalent persons in Hennepin County. We found considerable variation among the counties in the amount of staff time allocated for individual clients. For example, both Chisago and Otter Tail Counties have the equivalent of one full-time staff person, yet Chisago County serves 15 clients, and Otter Tail County serves 111 persons. Similarly, both Itasca and Kandiyohi Counties serve 100 mentally ill clients. However, Itasca County has seven full-time equivalent staff persons, and Kandiyohi County has 1.5 case managers.

3. CASELOAD SIZE

We found that caseload size differs significantly from county to county. In order to compare caseloads equitably, we calculated the caseload for one full-time equivalent caseworker in each county. We found that the median caseload among all counties is 48 clients per caseworker. Caseloads range in size from ten clients per case manager in Kanabec County, to 567 clients in Cottonwood County.

Although there is currently no state-established standard for appropriate caseload size, the mental health professionals we interviewed recommended caseloads of 30 clients. As shown in Table 2.5, we found that only 16 counties have case managers with average caseloads of thirty clients or fewer. In contrast, case managers in three-fourths of Minnesota's counties carry caseloads considerably larger than 30 clients.

A number of projects across the nation have demonstrated the benefits of reducing caseloads. One example in Minnesota was the Hennepin County Community Support Project, begun in 1978 with funds from the National Institute of Mental Health. A 1979 evaluation of the program reported that after one year, hospitalization rates were lower for clients receiving more intensive, specialized case management than for clients receiving less intensive, generalized service. In addition, clients receiving more intensive services through the project reported increased satisfaction with their case management.[11]

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[10]Our analysis does not include county contracted services such as psychologists, psychiatrists, community mental health centers, homemakers or pre-petition screeners.

[11]Hennepin County, *Five-Year Directional Statement and Plan for Mental Health Services for the Adult Chronically and Seriously Mentally Ill*. Minneapolis: Department of Community Services, Mental Health Division, August 1980.

TABLE 2.5

SURVEY OF COUNTY CASE MANAGEMENT FOR MENTALLY ILL PERSONS

County	Clients Served	FTE Staff[a]	Client to Staff Ratio	County	Clients Served	FTE Staff[a]	Client to Staff Ratio	County	Clients Served	FTE Staff[a]	Client to Staff Ratio
Aitkin	12	0.08	150.0	Hubbard	16	0.35	45.7	Polk	39	0.50	78.0
Anoka	185	4.25	43.5	Isanti	20	0.50	40.0	Pope	15	0.30	50.0
Becker	46	0.24	191.7	Itasca	100	7.00	14.3	Ramsey	1,150	20.00	57.5
Beltrami	71	1.00	71.0	Jackson	78	1.53	51.0	Red Lake	5	0.05	100.0
Benton	25	0.50	50.0	Kanabec	5	0.50	10.0	Redwood	37	0.73	50.7
Big Stone	16	0.60	26.7	Kandiyohi	100	1.50	66.7	Renville	57	0.50	114.0
Blue Earth	777	3.50	222.0	Kittson	5	0.30	16.7	Rice	25	0.50	50.0
Brown	80	1.20	66.7	Koochiching	21	0.50	42.0	Rock	8	0.25	32.0
Carlton	44	1.00	44.0	Lac Qui Parle	24	0.50	48.0	Roseau	25	0.50	50.0
Carver	72	2.00	36.0	Lake	9	0.40	22.5	St. Louis	475	14.00	33.9
Cass	55	2.00	27.5	Lake of Woods	28	0.15	186.7	Scott	30	0.60	50.0
Chippewa	23	1.00	23.0	Le Sueur	40	0.25	160.0	Sherburne	40	1.25	32.0
Chisago	15	1.00	15.0	Lincoln/Lyon/				Sibley	15	0.20	75.0
Clay	28	0.50	56.0	Murray	121	4.00	30.3	Stearns	87	1.00	87.0
Clearwater	24	0.50	48.0	McLeod	55	0.75	73.3	Steele	25	0.70	35.7
Cook	32	0.75	42.7	Mahnomen	4	0.05	80.0	Stevens	35	1.00	35.0
Cottonwood	17	0.03	566.7	Marshall	9	0.20	45.0	Swift	30	0.50	60.0
Crow Wing	117	3.50	33.4	Meeker	50	0.80	62.5	Todd	16	0.70	22.9
Dakota	176	3.39	51.9	Mille Lacs	19	1.00	19.0	Traverse	8	0.18	44.4
Dodge	25	0.50	50.0	Morrison	38	1.00	38.0	Wabasha	10	0.15	66.7
Douglas	60	1.75	34.3	Mower	35	0.50	70.0	Wadena	10	0.50	20.0
Faribault/Martin/				Nicollet	35	1.00	35.0	Waseca	34	0.25	136.0
Watonwan	237	9.00	26.3	Nobles	36	0.33	109.1	Washington	103	5.18	19.9
Fillmore	48	0.10	480.0	Norman	25	0.48	52.1	Wilkin	7	0.25	28.0
Freeborn	65	1.00	65.0	Olmsted	197	5.00	39.4	Winona	96	2.00	48.0
Goodhue	59	1.20	49.2	Otter Tail	111	1.00	111.0	Wright	49	1.50	32.7
Grant	9	0.50	18.0	Pennington	30	1.00	30.0	Yellow Medicine	20	0.40	50.0
Hennepin	1,500	29.80	50.3	Pine	24	0.75	32.0				
Houston	28	0.50	56.0	Pipestone	6	0.15	40.0	STATE TOTAL	7,538	156.57	
								COUNTY MEDIAN			48.0

Source: Program Evaluation Division analysis of responses by 87 counties to a survey of case management for mentally ill persons, December 1985.

[a]Figures include full-time equivalents for social workers and case aides.

County case managers play a critical role in coordinating appropriate services for mentally ill persons. If county case managers carried caseloads closer to a standard of 30 to 40 clients, we believe that they would be able to spend more time arranging appropriate services for each client and following up on the delivery of these services.

The Rule 14 grant program funds services, including case management, which enable chronic mentally ill persons to remain and function in their own communities. In the past, some Rule 14 funds have been allocated to community support programs and other vendors who offer case management. Additional state funds are needed to encourage counties to reduce caseloads and implement innovative case mangement practices. Therefore, we recommend:

- The Legislature place a high priority on increasing Rule 14 funds during the next biennium. Half of the increase should be dedicated to improving county case management services.

We believe that additional Rule 14 funding, designated for case management, would enable counties to improve the availability and quality of these services for mentally ill persons.

In Chapter 3, we examine the role of county case managers in developing aftercare plans for mentally ill patients discharged from state hospitals. While these patients constitute only a part of a case manager's workload, many of them have long histories of repeated hospitalization for chronic mental illness. We will discuss the importance of county follow-up in helping these patients remain in their own communities.

TRANSITION FROM STATE HOSPITAL TO COMMUNITY

Chapter 3

Mental illness is a stigmatizing and poorly understood disability. In both chronic and acute forms, mental illness isolates people from their communities, impairs their independent living skills, and is difficult to treat.

Chronic mental illness generally refers to serious impairments in functioning which endure throughout a person's life. In most cases, medication and outpatient support services are successful in preventing major relapses, although many chronic patients do experience periodic acute recurrences. *Acute mental illness* generally describes situations in which a person's immediate symptoms are so severe that he or she has difficulty functioning in the community. Acute mental illness can occur in the context of chronic illness or as isolated episodes in the lives of otherwise healthy people.

Even though state hospital populations have declined dramatically in the last 30 years, the state hospitals still serve about 2,500 mentally ill people each year. During our interviews, we learned that most of these patients are chronically ill people who enter the hospitals during a crisis in their illness, remain for a few months, and return to the community until the cycle begins again.

In our study, we asked the following questions:

- Why do people enter state hospitals? How long do they stay?
- Are county case managers adequately involved in the discharge process?
- Are state hospital discharge practices effective and consistent?
- Do patients receive adequate community support when they leave state hospitals?
- What is the rate of readmission? Why do people return to state hospitals?

We assessed the role of state hospitals and counties in serving chronic mentally ill persons by studying records for a representative sample of patients who were released from state hospitals in 1984. First, we examined central Department of Human Services records for 287 patients, or about 15 percent of the 1,881 patients discharged from state hospital mental illness programs in 1984. (We used unduplicated patient counts in our study.) We included patients in three special programs: the Security Hospital at St. Peter, the adolescent unit at Willmar, and the psychogeriatric unit at Moose Lake. We gathered general demographic data about these patients, as well as specific information about their visits to state hospitals. This general information on patient characteristics is reported in Section A of this chapter.

We then visited each state hospital and further examined full medical records for a subsample of 209 patients, or a little more than ten percent of all patients discharged in 1984. In the hospital files, we looked for detailed diagnostic, case management, and discharge information. The survey instrument appears in Appendix B.

Table 3.1 shows the total number of patients discharged from each hospital in 1984, as well as hospital totals for the original sample and the subsample. Our findings on hospital stays, evidence of county case management, and discharge planning are reported in Sections B, C, and D of this chapter.

As part of each hospital visit, we also met with mental illness program managers, medical directors, and discharge counselors. We discussed the reasons people enter state hospitals, how long they stay, aftercare arrangements, and county involvement in admissions, discharge planning, and aftercare.

Because we analyzed only a portion of the population, the data do not necessarily describe the whole population in all instances. However, the data are generally consistent with information reported by the Department of Human Services, or individual hospitals.

A. GENERAL PATIENT CHARACTERISTICS

1. AGE

The patients in our sample were relatively young: the median age was 32. Nearly 70 percent were under 40 years old, as Table 3.2 shows. They were generally too young to have been affected by the first large-scale deinstitutionalization efforts between 1957 and 1965. Only two patients were originally admitted during that period. About 63 percent of the patients were male and 37 percent female.

TABLE 3.1

STATE HOSPITAL PATIENT SAMPLE
(Based on First 1984 Discharge)

Hospital	Patients Discharged	Patients in Sample	Patient Files Reviewed
Anoka	346	53	36
Brainerd	238	36	25
Fergus Falls	292	45	34
Moose Lake	204	30	25
St. Peter	470	42	34
Minnesota Security[a]	*	30	21
Willmar	331	51	34
TOTAL	1,881	287	209
PERCENT OF PATIENTS DISCHARGED		15.3%	11.1%

Source: Program Evaluation Division, October 1985.

[a]The state hospital billing system does not separate the open hospital at St. Peter and the Minnesota Security Hospital.

2. PREVIOUS HOSPITALIZATION AND READMISSIONS

We identified the hospital stay that corresponded to the first 1984 discharge as the primary unit of analysis. However, we found that for most patients, this stay was only one in a series of many visits to state hospitals. As Table 3.3 shows, two-thirds had been treated prior to the hospitalization we examined. About one-third of the sample had been treated three or more times.

Table 3.4 shows that 42.9 percent of the patients discharged in 1984 were later readmitted one or more times. The table also shows that approximately eight percent of the patients were readmitted three or more times following the first 1984 discharge.

Table 3.5 indicates that many patients were readmitted soon after discharge.

- About 21 percent of all patients came back within 90 days.[1]

[1]We counted returns from unauthorized absences after more than a day as separate visits; the hospitals vary in how they account for unauthorized absences.

TABLE 3.2

AGE DISTRIBUTION OF PATIENTS

Age	Number of Patients[a]	Percent of Patients
Under 20	27	9.4%
20-30	98	34.1
30-40	70	24.4
40-50	42	14.6
50-65	35	12.2
65 and over	15	5.2
TOTAL	287	99.9%[b]

MEDIAN AGE FOR SAMPLE: 32

Source: Program Evaluation Division analysis of Resident Billing System records, Department of Human Services, Reimbursement Division, November 1985.

[a]Analysis is based on a sample of 287 records for first 1984 discharge.

[b]Does not add to 100.0 percent due to rounding.

TABLE 3.3

PRIOR STATE HOSPITAL VISITS

Number of Prior Visits	Number of Patients[a]	Percent of Patients
0	96	33.4%
1-2	90	31.4
3 and over	101	35.2
TOTAL	287	100.0%

Source: Program Evaluation Division analysis of central patient records, Department of Human Services, Residential Facilities Management Division, November 1985.

[a]Analysis is based on a sample of 287 records for first 1984 discharge.

TABLE 3.4

NUMBER OF PATIENTS READMITTED FOLLOWING FIRST 1984 DISCHARGE

	Number of Patients[a]	Percent Readmitted
One or More Readmissions	123	42.9%
Two or more Readmissions	56	19.5
Three or More Readmissions	22	7.7

Source: Program Evaluation Division analysis of central patient records, Department of Human Services, Residential Facilities Management Division, November 1985.

[a]Analysis is based on a sample of 287 records for first 1984 discharge.

TABLE 3.5

INTERVAL BETWEEN DISCHARGE AND READMISSION

(By Days)

Days	Number of Patients[a]	Percent of Patients
0-90	60	20.9%
90-180	16	5.6
180-270	19	6.6
270-365	9	3.1
365 and over	19	6.6
No Readmissions As Of October 1985	164	57.1
TOTAL	287	99.9%[b]

Source: Program Evaluation Division analysis of central patient records, Department of Human Services, Residential Facilities Management Division, November 1985.

[a]Analysis is based on 287 records for first 1984 discharge.
[b]Does not add to 100.0 percent due to rounding.

People usually returned to the same hospital from visit to visit: 86.2 percent of the patients who were readmitted, returned to the hospital from which they had been discharged.

3. TYPES OF ADMISSION

In general, there are four ways for mentally ill people to enter state hospitals: emergency hold orders, involuntary judicial commitment, informal or voluntary admissions, and admission for court-related investigations.

a. *Hold Orders*

Under the Minnesota Commitment Act of 1982, peace or health officers may request emergency admission at "treatment facilities," such as hospitals, community mental health centers, or other institutions, for people whom they believe to be mentally ill and in imminent danger of hurting themselves or others if not immediately restrained.[2] Emergency holds are generally limited to 72 hours, exclusive of weekends and holidays. Emergency holds can be extended if a petition for commitment is filed in probate court, and if the court determines at a preliminary hearing that there is probable cause for continuing the hold. Under certain circumstances, the court may also initiate 72-hour holds after the commitment process has begun.

b. *Involuntary Judicial Commitment*

Prior to ordering a commitment, the court is required to consider reasonable alternatives such as "dismissal of petition, voluntary outpatient care, informal admission to a treatment facility, appointment of a guardian or conservator, or release." If no other alternatives appear suitable, the court must commit a person to "the least restrictive treatment facility which can meet the patient's treatment needs." Within 60 to 90 days of commitment, the head of the treatment facility must submit a written report to the court addressing the patient's condition and treatment. If the report says that the patient does not need further institutionalization, or if no report is filed, the patient is discharged. Otherwise, the initial commitment period may extend to six months. After six months, the court may decide that further treatment is necessary, and the commitment may be continued to twelve months without a new petition.

At any point during the commitment period, the head of a treatment facility may provisionally discharge a committed person, provided that specific requirements for aftercare plannning and review are met. Provisional discharges are subject to revocation or extension, but may not exceed the commitment period.

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[2]Minn. Stat. Chapter 253B. Certain provisions are different for patients who are mentally retarded, chemically dependent, or mentally ill and dangerous.

c. *Informal Admissions*

The Commitment Act prefers voluntary, informal admission to involuntary commitment and allows persons over 16 years of age to request admission to a treatment facility for "observation, evaluation, diagnosis, care and treatment." Under certain circumstances, persons under 16 years of age may also be admitted as informal patients. According to the law, all patients admitted informally for mental illness treatment have the right to leave within 12 hours of their request.

d. *Admission for Court-Related Investigations*

Under the Minnesota Rules Of Criminal Procedure, courts may send defendants to state mental hospitals or other facilities for up to 60 days in order to determine whether they are competent to stand trial. In addition, courts may order mental examinations of defendants in conjunction with pre-sentencing investigations and reports.[3]

Table 3.6 shows the breakdown of admissions within these categories. We found:

- Almost 42 percent of the patients entered the hospital as informal admissions, while 23.3 percent of the patients were committed to state hospitals.

In Table 3.7, admissions are reported by type and by hospital. The state hospital at Anoka had by far the largest proportion of committed patients (64.2 percent).[4] Hospital and county staff told us that the highest concentration of severely mentally ill people in the state is in the Twin Cities metropolitan area. Apparently, mentally ill people are often drawn to large urban centers for two reasons: a greater potential for anonymity than is possible in smaller communities, and a broader range of social services than is available elsewhere.

By comparison, the other hospitals, with the exception of the Minnesota Security Hospital, had many more informal patients than committed. This is in keeping with the functions that state hospitals in rural areas typically serve. Among these hospitals, Fergus Falls stands out with 80 percent informal admissions, compared to about 60 percent for the other hospitals. Hospital staff explained that many patients are admitted as emergency holds and then remain in the hospital for treatment on an informal basis because there are few other resouces for crisis care available in the region.

Eighty percent of the patients admitted to the Minnesota Security Hospital were hospitalized for court investigations, or other court-related purposes. This is consistent with the hospital's special role in diagnosing and treating persons who are mentally ill and dangerous.

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[3]Minnesota Rules of Criminal Procedure (1984), Rules 20, 27.

[4]Data provided by the hospital indicate that in 1985, 76 percent of the patients were committed.

TABLE 3.6

TYPES OF ADMISSION

	Number of Patients[a]	Percent of Patients
Informal[b]	120	41.8%
Hold[c]	72	25.1
Commitment[d]	67	23.3
Court-Related[e]	28	9.8
TOTAL	287	100.0%

Source: Program Evaluation Division analysis of central patient records, Department of Human Services, Residential Facilities Management Division, November 1985.

[a]Analysis is based on a sample of 287 records for first 1984 discharge.

[b]Does not include 33 patients whose status changed to informal from hold.

[c]Includes 21 patients who were discharged from holds as well as 51 patients whose status changed to one of the other admission categories following an initial hold.

[d]Includes the following commitment categories: mentally ill; mentally ill and dangerous, mentally ill and chemically dependent; does not include 18 commitments preceded by holds.

[e]Includes the following court-related admission categories: competency to stand trial; pre-sentencing investigation; court hold; juvenile court order; condition of probation.

4. LENGTH OF STAY

We found:

- Patients were hospitalized for relatively short periods of time. The median length of stay for the primary visit we examined was 65 days.

This illustrates a shift in the role of the state hospitals from long-term care to short-term crisis treatment.

As Table 3.8 shows, 85 percent of the patients were discharged within nine months. More than 60 percent left the hospital within 90 days. However, lengths of stay in our sample varied considerably; four patients left on the same day they were admitted, and seven patients were discharged after stays exceeding five years. Two patients had been hospitalized for more than 25 years.

TABLE 3.7

TYPES OF ADMISSION

(By Hospital[a])

Hospital	Informal[b]		Commitment[c]		Court-Related[d]		Hold[e]		Hospital Totals
	Number of Patients	Percent of Hospital Total	Number of Patients	Percent of Hospital Total	Number of Patients	Percent of Hospital Total	Number of Patients	Percent of Hospital Total	
Anoka	18	34.0%	34	64.2%	0	--	1	1.9%	53
Brainerd	23	63.9	6	16.7	2	5.6%	5	13.9	36
Fergus Falls	36	80.0	4	8.9	1	2.2	4	8.9	45
Moose Lake	18	60.0	11	36.7	0	--	1	3.3	30
St. Peter	26	61.9	10	23.8	0	--	6	14.3	42
Minnesota Security	0	--	5	16.7	24	80.0	1	3.3	30
Willmar	32	62.7	15	29.4	1	2.0	3	5.9	51
TOTAL	153	53.3%	85	29.6%	28	9.8%	21	7.3%	287

Source: Program Evaluation Division analysis of central patient records, Department of Human Services, Residential Facilities Management Division, November 1985.

[a]Analysis is based on a sample of 287 records for first 1984 discharge.

[b]Includes 33 patients whose status was changed to informal from a hold.

[c]Includes the following commitment categories: mentally ill (79); mentally ill and dangerous (3); and mentally ill and chemically dependent (3); includes 18 commitments preceded by holds.

[d]Includes the following court-related admission categories: competency to stand trial (12); pre-sentencing investigation (13); court hold (1); juvenile court order (1); condition of probation (1).

[e]Includes only patients who were discharged from a hold without further change of status; total number of holds reported in Table M.

TABLE 3.8

LENGTH OF STAY

(By Days)

Days	Number of Patients[a]	Percent of Patients
0-90	179	62.4%
90-180	50	17.4
180-270	15	5.2
270-365	11	3.8
365 and over	32	11.1
TOTAL	287	99.9%[b]

MEDIAN FOR SAMPLE: 65 Days

Source: Program Evaluation Division analysis of central patient records, Department of Human Services, Residential Facilities Management Division, November 1985.

[a]Analysis is based on a sample of 287 records for first 1984 discharge.

[b]Does not add to 100.0 percent due to rounding.

We found that the median stay for committed patients was about five months, or slightly less than the six-month maximum allowed by law. Patients admitted for court investigations, or for other court-related reasons, generally stayed about two months, which is the legally specified period for such purposes. The median stay for informal patients, however, was only 41 days, much shorter than the period for committed patients.

The median length of stay varied from hospital to hospital. As Table 3.9 shows, the median length of stay ranged from 110 days at Anoka to 22 days at Brainerd. The relatively long stay at Anoka is probably explained by the high proportion of committed patients. The short stay at Brainerd may be due to informal patients leaving the hospital voluntarily against medical advice. Hospital staff told us that this occurs regularly, and our sample of patient records bore it out.

TABLE 3.9

MEDIAN LENGTH OF STAY

(By Hospital)

Hospital	Days
Anoka	110
Brainerd	22
Fergus Falls	39
Moose Lake	73
St. Peter	46
Minnesota Security	60
Willmar	104
TOTAL	65

Source: Program Evaluation Division analysis of central patient records, Department of Human Services, Residential Facilities Management Division, November 1985.

[a]Analysis is based on a sample of 287 records for first 1984 discharge.

B. ADMISSION

1. PRIOR RESIDENCE

Most of the patients in our sample were admitted from their own homes. As Table 3.10 indicates, we found "home" cited as the prior residence of 63.2 percent of the patients. This includes longstanding family units, as well as casual living arrangements. While 5.3 percent came from Rule 36 facilities, 10.5 percent came from other group living situations such as boarding arrangements, other state hospitals, or nursing homes.

In the last section, we saw that the state hospital stay we analyzed was usually one in a series of hospitalizations. In analyzing individual patient records, we found that about two-thirds of the patients had previously been admitted to community hospitals for psychiatric care, and about one-third had been hospitalized three or more times. About 30 percent of the patients were admitted to state institutions directly from inpatient mental illness treatment in community hospitals.

TABLE 3.10

PRIOR RESIDENCE OF PATIENTS

Type	Number of Cases	Percent of Total Sample[a]
Home	132	63.2%
Rule 36[b]	11	5.3
Boarding Care[c]	11	5.3
Transfers from Other State Hospitals	7	3.3
Nursing Home[c]	4	1.9
Jail	2	1.0
Community Hospital[d]	2	1.0
Foster Care	2	1.0
Shelter	1	.5
Other[e]	21	10.0
No Information	16	7.7
TOTAL	209	100.2%[f]

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 209 records for first 1984 discharge.

[b]Includes facilities licensed under Department of Human Services program rule governing adult residential facilities for mentally ill people.

[c]Department of Health licensing status not verified.

[d]Includes only individuals who had extended stays in community hospitals.

[e]Includes detox center (1), homeless (2), hotels (3), and 12 residential programs which we were not able to classify.

[f]Does not add to 100.0 percent due to rounding.

2. DIAGNOSES

We identified six major diagnostic groupings for mental illness:[5]

[5]The groupings were based on the *Merck Manual of Diagnosis and Therapy*, 14th edition. Rahway, N.J.: Merck Sharp & Dohme Research Laboratories, 1982.

a. *Schizophrenic Disorders*

Schizophrenic disorders are mental disorders characterized by generally chronic disturbances of thinking, feeling, and behavior. This was the largest diagnostic group and affected about a third of the patients, as Table 3.11 shows.[6]

TABLE 3.11

MENTAL ILLNESS DIAGNOSES

Type	Number of Patients	Percent of Total Sample[a]
Schizophrenic Disorder	70	33.5
Affective Disorder	46	22.0
Personality Disorder	23	11.0
Organic Brain Disorder	13	6.2
Substance Use Disorder	9	4.3
Other[b]	24	11.5
Diagnosis of no mental illness[c]	12	5.7
Diagnosis Deferred	5	2.4
No Information	7	3.3
	209	99.9%[d]

Source: Program Evaluation Division analysis of individual patient records. Department of Human Services, Regional Treatment Centers.

[a]Analysis based on 209 records for first 1984 discharge.
[b]Includes adjustment disorders (8), schizo-affective disorders (5), and 11 other diagnoses which we were unable to classify.
[c]Includes eight patients admitted to the Minnesota Security Hospital for court-related examinations.
[d]Does not add to 100.0 percent due to rounding.

[6]This is the diagnostic category most clearly identified with chronic mental illness. However, it is likely that many patients in the other diagnostic groups also suffer from chronic mental illness. We learned from mental health professionals that chronic mentally ill people often exhibit different symptoms from crisis to crisis.

b. *Affective Disorders*

Affective disorders are psychiatric conditions related to abnormal mood changes, such as depression and mania. They were diagnosed in 22.0 percent of the patients.

c. *Personality Disorders*

Personality disorders are diagnoses used to describe individuals who display little insight into their behavioral problems and exhibit lifelong maladjustments in dealing with other people and external events. Common diagnostic categories include antisocial, paranoid, hysterical, and schizoid personalities. Personality disorders affected 11.0 percent of the patients.

d. *Organic Brain Disorders*

Organic brain disorders are psychological or cognitive disorders caused by, or associated with, impaired functioning of the brain. We found this diagnosis in 6.2 percent of the patients.

e. *Substance Use Disorders*

Substance use disorders describe deviant behaviors associated with drug addiction, abuse, or withdrawal. This group included 4.3 percent of the patients.

f. *Other*

Other is a category which includes adjustment disorders, schizo-affective disorders, and several other diagnoses which did not fit into the preceding categories. As shown in Table 3.11, there were 24 patients in this group.

As Table 3.12 indicates, 23.4 percent of the patients had a secondary diagnosis of chemical dependency in addition to their primary mental illness diagnosis. Thus, 27.7 percent of the patients had either a primary or a secondary diagnosis of substance abuse.

3. COUNTY INVOLVEMENT

The Minnesota Commitment Act of 1982 requires state hospital staff and county case managers to prepare written program plans for each patient. By statute:

> The program plan shall be devised and reviewed with the designated agency and with the patient. The clinical record shall reflect the program plan review. If the designated agency or the patient does not participate in the planning and review, the clinical record shall include reasons for non-participation and the plans for future involvement. The commissioner shall monitor the program plan and review pro-

cess for regional centers to insure compliance with the provisions of this subdivision.[7]

TABLE 3.12

SECONDARY DIAGNOSES

	Number of Patients	Percent of Total Sample[a]
Chemical Dependency	49	23.4%
Mental Retardation	10	4.8
Other[b]	10	4.8
No Information	140	67.0
TOTAL	209	100.0%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, Regional Centers, November 1985.

[a]Analysis based on 209 records for first 1984 discharge.
[b]Includes strokes, seizure disorders, complicating physical diseases, etc.

We reviewed the files to determine whether county case managers were identified at admission for both informal and committed patients. We wanted to assess county participation in admission and treatment planning decisions. Since hospital staff told us that they regularly notify counties of admissions, we looked for evidence of case managers being assigned to patients by counties and appearing in hospital records within about 10 days of admission. We found that:

- Less than half of the patients had assigned county case managers at admission.

However, the involvement of case managers varied by type of admission, as Table 3.13 shows:

- We found that about 40 percent of the committed patients entered state hospitals without an assigned county case manager, even though counties are required to participate in commitment proceedings.

[7]Minn. Stat. §253B.03, subd. 7; by statutory definition, *patient* applies to any person who is institutionalized or committed.

TABLE 3.13

COUNTY CASE MANAGEMENT AT ADMISSION

Admission Type	Number of Patients in Sample[a]	Patients with Named County Case Manager[b]	
		Number	Percent
Committed[c]	61	37	60.7%
Informal[d]	113	53	46.9
Court-Related	18	3	16.7
Hold[e]	17	2	11.8
TOTAL	209	95	45.5%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, Regional Centers, November 1985.

[a]Analysis based on 209 records for first 1984 discharge.

[b]In 114, or 54.5 percent of the cases, no information was found to indicate county involvement.

[c]Includes 15 patients whose status changed from hold.

[d]Includes 25 patients whose status changed from hold.

[e]Includes only patients directly discharged from a hold; 40 patients who were admitted under hold orders but whose status later changed are included in other categories.

More than half of the informal patients did not have county case managers assigned at admission. This confirms the impressions of the hospital staff and county representatives whom we interviewed, although we were told that prior to hospitalization, many informal patients are already receiving services from county agencies for mental illness or for other reasons.

We found a much lower incidence of case manager involvement for court-related admissions (16.7 percent) and for patients directly discharged from holds (11.8 percent). The fact that patients discharged directly from holds generally did not have case managers is consistent with the short length of the visit; the same is true of patients hospitalized for court-related investigations. In addition, patients hospitalized for court-required examinations have their admissions arranged by the court system rather than by the social service system.

C. DISCHARGE PLANNING

We reviewed the hospital files for a subsample of 209 patients discharged from state hospitals in 1984 to answer the following questions about the discharge process:

- What are the roles and responsibilities of state hospitals and county social service agencies in discharge planning? Who else is involved in the process?
- Do aftercare plans adequately address individual patient needs?

1. THE ROLE OF THE STATE HOSPITALS

The Minnesota Commitment Act of 1982 describes in detail the responsibilities of the state hospitals in treating mentally ill persons and preparing them for discharge. By statute, the hospital is responsible for writing a program plan for each patient which describes the patient's problems, presents goals for treatment, and estimates the time required for achieving these goals.[8]

A cursory review of the files showed evidence of goals being established for each patient early in the course of treatment. Hospital staff record patient progress toward achieving these goals in daily entries to the file, and make comprehensive assessments at quarterly and annual reviews. We also found evidence of hospital social workers meeting with county case managers and local service providers in preparation for patient discharge.

2. THE ROLE OF COUNTY CASE MANAGERS

The Minnesota Commitment Act of 1982 mandates county involvement in discharge planning for all state hospital patients. By statute:

> Prior to the date of discharge, provisional discharge or partial institutionalization of any committed person, the designated agency of the county of the patient's residence, in cooperation with the head of the treatment facility, and the patient's physician . . . shall establish a continuing plan of after-care services for the patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and other assistance the patient needs. The designated agency shall provide case management services, supervise and assist the patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and aid in his readjustment to the community.[9]

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[8] *Ibid.*

[9] Minn. Stat. §253B.20, subd. 4; by statutory definition, *patient* applies to any person who is institutionalized or committed.

We reviewed the files to determine whether county case managers participate in discharge planning for both informal and committed patients and whether there is variation among hospitals in the level of county involvement.

As noted earlier, in 45 percent of all cases we found evidence of a specific county case manager being involved within ten days of patient admission to the state hospital. Sixty-two percent of the patients had a specific case manager representing the county during the planning process or at the final discharge meeting. However, in only 22 percent of all cases was the same county case manager named at admission and at discharge.

The involvement of county case managers during discharge planning varied according to the patient's admission status. We found:

- Ten percent of all committed patients did not have a named county case manager participating in discharge planning.

- About 40 percent of all informal patients did not have assigned county case managers during discharge.

Informal patients, unlike committed patients, may refuse county case manager services. However, our interviews indicate that this rarely occurs, and does not account for the disparity in case manager involvement with informal and committed patients.

As shown in Table 3.14, we also found minimal county case manager representation for patients who entered the state hospitals through the courts. County case managers were involved in only 11.1 percent of these cases, most of whom were patients at the Minnesota Security Hospital. These patients are hospitalized for short-term, court-ordered evaluations, and social service agencies are typically not involved.

Finally, we compared county participation in discharge planning at each hospital. As Table 3.15 indicates, Fergus Falls had the highest rate of county representation; a specific case manager was involved in 82.4 percent of the discharges for that hospital. Because county case manager involvement in discharge planning for informal patients is low, we did not expect to find such extensive county involvement at the hospital which had the highest rate (85.3 percent) of informal admissions.[10] Our findings supported statements by administrators at Fergus Falls, who told us that they make a concerted effort to involve counties in treatment and discharge planning.

The state hospital at Anoka had the second highest rate of county representation; a case manager was named at 72.2 percent of its discharges. This figure closely reflects the percentage of committed patients at the hospital. Staff at this hospital told us that they generally make actual discharge arrangements, which are subject to county approval.

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[10]This figure is based on 209 records for the first 1984 discharge.

TABLE 3.14

COUNTY CASE MANAGER PARTICIPATION IN DISCHARGE PLANNING
(By Type of Admission)

Admission Type	Patients[a]	Patients with Named County Case Manager[b] Number	Percent
Informal	113	66	58.4%
Committed	61	55	90.2
Court-Related	18	2	11.1
Hold	17	7	41.2
TOTAL	209	130	62.2%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November, 1985.

[a]Analysis based on 209 patient records for first 1984 discharge.

[b]In 79 cases (37.8 percent), we found no information on county case manager involvement during discharge planning.

The lowest rate of county case manager participation was found at Brainerd, where the county was represented in 52 percent of all discharges. Administrators at this hospital told us that they expect the counties in their catchment area to take the lead in discharge planning, while hospital personnel serve in an advisory capacity. Therefore, we expected to see extensive county case manager involvement. We did not find this to be so. However, limited county participation may be explained by the fact that 28 percent of the patients from this hospital were discharged against medical advice and therefore had little in the way of a formal discharge plan.

The link between state hospital staff and county case managers is critical if patients are to make a smooth transition from the hospital back to the community. Therefore, we recommend that all patients, regardless of admission status, should be assigned a county case manager who is responsible for participating in discharge planning and follow-up on the delivery of aftercare services.

TABLE 3.15

COUNTY CASE MANAGER PARTICIPATION IN DISCHARGE PLANNING
(By Hospital)

Hospital	Patients[a]	Patients with Named County Case Manager[b]	
		Number	Percent
Anoka	36	26	72.2%
Brainerd	25	13	52.0
Fergus Falls	34	28	82.4
Moose Lake	25	16	64.0
St. Peter	34	22	64.7
Minnesota Security	21	3	14.3
Willmar	34	22	64.7
TOTAL	209	130	62.2%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 209 patient records for first 1984 discharge.

[b]In 79 cases (37.8 percent), we found no information on county case manager involvement during discharge planning.

3. THE ROLE OF FAMILY AND OTHERS

We reviewed the discharge plans for evidence of involvement by family, residential providers, or others. We found that:

- More than half of all patients had no additional persons involved.

Only 26 percent of patients had a family member participating in discharge planning. Another 18 percent of the patients had a friend, spiritual advisor, Division of Vocational Rehabilitation counselor, physician, residential program or court representative involved in discharge planning.

In our interviews with hospital staff, we were told that many mentally ill persons function alone without the support of family or other concerned persons. We found this to be true for more than half of the patients in our sample.

4. DISCHARGE DESTINATIONS

We examined discharge plans for information about patient destinations when they leave state hospitals to determine whether committed and informal patients are discharged to the same types of places, and whether destinations vary by hospital.

We found that:

- The largest group of patients, 34.4 percent, were discharged to "home," which includes both family situations and a wide range of casual living arrangements.

As shown in Table 3.16, the second largest group, 23.4 percent, were discharged to other group living arrangements, most of which are not specifically licensed to serve mentally ill persons. These include: nursing homes, other state and community hospitals, foster care, board and care facilities, and halfway houses. Less than one-sixth of the patients were discharged to Rule 36 facilities.

TABLE 3.16

DISCHARGE DESTINATIONS FOR PATIENTS LEAVING STATE HOSPITALS IN 1984

Type	Number of Patients[a]	Percent
Home	72	34.4%
Rule 36 Facility[b]	32	15.3
Court or Jail	23	11.0
Other Group Living Arrangements[c]	49	23.4
Discharged Against Medical Advice	21	10.1
No Information[d]	12	5.7
TOTAL	209	99.9%[e]

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 209 patient records for first 1984 discharge.

[b]Includes facilities licensed under Department of Human Services program rule governing residential facilities for mentally ill persons.

[c]Includes board and care facilities, foster care, other hospitals, nursing homes, halfway houses, hotels and ICFs-MR.

[d]In 12 of the cases, there was no information included in the file regarding a discharge destination, although the patient was formally discharged by the hospital.

[e]Total does not equal 100.0 percent due to rounding.

An additional 15.8 percent of the patients had no discharge destination specified in their files. However, only a few of these patients were granted a formal discharge. The rest left against medical advice before an appropriate discharge destination could be determined.[11]

As shown in Table 3.17, we generally found similar discharge destination patterns for all of the hospitals. The exceptions were: a higher than average rate of discharge to home at Brainerd (52.0 percent), and at Fergus Falls (50.0 percent); a higher than average rate of discharge to Rule 36 facilities at Moose Lake (36.0 percent) and at Anoka (22.2 percent). The Minnesota Security Hospital was unique in discharging about 95.2 percent of its patients to court or jail. We also found no discharge destination for 19.4 percent of the patients at Anoka, although these patients were formally discharged by the hospital.

As shown in Table 3.18, we found that the type of admission usually did not affect discharge destination. However, we did note that 29.5 percent of the committed patients were discharged to Rule 36 facilities, compared to only 11.5 percent of informal patients.

5. AFTERCARE PLANS

We examined discharge plans to determine whether vocational, social and medical needs of individual patients were addressed adequately. We also looked for evidence of family involvement in discharge planning, and for documentation that persons or agencies would be monitoring the patient's medications after discharge.[12] We found:

- Patient aftercare plans generally did not include recommendations for community support services, such as vocational programs, day treatment programs, or medical follow-up.

We analyzed aftercare plans for patients who were discharged to home, as this was the destination cited most frequently in the files. Since 63 percent of the patients were admitted to state hospitals from home, it is not surprising to find that so many patients return home upon discharge. While a person's home may afford the opportunity for the least restrictive and most normal lifestyle, it does not offer trained staff to follow-up on patient progress. Therefore, we specifically asked for patients discharged to home whether a family member participated in discharge planning, and whether additional community support services were built into the discharge plans.

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[11]A total of 23, of 11.1 percent of the patients were discharged against medical advice. However, two of these patients were discharged to home and have been included in those counts.

[12]Alvira B. Brands, editor, *Planning for Discharge and Follow-up Services for Mentally Ill Patients*. Rockville, MD: the Health Standards and Quality Bureau of the National Institute of Mental Health, 1979.

TABLE 3.17

DISCHARGE DESTINATIONS

(By Hospital)

State Hospital	Number of Patients						
	Home	Rule 36 Facility	Court or Jail	Other Group Living Arrangements	Discharged Against Medical Advice[a]	No Information	Total By Hospital
Anoka	9	8	0	11	1	7	36
Brainerd	13	2	0	4	6	0	25
Fergus Falls	18	2	0	13	1	0	34
Moose Lake	6	9	0	7	3	0	25
St. Peter	13	5	3	6	4	3	34
Minnesota Security	0	1	20	0	0	0	21
Willmar	13	5	0	8	6	2	34
TOTAL	72	32	23	49	21	12	209

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Two additional patients, one at the Brainerd Regional Human Services Center, and another at the Willmar Regional Treatment Center, were discharged against medical advice to home. They have been included in the "Home" column.

TABLE 3.18

DISCHARGE DESTINATION

(Compared to Admission Status[a])

	Informal Admissions	Commitment Admissions	Holds	Court-Related Admissions
Home	37.2%	36.1%	47.1%	0.0%
Rule 36 Facility	11.5	29.5	5.9	0.0
Court or Jail	0.9	1.6	17.6	100.0
Other Group Living Arrangements	25.7	29.5	11.8	0.0
No Information	24.8	3.3	17.6	0.0
	100.1%[b]	100.0%	100.0%	100.0%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 209 patient records for first 1984 discharge.

[b]Total does not equal 100.0% due to rounding of figures.

We found no family involvement for 61.1 percent of the patients discharged to home. We also found that in only 8.3 percent of the plans for patients discharged to home was the person's day given formal structure through employment or placement at a sheltered workshop or day treatment program. Aftercare plans for 44.4 percent of the patients discharged to home did not include any arrangements for appropriate community support services. The remaining cases included some reference to vocational or medical follow-up. However, the reference was frequently a vague suggestion, rather than naming a specific source or agency responsible for service.

Aftercare plans for patients discharged to Rule 36 facilities showed similar gaps. In 43.8 percent of these cases, there were no recommendations for any additional support services.

In our interviews at the hospitals, we learned that, as time permits, some hospital staff members follow patients after discharge. However, it was not possible to measure the extent of state hospital involvement in follow-up because there was no documentation of this in the files.

6. USE OF MEDICATIONS

Psychotropic drugs, or drugs which affect mental functioning and behavior, are routinely prescribed in state hospitals, and are considered a normal part of treatment for certain mental illnesses. While these drugs do not

offer a cure, they can control certain behaviors and symptoms associated with mental illness. In our interviews with hospital staff, we learned that patients sometimes return to state hospitals because of problems related to their medications. For example, it is not uncommon for a patient to discontinue taking his medication because of unpleasant side effects, or because he feels better, without understanding that he feels better as a result of the medication. Medical directors at some of the state hospitals told us that patients discontinue medication because of cost, or because a private physician recommends lowering a seemingly high dosage, which is, in fact, what the patient needs to maintain stability.

We found that:

- Fifty-six percent of the patients were discharged from state hospitals with medications. The discharge plans for one-half of these patients did not designate a person or agency to monitor the use of medication after the patient returned to the community.

We also found interesting differences in how individual hospitals use medications. As shown in Table 3.19, Moose Lake discharged 76.0 percent of its patients with medications. We were unable to explain why doctors at this hospital prescribed medications to more patients than the other hospitals. In contrast, Brainerd discharged only 40.0 percent of its patients with medications. This may be explained by the fact that many patients left against medical advice, before a discharge plan was completed. Almost all patients at the Minnesota Security Hospital were discharged without drugs, which is explained by the fact that these patients were hospitalized for court-related evaluations, rather than for actual treatment of mental illness.

D. READMISSION

In recent years, patient stays have become shorter, readmission rates have increased, and the interval between visits has decreased. As we discussed earlier in this chapter, about two-thirds of the patients discharged from state hospitals in 1984 had been treated at a state hospital prior to the visit we examined. One-fourth of the patients returned within six months of discharge for additional treatment. We asked:

- Do patients return to state hospitals for additional treatment of the same illnesses or because of different illnesses?
- How do state hospitals plan for discharge and follow-up during subsequent visits?
- Is there continuity in county case management for patients with multiple admissions to state hospitals?

TABLE 3.19

PATIENTS DISCHARGED WITH MEDICATIONS

(By Hospital)

Hospital	Patients[a]	Patients Discharged With Medication[b] Number	Percent
Anoka	36	26	72.2%
Brainerd	25	10	40.0
Fergus Falls	34	22	64.7
Moose Lake	25	19	76.0
St. Peter	34	19	55.9
Minnesota Security	21	1	4.8
Willmar	34	20	58.8
TOTAL	209	117	56.0%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 209 patient records for first 1984 discharge.

[b]In 92 of the cases (44.0 percent), patients were discharged without medications, or there was no documentation of medications being prescribed in the file.

1. PATIENT DIAGNOSES

We found that readmission rates for state hospitals are high. About 43 percent of mentally ill patients discharged in 1984 were readmitted to state hospitals at least once, and 19.5 percent were readmitted a second time. In most cases, patients returned because of a recurrence of the same illness.

We compared the patient diagnosis for the first visit with the diagnosis at readmission. As shown in Table 3.20, in about two-thirds of the cases, the patient diagnosis was the same at the first readmission as it had been for the previous visit. The diagnoses for the two visits were different in 15.9 percent of the cases. In the remaining 18.3 percent of the cases, we were unable to find a diagnosis documented in the files for one or both visits, or we found a notation indicating that the diagnosis had been deferred.

TABLE 3.20

DIAGNOSIS FOR FIRST AND SECOND READMISSION
(Compared to Diagnosis for First 1984 Discharge)

	First Readmission[a]	Second Readmission[b]
Same Diagnosis	65.9%	48.5%
Different Diagnosis	15.9	9.1
No Diagnosis or Diagnosis Deferred	18.3	42.4
TOTAL	100.1%[c]	100.0%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 82 records for patients with at least one readmission following first 1984 discharge.

[b]Analysis based on 33 records for patients with a second readmission following first 1984 discharge.

[c]Figure does not total 100.0% due to rounding.

We were not surprised to find a high percentage of patients readmitted for further treatment of the same illnesses. Because many mental illnesses are chronic, it is likely that many patients will return for recurrences of the same symptoms and behaviors which caused earlier hospitalizations.

2. DISCHARGE DESTINATIONS

We found that the distribution of patients by discharge destination remained constant for each visit. As shown in Table 3.21, 26.8 percent of the patients were discharged to their homes. Almost 40 percent were discharged to some type of group living arrangement, and 15 percent left against medical advice before an appropriate discharge destination could be determined. Over one-fourth of the patients with at least one readmission were discharged to the same location as was recorded for the first 1984 discharge.[13]

[13]We have not reported a comparable analysis for patients with a second readmission, as only 11 of these patients had a discharge destination documented in their files.

TABLE 3.21

DISCHARGE DESTINATIONS FOLLOWING FIRST AND SECOND READMISSIONS

	First Readmission[a]	Second Readmission[b]
Home	26.8%	15.2%
Group Living Arrangements[c]	39.2	18.2
Discharged Against Medical Advice	14.6	21.2
Patient Still Hospitalized[d]	9.8	24.2
No Information	9.8	21.2
	100.2%[e]	100.0%

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 82 records for patients with at least one readmission following first 1984 discharge.

[b]Analysis based on 33 records for patients with a second readmission following first 1984 discharge.

[c]Includes other hospitals, nursing homes, board and care homes, Rule 36 facilities and jail.

[d]Patient was still hospitalized as of October 1985.

[e]Figure does not equal 100.0% due to rounding.

With each successive visit, we found it increasingly difficult to locate information in the files about discharge destinations. This information was not available for six percent of the first 1984 discharges, for ten percent of the first readmissions, and for 21 percent of the second readmissions.

3. AFTERCARE PLANNING

We found:

- Seventy percent of all patients discharged from a first readmission had no recommendations for follow-up care or community support services in their aftercare plans.[14]

[14]Figures for patients with a second readmission are skewed by the eight patients who are still hospitalized.

Six percent of the patients were sent to sheltered workshops for vocational programs, and 12 percent of the patients were referred to community mental health centers for follow-up. A few files included vague references to some type of follow-up care. We also found that medications were recommended for 57 percent of the patients discharged from a first readmission. However, for over half of these patients, we did not find an individual or agency designated to monitor the use of medication.

In reviewing aftercare plans for patients with second readmissions we found that none of these patients were referred to community support services for follow-up.

4. COUNTY CASE MANAGER INVOLVEMENT

We reviewed the files to determine whether county case managers named at the first 1984 discharge were still involved with patients at subsequent hospitalizations. We found a lack of continuity: most mentally ill patients with repeated hospitalizations during the past two years did not have the same county case manager involved throughout that time. We further found that it became increasingly difficult to find any evidence of county case manager involvement with each successive hospitalization.

As shown in Table 3.22, 62.2 percent of patients who were readmitted at least once did not have a county case manager named at one or both visits. Twenty-seven percent of the patients had the same county case manager involved at both visits, and 11 percent of the patients had a different county case manager for each visit.

Table 3.22 also compares county case manager involvement at the first 1984 discharge and the second readmission. As indicated in the table, 75.8 percent of the patients did not have a county case manager named at one or both visits, 18.2 percent had the same case manager throughout, and 6.1 percent of the patients had different case managers for each visit.

5. HOSPITAL AND COUNTY ROLES

We found:

- Discharge planning for patients becomes progressively less detailed with each successive hospitalization.
- Continuity in county case manager involvement decreases with successive hospitalizations.

The patients in our study had long histories of mental illness, with repeated hospitalizations documented in their files. However, we found that patient aftercare plans contained progressively less information as the number of hospitalizations increased. If chronic mentally ill patients are to succeed in the community, their discharge planning must be done thoughtfully and with attention to detail. State hospital staff and county case managers have a responsibility to prepare these plans and document them in patient files with equal care for every hospitalization.

TABLE 3.22

COUNTY CASE MANAGER FOR FIRST AND SECOND READMISSION
(Compared to Case Manager for First 1984 Discharge)

	First Readmission[a]	Second Readmission[b]
Same Case Manager	26.8%	18.2%
Different Case Manager	11.0	6.1
Case Manager Not Named at One or Both Visits	62.2	75.8
TOTAL	100.0%	100.1%[c]

Source: Program Evaluation Division analysis of individual patient records, Department of Human Services, November 1985.

[a]Analysis based on 82 records for patients with at least one readmission following first 1984 discharge.

[b]Analysis based on 33 records for patients with a second readmission following first 1984 discharge.

[c]Figure does not total 100.0% due to rounding.

CONCLUSIONS AND RECOMMENDATIONS

Chapter 4

The data in this report show that mental illness programs at state hospitals serve a large number of *repeat* patients with lengthy histories of state and community hospitalizations. Many patients leave state hospital mental illness programs at high risk of returning--because of their illnesses, because of gaps in discharge planning, and because of limited participation of county case managers and family in care after discharge.

To summarize, we found:

- About two-thirds of all patients had been admitted to a state hospital at least once in the past for psychiatric care.
- Approximately two-thirds of the patients whose files we examined had also been hospitalized in community facilities for treatment of mental illness.
- About 21 percent of all patients were readmitted to state hospitals within 90 days of the visit we examined.

We believe that the data reflect a serious breakdown in the system of care for chronic mentally ill people. Although we acknowledge that mental illness is difficult for the public to accept and for professionals to treat, we believe that the state can and should be doing more to ensure that patients leave the hospitals with comprehensive discharge plans and active support from county case managers.

Discharge planning is a critical factor in reducing readmissions, because it is the element of inpatient treatment that links hospital care and follow-up support in the community. However, we found that:

- More than half of the patients were discharged without any evidence of follow-up support from family or others.
- Almost 40 percent of the patients had no evidence of county case managers participating in discharge planning.

The absence of family and social service support is particularly significant in light of the fact that:

- More than half of all patients were discharged with medications. The discharge plans for half of these patients did not designate a person or agency to monitor the use of medication after the patient returned to the community.

- About one-third were discharged to "home," in most cases, without specific arrangements for community follow-up services.

Furthermore, the aftercare plans we found in the files were progressively less detailed for each subsequent state hospital visit. This suggests that neither the hospitals nor the counties pay as much attention to discharge planning and case management for patients with an established pattern of readmissions.

Our research was not intended to document gaps in case management and community support services in particular counties. However, in interviewing hospital, county, and community representatives, we learned about problems in the availability of these services throughout the state. We were not surprised to find gaps in county case management for state hospital patients. Our survey of county caseloads for mentally ill people suggests that caseworkers generally carry high loads.

- According to our analysis, the statewide median is one full-time county case worker for 48 clients. Mental health professionals generally recommend 30 to 40 clients per case worker.

In interviewing hospital, county and community representatives, we also learned about problems and gaps throughout the state in the availability of residential programs and community support services for mentally ill people. In analyzing the distribution of Rule 12 and Rule 14 grants for community residential support services, we found that:

- About 64 percent of all beds funded by Rule 12 are concentrated in six metropolitan counties which contain about 50 percent of the state's population. In 57 counties, mentally ill persons must travel considerable distances to the nearest residential facility with a Rule 36 program license.

- Five of the seven metropolitan counties have received Rule 14 community support grants, but less than one-fifth of the outstate counties have been recipients.

The Department of Human Services has awarded a high proportion of Rule 12 and 14 grants to the metropolitan area. This has led to an over-concentration of services for mentally ill people in one region of the state. These awards should be distributed more evenly in order for mentally ill people to remain and function in their own communities.

We believe that gaps in the availability of services have a definite, but unmeasurable, impact on the frequency and number of readmissions to state

hospitals. They also severely limit the discharge planning options available to hospital and county staff. Therefore, we believe that steps must be taken to improve the availability and quality of support services that chronic mentally ill patients receive when they leave state hospitals.

In particular, we think that many counties need to devote additional staff to case management and to discharge planning for state hospital patients. One state mechanism which exists to fund such efforts is the Rule 14 grant program. However, we found little evidence that the Department of Human Services considers the role of these services in preventing admissions and readmissions to state hospitals. We recommend that:

- The hospitals and counties should focus discharge planning on community support services and residential arrangements which would enable patients to remain in the community. Where needed services are not available, the gaps should be documented, and the Department of Human Services should use this information to target the Rule 12 and 14 grant programs accordingly.

- The Legislature should place a high priority on increasing the funds for the Rule 14 grant program in the next biennium. Half of the increase should be dedicated to innovative case management projects. The other half should be earmarked for new community support projects in outstate communities without ready access to these services.

- The Department of Human Services should establish regional priorities to ensure a more even distribution of Rule 36 facilities, and should consider these priorities when awarding Rule 12 grants.

Because we found significant gaps and variations in discharge planning at state hospitals, we also recommend that:

- The Department of Human Services should review discharge planning procedures at all hospitals, and should develop minimum system-wide standards for the content of discharge plans.

- The Department of Human Services should place strong emphasis on discharge planning when it conducts quality assurance reviews of the hospitals.

- The Department of Human Services should develop a program to educate hospital and county staff about the community support services available in a region which could be helpful in maintaining patients in the community and in diverting potential readmissions.

- The Department of Human Services should establish consistent recordkeeping procedures for discharge planning and patient follow-up at all hospitals.

As we indicated earlier, the Minnesota Commitment Act of 1982 specifically requires county case management for patients committed to state hospitals.

We recognize, however, that the Department of Human Services and individual state hospitals have no power to enforce this provision of the law.

- About 10 percent of the committed patients in our sample did not have a named county case manager participating in discharge planning.

The Commitment Act also requires county involvement in discharge planning for informal patients, but we found that:

- About 40 percent of the informal patients left state hospitals without a named county case manager.

However, we did find a high rate of county case manager involvement with informal patients at Fergus Falls. This suggests that hospitals and counties could be doing a much better job of coordinating follow-up for all patients, but in particular, for informal patients. We think that the Department of Human Services should play a leadership role in solving this problem. Accordingly, we recommend that:

- The Legislature should direct the Department of Human Services to establish a task force made up of state, county, and community representatives to examine and recommend ways of improving the coordination of discharge planning between state hospitals and counties. The task force should consider changes in law and hospital procedure.

We believe that such a task force should examine a variety of alternatives, including changes in the Commitment Act relating to case management for informal patients, better hospital procedures for involving counties in discharge planning, possible hospital involvement in providing follow-up services, and ways to support stronger and more innovative case management. We further recommend that:

- The Department of Human Services should report to the Legislature annually on the availability and quality of case management services provided by counties for mentally ill people.

Our recommendations are intended to help maintain mentally ill people in their communities and to avoid admissions to state hospitals. Nevertheless, despite efforts to shift the focus of care for mentally ill people away from institutions and into the community, we generally conclude that:

- State hospitals continue to play an important role in providing care for mentally ill persons in Minnesota.

The role of state hospitals is different than it was 30 years ago when public institutions served large numbers of people on a long-term basis. Today, the primary role of the hospitals is to provide crisis care for people experiencing acute episodes of mental illness.

Each hospital has a clear identity. Some hospitals offer special statewide programs, while others have distinctive patient populations. In

general, these differences reflect and complement the type and availability of mental illness treatment services in the surrounding communities.

Without question, major changes will be required in hospital and community programs before the state can adequately fulfill its responsibilities to mentally ill people. Some changes will require greater public awareness of mental illness, and therefore, are likely to take years to bring about. In this report, we focused on practical changes in the state hospital discharge process which we think will result in improved hospital and community services for all mentally ill people.

APPENDICES

APPENDIX A

SURVEY OF COUNTY CASE MANAGEMENT FOR MENTALLY ILL PERSONS

OFFICE OF THE LEGISLATIVE AUDITOR
PROGRAM EVALUATION DIVISION

NAME OF RESPONDENT: _____ PHONE: _____

1. What is the total number of persons who are currently receiving case worker services from your agency for reasons of mental illness?

_____

2. How many of these persons had direct contact with a county case worker during the past three months?

_____

3. What is the full-time equivalent of case workers with responsibilities for mentally ill persons? (For example, if a case worker spends half of his/her time with mentally retarded clients, and the other half with mentally ill clients, that would be 0.5 FTE.)

_____

APPENDIX B

DATA COLLECTED FROM CENTRAL PATIENT RECORDS AND INDIVIDUAL PATIENT FILES

CONFIDENTIAL DATA
Office of the Legislative Auditor
State Hospital MI Patient Sample, FY 1984

IDENTIFIER FIELDS

1. Name_____2. Welfare ID Number_____
3. Date of Birth_____
4. County of Residence_____5. Hospital_____
6. Type of Discharge_____7. Date of Discharge_____
8. Date of Provisional Discharge_____
9. Sex_____

ADMISSION FIELDS

10. Hold Date_____11. Admission Date_____
12. Type of Admission_____
13. Name of County Case Manager_____
14. County_____
15. Number of Prior State Hospital Visits_____
16. Name of Last State Hospital Visited_____
17. Number of Prior Community Hospital Visits_____
18. Type of Residence Prior to Admission_____
19. Name of Residential Program_____
20. Admission from Community Hospital_____
21. Mental Illness Diagnosis_____
22. Other Disabilities_____

DISCHARGE FIELDS

24. Date of Last Discharge Meeting_____25. County notified_____
26. Name of County Case Manager_____
27. County_____
28. Family or Others involved_____
29. Discharge Destination_____
30. Name of Residential Program_____
31. County of Residential Program_____
32. Discharged to Home_____
33. Type of Community Support Program_____
34. Name of Community Support Program_____35. County_____
36. Medication_____
37. Other Follow-up_____

PROVISIONAL DISCHARGE FIELDS

39. Date Provisional Discharge Revoked_____
40. Date Provisional Discharge Extended_____
41. Date Provisional Discharge Made Permanent_____

FIRST READMISSION FIELDS

43. Date_____44. Type_____45. Hospital_____
46. Mental Illness Diagnosis_____
47. Residence Prior to Admission_____
48. Name of Residential Program_____
49. Admitted From Community Hospital_____
50. Name of County Case Manager_____
51. County_____
52. Date of Discharge_____53. Type of Discharge_____
54. County Notified_____
55. Discharge Destination_____
56. Name of Residential Program_____57. County_____
58. Discharged to Home_____
59. Type of Community Support Program_____
60. Name of Community Support Program_____61. County_____
62. Medication_____
63. Other Follow-up_____

SECOND READMISSION FIELDS

65. Date_____66. Type_____67. Hospital_____
68. Mental Illness Diagnosis_____
69. Residence Prior to Admission_____
70. Name of Residential Program_____
71. Admitted From Community Hospital_____
72. Name of County Case Manager_____
73. County_____
74. Date of Discharge_____75. Type of Discharge_____
76. County Notified_____
77. Discharge Destination_____
78. Name of Residential Program_____79. County_____
80. Discharged to Home_____
81. Type of Community Support Program_____
82. Name of Community Support Program_____83. County_____
84. Medication_____
85. Other Follow-up_____

OTHER READMISSION FIELDS

87. Number of Subsequent Readmission_____
88. Names of State Hospitals Visited_____

NOTES:_____

_____

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STUDIES OF THE PROGRAM EVALUATION DIVISION

Final reports and staff papers from the following studies can be obtained from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

1977

1. Regulation and Control of Human Service Facilities
2. Minnesota Housing Finance Agency
3. Federal Aids Coordination

1978

4. Unemployment Compensation
5. State Board of Investment: Investment Performance
6. Department of Revenue: Assessment/Sales Ratio Studies
7. Department of Personnel

1979

8. State-sponsored Chemical Dependency Programs
9. Minnesota's Agricultural Commodities Promotion Councils
10. Liquor Control
11. Department of Public Service
12. Department of Economic Security, Preliminary Report
13. Nursing Home Rates
14. Department of Personnel: Follow-up Study

1980

15. Board of Electricity
16. Twin Cities Metropolitan Transit Commission
17. Information Services Bureau
18. Department of Economic Security
19. Statewide Bicycle Registration Program
20. State Arts Board: Individual Artists Grants Program

1981

21. Department of Human Rights
22. Hospital Regulation
23. Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill
24. State Designer Selection Board
25. Corporate Income Tax Processing
26. Computer Support for Tax Processing
27. State-sponsored Chemical Dependency Programs: Follow-up Study
28. Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights
29. Individual Income Tax Processing and Auditing
30. State Office Space Management and Leasing

1982

31. Procurement Set-Asides
32. State Timber Sales
33. *Department of Education Information System
34. State Purchasing
35. Fire Safety in Residential Facilities for Disabled Persons
36. State Mineral Leasing

1983

37. Direct Property Tax Relief Programs
38. *Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes
39. *Community Residential Programs for Mentally Retarded Persons
40. State Land Acquisition and Disposal
41. The State Land Exchange Program
42. Department of Human Rights: Follow-up Study

1984

43. *Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf
44. The Administration of Minnesota's Medical Assistance Program
45. *Special Education
46. *Sheltered Employment Programs
47. State Human Service Block Grants

1985

48. Energy Assistance and Weatherization
49. Highway Maintenance
50. Metropolitan Council
51. Economic Development
52. Post Secondary Vocational Education: Follow-Up Study
53. County State Aid Highway System
54. Procurement Set-Asides: Follow-Up Study

1986

55. Insurance Regulation
56. Tax Increment Financing
57. Fish Management
58. Deinstitutionalization of Mentally Ill People

Deinstitutionalization of Mentally Retarded People (in progress)
Public Employee Pensions (in progress)

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*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.