Community Residences for Adults With Mental Illness

This document is made available electronically by the Minnesota Legislative Reference Library as part of an ongoing digital archiving project. http://www.leg.state.mn.us/lrl/lrl.asp

December 1989

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

The Program Evaluation Division was established by the Legislature in 1975 as a center for management and policy research within the Office of the Legislative Auditor. The division's mission, as set forth in statute, is to determine the degree to which activities and programs entered into or funded by the state are accomplishing their goals and objectives and utilizing resources efficiently. Reports published by the division describe state programs, analyze management problems, evaluate outcomes, and recommend alternative means of reaching program goals. A list of past reports appears at the end of this document.

Topics for study are approved by the Legislative Audit Commission (LAC), a 16-member bipartisan oversight committee. The division's reports, however, are solely the responsibility of the Legislative Auditor and his staff. Findings, conclusions, and recommendations do not necessarily reflect the views of the LAC or any of its members.

The Office of the Legislative Auditor also includes a Financial Audit Division, which is responsible for auditing state financial activities.

Professional Staff

James Nobles, *Legislative Auditor*

Roger Brooks, *Deputy Legislative Auditor*

Joel Alter
David Chein
Mary Guerriero
Marilyn Jackson-Beeck
Daniel Jacobson
Elliot Long
Kathleen Vanderwall
Jo Vos
Tom Walstrom
Deborah Woodworth
John Yunker

Support Staff

Jean Barnhill
Mary Moser
Theresa Wagner

Community Residences for Adults With Mental Illness

December 1989

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Veterans Service Building, Saint Paul, Minnesota 55155 • 612/296-4708

STATE OF MINNESOTA
OFFICE OF THE LEGISLATIVE AUDITOR
VETERANS SERVICE BUILDING, ST. PAUL, MN 55155 • 612/296-4708
JAMES R. NOBLES, LEGISLATIVE AUDITOR

December 20, 1989

Senator John Brandl, Chairman
Legislative Audit Commission

Dear Senator Brandl:

In recent years, Minnesota has increased its reliance on community-based services to meet the needs of people with serious and persistent mental illness. Because of concerns about the quality of these services, in October 1988 the Legislative Audit Commission directed the Program Evaluation Division to evaluate community residences for adults with mental illness.

Although there have been many improvements in the mental health system since the Legislature initiated reforms in 1986, we found that the Legislature's goal of a comprehensive mental health system by 1990 has not been met. Case management and other supportive services for clients are inadequate, treatment programs often ignore clients' important mental health problems, and there is too little financial and programmatic accountability in community facilities.

But these problems can be solved. They should not deter the Legislature from its commitment to deinstitutionalization. With proper support, the vast majority of people with mental illness can live successfully in the community.

We received the full cooperation of the Department of Human Services, Department of Health, Office of the Ombudsman for Mental Health and Mental Retardation, counties, and community facilities serving adults with mental illness across Minnesota.

This report was researched and written by Joel Alter (project manager), Mary Guerriero, and Kathi Vanderwall, with assistance from Lynnette Hjalmervik.

Sincerely yours,

James R. Nobles
Legislative Auditor

Roger A. Brooks
Deputy Legislative Auditor

TABLE OF CONTENTS

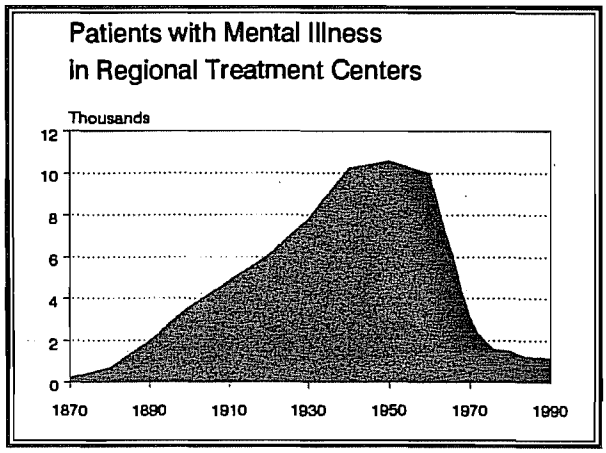
LIST OF TABLES AND FIGURES

COMMUNITY RESIDENCES FOR ADULTS WITH MENTAL ILLNESS

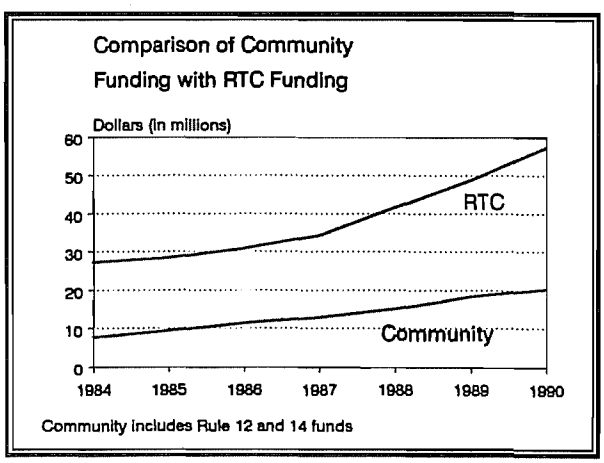
Executive Summary

Most adults with mental illness now live in the community, not in regional treatment centers.

The number of patients with mental illness in Minnesota's regional treatment centers (formerly called state hospitals) has declined from more than 10,000 in the 1950s to about 1,100 today. This reduction was largely caused by concerns about quality of care, the belief that people with mental illness should live in "normalized" living settings, and the development of psychotropic drugs that helped manage the symptoms of mental illness. Initially, many people discharged from regional treatment centers went to other institutional settings, such as nursing homes.



Today, after three decades of "deinstitutionalization," Minnesota has a complex community-based service system for adults with mental illness. This system consists primarily of residential treatment facilities (commonly called "Rule 36" facilities), case management provided by counties, and an array of non-residential mental health services. In addition to these community services, the state still operates six regional treatment centers for adults with mental illness. Funding for mental health services in regional treatment centers has continued to grow rapidly, and the most recent RTC funding increase was larger than the increase for community programs.



As more clients have been served in the community, more questions have been raised about the adequacy of Minnesota's mental health system. In 1986, reports to the Legislature and Governor cited inadequate discharge planning for patients in regional treatment centers and

insufficient community services. As a result, the Legislature mandated major changes to improve client services. The Legislature directed the Commissioner of Human Services to create a "unified, accountable, comprehensive mental health service system" by February 15, 1990.

In September 1988, the Legislative Audit Commission directed the Legislative Auditor to evaluate community residences for adults with mental illness. In our study, we asked:

- **What level of care and treatment do adults with mental illness receive in community facilities?**
- **Does Minnesota have an array of community residential living arrangements sufficient to meet the needs of adults with mental illness?**
- **How effective are community programs in treating mental illness?**

To answer these questions, we visited nearly 50 community facilities that house adults with mental illness. About half were Rule 36 treatment facilities, while others were "board and lodging facilities" not licensed to provide human services programs. We reviewed the treatment plans of 263 current residents of Rule 36 facilities, and we also talked with residents and staff. We surveyed all Minnesota counties about case management and client living arrangements, and we surveyed staff from Minnesota's psychiatric hospitals about client placements. We also surveyed Rule 36 facilities about staffing and salaries.

The Legislature's goal of a comprehensive mental health system by 1990 has not been met.

Although there have been recent improvements in community mental health services, we found that the Legislature's goal of a comprehensive mental health system by 1990 has not been met. Specifically, people with mental illness still have too few choices about where to live and receive mental health services. Although many adults with serious and persistent mental illness live on their own (or are capable of doing so), there are too few mental health case managers and supportive services to ensure that their needs are properly met. We also found that existing residential treatment programs often fail to address residents' serious mental health problems, and residents' medications are not adequately monitored. In addition, state review of residential programs' finances and program content is lax. We think these problems with the community mental health system are serious but solvable, and the state should continue to serve as many clients as possible in community settings.

AVAILABILITY OF HOUSING AND SUPPORTIVE SERVICES

Adults with mental illness live many places in the community--some in Rule 36 treatment facilities, some in board and lodging houses, and some with their families or on their own. Mental health placement staff from community hospitals and the state's regional treatment centers told us that making appropriate community placements is more difficult now than it was two years ago. They reported that, of those patients discharged during a two-week period in

June 1989, 22 percent had their placements delayed due to problems finding appropriate community settings. Clients are sometimes placed where there is an available slot, rather than where they would be best served. Hospitals have difficulty placing clients who have certain behaviors (such as a history of chemical dependence, violence, or fire-setting), and 77 percent of hospital staff reported that Rule 36 facilities are frequently unwilling to take their most difficult patients.

According to staff in most Minnesota hospitals, Rule 36 facilities are often unwilling to take their most difficult patients.

Question: How Often Are Rule 36 Facilities Willing To Accept Your Hospital's Most Difficult Cases?

	Percent Of Hospital Staff Who Responded:
Rarely or Never	22.7%
Sometimes	54.5
Often	9.1
Usually or Always	13.6

N = 22 hospitals

Source: Hospital discharge staff response to survey by the Office of the Legislative Auditor.

Minnesota appears to rely more heavily on facilities to provide community mental health services and treatment than most other states. Most of these facilities operate near capacity. We think the current number of Rule 36 beds statewide might be adequate if more services could be provided to clients in other living arrangements. We found that:

- **It is difficult for an adult with serious and persistent mental illness in Minnesota to receive ongoing supportive services at home, unless this person's "home" is a Rule 36 facility or one of a few board and lodging facilities providing these services.**

Minnesota does not have a home-based program of supportive living services for adults with mental illness as it has for adults with mental retardation. Many people living on their own have access to community mental health services, but some may be so ill that they require services brought to their home or periodic visits from mental health professionals. Hospitals often discharge patients to "independent" living arrangements, but hospital placement staff expressed concern to us about the lack of necessary services for these people.

One crucial element of a comprehensive community mental health system is adequate case management. The 1987 Legislature required counties to provide case management by January 1989 to all adults with serious and persistent mental illnesses who request this service or who are referred by a provider. Case management is supposed to provide clients with ongoing coordination of mental health services, regardless of where the client lives or whether the client is receiving treatment. Although mental health professionals usually recommend caseloads no higher than 30, we found that:

- **The average mental health caseworker in Minnesota has about 40 clients with serious and persistent mental illness, and the most populous counties have even higher caseloads.**

Most county mental health caseworkers have caseloads that are too high.

It is doubtful that Minnesota will succeed in providing supportive mental health services to clients in their residences of choice unless it achieves a higher level of case management.

People with mental illness may need many other community services, such as vocational programs and psychiatric services. Many (but not most) mental health clients have difficulty getting these services. We found that:

- **Hospital placement staff reported that 22 percent of the services they considered "very important" for patients discharged in June 1989 were unlikely to be available in the patients' new living settings.**

Some services are not adequately tailored to the needs and abilities of clients with mental illness, while others have long waiting lists. In addition, clients living on their own have difficulty getting ongoing assistance with their medications.

Another issue related to placement of adults with mental illness in the community is their acceptance by other community residents. Some people have raised concerns about the siting of mental health facilities in residential neighborhoods, so we assessed the attitudes of Rule 36 facilities' neighbors. During our visits to facilities, we contacted a sample of neighbors and found that:

- **Neighbors usually have good or neutral impressions of Rule 36 facilities.**

Over 80 percent of the neighbors we contacted said the facility does not increase their likelihood of moving out of the neighborhood.

QUALITY OF CARE IN COMMUNITY FACILITIES

We identified a variety of indicators for quality of care in community treatment facilities. For example, treatment plans should be tailored to client needs, and the planning process should involve the client extensively. Because medications have serious and potentially irreversible side effects, they should be monitored systematically. Clients should live in places that are clean, well-maintained, and homelike. Clients should have opportunities to participate in community life and to learn skills that will help them live more independently. Staff should be well qualified, and staff turnover should be as low as possible.

We reviewed treatment plans in Rule 36 facilities and found that:

- **Treatment plans often fail to address important symptoms and behaviors of residents' mental illnesses.**

Many treatment facilities fail to address the mental health problems of their residents.

While facilities usually make strong efforts to provide social activities and training in independent living skills, they often do not directly address mental health problems that led to Rule 36 placement. We saw numerous instances in which problems such as hallucinations, angry outbursts, and inappropriate social behaviors were not addressed in treatment plans.

In addition, we found that treatment plans focus too much on client activities rather than client results. Most plans call for clients to participate in programs, but many do not indicate what these activities are intended to accomplish. Also, the plans are not particularly creative, and some place too much emphasis on management of the illness through medication compliance.

Many treatment plans that we reviewed failed to comply with state requirements. Specifically:

- **Less than one-third of recently admitted clients had diagnostic assessments that were complete, on time, and up-to-date.**
- **One-fifth of the plans were completed late, and about eight percent of the clients in facilities for at least 30 days did not have treatment plans on file.**
- **About 30 percent of the treatment plans did not have lists of client "strengths and needs," as required.**
- **The clients' personal objectives or preferences for services were seldom noted.**

In general, we concluded that many treatment plans are inadequately tailored to individual needs. In many facilities, plans have similar goals and identical time frames for most clients. Although most facilities kept notes on client progress, these notes were not directly linked to the clients' individual goals and objectives in about one-third of the files we examined.

The effects of medications are not properly monitored.

We also reviewed facility medication practices, since at least 90 percent of Rule 36 residents take drugs for their psychiatric symptoms. Medication experts suggest that the effects of these drugs should be regularly monitored with standardized methods. We found that:

- **Rule 36 staff assessed medication side effects with a standardized method in only 11 percent of the cases we reviewed.**

In contrast to this lack of monitoring for residents with mental illness, a recent study by the state Office of the Ombudsman for Mental Health and Mental Retardation concluded that most adults with *mental retardation* in community facilities have their medications monitored with standardized methods.

Although mental health professionals often disagree about which treatment approaches are most effective, there is general agreement that clients should be served in well-maintained, homelike settings. We found that most Rule 36 facilities are clean and well-kept. Many have characteristics that are very homelike, but some facilities are too large or crowded.

- **The average Rule 36 facility has 21 residents, but four Rule 36 facilities have more residents than some of the state's regional treatment centers.**

Comparison of Facility Size Between Regional Treatment Centers and Four Large Rule 36 Facilities

Some Rule 36 facilities have more residents than regional treatment centers.

Regional Treatment Center	1989 Average Of Patients With Mental Illness	Rule 36	Number of Adults With Mental Illness
Anoka	237	Andrew Care Home (Minneapolis)	210
Brainerd	76	Familystyle Homes (St. Paul)	108
Fergus Falls	100	Hoikka House (St. Paul)	108
Moose Lake	80	Guild Hall (St. Paul)	76
St. Peter	160		
Willmar	275		

Source: Governor's 1990-91 Biennial Budget; Program Evaluation Division interviews with Rule 36 staff. The number of Rule 36 residents shown is the number at the time of our visits.

By comparison, the average community facility for adults with mental retardation has 14 residents. Compared with small Rule 36 facilities, we observed that the larger Rule 36 facilities tend to be less homelike, have fewer staff per resident, and offer residents fewer opportunities to use independent living skills.

We found that most residential facilities are in locations that provide convenient access to community services. However, residents' participation in community life may be hindered by lack of transportation, restrictions on telephone use, problems with neighborhood safety, and the facilities' program schedules. For example, about one-third of the Rule 36 facilities we visited are not accessible to public transportation, and about one-third have at least 20 residents per resident telephone.

Another indicator of treatment quality is the quality of staff that facilities are able to retain. We compared staffing patterns in Rule 36 facilities and regional treatment centers and found that:

Compared to regional treatment centers, Rule 36 salaries are low and turnover is high.

- **Rule 36 turnover rates are five times as high as the rates for comparable RTC employees.**

It is likely that turnover rates are related to salary and benefit levels. We found that, on average, Rule 36 salaries are 36 percent lower than those of regional treatment center employees with comparable duties. In addition, Rule 36 full-time employees are less likely than their RTC counterparts to have pension benefits, and part-time Rule 36 employees are less likely to have pensions, health insurance, and paid days off. The salary and benefit levels may reflect the fact that most Rule 36 employees are not members of unions. Also, the Department of Human Services has primarily used recent increases in state program funds to start new facilities, not to significantly increase existing facilities' program budgets.

There is too little state oversight of board and lodging facilities.

Finally, we examined the quality of many "board and lodging" facilities that are not licensed by the Department of Human Services to provide mental health treatment. These facilities are supposed to have Rule 36 licenses if they serve more than five adults with mental illness, unless these residents have been offered and refused treatment. We visited many facilities violating this requirement. In addition, some of the board and lodging facilities provide services similar to those offered in treatment facilities, but they are not subject to comparable state regulation. We also found that staff in most board and lodging facilities handle resident medications (in violation of state rules at the time of our visits), and some facilities have inadequate living conditions.

CLIENT OUTCOMES IN COMMUNITY TREATMENT FACILITIES

According to research literature we reviewed, none of the studies which compare hospitalization with alternative care for adults with mental illness have found hospitalization to yield more favorable outcomes. While there are instances in which hospitalization is appropriate, the research we reviewed supports the continued use of community services for most people with mental illness. Unfortunately, research has not clearly indicated which alternatives to hospital care are more effective than others.

To measure program effectiveness, researchers often compare clients' rates of psychiatric hospitalization before and after their treatment. Many clients are not hospitalized immediately before or after Rule 36 treatment, but from our review of hospitalization rates for 240 Rule 36 clients, we found that:

- **On average, client hospitalization rates in the six months following Rule 36 discharge are about half of the rates in the six months preceding Rule 36 admission.**

Hospitalization rates decline following Rule 36 stays.

Days in the Hospital Before, During, and After Rule 36 Stays

	Days In Community Hospitals	Days In Regional Treatment Centers	Total Days In Hospital
Before Rule 36 Stay (6 mos.)	1,354	6,320	7,674
During Rule 36 Stay (average: 10 mos.)	567	37	604
After Rule 36 Stay (6 mos.)	680	3,066	3,746

Source: Program Evaluation Division analysis of Medical Assistance and regional treatment center records for 243 clients admitted to Rule 36 facilities after June 1984 and discharged in the last six months of 1987.

The findings are encouraging, although it is important to caution that factors other than Rule 36 treatment might account for these reductions.

Treatment programs can also be assessed by the extent to which they help their residents live more independently and find employment. We found that, on average, Rule 36 facilities discharge clients to more independent living arrangements than those from which they were admitted. In addition, Rule 36 residents are more likely to be working when they leave a facility than when they enter it, although the increase in full-time competitive employment is small. Unfortunately, the Department of Human Services presently lacks reliable means of tracking these outcome measures beyond the date of discharge.

Another measure of program effectiveness is client satisfaction. We met with about 70 current Rule 36 residents and surveyed some former Rule 36 residents to give us a better understanding of their views. Most residents told us they find the facilities at least somewhat helpful and generally prefer the facilities to other housing options presently available. However, we heard some concerns about lack of privacy, disrespectful treatment, and difficulty getting needed services. Also, many residents would rather be living on their own with supportive services.

FINANCIAL ISSUES

Many people with mental illness are unemployed, so they receive assistance payments from the state and federal governments. The primary state assistance programs are General Assistance (GA) and Minnesota Supplemental Aid (MSA). State law authorizes counties to contract with facilities to provide living quarters for GA and MSA recipients at reimbursement rates negotiated by the counties and facilities. The Legislature froze these rates in 1985, except for inflation adjustments. All Rule 36 facilities are "negotiated rate facilities," as are many of the state's board and lodging facilities not licensed to provide mental health treatment. We found that:

State room and board payments are inequitable.

- **Individuals living in negotiated rate facilities usually receive larger state assistance payments for room and board than individuals living elsewhere.**

We think it is inequitable for the state's level of public assistance for room and board to depend on where a person lives. Currently, a GA recipient living in a facility with a monthly negotiated rate of $600 per client would receive a state subsidy of about $600 per month for room and board. In contrast, a GA recipient living in an apartment would receive about a $200 state subsidy. This disparity results largely from the fact that room and board payments to people in negotiated rate facilities are determined by counties, while payments to people living elsewhere are determined by the state.

Another financial issue is the state's accountability for Rule 36 costs. We concluded that:

- **There is inadequate state oversight and control of Rule 36 expenditures.**

There is little state scrutiny of room and board costs.

First, state officials do not receive useful reports of actual Rule 36 expenditures. Costs are reported to the state in categories that are poorly defined, making comparisons of facility costs virtually impossible. Counties and Rule 36 facilities sometimes categorize costs in ways that maximize the state revenues they can receive, which undermines the comparability of expenditure data from one facility to the next. Second, there is little state auditing or review of actual Rule 36 expenditures, in contrast to the oversight given to costs in comparable facilities for adults with mental retardation. Third, although the state pays most Rule 36 "room and board" costs, state officials have not scrutinized these costs because they have not been involved in negotiating room and board reimbursement rates. Counties have negotiated room and board costs, but without state guidelines. Thus, for example, there has been little state oversight of property costs, which are a primary source of profit for Rule 36 owners.

We also learned that counties often fund only a small portion of the costs of Rule 36 treatment. State law requires the state to pay 75 percent of program costs and does not designate a funding source for the remaining 25 percent. State rules refer to this remainder as the "local share." Although many counties pay for the local share with their own tax dollars or social service block grant funds, it is not unusual for the local share to be paid by General Assistance or Minnesota Supplemental Aid, which consist primarily of state dollars.

RECOMMENDATIONS

Although the Legislature had hoped that a high quality community mental health system would be in place by 1990, it is apparent to us that the present system is neither comprehensive nor accountable. Mental health services remain unavailable to many people living on their own, and there is little state-level quality assurance for the services that exist. The problems are serious, but we think solutions are available. Among our key recommendations are the following:

State-level quality assurance efforts must improve.

- **The Legislature's immediate funding priorities should be (1) additional case management, (2) supportive services that are not tied to residence in a facility, including continued funding for the state's housing support services pilot projects, and (3) additional staff in Rule 36 facilities serving "difficult" clients, rather than the funding of new Rule 36 beds.**

- **The Department of Human Services and the Office of the Ombudsman for Mental Health and Mental Retardation should more closely monitor the quality of individual treatment plans and community support plans. This may require additional resources.**

- **To ensure that clients' plans are better suited to their needs, the Department of Human Services should provide more technical assistance to county case managers and staff in community facilities. There is a particular need for a treatment planning handbook that outlines the characteristics of appropriate plans and suggests possible service strategies for various types of clients.**

- **The Department of Health should clarify its medication rules in various types of facilities and ensure more consistent enforcement of these rules.**

- **The Legislature should require county case managers to arrange for standardized assessments of side effects for all their clients who are on psychotropic medications. Facilities that store medications for their residents should arrange for or conduct these assessments for any residents that do not have a county case manager.**

- **The Legislature should require "board and lodging" facilities to have Rule 36 licenses if they provide treatment for residents, but it should repeal requirements that board and lodging facilities have licenses if they house more than five adults with mental illness. The Department of Human Services should develop a definition of treatment that Department of Health inspectors can use to determine whether board and lodging facilities require human services licenses.**

- **The Legislature should extend relevant portions of the Vulnerable Adults Act and patients' bill of rights to residents of board and lodging facilities with "health supervision" and "supportive services" licenses. Board and lodging facilities should annually report the number of residents for whom they store psychotropic medications, and the authority of the Ombudsman for Mental Health and Mental Retardation should be extended to persons that take psychotropic medications in these facilities. The Office of Health Facility Complaints should be authorized to receive and investigate complaints about board and lodging facilities.**

- **The Department of Human Services should require large Rule 36 facilities to reduce their populations in the next few years to levels commensurate with other facilities.**

- **The Legislature should consider replacing its system of "negotiated rate facilities" with a voucher system that GA and MSA recipients can use to obtain room and board. If recipients require additional supportive services, as determined by county assessment, these should be available regardless of where clients choose to live. Not only should these services be available in each county, they should also be provided at the clients' homes as needed, within reasonable limits.**

The Legislature should consider a voucher system for room and board payments.

- **The Department of Human Services should rewrite rules governing funding for residential programs and should scrutinize expenditures more closely. The department should collect better information on property expenditures, and the Legislature should implement safeguards against frequent sales of residential facilities.**

If the Legislature funds the additional community services that we have recommended (more case managers, more supportive services regardless of where clients live, higher staffing in certain Rule 36 facilities), the cost of community services relative to regional treatment centers will increase. Currently,

community treatment appears to be less expensive per client than treatment in regional treatment centers, largely due to lower salary and staffing levels. We think additional investment in community services is warranted by (1) research supporting the efficacy of community programs, (2) the legal right of most clients to live where they choose, (3) the apparent preference of clients for community-based rather than institution-based services, and (4) evidence that clients are not getting all services they need in the community.

INTRODUCTION

Chapter 1

Adults with mental illness live in a variety of community settings: in treatment facilities, on their own, with friends and family, and in hospitals. In recent years, the Legislature has tried to create a more coordinated, accessible array of services to meet their needs. This report focuses on residential settings in which the state has a funding or regulatory role. Also, because many clients need continued services after they leave a residential facility (such as case management and medication monitoring), we examined the availability of these types of services. The following sections provide an overview of community residences that serve adults with mental illness, the state's role in these facilities, and recent legislative actions.

TYPES OF MENTAL ILLNESS

Mental illnesses do not lend themselves to precise or completely objective definitions. State law defines mental illness as "an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior...that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation."[1] The law requires that the illness meet the definitions of at least one of two clinical manuals used extensively by the psychiatric profession.[2] Mental health professionals usually make determinations of mental illness by documenting behaviors, not by administering standardized tests.

Not all mental illnesses are disabling, and some are brief rather than long-term. As a result, state law supplements the general definition of mental illness with a definition of "serious and persistent mental illness," as shown in Figure 1.1. In contrast, "acute" mental illness usually refers to serious but short-term episodes of mental illness, and care for acutely ill people typically occurs in hospitals.

---

1 *Minn. Stat.* §245.462, Subd. 20.

2 These manuals are (1) the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, and (2) the clinical manual of the International Classification of Diseases.

Figure 1.1: Criteria For A "Serious And Persistent" Mental Illness

(1) The adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months, or

(2) The adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months, or

(3) The adult:

  (a) Has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder,

  (b) Indicates a significant impairment in functioning, and

  (c) Has a written opinion from a mental health professional stating that future episodes of inpatient or residential treatment of the frequency described in (1) or (2) is likely without ongoing community support services, or

(4) The adult has been committed by a court as a mentally ill person under Minn. Stat. §253B, or such a commitment has been stayed or continued.

Source: Minn. Stat. §245.462, subd. 20.

Two common mental illnesses are schizophrenia and affective disorders.

Two common and often disabling types of mental illness are schizophrenia and affective disorders. As with most major mental illnesses, schizophrenia appears to be caused by a combination of genetic and environmental factors. In other words, social stresses and other life events may trigger schizophrenia in people born with a vulnerability to develop this illness. People with schizophrenia often have delusions, hallucinations (such as hearing voices), and odd social behavior. Schizophrenic behaviors usually come and go over time, and they are rarely exhibited 24 hours a day.[3] At any given time, about 0.7 percent of the U.S. population have a schizophrenic disorder.[4]

Affective disorders are a second common form of mental illness. Most people respond to pleasant events with happiness and unpleasant events with sadness. People with affective disorders respond to life events with inappropriate or extreme emotions, or they experience mood swings from one emotional extreme to another. Such people are often referred to as "depressed" or

3 Robert Liberman, et al., "The Nature and Problem of Schizophrenia," in *Schizophrenia: Treatment, Management, and Rehabilitation,* ed. Alan Bellack (Orlando: Grune and Stratton, 1984), p. 28.

4 Darrel A. Regier, et al., "One-Month Prevalence of Mental Disorders in the United States," *Archives of General Psychiatry*, November 1988, p. 981.

"manic." At a given time, more than six percent of the U.S. population have affective disorders.[5]

Other types of mental illness include anxiety disorders (characterized by phobias, panic, or obsessive behaviors), dependence on drugs or alcohol, and personality disorders.[6]

The most comprehensive study to date suggests that about 15 percent of Americans have a mental disorder at a given time, and about one-third will have a mental disorder sometime during their lifetime.[7] Most people affected by these illnesses need coping skills and support from others, although they do not necessarily need lengthy treatment or rehabilitation.

Even the most seriously ill people have potential for recovery.

Our review of research literature indicates that, contrary to long-standing assumptions, there is real potential for improvement and recovery among many of the most severely disabled people. Some people's symptoms go into remission, whereas other people learn effective ways to cope with their illness. For example, a clinical team at the Vermont State Hospital selected 269 patients in the late 1950s who were believed to be among the hospital's most severely disabled residents. These patients had not responded positively to drug therapy. Since their placement in community treatment and services more than 30 years ago, one-half to two-thirds have achieved considerable improvement or recovery, and this is consistent with several similar studies of people who were severely disabled.[8] A recent review of literature concluded that mental illness is not necessarily life-long, and that many people with severe mental illness can maintain jobs, housing, and good social relationships despite their psychiatric symptoms.[9] However, some observers caution that the long-term studies should not mislead clinicians to expect short-term results that are beyond the individual capabilities of clients, nor should clinicians assume that each person will make long-term progress.[10]

---

5 Regier, et al., "One-Month Prevalence of Mental Disorders," p. 981.

6 Alcohol and drug abuse are not included in Minnesota's statutory definition of mental illness, but the prevalence estimates in the next paragraph include them.

7 Regier, et al., "One-Month Prevalence of Mental Disorders," p. 981.

8 Courtenay M. Harding, et al., "The Vermont Longitudinal Study of Persons with Severe Mental Illness, I: Methodology, Study Sample, and Overall Status 32 Years Later," *American Journal of Psychiatry*, June 1987, pp. 718-726. Studies in Iowa, Switzerland, and West Germany have yielded similar results.

9 Susan F. Wilson, "Community Support and Community Integration: New Directions for Client Outcome Research" (University of Vermont Center for Change Through Housing and Community Support: June 1988), p. 6.

10 H. Richard Lamb, "Deinstitutionalization at the Crossroads," *Hospital and Community Psychiatry*, September 1988, pp. 941-945.

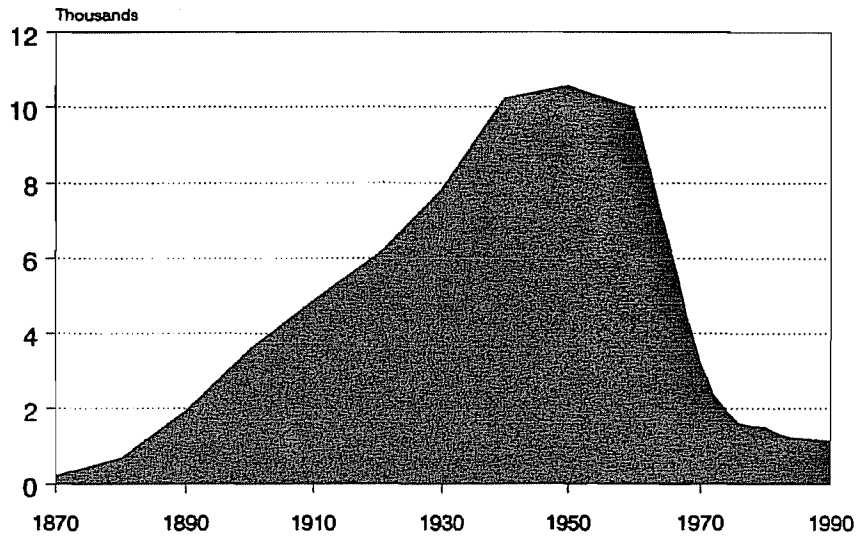
DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS

Until the mid-1850s, care and treatment of people with mental illness in the United States was typically a local responsibility. Such people lived in boarding houses, workhouses, and jails. However, living conditions were often poor, so states began to assume responsibility for mentally ill people and built large institutions that could provide "moral treatment."

The state of Minnesota opened its first hospital for people with mental illness in 1866 at St. Peter. By the 1950s, Minnesota state hospitals had 10,000 beds for people with mental illness and were the principal service providers for this population. Since then, as shown in Figure 1.2, there has been a dramatic reversal of past reliance on state hospitals (now called "regional treatment centers") for mental health treatment.[11] The reasons for this "deinstitutionalization" in Minnesota and other states include the following:

Institutionalization peaked in Minnesota in the 1950s.

Figure 1.2: Patients with Mental Illness in Regional Treatment Centers



Source: Department of Human Services

- In the 1950s, psychotropic drugs were developed to help manage psychotic symptoms and permit people with mental illness to lead more normal lives.

- There were increasing concerns about the effects of institutions on residents, and social reformers believed that disabled people should live in "normalized" living settings and the "least restrictive environments" possible.

11 Many people went to nursing homes after leaving state hospitals. However, nursing homes are better equipped to address physical than mental disabilities, and the state is now trying to ensure that persons with primary diagnoses of mental illness are not living in nursing homes.

- There was concern about the physical deterioration of some state hospitals and the cost of upgrading them.

State laws and court rulings have reinforced the deinstitutionalization movement in Minnesota. The 1957 Legislature passed the Community Mental Health Services Act, authorizing the development and funding of community mental health programs.[12] The act was similar to federal legislation passed in 1963 establishing community mental health centers nationwide. In the 1967 Hospitalization and Commitment Act, the Legislature said that involuntary hospitalizations of people with mental illness must be preceded by "careful consideration of reasonable alternative dispositions."[13] In 1974, the U.S. District Court, District of Minnesota, declared that people with mental retardation committed to state hospitals have a right to treatment and care in the least restrictive setting appropriate to their mental and physical abilities.[14] This case was widely assumed to pertain to other disability groups as well. The 1976 Legislature amended the state's housing finance agency law to endorse deinstitutionalization for people with mental illness and other disabilities. The law declares that people with mental illness are "better served through the development of a comprehensive, community based system of treatment and care which requires the availability of adequate financing for the construction, renovation, or rehabilitation of residential care facilities as well as sufficient funds for their operational start-up costs."[15]

State laws and court rulings have supported deinstitutionalization.

During the past decade, Minnesota has developed a network of mental health treatment facilities and services in the community. Meanwhile, the state continues to operate six regional treatment centers that provide inpatient care to adults with mental illness. Table 1.1 indicates the size and average length of stay of each of these centers. Although the number of people in the state's re-

Table 1.1: Regional Treatment Center Populations and Lengths of Stay, 1988

Regional Treatment Center	1988 Average Daily Population of Persons With Mental Illness	Average Length of Stay Among Patients Discharged in 1988 (days)
Anoka	236	275
Brainerd	72	34
Fergus Falls	100	164
Moose Lake	72	99
St. Peter	161	178
State Security Hospital	223	NA
Willmar	264	129

Source: Governor's 1990-91 Biennial Budget.

Note: Includes both adults and children.
NA = Not available.

12 *Minn. Laws* (1957), Ch. 392.

13 *Minn. Stat.* §253A.07, Subd. 17.

14 *Welsch v. Likens*, 373 F. Supp. 487 (District of Minnesota), 1974.

15 *Minn. Stat.* §462A.02, Subd. 9.

Readmissions to regional treatment centers are quite common.

gional treatment centers at any given time is much smaller now than it was 30 years ago, readmission rates are quite high. A recent evaluation of regional treatment center discharge planning revealed that two-thirds of the patients discharged in 1984 had been in a regional treatment center at least once previously for treatment of a mental illness. About one-fifth of the patients discharged in 1984 were readmitted within 90 days.[16] Although relapses are not uncommon among people with mental illness, the study concluded that the high level of readmissions was partially due to inactive involvement by county case managers in regional treatment center discharge planning and lack of community support services. Mental health professionals also suggest that the patients in regional treatment centers today are relatively more ill than patients in the centers several years ago, thus increasing the likelihood of readmission.

Figure 1.3 shows the array of possible community residential settings that could be available to people with mental illness. These settings differ in the types of services and amount of structure and support they are able to offer residents. Most states do not have all of the residential settings noted. The settings most widely available in Minnesota, as discussed in Chapter 2, are community hospitals, treatment programs, boarding homes, and independent living. The figure at right lists some of the support services that clients with mental illness often need in the community.

COMMUNITY MENTAL HEALTH SERVICES

- County case management
- Social and recreation programs
- Medication administration or monitoring
- Group therapy
- Individual therapy, evaluation, and counseling
- Vocational training and supported employment
- Training in independent living skills or apartment living
- Emergency and crisis services (including mobile outreach teams)
- Peer support groups
- Education and prevention services

THE STATE'S ROLE IN COMMUNITY RESIDENCES FOR ADULTS WITH MENTAL ILLNESS

Community residences for adults with mental illness are mainly privately owned and operated. The state, however, helps to fund the residences and regulates their facilities and programs. The state funds treatment programs and makes assistance payments to low income residents for room and board. It also regulates treatment programs through the Department of Human Ser-

16 Office of the Legislative Auditor, *Deinstitutionalization of Mentally Ill People*, February 1986.

Possible living arrangements are varied and diverse.

Figure 1.3: Places Where Adults with Mental Illness Might Live in the Community

- **Community Hospitals:** Inpatient psychiatric care has usually been used to provide short-term (two to three week) treatment of acutely ill persons. Minnesota has about 30 community hospitals with psychiatric services.
- **Quarterway House:** Hospital patients begin preparing for community life by living in small group residences, often on hospital grounds. Minnesota has no quarterway houses.
- **Group Homes for People in Crisis:** These homes serve acutely ill people in non-hospital settings. They usually provide respite from difficulties that are contributing to a worsening of a person's mental illness. There are a few of these facilities in Minnesota.
- **Treatment Programs (or "Rule 36 facilities" in Minnesota):** These are group residences that help people learn about their illness and possible coping skills. Typically, such homes have professional mental health staff and 24-hour supervision. These programs might also be oriented toward providing residents with education or vocational training. Minnesota has 82 Rule 36 facilities.
- **Respite Care Homes:** Sometimes people who are leaving a hospital need time to develop long-range plans or are on waiting lists for other housing options, and respite facilities provide temporary residence. Minnesota has two respite facilities, both in the Twin Cities metropolitan area.
- **Fairweather Lodges:** People live and work together in a supportive, communal setting, usually after receiving job skills training. Residents make their decisions as a group and do not have live-in staff. There are six of these lodges in Minneapolis and St. Paul.
- **Supported Apartments:** Mental health staff provide regular supportive services to people living in scattered site apartments, although staff usually do not live in the home. Residents may lease apartments from the providers, or they may be able to receive services in the housing option of choice. In Minnesota, there are 700 supported apartments, at most.
- **Foster care:** Providers are paid to offer room, board, and minimal services to people in a normal, homelike setting. Typically the resident lives in the provider's home with other family members. Foster care is rarely used in Minnesota because counties have had difficulty recruiting providers.
- **Boarding homes:** Some of these group residences provide just room and board for residents, while others provide personal care, supervision, and perhaps medical services. There are more than 100 boarding homes in Minnesota that serve adults with mental illness (the precise number is not known).
- **Chronic care settings:** Nursing homes and intermediate care facilities are examples. Their focus tends to be on personal care and supervision, rather than treatment or rehabilitation.
- **Independent living:** Most people with mental illness live on their own or with families. They usually must go outside the home to receive services. As discussed in Chapter 2, this is the most common living arrangement for people discharged from psychiatric inpatient care.

vices, and regulates facilities' physical characteristics and health-related services through the Department of Health.

State Regulation and Program Funding in Treatment Facilities

The 1971 Legislature authorized the Department of Human Services (then called the Department of Public Welfare) to "license and regulate day care and residential facilities for the mentally ill, inebriate, and physically handicapped."[17] In response, the department promulgated what is commonly referred to as "Rule 36" in 1974.[18] Although the department originally estimated that 150 facilities might be eligible for Rule 36 licensure, very few facilities obtained licenses during the 1970s.[19] As a result, the 1981 Legislature authorized additional funding for Rule 36 facilities, and the department promulgated a rule ("Rule 12") to govern this funding.[20]

Minnesota has 82 "Rule 36" treatment facilities.

State law requires that residential programs for five or more persons with a mental illness be licensed by the Department of Human Services. Currently, 82 facilities with a total of 1,700 beds have Rule 36 licenses.[21] State rules require these facilities to provide or arrange for the following services for their residents: case management, crisis services, independent living skills training, mental health therapy, motivation and remotivation services, recreation and leisure services, socialization, support groups, social services, and vocational services.

Facilities are supposed to complete a diagnostic assessment of residents within five days of admission, or update an assessment done within 90 days before admission. During a resident's first 10 days at a Rule 36 facility, program staff must work with the resident to write goals that address immediate needs. Within 30 days of admission, staff must work with the resident to develop an individual program plan to meet longer-term needs. The plan must include:

- an assessment of the resident's strengths and needs;
- a prioritized list of goals;
- goal-related objectives that are specific, measurable, and time-limited;

---

17 Minn. Laws (1971), Ch. 627.

18 The state no longer numbers rules in this way, but the term "Rule 36 facility" remains in common use. Rule 36 is now contained in *Minn. Rules* Ch. 9520.0500 to 9520.0690.

19 There were 10 facilities licensed under Rule 36 in 1980, including two state hospitals. Many existing facilities serving mentally ill adults feared that licensure under Rule 36 would make them "institutions for mental diseases," thus rendering them ineligible for federal Medical Assistance funding. Other facilities did not want to incur costs required to comply with Rule 36 standards.

20 "Rule 12" is now *Minn. Rules* Ch. 9535.2000 to 9535.3000.

21 Department of Human Services, Mental Health Division, *Report to the Legislature on Grants to Counties for Adults with Serious and Persistent Mental Illness*, January 1989. The number of facilities varies from one source to another because some licenses cover more than one building.

- strategies for accomplishing the goals and objectives;
- names of people who will help the resident implement various parts of the plan; and
- progress notes.

Staff must review the plan with residents at least once every three months.

Category I facilities provide most services "in-house."

There are two categories of facilities. According to state rules, "Category I" facilities should emphasize provision of services "in-house," and "Category II" facilities should encourage clients to use more outside resources. In addition, Category I programs must have at least one full-time-equivalent mental health staff for every 5 residents, and Category II programs must have at least one for every 10 residents.

Facilities which received their initial licenses after June 1980 can have no more than 25 beds. The rules set size limits on facilities licensed before this time (40 for Category I, 25 for Category II), but the limits may be exceeded if the facility is divided into "living units" of no more than 25 beds each. Each living unit must provide a living room or lounge area for its residents. Currently, four Rule 36 facilities have more than 40 beds, and the largest has 210.

Rules 12 and 14 govern most program funding.

Two state rules--Rules 12 and 14--govern most "program" funding for Rule 36 residents. "Rule 12" regulates funding for programs offered on site at most Rule 36 facilities. Table 1.2 shows a history of the number of facilities funded under Rule 12. According to state law, grants made under Rule 12 by the Department of Human Services shall finance 75 percent of the counties' costs of expanding or providing program services in residential facilities. The amount of the department's Rule 12 grants varies widely, ranging from $8 per resident per day (Guild Hall, St. Paul) to $256 (Journey House, Minneapolis). Chapter 6 discusses these variations in more detail. Several Rule 36 facilities receive no Rule 12 funds.[22] Reports filed by counties with the Department of Human Services indicate that salaries and benefits account for about 60 percent of facilities' total expenditures.

"Rule 14" regulates funding for community support services in all 87 counties.[23] Counties use Rule 14 funds to establish drop-in centers, classes, and services in the community for adults with mental illness. Rule 36 residents--especially those in Category II facilities--often attend programs funded under Rule 14, but the Rule 14 programs also serve many other clients. The Department of Human Services estimates that counties spent about $7 million in Rule 14 funds in 1989.

---

22 Andrew Care Home in Minneapolis has 10 beds that are Rule 12 funded, but about 200 others are funded through a room and board rate established in statute. Four group homes in Faribault have Rule 36 licenses but serve only private-pay clients (most from outside Minnesota). The daily rate charged to residents of the Faribault facilities, including both program and room-and-board costs, is about $440.

23 "Rule 14" is now *Minn. Rules* Ch. 9535.0100 to 9535.1600.

Table 1.2: History of Rule 12 Funding

	1982	1983	1984	1985	1986	1987	1988	1989
Number of Counties with Rule 12 Funded Facilities	5	13	13	29	30	31	34	34
Number of Facilities Funded	19	48	48	70	73	73	76	76
Total Rule 12 Grants (millions of dollars)	$0.7	$3.7	$4.9	$6.5	$8.2	$9.2	$9.9	$10.8
Percent of Rule 12 Grants Going to Hennepin and Ramsey Counties	72%	66%	61%	56%	56%	53%	52%	51%

Source: Department of Human Services, Mental Health Division.

State Health Department Regulation

Facilities housing adults with mental illness usually have one of three health licenses.

Facilities with five or more beds that offer lodging to people with mental illness usually have one of three licenses from the Minnesota Department of Health or local health departments: (1) board and lodging, (2) supervised living facility, or (3) boarding care.[24]

As defined by state rules, "board and lodging facilities" provide meals and sleeping accommodations for five or more people for a period of one week or more. State rules regulate cleanliness, space requirements, food storage, and building characteristics.[25] Currently, state law only authorizes "health supervision services" (such as medication handling) in board and lodging facilities if a licensed nurse is on site at least four hours a week.[26] There are no other staffing requirements for board and lodging facilities.

"Supervised living facilities" provide supervision, meals, lodging, and housekeeping services to five or more people who are mentally retarded, chemically dependent, mentally ill, or physically handicapped. All such facilities must be licensed by the Department of Human Services to provide programs for their residents. The residents must not need ongoing medical or nursing care. Like board and lodging facilities, supervised living facilities are subject to regulations governing cleanliness, building characteristics, and food storage. But, unlike most board and lodging houses, supervised living facilities are authorized

24 "Board and lodging" facilities actually have two health department licenses, one for boarding and one for lodging. For simplicity, we discuss board and lodging facilities as a single category of licensure, since most lodging houses have both licenses.

25 Minn. Rules Ch. 4625.

26 Minn. Laws (1989), Ch. 282, Art. 2, Section 49.

to provide a wide array of health and supportive services. For example, the rules authorize supervised living facilities to store and administer medications, and the facility must keep health records for all residents. The rules state that supervised living facilities should provide a "homelike" setting for their residents.[27]

"Boarding care facilities" provide care, meals, and lodging for "aged or infirm people who require only personal or custodial care and related services."[28] Residents must not need ongoing nursing services, and there must be a program of supervision and activities for residents incapable of properly caring for themselves. Boarding care homes may provide "supervision over medications which can be safely self-administered." They may provide help with bathing and dressing. Boarding care facilities are authorized to store resident medications, and "all medications shall be distributed and taken exactly as ordered by the physician." Facility staff must record information on all medications distributed to residents. There are extensive rules regarding the physical plant and cleanliness of these facilities.

Facilities with any of these three health licenses may also have a program license from the Department of Human Services, although only supervised living facilities are *required* to have a program license. Figure 1.4 illustrates the complicated licensing structure for facilities housing mentally ill adults. For the most part, Category II Rule 36 facilities have board and lodging facility licenses and Category I facilities have supervised living facility licenses.

Figure 1.4 shows that about 400 board and lodging facilities do not have a Rule 36 program license.[29] These facilities are noteworthy because they are subject to minimal regulation, yet it is clear from our site visits and discussions with counties that many house people with mental illness.

It is virtually impossible to determine how many adults with mental illness live in board and lodging facilities because (1) the definition of mental illness is not precise, (2) facility operators often do not inquire about the health history of residents, and (3) facilities do not report information on their residents to the state. State law requires residential programs with five or more persons with mental illness to have a human services program license. However, until July 1990, this requirement does not apply to board and lodging facilities that provide service to more than five people with a primary diagnosis of mental illness who have refused an appropriate residential program offered by a county agency.[30] The 1988 Legislature asked the Department of Health to recom-

---

27 Minn. Rules Ch. 4665.

28 Minn. Rules Ch. 4655.

29 Minnesota Department of Health, *A Report to the Legislature Regarding the Monitoring of Boarding Care Homes and Board and Lodging Houses*, p. 11. Some of these facilities primarily serve people whose room and board is paid by state assistance programs. The Department of Human Services is presently conducting a survey to find out how many of these facilities there are.

30 Minn. Laws (1989), Ch. 282, Art. 2, Section 67. The Legislature extended an earlier deadline of July 1989.

It is unclear how many adults with mental illness live in facilities without Rule 36 licenses.

Figure 1.4: Licensure of Facilities Serving Adults With Mental Illness

Department of Health License:	Does facility have a Rule 36 license? Yes	No
BOARD AND LODGING	**33 Facilities** (all are Category II)	**400 Facilities**[1]
SUPERVISED LIVING FACILITY	**40 Facilities** (all but three are Category I)	Not applicable–few have any adults with mental illness
BOARDING CARE	**6 Facilities** (4 Category II, 2 Category I)	**44 Facilities**[1]

Source: Minnesota Department of Human Services, Mental Health Division, Report to the Legislature: Grants to Counties for Adults with Serious and Persistent Mental Illness, January 1989, as amended by information gathered on Program Evaluation Division site visits; Minnesota Department of Health, A Report to the Legislature on the Monitoring of Boarding Care Homes and Board and Lodging Houses, March 1989.

[1]This does not include student housing or facilities with corrections or other program licenses. It is unclear how many of these facilities house adults with mental illness. Some of these are negotiated rate facilities, but presently there is no data to indicate how many.

Note: Three Rule 36 facilities do not fit neatly into this matrix. Familystyle Homes of St. Paul has a single Rule 36 license, but it has 21 beds that are licensed as Category I - boarding care, and 91 beds that are licensed as Category II - board and lodging. Guild Apartments of St. Paul and Northwestern Apartments of Crookston have Category II Rule 36 licenses but no Department of Health licenses.

mend means of enforcing this requirement.[31] The department suggested several options, each costing about $250,000 per year, but the 1989 Legislature did not fund or mandate any of these.

During our study, we visited 19 board and lodging facilities around the state, and all but one had more than four residents who staff said were mentally ill.[32] While facility staff indicated that many of their residents had been through Rule 36 programs before living in the board and lodging facility, staff rarely said their residents had refused treatment, and they were usually unable to tell precisely how many residents had refused a residential program. Based solely on the estimates of facility staff, nearly half of the 700 beds in these 19 facilities were occupied by mentally ill adults. There are about 400 board and lodg-

31 Minn. Laws (1989), Ch. 411.

32 To select these facilities, we asked county mental health staff to identify facilities where adults with mental illness were living. County staff often were unsure how many people with mental illness were at the board and lodging facilities, so the facilities we selected were ones that county staff said housed at least several such people.

ing facilities that we did not visit, and it is likely that these facilities house hundreds of adults with mental illness.

State Payment of Room and Board in Negotiated Rate Facilities

The state pays most room and board costs.

A final role of the state in group residences serving adults with mental illness is payment of room and board expenses. Many people with mental illness receive income assistance from one of three programs. Supplemental Security Income (SSI) is a federal program for elderly, blind, and disabled people, and Minnesota Supplemental Aid (MSA) augments SSI to guarantee income equal to state-determined need levels. MSA is 85 percent state-funded and 15 percent county-funded until 1992, when the state will pay 100 percent. A third program, General Assistance (GA), provides a monthly grant for low income people. The state pays 75 percent of GA costs (and counties 25 percent) until 1992, when the state will pay 100 percent.

Many board and lodging, supervised living, and boarding care facilities in Minnesota are "negotiated rate facilities." This means that a facility negotiates a rate for room and board with the county in which it is located. The rate is recognized as the amount needed for residents' basic subsistence for purposes of determining residents' MSA or GA payments. MSA or GA pays the difference between this rate and the resident's other income sources. For example, if a GA recipient lives in a facility with a rate of $700 per month, GA usually pays this full amount since most GA recipients have no other income sources. Chapter 6 discusses the amount of state income assistance that residents in various living arrangements receive.[33]

Because of a freeze that the Legislature placed on most facility rates in 1985, rates are actually not "negotiated" by counties and facilities today. Instead, facilities receive inflation-related increases in their rates each year, using the 1985 rate as the base. The 1985 Legislature set an $800 maximum on these rates; this maximum was $920 in 1989.[34]

SSI, MSA, and GA are the primary income sources for about two-thirds of Rule 36 residents at the time they are discharged.[35] In 1989, Minnesota's MSA and GA programs will fund about $10 million in Rule 36 room and board costs.[36]

---

33 The average monthly MSA payment for residents of negotiated rate facilities is $430 (in addition to $350 from SSI).

34 Facilities entering initial agreements with counties for room and board payments after May 1989 are limited to 90 percent of the maximum statutory rate for room and board.

35 Department of Human services data for clients discharged in 1988.

36 SSI will fund about $4.3 million, according to December 1988 estimates by the Department of Human Services.

RECENT LEGISLATIVE ACTIONS

Legislators have given considerable attention to adults with mental illness in the past four years. Significant changes have been initiated, and many are still being implemented. Through its recent actions, the Legislature has tried to define the mission of mental health services and improve the ability of local communities to provide services.

Recent reports criticized the mental health system.

1986-88

Two reports issued in February 1986 focused legislative attention on problems within the mental health system, and there were efforts in each subsequent legislative session to address the system's shortcomings. The Governor's Mental Health Commission concluded that Minnesota had a "nonsystem" with an unclear mission, poor coordination of services, and a lack of leadership.[37] The Office of the Legislative Auditor found that patients discharged from regional treatment centers often lacked county case management and community support services.[38]

A key action of the 1986 Legislature was passage of a mental health mission statement, shown in Figure 1.5. The Commissioner of Human Services was directed to create a "unified, accountable, comprehensive mental health service system" by February 15, 1990.

In 1987, the Legislature passed the Comprehensive Mental Health Act and authorized more than $13 million in new funding for mental health services. The act, as subsequently amended, established the following timetable for county implementation of an array of community mental health services:

- **January 1988.** Each county must submit its first two-year "mental health proposal," including outcome goals, estimated number of clients, and estimated expenditures.

- **July 1988.** The Department of Human Services and counties must complete planning for a unified, accountable, and comprehensive mental health system. Each county must provide or contract for enough emergency, outpatient, education, prevention, community support, residential treatment, and acute care inpatient services to meet the needs of county residents.

- **January 1989.** Case management must be available to all persons with serious and persistent mental illness, and caseloads "must be sufficient to serve the needs of the clients." Case managers must develop community support plans for their clients that incorporate the clients' individual treatment plans.

---

37 Mandate for Action: Recommendations of the Governor's Mental Health Commission, February 3, 1986.

38 Office of the Legislative Auditor, *Deinstitutionalization of Mentally Ill People*, February 1986.

The 1986 Legislature defined the mission of the mental health system.

Figure 1.5: Mental Health System Mission Statement

The commissioner shall create and ensure a unified, accountable, comprehensive mental health service system that:

(1) recognizes the right of people with mental illness to control their own lives as fully as possible;
(2) promotes the independence and safety of people with mental illness;
(3) reduces chronicity of mental illness;
(4) reduces abuse of people with mental illness;
(5) provides services designed to:
  (i) increase the level of functioning of people with mental illness or restore them to a previously held higher level of functioning;
  (ii) stabilize individuals with mental illness;
  (iii) prevent the development and deepening of mental illness;
  (iv) support and assist individuals in resolving emotional problems that impede their functioning;
  (v) promote higher and more satisfying levels of emotional functioning; and
  (vi) promote sound mental health; and
(6) provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.

Source: Minn. Stat. §245.461, subd. 2.

The Legislature mandated counties to have coordinated service systems by January 1990.

- **July 1989.** Each county must develop community day treatment services for residents with mental illness.
- **January 1990.** Each county must have a coordinated community service delivery system in place.
- **January 1992.** Counties must screen all persons before they receive publicly funded treatment in a residential facility, acute care hospital, or regional treatment center.

In addition, the 1987 act created a mental health division within the Department of Human Services to "enforce and coordinate the laws" and "oversee and coordinate services to people with mental illness in both community programs and regional treatment centers." The Legislature also created a 30-member state advisory council on mental health to report to the Governor, Legislature, and state agencies about mental health issues. The Legislature established an Office of Ombudsman for Mental Health and Mental Retardation to "promote the highest attainable standards of treatment, competence, efficiency, and justice for people receiving care or treatment." The ombudsman is appointed by the Governor and can be removed only for just cause. The ombudsman presently has 18 staff and an annual budget of $880,000.

The 1987 Legislature asked the Department of Human Services to review the adequacy of Rule 36. The department was instructed to define mental health

treatment in the rules and to "provide in rule for various levels of care to address the needs of persons with mental illness."[39] The Legislature asked the department to assess the housing needs of people with mental illness and report to the Legislature by February 1988.[40]

Regarding board and lodging facilities without human services licenses, the 1987 Legislature said that the Department of Human Services should not make payments to negotiated rate facilities with more than four mentally ill residents if they were licensed after July 1987.[41] Also, the Legislature repealed the only reference to "supportive living residences" in the human services licensing act pending the study of housing needs for adults with mental illness.[42] The term "supportive living residence," although not clearly defined in statute or rule, usually refers to board and lodging facilities certified by counties to provide services for residents beyond food and shelter. Three counties (Hennepin, Ramsey, and St. Louis) have certification processes for such facilities.

The 1988 Legislature fine-tuned the previous year's mental health legislation. The Legislature defined the experience and training requirements for case managers and required clinical supervision of their activities by mental health professionals. The 1988 Legislature also outlined circumstances in which people with mental illness can be committed to community-based treatment by a court.[43]

1989 ACTIONS

The 1989 Legislature mandated reductions in the number of mentally retarded patients in the regional treatment centers from about 1,400 currently to 250 by the year 2000. Many of these residents will be transferred into 95 state-operated community-based residential programs to be developed in the next decade. The Legislature did not mandate a similar plan for mentally ill patients at the centers, but it asked the Department of Human Services to assess all the patients to determine their needs for psychiatric services. Based on this study, the department must develop a comprehensive mental health plan and a capital facilities plan for the regional treatment centers.

The Department of Human Services must develop a comprehensive mental health plan.

The Legislature authorized the department to establish a system of state-operated, community-based services for persons with mental illness, starting in July 1991. The department must evaluate these services and present the results to the 1993 Legislature.

The 1989 Legislature also required board and lodging facilities to get special licenses from the Department of Health if they provide "supportive services" (such as assisting residents with independent living skills, bathing, and arranging appointments) and "health supervision services" (such as assistance with medications). Until permanent rules are developed, such facilities may only

39 Minn. Laws (1987), Ch. 197, Section 3.

40 Minn. Laws (1987), Ch. 197, Section 4.

41 Minn. Laws (1987), Ch. 197, Section 5.

42 Minn. Laws (1987), Ch. 333, Section 20.

43 Minn. Laws (1988), Ch. 623.

provide health supervision services if a licensed nurse is on site at least four hours a week. The departments of health and human services must jointly issue a report by February 1990 recommending the regulation of these facilities.

The Legislature adopted a "housing mission statement" for persons with mental illness. The human services commissioner must ensure that housing services provided as part of a comprehensive mental health system:

- allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;
- allow persons with mental illness to participate actively in the selection of their housing from those living environments available to the general public; and
- provide necessary support regardless of where persons with mental illness choose to live.[44]

In addition, the 1989 Legislature required the Department of Human Services to submit a plan during 1991 for increasing the number of community-based beds and programs for people with mental illness, and to recommend ways to maximize medical assistance coverage for this population.

The Legislature provided guidelines for revision of state mental health rules.

The Legislature also provided some guidelines for revising Rule 36, a process which was started by the Department of Human Services in 1989. The rule must:

> assure that persons with mental illness are provided with needed treatment or support in the least restrictive, most appropriate environment, that supportive residential care in small homelike settings is available for persons needing that care, and that a mechanism is developed to ensure that no person is placed in a care or treatment setting inappropriate for meeting the person's needs. To the maximum extent possible, the rule shall assure that length of stay is governed solely by client need and shall allow for a variety of innovative and flexible approaches in meeting residential and support needs of persons with mental illness.[45]

The Legislature said that these innovative approaches should include "supportive small group residential care, semi-independent and apartment living services, and crisis and respite services."

As noted earlier, many board and lodging facilities receive payments for residents based on rates negotiated with counties. The Legislature mandated the Commissioner of Human Services to establish a comprehensive statewide system of rates for negotiated rate facilities, to take effect in 1992.

---

44 Minn. Laws (1989), Ch. 282, Art. 4, Section 1.

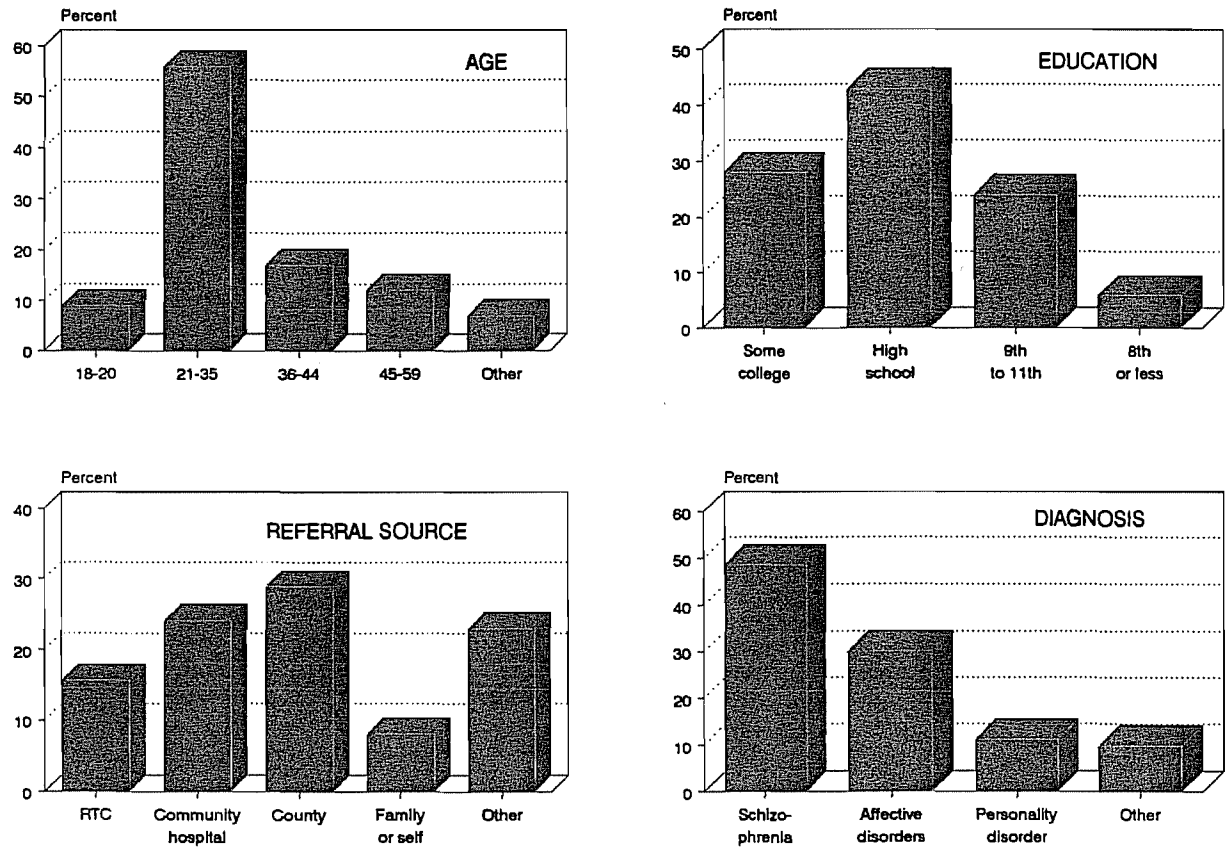
45 Minn. Laws (1989), Ch. 282, Art. 4, Section 61.

The 1989 Legislature also authorized the General Assistance Medical Care program to pay for psychological and case management services for residents of Rule 36 facilities with more than 16 beds. Recently, the federal government deemed such facilities "institutions for mental diseases," thus disqualifying their residents from Medical Assistance coverage.

CHARACTERISTICS OF RESIDENTS IN RULE 36 FACILITIES

Figure 1.6 shows characteristics of clients served in Rule 36 facilities between July 1987 and July 1988, as reported by facility staff.[46] About two-thirds of all clients are under age 36, 56 percent are men, and only about one-fourth have education beyond high school.

Figure 1.6: Characteristics of Rule 36 Residents



Source: Department of Human Services Mental Health Division, Clients Served in Fiscal Year 1988.

46 Department of Human Services Mental Health Division, *Report to the Legislature on Grants to Counties*, January 1989.

On average, people discharged from Rule 36 facilities in 1988 had been there 11 months.

About half of Rule 36 residents have a primary diagnosis of schizophrenia, and about 30 percent have affective disorders. Many residents have disabilities in addition to their mental illnesses. Rule 36 staff report that about 27 percent of the clients also have chemical dependency problems, and 11 percent are mentally retarded. Nine percent of the Rule 36 residents have lived in a regional treatment center for more than five years, and 36 percent have been committed to one of these centers in the past. Nineteen percent of residents require help in taking care of their physical needs.

Pursuant to the so-called "vulnerable adults act," Rule 36 facilities assess new residents to determine whether they may be potential victims or perpetrators of abuse.[47] According to these assessments, 40 percent of Rule 36 residents have been physically, sexually, or financially exploited by others in the past, while 22 percent have exploited others. Staff indicated that more than one-third of Rule 36 residents have attempted suicide or mutilated themselves at some time.

As of July 1988, 43 percent of Rule 36 residents had been living in a given facility for more than one year. For those clients discharged during 1988, the average length of stay statewide was about 11 months. Length of stay varies widely from one facility to the next, partly due to program differences. For example, some facilities are designed and staffed for short-term stays that address crises or provide respite care. Among the 24 facilities we sampled, the average length of stay ranged from 42 days for a facility providing respite services to seven years in another facility.[48]

---

47 Minn. Stat. §626.557.

48 This is the average length of stay for all clients discharged from these facilities in Fiscal Year 1988.

AVAILABILITY OF HOUSING AND SERVICES

Chapter 2

Like any other individuals, adults with mental illness need decent, safe, affordable places to live. In addition, many need supportive services of various types, either occasionally or continuously, to enable them to live in the community. We asked:

- **Where do adults with mental illness live after they are discharged from hospitals?**
- **Are there enough residential treatment beds to serve adults with mental illness in Minnesota?**
- **Are clients able to get necessary support services, regardless of their living arrangements?**
- **Are case management services adequate to provide appropriate support to adults with mental illness living in the community?**

To assess the availability of housing and services, we drew on a number of sources. We surveyed staff who have responsibility for discharging patients from mental health treatment in community hospitals and regional treatment centers. We chose to survey this group because (1) about 40 percent of Rule 36 residents were in a hospital or regional treatment center immediately prior to Rule 36 admission, and (2) hospitalizations are a rough proxy for severity of illness. In addition, we surveyed mental health staff in all 87 counties. Also, during our visits to 24 Rule 36 facilities, we talked to staff and clients and reviewed client files.

Our survey of hospital placement staff consisted of two parts. First, we asked staff to provide general impressions about the availability of residential settings and other services for their discharged patients. Second, we asked hospital staff to complete a questionnaire for each patient discharged from their psychiatric unit during the two-week period from June 5 through June 18, 1989. We asked about characteristics of individual patients which may have caused placement difficulties, the placement process, the type of placement finally made, and staff and patient satisfaction with the placement.[1]

---

1 We sent questionnaires to all 38 community hospitals and regional treatment centers with psychiatric units in Minnesota. We received responses from 22 facilities, giving information on 484 patients. Appendix B provides a summary of responses.

A previous study found that housing and support services are limited.

In October 1987 the Department of Human Services contracted with the firm of Ernst and Whinney for a study of housing needs of persons with severe and persistent mental illness. The final report was presented in February 1988.[2] From its survey of mental health service providers and consumers, the firm observed that both groups, as well as clients' families and advocates, desired a spectrum of housing alternatives which would be able to meet the diverse and dynamic needs of clients. Although clients who responded to the survey reported that their basic needs were being met, they also reported that they (1) had limited housing choices, (2) had little money left after paying for housing and, (3) wanted additional crisis services and other mental health support services. Our findings, reported in this chapter, are similar.

Overall, we think Minnesota's community mental health system provides inadequate supportive services for people who choose to live somewhere other than in a treatment facility. Specifically, most adults with mental illness are not able to get services such as medication supervision at home unless their "home" is a treatment facility. Although it is sometimes difficult for clients to find available beds in the treatment facility of choice, we think the Legislature should focus on improving supportive services rather than increasing the number of facility beds.

PATIENT AND STAFF SATISFACTION WITH COMMUNITY PLACEMENTS

Psychiatric units of community hospitals are most often used as a place to stabilize the conditions of patients who have experienced acute episodes of mental illness. While regional treatment centers tend to have somewhat longer patient stays than community hospitals, both are seen as temporary settings for patients who need a period of intensive treatment for serious and persistent mental illness. Many patients will need continuing services, as well as a place to live, after their discharge from a community hospital or regional treatment center. In this section we discuss where adults with mental illness go after discharge, how satisfied patients and staff are with discharge settings, and problems that exist in finding appropriate community settings for patients discharged from community hospitals or regional treatment centers.

To What Settings are Patients Discharged?

Adults with mental illness live in many settings other than Rule 36 facilities. In fact, as Table 2.1 shows,

- **Most (88 percent) of the placements in our survey were outside of Rule 36 facilities.**

2 Ernst and Whinney, *Final Report on the Study of Housing and Support Services Needs for Minnesotans with Severe and Persistent Mental Illness* (Minneapolis, February 1988).

Table 2.1: Staff and Client Satisfaction With Placement Settings

	Percent of Patients Placed in Each Setting	Percent of Hospital Staff Satisfied With Placement			Percent of Clients Satisfied With Placement		
		Very Satisfied	Somewhat Satisfied	Dissatisfied	Very Satisfied	Somewhat Satisfied	Dissatisfied
Rule 36 Facility	12.0	74.1	19.0	6.9	53.4	43.1	1.7
Boarding House	3.1	33.3	33.3	13.4	26.7	66.7	6.7
Nursing Home	8.2	67.5	17.5	5.0	35.0	45.0	7.5
Regional Treatment Center	4.1	60.0	20.0	20.0	15.0	30.0	40.0
Correctional Facility	1.9	22.0	0.0	0.0	22.2	11.1	77.8
Foster Care	0.6	100.0	0.0	0.0	100.0	0.0	0.0
With Parents or Relatives	11.3	21.8	38.2	32.8	47.3	25.5	3.6
Independent Living	39.2	44.2	30.0	16.3	65.3	11.6	3.2
Other or No Responses	19.4						

Source: OLA analysis of hospital discharge staff survey responses for 484 patients placed in June 1989.

[1]Responses other than "very satisfied," "somewhat satisfied," and "dissatisfied" are not shown, so the satisfaction totals for each type of facility may add to less than 100 percent. Client satisfaction is reported by placement staff.

We asked hospital placement staff for their general impressions about discharge settings. Most (68 percent) said that the majority of their patients are discharged to settings with an appropriate level of supervision and support.[3] On the other hand, 55 percent reported that clients are sometimes discharged to settings with more services than they need because less supervised settings are unavailable. In addition, 59 percent responded that the typical length of stay in their hospital is only sometimes, rarely or never adequate to stabilize the patient and arrange for an appropriate discharge setting.

Many patients discharged from hospitals live on their own or with relatives.

Table 2.1 shows staff and patient satisfaction with various placements, as reported by placement staff.[4] Although, as Table 2.1 shows, only 12 percent of the placements described in our survey were to Rule 36 facilities:

- **Hospital staff were more satisfied with Rule 36 placements.**

The greatest number of discharges were to independent living. Hospital staff were often dissatisfied with such placements, because they were uncertain that needed services would be available or that clients would avail themselves of services which were arranged. However, clients preferred independent placements to all others except foster care.

Few adults with mental illness live in adult foster care in Minnesota, mainly due to the difficulty counties have had recruiting providers. Only three people in our survey were placed in foster care. All three placements were seen as very satisfactory by both staff and client.

Compared to community hospitals, regional treatment centers which responded to our survey discharge more patients to Rule 36 facilities and board and lodging houses and far fewer patients to independent living. Virtually all patients at regional treatment centers have serious and persistent mental

3 When asked about individual patients, staff thought that 58 percent were discharged to settings that would provide an appropriate level of care and supervision.

4 Our survey also showed that, for 60 percent of the clients, discharge staff had never visited the residential settings where these clients were placed.

illnesses, while community hospital patients are more likely to be treated for brief episodes of illness.

Placement Problems

Staff at the majority (59 percent) of hospitals that responded to our survey said that making appropriate community placements is more difficult now than it was two years ago. Although hospital staff preferred Rule 36 placements over other settings, they reported some problems with Rule 36 facilities, including complex, time-consuming intake procedures, and lack of cooperation and accommodation by Rule 36 staff or administrators.

Hospital staff have difficulty placing adults with mental illness who also have chemical dependency or histories of violence.

Many adults with serious and persistent mental illness have problems in addition to their mental illness and these can make it more difficult to find a community placement to fit their needs. Hospital staff said the most difficult-to-place patients are those with chemical dependency in addition to mental illness, and those with a history of violent behavior. People with a diagnosis of mental retardation along with mental illness and those with a history of setting fires are also considered difficult to place. Such patients were most often placed in Rule 36 facilities (20 percent), independent living (20 percent), or nursing homes (14 percent).

- **Of patients described by hospital staff as difficult to place, about 32 percent presented behavior problems, 13 percent were chemically dependent, 12 percent were considered dangerous to others, and 9 percent were dangerous to themselves.**

We asked hospital staff whether they have more difficulty placing clients in certain age groups than others. Some (36 percent) said that no age group is harder to place than another, but 27 percent said those over age 65 were most difficult to place, and 23 percent said the 18-24 age group was hardest to place.

Hospital staff also commented frequently on the problems they have in finding placements for elderly patients who have a diagnosis of mental illness. They reported that many such patients do not fit in Rule 36 facilities because of the level of medical care they require and their inability to participate in Rule 36 programming. At the same time, nursing homes are reluctant to take such patients. Staff there are unprepared to deal with difficult behavior and uncertain about the effects of nursing home reforms required under a new federal law. [5]

Hospital staff did not find it difficult to place patients with positive HIV or AIDS, and most Rule 36 facilities said they would accept such clients but have not yet had any experience with this group. Staff at one facility thought that they are prohibited from accepting residents with AIDS because it is a communicable disease. The Department of Health currently prohibits people with "reportable and communicable" diseases from residing or working in group fa-

5 Federal Nursing Home Reform Act (P.L. 100-203). This law requires that an alternative disposition plan be developed and implemented for persons with mental illness who are determined inappropriate for nursing home placement under new federal guidelines. The state Department of Human Services will be implementing these changes over the next three years.

cilities which the department regulates. The department is working to clarify how AIDS fits into this classification.

We asked hospital staff which types of services or living arrangements they would prefer to see expanded. Their first priority was for Rule 36 facilities with higher staffing levels than existing Rule 36 facilities have (41 percent). About one-fourth of respondents identified more regional treatment center beds as their first priority, especially for clients who *choose* to be treated there. In addition, hospital staff report that patients need many types of residential settings besides Rule 36 facilities, such as:

Many hospital staff would like to see higher staffing levels in Rule 36 facilities.

- intermediate care facilities and skilled nursing facilities specifically for psychiatric long-term care,
- board and care facilities,
- adult foster homes,
- semi-independent living settings,
- group living arrangements with some supervision, but without a high level of structure, and
- facilities for single parents with children.

Adults with mental illness also face the shortage of affordable housing in the community, which is a problem for all low-income groups. As we discussed in Chapter 1, most adults with serious and persistent mental illness have very low incomes, usually from some type of public assistance. This population must compete with low income families, the elderly, and others with disabilities for the few subsidized or inexpensive housing units available. In addition, persons with serious and persistent mental illness may need other services to enable them to live independently in the community. These services are discussed later in this chapter.

During our conversations with Rule 36 residents (discussed more fully in Chapter 5), they often mentioned the need for additional housing options. Residents told us that it is difficult to find decent, affordable housing in the community. Many residents told us that, although they found Rule 36 programs helpful to some extent, they would prefer to be on their own in the community or living in apartments with some supervision.

AVAILABILITY OF RULE 36 BEDS

Our impression from interviews and literature reviews is that Minnesota relies more heavily on "facilities" to provide community mental health services and treatment than most other states. Minnesota has an extensive network of Rule 36 facilities throughout the state, and they have received most of the state's community mental health funds in the past decade. The need for more Rule 36 beds depends partly on the state's future role as a direct provider of

treatment services. The 1989 Legislature authorized the Department of Human Services to establish state-operated community-based "treatment and habilitation" programs for persons with mental illness. According to the statute, "The role of state-operated services must be defined within the context of a comprehensive system of services for persons with mental illness."[6] It is unclear what function these facilities might serve that is different from existing Rule 36 facilities.

The present number of Rule 36 beds may be adequate if more services can be provided in the community.

Whether the current number of Rule 36 beds is adequate also depends, in part, on how services for adults with mental illness are provided. If the state continues to expect residential facilities to provide most mental health treatment, then there probably are not enough beds, at least in some areas of the state and for some groups of clients. On the other hand, if services can be provided to clients wherever they choose to live, then the current number of Rule 36 beds may be more than adequate. The need for Rule 36 beds will also be determined by other factors, including the extent to which existing Rule 36 facilities are reduced in size, the number of current nursing home residents with mental illness who will be moved to the community (approximately 300 are expected to be moved by 1992), and the number of additional persons in need of mental health services who are identified by counties.

Waiting Lists

The 24 Rule 36 facilities that we visited were at 95 percent capacity at the time of our visits. Nine had no waiting lists, and two others had enough open beds to accommodate those on their waiting lists. The facilities with the longest waiting lists were those which served more difficult clients, offered specialized programs, or had apartment-based programs.

Respondents to our survey of hospital staff often cited long waiting lists, especially at "good" facilities, as a major problem with placing discharged patients in Rule 36 facilities. As a result:

- **Clients are sometimes placed where there is an available slot, rather than where they would be best served.**

- **Of hospital patients in our sample who were eventually placed in a Rule 36 facility, 22 percent experienced delays in finding an appropriate placement. The average delay was 18 days.**

In the process of placing clients in Rule 36 facilities, community hospital staff told us they contacted an average of about two Rule 36 facilities for each client. However, in 18 cases (compared to a total of 58 who were placed in Rule 36 facilities) hospital staff reported contacting up to eight facilities before finally giving up and sending the patient home or to some other type of setting.[7] While it is difficult to say whether there currently are enough Rule 36 slots, it is clear that some clients are not served in settings preferred by them or by staff.

---

6 *Minn. Laws* (1989), Ch. 282, Section 28.

7 Staff described 15 of the 18 as "difficult" clients.

Beds for Difficult-to-Place Clients

Most Rule 36 staff told us they would admit clients with difficult characteristics. However, as Table 2.2 shows:

- **Staff from 77 percent of hospitals reported that Rule 36 facilities were frequently unwilling to accept their most difficult clients.**

Table 2.2: Question: How Often Are Rule 36 Facilities Willing To Accept Your Hospital's Most Difficult Cases?

	Percent Of Hospital Staff Who Responded:
Rarely or Never	22.7%
Sometimes	54.5
Often	9.1
Usually or Always	13.6

N = 22

Source: Hospital discharge staff response to survey.

Admission policies restrict Rule 36 access for some clients.

Programs at Rule 36 facilities vary in many ways, and some may not be well-suited to certain clients. For example, some facilities require residents to be out of the house during the day, pursuing treatment or work activities. Such a program may not fit the needs of elderly clients or those who are currently very ill. On the other hand, some facilities primarily provide social activities, which may not provide a level of activity and treatment appropriate for younger or healthier clients. We saw examples of this in site visits, and it is a problem that clients frequently mentioned to us.

Facilities' admission policies restrict Rule 36 availability for some types of clients. For instance, of the 24 Rule 36 facilities we visited, three would not take residents who had a diagnosis of chemical dependency, and six would not take mentally ill residents who have additional diagnoses of mental retardation. Of those facilities that admit residents with chemical dependency, most required them to have had no use of chemicals in the past three to six months.

Seven of the 24 facilities visited (including three of the four largest) would not take residents with a history of setting fires. Others (nine of the 24) said they might accept such residents, but only if the clients had not engaged in fire-setting in the recent past.

Hospital staff noted that people with both mental illness and medical problems have very few treatment options in the community. During our site visits, we found only one Rule 36 facility that is completely accessible to people with impaired mobility, and two that are partially accessible. In 1988, six of 74 Rule 36 facilities reported to the Ombudsman for Mental Health and

Mental Retardation that their facilities were accessible to people in wheelchairs.[8]

Finally, we found only one facility with a program for non-English speaking clients. That program, at Familystyle Homes in St. Paul, serves Southeast Asian clients. Staff at several programs said they would do their best to serve non-English speaking clients, but most had no means of providing such services.

Facility Location

Although Minnesota has increased its number of Rule 36 facilities in recent years, there are considerable distances between facilities in some areas. Also, because many facilities operate at or near capacity, there may not be an opening in a facility close to home when it is needed. This problem was mentioned by hospital discharge staff in our survey, by county staff, and by clients.

We assessed the extent to which Rule 36 residents live in their "home" counties, defined as the county with financial responsibility.[9] We found that:

- **Statewide, 65 percent of Rule 36 clients lived in facilities in their "home" counties during 1988.**

Clients living outside of Hennepin and Ramsey counties were much less likely to live in Rule 36 facilities in their home counties. About 93 percent of Hennepin and Ramsey Rule 36 residents live in facilities within their "home" counties, compared with 45 percent of residents of other counties.

AVAILABILITY OF SERVICES

Regardless of where adults with serious and persistent mental illness live, they are likely to need at least some services which are not available within their residence. These include day programs, such as vocational training and rehabilitation, recreation, therapeutic groups, psychiatric services, and crisis intervention. This section discusses the availability of community services other than case management, which is discussed separately in the next section.

We asked hospital discharge staff, Rule 36 staff, and clients what types of services were needed, and whether those services were readily available. We found that:

- **Many (but not most) Rule 36 residents have serious problems getting needed services. These problems include long waiting periods, long intake processes, inappropriate vocational services, and a lack of psychiatric services funded by Medical Assistance.**

---

8 Office of the Ombudsman for Mental Health and Mental Retardation, "Ombudsman News," January 1989, p.5.

9 The home county may not be the person's long-term home. Clients who receive public assistance in one county usually remain residents of that county until they apply for public assistance elsewhere. Typically, the original county of residence remains financially responsible for a client for one to two months after a move.

Day Programs and Crisis Services

Table 2.3 shows those services which hospital staff felt were important for their discharged patients, and the percentage of patients staff thought were unlikely to have adequate access to the service after discharge. We found that:

- **Hospital discharge staff thought that 22 percent of those services which they considered "very important" for clients were unlikely to be adequately available in the current living setting.**

Some "very important" services are not available.

Table 2.3: Importance of Services After Discharge From Hospital

Service	Percent for Whom Service is Very Important	Somewhat Important	Not Important	Of Very Important Services, Percent That Are Unlikely To Be Available
Advocacy Services (legal assistance, case management)	35.7	23.1	21.7	19.1
Interpersonal Services (socialization, group psychotherapy)	57.6	23.3	5.4	14.3
Family Services (parenting, family planning)	24.6	24.6	30.6	24.4
Vocational Development (job placement, education, training)	22.5	23.8	33.7	32.1
Medication Monitoring	50.8	18.2	15.9	19.1
Skill Development (finding housing, shopping, budgeting)	19.4	21.1	39.5	26.6
Substance Abuse Services	44.6	11.2	22.7	38.2
All Services	33.4	20.7	27.3	22.2

Source: OLA analysis of hospital discharge staff survey responses for 484 patients placed in June 1989.

Note: Percentages do not sum to 100 because nonresponses are not included.

Some community services are not tailored to clients' needs or have long waiting lists.

Rule 36 staff reported that, despite some recent improvements in the Division of Vocational Rehabilitation's programs, it is still difficult for many Rule 36 residents to get timely, appropriate vocational services. Staff from a Hennepin County facility reported that the time it takes to get clients into county vocational programs exceeds the facility's average length of stay. Hospital discharge staff also reported a shortage of vocational activities and support services in general. Current Rule 36 residents frequently complained of inability to get into appropriate day programs.

Hospital discharge staff and clients told us of other problems with supportive services. For example, some day programs are aimed primarily at persons with mental retardation, so people with mental illness do not feel comfortable participating. Some programs require daily attendance or early morning classes, and mentally ill clients have occasional problems with rigorous schedules. One Rule 36 program director said that residents who are on Medical Assistance must wait six to eight weeks to see a psychiatrist. Another stated that psychiatric services are simply not available to clients who are on General Assistance. While these problems are not pervasive among Rule 36 residents, they are frequent enough to warrant the Legislature's attention.

Another service lacking in some counties is crisis intervention. A crisis may be caused by a periodic worsening of mental illness. Crises may also be brought on by life problems, such as loss of a job, or the break down of an important relationship. When a crisis arises, a person may need very intense, though usually short-term, services. Crisis services might include medication management, therapy, or advocacy.

Hennepin County funds a crisis intervention program for Rule 36 residents and some board and lodge residents. Through the Behavioral Emergency Outreach Program (BEOP), psychiatric nurses visit facilities to help resolve crises. Some county and Rule 36 staff in Ramsey and Anoka counties lamented their counties' lack of similar services. A program director in Ramsey County said that county residents in crisis have few alternatives to a hospital admission. Ramsey County has one non-hospital crisis facility (Safe House) but its 10 beds are usually full.

Housing and Supportive Services

The Legislature has supported the notion of "normal" housing for adults with mental illness.

Changing residence is stressful for most people. Adults with mental illness perhaps have even more need for stability in their environments than the general population, but Minnesota's facility-based mental health system increases the likelihood that clients will have to move as their needs change. Placement in Rule 36 facilities usually means two moves--at admission and at discharge--since few facilities provide permanent housing. Also, the stress of moving may be compounded by the stress of having to transfer skills learned in the facility to an entirely new environment.

The 1989 Minnesota Legislature established a "housing mission statement" calling for housing services that allow persons with mental illness to choose among normal housing options and that provide support regardless of where they choose to live. The Legislature also appropriated $500,000 to the Department of Human Services Mental Health Division to support several housing support pilot programs for a second year.

People in independent settings need many of the same services that Rule 36 residents need: case management, crisis intervention, and vocational or employment services. In addition, some people may need medication management, transportation, or homemaking, shopping, or leisure services.

Over half of the placements in our survey were to independent living or family settings. Based on hospital staff descriptions, it was clear to us that some of these were patients who needed only brief treatment for an episode of illness, and who quickly returned to their previous level of functioning in the community. Many patients, however, will require additional services if they are to maintain their independent status. Unfortunately, we found that:

- **It is difficult for Minnesota adults with serious and persistent mental illness to get ongoing services at home, unless their "home" is a Rule 36 facility or one of a few supportive board and lodging facilities.**

Minnesota has too few home-based services.

Hospital placement staff told us that some counties still have not implemented community support or case management services. They note a lack of support services in general, and a lack of psychiatric follow-up for people on Medical Assistance or General Assistance Medical Care in particular. Hospital staff felt that clients in independent or family settings were less likely than any others (except for clients placed in correctional settings) to receive important services such as substance abuse services and training in activities of daily living.

The National Association of State Mental Health Directors and the federal Department of Health and Human Services National Institute of Mental Health (NIMH) have taken positions encouraging provision of mental health services in "normal" housing. A technical transmittal from NIMH to state mental health program directors states, in part:

> Programmatic consensus is emerging from both the mental health and physical disabilities fields that the majority of individuals with long-term mental illness can meet their housing needs in the same living environments available to the general public, if appropriate supportive services are readily available and are provided in a flexible, individualized manner.[10]

Several states are moving fairly quickly away from services tied to residence and toward a policy of providing services wherever people choose to live. One such state is Ohio. The Ohio Department of Mental Health intends to continue funding residential treatment facilities at current levels, but to authorize no new facilities except under extraordinary conditions. Instead, any new or increased funding will be directed toward provision of housing and supportive services necessary to sustain people in their own housing.

---

10 "Technical Assistance Transmittal", Division of Education and Service Systems Liaison, National Institute of Mental Health, September 1987.

In Minnesota, the Department of Human Services is currently evaluating eleven state-funded housing support pilot projects. In addition to information and referral services, the projects are expected to provide housing services to over 300 people in 12 counties.[11] The projects are designed "to provide a wide array of housing support services for people when they are discharged from Rule 36 facilities, regional treatment centers and also for those already living in the community."[12] Preliminary results of the department's evaluation indicate that the projects are serving the targeted population, and that clients are very satisfied with the services they are receiving. The evaluators noted, however, that lack of affordable housing in many areas of the state have caused some problems, and clients have little money remaining after paying rent.[13]

We visited four established supported housing programs (not among the pilot projects described above), which are described in more detail in Figure 2.1. Together, these programs can serve about 160 clients. They provide or arrange for many of the services their clients need to remain in their apartments, including crisis intervention, social and therapeutic groups, case management, and referrals to community resources. One important feature shared by these programs (except Safe House's ten crisis apartments) is that they allow for *permanent* housing, either in the client's own apartment, or in housing rented by the program and leased to the client. Services are adjusted to meet clients' needs, rather than having clients move to different service settings as their needs change.

At most, 700 Minnesotans with mental illness live in "supported housing."

In addition to the four supported housing programs, there are a few programs which provide supervised apartments, and several programs which provide short-term apartment training. Supervised apartments are generally owned or leased by the provider, and staff are present at least some of the time to assist residents. These programs are intended to be temporary, and clients move when their need for services change.

In spite of recent support by state policy makers for supportive services, Rule 36 staff claim that more supported housing is needed. Staff in the 24 facilities we visited estimate that about 22 percent of their residents could be in more independent settings if supportive services were available. It is clear from our conversations with Rule 36 residents that many would like to live independently, but they recognize the need for some supports to do so. While the state funds 1,100 semi-independent living (SIL) slots for persons with mental retardation, there is no statewide SIL program for adults with mental illness. At most, there are 700 people with mental illness in Minnesota receiving some sort of supported housing, and some of these arrangements are time-limited.

---

11 Those counties are Aitkin, Blue Earth, Carver, Clay, Hennepin, Itasca, Kandiyohi, Koochiching, Olmsted, Otter Tail, Ramsey, and St. Louis (two projects).

12 Minnesota Department of Human Services, "Request for Proposals for Pilot Projects for Housing Support Services for Adults with Serious and Persistent Mental Illness," July 1988.

13 Department of Human Services Mental Health Division, "Evaluation Summary of Minnesota's Housing Support Projects" (preliminary draft).

Figure 2.1 Supported Apartment Programs

- **Vail Place** is a clubhouse model in Minneapolis and Hopkins. Housing support services include assistance in locating housing and weekly on site visits to help maintain independent living. The clubhouses have resource centers with information on community resources and programs. Educational groups are provided bi-monthly. Members run a snack bar at the clubhouse, and plan and implement social activities. A pre-vocational program involves work at several stations within the clubhouse, and a transitional employment program provides entry level supported work in "real" jobs. Vail also leases and sublets 15 to 20 apartments to members. The length of stay in the apartment is unlimited, and some attempt is made to hold apartments for people experiencing brief hospitalizations.

- **People's Apartment Network** consists of one and two bedroom apartments scattered in St. Paul's East Side. They have the capacity to serve 50 clients. Services offered include independent living skills instruction, 24-hour crisis intervention, evening programs provided by staff, social activities, and referral to community programs. Clients may continue in the program indefinitely. The focus is on housing and independent living, not mental health as such.

- **Safe House** occupies an 18-unit apartment building in St. Paul. Eight of the units are used by Safe House clients, one is an office and crisis bed, and the remaining nine are private. The program is designed for people leaving a hospital with no where else to go, or as an alternative to hospitalization during crises. While at Safe House, clients plan for independent living in the community. Maximum length of stay is six weeks. Safe Alternatives is a related program which provides support services to up to 23 clients in apartments leased by the program and sublet to clients. The program does outreach to persons with mental illness living alone in the community, but staff try to be very unobtrusive, not interfering in clients' lives unnecessarily. Services include case management, 24-hour crisis intervention, and community resource referral.

- **Tasks Unlimited** is a Fairweather Lodge program with capacity to serve 55 people in St. Paul and Minneapolis. Each lodge is home for five to ten adults with mental illness, who live and work together with little outside support or supervision. All are trained by Tasks to work as janitors in Tasks' janitorial service company. Tasks is primarily the landlord for the lodges, and also provides a lodge coordinator who is both vocational and clinical supervisor. All residents are financially self-supporting. Tasks contracts with a psychiatrist for any services needed, and staff are available for crises. The program philosophy is self-reliance, with group support from peers.

Supported housing programs such as these should be more widely available.

CASE MANAGEMENT SERVICES

The Comprehensive Mental Health Act of 1987 required counties to provide case management by January 1989 to all adults with serious and persistent mental illness who request this service or are referred by a provider. According to the act, case management includes "developing a functional assessment (and) an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services."[14] State rules require Medical Assistance to pay for case management, where possible. Case managers must meet face-to-face with clients once a month unless the client lives outside the county of financial responsibility, in which case meetings must occur every two months.

Case managers are supposed to coordinate service and advocate on clients' behalf, regardless of where the clients live.

The purpose of case management is to provide clients with a person who can work with them continuously during the course of their illness. This service is not tied to the provision of other services, such as treatment. Rather, the case manager works on behalf of clients regardless of their living arrangements or program involvement. While Rule 36 plans sometimes focus on services provided by the facility, the case manager's community support plans are supposed to examine the "big picture" and see to it that the client's overall needs are met. Effective case management is crucial to a comprehensive mental health system.

Availability of Case Management Services

To determine the availability of case management services in Minnesota, we (1) interviewed Rule 36 staff and residents, (2) surveyed counties about their caseloads of clients with serious and persistent mental illness, and (3) looked for evidence of case manager involvement in Rule 36 client files. Rule 36 staff indicated that virtually all of their residents have a "serious and persistent" mental illness (thus qualifying them for case management), and we did not examine the availability of case management services for clients whose illness is not serious and persistent. We found that:

- **Staff at Rule 36 facilities said that most of their residents receive active case management, but they expressed particular concern about inadequate case management for Hennepin County residents.**

Staff at several facilities said that case management services in various parts of the state have improved in the past year. However, there are still problems with large caseloads and variation in the quality of individual case managers. Most of the Rule 36 residents we talked to have case managers, but several said case managers are not active enough. Hennepin County staff told us that the county's goal is to get clients off case management within two years, which we think is inappropriate given the long-term support needs of many clients.

---

14 Minn. Stat. §245.462, Subd. 3.

Obviously, the number of clients assigned to a case manager influences the quality of service provided. According to state law, "staffing ratios must be sufficient to serve the needs of the clients," although neither law nor rules specify maximum caseloads.[15] Most mental health professionals recommend mental health caseloads of 30 or less, although 40 may be acceptable for the types of case management services required in Minnesota.[16]

In 1986, the average caseload of Minnesota's mental health workers was 48.[17] As a result, case managers were not sufficiently active participants in regional treatment center discharge planning. We surveyed counties in September 1989 to update caseload information. It is important to note that our survey pertains only to clients with a "serious and persistent" mental illness, for whom the state mandated case management in 1987. In contrast, the 1986 survey asked counties about case management for all mental health clients, including those who do not have serious and persistent mental illnesses. We found that:

- **On average, county mental health workers have caseloads of 39 adults with serious and persistent mental illness.**

The state's more populous counties have extremely high caseloads.

Table 2.4 shows the average caseload in each county. The caseloads in some of Minnesota's more populous counties are particularly high, such as Hennepin (46.3), Ramsey (53.6), Olmsted (55.8), and Dakota (46.0).

We also tried to assess the availability of case managers during our review of Rule 36 client files. We found that 54 percent of client files clearly documented case manager participation. About nine percent showed no evidence of a case manager, and usually it was unclear whether this was the client's choice. In 37 percent of the files, we were unable to determine whether the client had a case manager, and there was no indication of active involvement.

It is possible that reimbursement rates are causing some of the case management availability problems. Many case managers in metropolitan counties have education and experience levels significantly greater than those required by state rules, and Medical Assistance does not fully reimburse counties for the salaries of their experienced social workers.[18]

---

15 Minn. Stat. §245.4711, Subd. 1.

16 Mental health professionals recommended caseloads of 30 to Program Evaluation Division staff during our 1986 study of regional treatment center discharge planning. A 1988 study group on case management sponsored by the University of Minnesota's Center for Urban and Regional Affairs said that caseloads of 15 to 25 are appropriate for high risk clients in unstable situations, while higher caseloads may be appropriate for more chronic, stable clients. Gail K. Robinson and Gail Toff Bergman in *Choices in Case Management: A Review of Current Knowledge and Practice for Mental Health Programs, Summary Report* (Policy Resources, Inc.: Washington, D.C., March 1989), p. 2, suggests that 40 may be an appropriate caseload for workers who play primarily a coordinating role.

17 Office of the Legislative Auditor, *Deinstitutionalization of Mentally Ill People*, February 1986, pp. 24-25.

18 Department of Human Services Mental Health Division, *Three-Year Plan for Services for Persons with Mental Illness (Revised)*, September 1989, p. 35.

Table 2.4: County Caseloads of Clients With Serious and Persistent Mental Illness

County[a]	Clients	FTE	Caseload
Aitkin	17	1.00	17.0
Anoka	160	4.03	39.7
Becker	45	1.25	36.0
Beltrami	58	1.75	33.1
Benton	55	2.00	27.5
Blue Earth	81	2.50	32.4
Brown	61	1.00	61.0
Carlton	60	1.00	60.0
Carver	21	0.75	28.0
Cass	47	2.00	23.5
Chippewa	15	0.50	30.0
Chisago	18	0.50	36.0
Clay	25	1.00	25.0
Clearwater	14	0.40	35.0
Cook	15	1.00	15.0
Cottonwood	25	1.00	25.0
Crow Wing	94	4.40	21.4
Dakota	276	6.00	46.0
Dodge	10	0.50	20.0
Douglas	65	1.00	65.0
Faribault/Martin/ Watonwan	83	2.00	41.5
Fillmore	25	1.00	25.0
Freeborn	10	0.66	15.2
Goodhue	14	0.33	42.4
Grant	5	0.20	25.0
Hennepin	1435	31.00	46.3
Houston	46	1.25	36.8
Hubbard	12	0.67	17.9
Isanti	31	1.00	31.0
Itasca	82	1.50	54.7
Jackson	15	0.46	32.6
Kanabec	12	1.00	12.0
Kandiyohi	98	1.70	57.6
Kittson	0	0.23	-
Koochiching	40	0.80	50.0
Lac Qui Parle	10	0.40	25.0
Lake	5	0.34	14.7
Lake of the Woods	5	0.10	50.0
LeSueur	36	1.00	36.0
Lincoln/Lyon/Murray	90	2.00	45.0
Mahnomen	4	0.08	50.0
McLeod	34	0.54	63.0
Marshall	13	0.50	26.0
Meeker	1	0.05	20.0
Mille Lacs	20	1.00	20.0
Morrison	95	4.50	21.1
Mower	15	1.00	15.0
Nicollet	80	2.00	40.0
Nobles	24	1.25	19.2
Norman	5	0.67	7.5
Olmsted	223	4.00	55.8
Otter Tail	90	2.00	45.0
Pennington	27	0.80	33.8
Pine	35	2.00	17.5
Pipestone	5	0.50	10.0
Polk	68	0.50	136.0
Pope	17	0.33	51.5
Ramsey	1180	22.00	53.6
Red Lake	12	0.30	40.0
Redwood	20	0.75	26.7
Renville	37	1.30	28.5
Rice	34	0.67	50.7
Rock	7	0.50	14.0
Roseau	6	0.50	12.0
Scott	74	2.00	37.0
Sherburne	40	1.00	40.0
Sibley	25	0.67	37.3
St. Louis	465	13.00	35.8
Stearns	157	3.50	51.5
Steele	28	1.00	28.0
Stevens	7	0.35	20.0
Swift	15	0.33	45.5
Todd	10	0.33	30.3
Traverse	6	0.25	24.0
Wabasha	22	0.80	27.5
Wadena	6	0.25	24.0
Waseca	26	0.70	37.1
Washington	117	2.50	46.8
Wilkin	30	0.75	40.0
Winona	83	3.50	23.7
Wright	32	1.17	27.4
Yellow Medicine	14	0.50	28.0
TOTALS	6,453	161.56	39.9

Source: Program Evaluation Division survey of counties, September - October 1989.

[a]Big Stone County did not respond to the survey.

Community Support Plans

State law requires county case managers to develop a "community support plan" for each of their clients.[19] The plan must be developed within 30 days of client intake, and it must include goals for each service, activities for accomplishing each goal, a schedule for each activity, and an indication of how often the client and case manager will meet. The community support plan must incorporate the individual treatment plan developed by the Rule 36 facility.

Case managers are supposed to write "community support plans" for each of their clients.

In our review of 263 Rule 36 client files, we saw only two community support plans, and facility staff sometimes indicated that they had never seen a community support plan. This may be understandable, since the county's community support plan must incorporate the Rule 36 plan, not vice versa.

In order to better assess the content of community support plans, we contacted seven counties that, according to Rule 36 files, had residents in the facilities we visited. We requested the community support plans for 26 individuals whose Rule 36 files we had reviewed, and counties sent us 17 plans.[20] While this number was too small to be representative of all Minnesota clients with case managers, we found similarities in the plans we reviewed. Specifically:

- **The community support plans we reviewed were usually terse, focused on client activities rather than client behaviors, and not very creative.**

The plans usually were very brief and vague, with goals such as "mental health" or "independent living skills." Plans usually gave little indication of specific behaviors that services might address, or expected outcomes of program participation. Figure 2.2 is the community support plan for one client. In this case, it is unclear why employment is a goal, what specific skills the client needs to become employed, and how the case manager can be of help. Chapter 3 discusses client mental health plans in more detail, including problems we found in treatment facilities' plans.

Conclusion

It is disturbing to us that community support plans are so lacking and that caseloads remain high for the most seriously ill clients. Although we think that Minnesota's present community mental health system relies too heavily on facilities and too little on supportive services for people living on their own,

- **We question whether a shift to more supportive living settings could be accomplished with the current level of case management.**

The Department of Human Services' mental health plan calls case management a "cornerstone" of a comprehensive mental health system, and says that development of community support plans is the primary responsibility of case

19 Minn. Stat. §245.471, Subd. 2.

20 There were several cases in which Rule 36 facilities incorrectly listed the client's home county, so we were unable to obtain a community support plan.

We saw many examples of vague plans that lacked creativity.

Figure 2.2: Example of a Community Support Plan

CLIENT GOALS	SERVICES NEEDED	SERVICE GOALS	AMOUNT, FREQUENCY DURATION, SCOPE
Employment	Counseling Referral	Competitive Employment	on-going
Medication Compliance	Medical Appointment	100% Compliance	on-going
Sobriety (Alcohol Drugs)	A.A. Referral	100% Compliance	Weekly

CLIENT RESPONSIBILITIES:	CASE MANAGER RESPONSIBILITIES:
1. Keep Appointments	1. Monitor
2.	2.
3.	3.
4.	4.

DESCRIBE SERVICES INVOLVING THE CLIENT'S FAMILY OR OTHER INTERESTED PERSONS:

managers. If this is true, and if our sample of community support plans is at all indicative of plans statewide, then we think the community mental health system rests on a weak foundation.

RECOMMENDATIONS

We conclude that many adults with mental illness in Minnesota lack the supportive services they need to live in community settings. In our opinion, the present community mental health system is too facility-based and does not maximize client choice. We found bottlenecks in the present community mental health system that sometimes cause delays in placing clients in appropriate living arrangements. Facility-based systems (such as Minnesota's Rule 36 system) will always have bottlenecks because beds are limited, and client needs cannot always be met in the facilities that happen to have space. In contrast, if clients could be provided services while living in community housing, they would rarely have to move to receive services.

The Legislature (through its 1989 "housing mission statement") and the Department of Human Services have expressed their commitment to develop a comprehensive community-based mental health system. Such a system will not be created overnight, and there is little doubt that increased funding will be required. We recommend:

- **The Legislature's immediate funding priorities should be (1) expanded and improved case management, (2) supportive services that are not tied to residence in a facility, such as the department's pilot projects for housing support services for adults with serious and persistent mental illness, and (3) increased staff at Rule 36 facilities that provide treatment for difficult-to-serve clients.**

Improvements to mental health services will probably require increased funding.

The Department of Human Services plans to present the 1990 Legislature with a plan for an array of housing supports. We recommend:

- **The plan should include (1) a framework for regulating new services, including a schedule for implementation of new rules, (2) a discussion of funding options which addresses ways to create incentives for counties to place clients in the least restrictive setting possible, and (3) means of assessing clients' need and eligibility for ongoing supportive services.**

Presently, there is no requirement that counties screen clients prior to their placement in Rule 36 facilities.[21] If the Legislature does expand the array of available living arrangements by funding more housing supports, then the client screening process will become even more important. Expanding the array of available living arrangements will present clients with more choices, and counties will need to develop better means of assessing clients' needs and presenting clients with clear descriptions of housing and service options.

We think the need for state-operated community facilities is not yet clear. If the department plans to proceed with the development of such facilities, we recommend that:

- **The department should determine what unique role state-operated facilities can play in the developing community mental health system and who would monitor these facilities.**

Because good case management is crucial to the operation of a community-based mental health system, and because community support plans show considerable room for improvement, we recommend:

- **The Department of Human Services should improve its treatment and service planning manual for case managers.**

The manual should more clearly describe the elements necessary for a good community support or facility treatment plan, and it should provide more discussion of service strategies that might be appropriate for various clients.

---

21 State law requires that, by 1992, counties must screen all adults prior to their admission for treatment of mental illness to residential treatment facilities, acute care hospitals, or informal admission to a regional treatment center.

In addition, it appears that mental health caseloads are still too high in many counties. While we recognize that counties need flexibility to set caseloads to meet client needs, we recommend that:

- **The department or Legislature should consider setting maximum caseloads for counties.**

For example, the department or Legislature might consider a requirement that no county case manager have responsibility for more than 30 clients with serious and persistent mental illness. Since most case managers are funded primarily through the Medical Assistance program, caseload reductions would require additional state funding.

Finally, as we discuss more fully in the next chapter, the state needs to improve its quality assurance of client treatment and service planning. We recommend:

- **The Department of Human Services and the Office of the Ombudsman for Mental Health and Mental Retardation should more closely monitor the quality of community support plans. This may require more resources.**

QUALITY OF CARE AND HOUSING

Chapter 3

As a result of the deinstitutionalization movement, most adults with mental illness now live in the community--in treatment programs, boarding houses, and on their own. We visited nearly 50 group residences funded or regulated by the state and asked:

- **Are residences where people with mental illness live well-maintained and homelike?**
- **Do residents of Rule 36 facilities have individualized treatment plans that address their mental health needs?**
- **How do facilities oversee medications and monitor side effects?**

Overall, as we show in this chapter, we found that too many treatment plans are poorly written and fail to address residents' mental health problems. In addition, staff inadequately monitor the effects of medications, and the state's rules on medication handling are vague and inconsistently enforced. On the other hand, facilities generally provide good opportunities for community integration, social activities, and training in independent living skills. Most Rule 36 facilities are well-maintained, but some are too large or crowded. The living environments in board and lodging facilities vary considerably, and some provide inappropriate living environments for people with serious illnesses.

METHODS

We visited nearly 50 group residences funded or regulated by the state.

Between May and August 1989, we visited 24 of Minnesota's 82 Rule 36 facilities, chosen randomly after weighting facilities by the number of beds they have. The facilities we visited include nearly 900 of the state's 1,700 Rule 36 beds. We reviewed the files of 263 current residents (or about one-third of the current residents). At each facility, we reviewed the files of the residents who had lived there the longest and shortest times, and we selected other files randomly. We interviewed program staff and about 70 residents. Usually we selected residents who happened to be available at the time of our visit, although sometimes we asked facility staff to help us identify residents who would be willing to meet with us. We toured each facility and observed its physical characteristics, maintenance, cleanliness, atmosphere, and medication handling practices. Staff usually had one to two weeks' notice of our visits.

We also visited 20 facilities licensed by the Department of Health but lacking human services licenses (usually referred to in this chapter as "board and lodging facilities"). We selected facilities which, according to mental health staff in various counties, were likely to be serving mentally ill people. These visits consisted of a staff interview, a tour, and a review of medication handling practices.

The research team visiting each facility consisted of two or three staff from the Program Evaluation Division and a mental health professional employed by the division as a technical consultant. To help us develop a structured approach to our evaluation of facilities and program quality, we reviewed research literature and collected survey instruments used to evaluate community facilities in other places.[1] Although there is not complete consensus on indicators of good care and treatment, our evaluation focused on some general principles that emerged from our review of literature and state law, as well as our discussions with mental health professionals. We assumed that care and treatment should be provided in clean, pleasant, homelike places that provide sufficient privacy to residents. Treatment plans should meet the requirements of state rules, be individualized, and focus on residents' serious mental health problems. Clients should be extensively involved in treatment planning. They should have opportunities to participate in community life and to learn skills that will help them live more independently. Because medications have serious and potentially irreversible side effects, they should be monitored systematically through standardized methods.

FACILITY MAINTENANCE AND ATMOSPHERE

Mental health professionals often disagree about what types of programs are best for clients. However, there is general agreement that, regardless of the type of services offered, facilities should respect residents' dignity by providing living quarters that are clean, well-maintained, homelike, and allow for adequate privacy. Such living arrangements help to minimize possible sources of stress for residents, and their "homelike" kitchens, bedrooms, and living areas are similar to those available to clients when they move elsewhere.

At each facility we visited, we rated exterior maintenance (yard, paint, windows, and roofs), interior maintenance (plaster, paint, plumbing, and light-

---

1 Some of the more helpful resources included: National Institute on Mental Retardation, *Program Analysis of Service Systems Handbook* (Washington, D.C., 1975); reports and evaluation instruments from the New York State Commission on Quality of Care for the Mentally Disabled; U.S. Department of Health and Human Services, *Assessing Therapeutic Environment for Active Psychiatric Treatment Settings* (Washington, D.C., 1984); Rudolph H. Moos, *Community-Oriented Programs Environment Scale* (Palo Alto, California: Consulting Psychologists Press, 1974); Association for Retarded Citizens in Minnesota, *Partnership for Quality Services: General Monitoring Tool* (undated); Florence A. Hauber, et al., *1978-1979 In-depth National Interview Survey of Public and Community Residential Facilities for Mentally Retarded Persons: Methods and Procedures*, University of Minnesota Developmental Disabilities Project on Residential Services and Community Adjustment Project Report No. 11, August 1981; Steven J. Taylor, et al., *The Nonrestrictive Environment: On Community Integration for People with the Most Severe Disabilities* (Syracuse, New York: Human Policy Press, 1987).

ing), and cleanliness. We also observed whether the atmosphere in the facilities seemed homelike or institutional, and we evaluated the privacy afforded to residents. Our key findings were that:

- **With a few exceptions, Rule 36 facilities are clean and well-maintained. The maintenance of board and lodging facilities is more variable, ranging from extremely poor to immaculate.**
- **Crowding and lack of privacy is a problem in some Rule 36 facilities, particularly the larger ones.**
- **The larger Rule 36 facilities usually have a more institutional character than smaller ones.**

Rule 36 Facilities

Among Rule 36 facilities, the only serious structural problems we saw were at a multi-building facility in St. Paul, which had rotting or sagging wood in a few building exteriors. Cleanliness problems were more common than structural problems in Rule 36 homes, but they rarely constituted what we considered a serious problem. We noted stale or foul odors in about one-third of the facilities, making this the most common housekeeping problem.

State rules require Rule 36 facilities to ensure resident privacy during treatment, communication with others, and personal care activities.[2] As shown in Table 3.1, most residents share a room with at least one other person, and most share restroom facilities with several other people. We observed problems with crowding and lack of resident privacy in some Rule 36 facilities we visited, such as:

Residents of some facilities are crowded or lack privacy.

- Three facilities have three or four residents per room, with hospital-like curtains between beds. One facility has a dormitory-style room with seven residents.
- A 108-bed facility has four residents in most of its rooms. It has only four restrooms, each with a combined tub and shower.
- A facility that primarily serves elderly residents has some closet-sized bathrooms that contain only a single toilet.
- In one facility, 17 women usually use the same bathroom, which has one shower, one toilet, and two sinks.
- Few facilities provide much privacy for telephone calls. Typically, resident phones are in hallways or common areas.
- Several facilities do not have large enough yards for active recreation, such as volleyball or croquet.

2 *Minn. Stat.* §144.651; *Minn. Rules* Ch. 9520.0650 and 9520.0630.

Table 3.1: Characteristics of Rule 36 Facilities Visited By Program Evaluation Division

	Average	Range
Number of Residents Per Room	1.9	1.0 to 3.4
Number of Residents Per Shower	5.3	1.4 to 27.0
Number of Residents Per Toilet	3.9	1.4 to 7.5

Source: Program Evaluation Division interviews with staff in 24 Rule 36 facilities, May to August 1989. "Number of Residents" is the facility's capacity.

We also toured facilities to determine whether they have characteristics that are homelike, and we found many Rule 36 facilities to be very pleasant. For example, a 15-bed Rule 36 facility in Little Falls is an attractive addition to a new housing subdivision. It has several comfortable common areas, a large yard, and a homelike kitchen that residents use to prepare all meals. We also visited 12-bed facilities in Bemidji and New Ulm that consist of spacious, modern apartments.

Thirty percent of Minnesota's Rule 36 residents live in one of four large facilities.

However, many of the state's 1,700 Rule 36 beds are in relatively large facilities. In fact, four facilities have 30 percent of Minnesota's Rule 36 residents, and these facilities each have more residents than some of the regional treatment centers' psychiatric units, as shown in Table 3.2. These large facilities account for the fact that:

- **The average number of residents in a Rule 36 facility is 21, compared to 14 for intermediate care facilities for persons with mentally retardation.**[3]

Of the facilities shown, Andrew Care Home and Hoikka House closely resemble hospitals or nursing homes, while Guild Hall resembles a college dormitory. Familystyle Homes houses 112 people in 15 clustered buildings, most of which were previously single-family homes.

State rules permit Category I Rule 36 facilities to have up to 40 beds, and Category II facilities may have up to 25. However, the rules permit facilities to exceed this maximum if the facility is subdivided into "living units" of up to 25 persons. Each living unit must provide a lounge or living room for its residents. In our judgment, the "living unit" distinction is not particularly meaningful and merely allows certain facilities to exceed the rule's preferred facility size limits. Of the four large facilities, only Familystyle Homes has living units

3 The ICF-MR data is from January 1988, while the Rule 36 data is from January 1989. The Rule 36 average would be 18 if Familystyle Homes' 15 buildings were considered separate Rule 36 facilities. However, Familystyle Homes has a single Rule 36 license and each building is centrally administered, so we think it is appropriate to treat it as a single facility.

Table 3.2: Comparison of Facility Size Between Regional Treatment Centers and Four Large Rule 36 Facilities

Regional Treatment Center	1989 Average Of Patients With Mental Illness	Rule 36	Number of Adults With Mental Illness
Anoka	237	Andrew Care Home (Minneapolis)	210
Brainerd	76	Familystyle Homes (St. Paul)	108
Fergus Falls	100	Hoikka House (St. Paul)	108
Moose Lake	80	Guild Hall (St. Paul)	76
St. Peter	160		
Willmar	275		

Source: Governor's 1990-91 Biennial Budget; Program Evaluation Division interviews with Rule 36 staff. The number of Rule 36 residents shown is the number at the time of our visits.

that are clearly discrete parts of the larger facility. Despite having separate "living units," the large facilities are more institutional than homelike.

Some treatment facilities are not "homelike."

Each of the state's four largest facilities, in addition to some smaller Rule 36 facilities we visited, has kitchen and congregate dining areas that are institutional in nature. Institutional kitchens are usually designed to prepare large quantities of food or have appliances suited for commercial rather than residential uses. Of the 24 Rule 36 facilities we visited, 11 have kitchens that are less than homelike, including seven that are very institutional.

In about 60 percent of the facilities we rated, the common areas are well-furnished, attractive, and homelike.[4] The remaining facilities had common areas that were lacking in some regard. Some seemed more like waiting rooms than comfortable areas for reading or socializing. Others were stark, uninviting, or small.

Some other observations that we made about Rule 36 buildings and atmospheres include:

- Eleven facilities (representing 54 percent of the beds in facilities we visited) have no air-conditioning in building areas used by residents. Five other facilities have partial but not total air-conditioning. During our summer visits, we encountered several facilities that were uncomfortably hot.

- Residents in at least two facilities sleep in hospital-type beds, giving the facility an institutional atmosphere.

4 We did not try to rate the common areas at Familystyle Homes' 15 buildings individually or as a group. There was considerable variation in the quality of the living environments within the various Familystyle buildings.

- Staff and resident restrooms are separate in about 70 percent of the facilities we toured. The literature we reviewed suggested that this may foster a "we-they" attitude among residents.

Some facility medication practices were more characteristic of institutions than homes. For example, residents lined up for their medications in some facilities, and in one case, a ringing bell signalled medication time for the residents.

Board and Lodging Facilities

We observed much variation in the physical characteristics of board and lodging facilities, more so than in Rule 36 facilities. In particular, we observed more board and lodging facilities that had serious problems with cleanliness or building maintenance. Among the 20 board and lodging facilities we toured, several stood out as having particular problems, such as:

The physical characteristics of board and lodging facilities vary considerably.

- dirty common areas, bedrooms, bathrooms, or kitchens;
- foul or stale odors;
- poorly lighted rooms;
- lack of hot water; or
- walls and ceilings in disrepair.

Some of the poorly maintained facilities were also noteworthy for their lack of private space or usable common areas. For example:

- A facility with a 250-person capacity had just one common area: a stark, poorly maintained, one-room building with only a single television and several benches.
- The basement common areas of one facility had little or no lighting, and the ping pong table was covered with used clothing. A second-floor common area had desks but no chairs. There was an attractive lobby on the main floor, but the manager told us he sometimes asks unkempt residents not to sit there so they do not give visitors a bad impression.
- A facility with 50 mentally ill residents had a single "day room," with space for just a few residents. A larger basement "activity room" was kept locked except for group meetings.

In contrast, we visited some board and lodging facilities that were immaculate and sometimes lavishly furnished. For example, a huge, beautifully furnished mansion in Duluth housed more than 20 residents with mental illness. Among the best maintained board and lodging facilities were those characterized by

staff as "supportive living residences," or homes that offer programs, treatment planning, or ongoing active support.[5] The negotiated monthly rates in the better maintained facilities usually range from $600 to $900 per resident, whereas the more poorly maintained facilities usually have lower rates.

Some of the board and lodging facilities we visited housed at least 60 residents. Most of these facilities were more like rooming houses than private homes or apartments, although some of the staff gave residents personal attention that probably made the facilities more homelike than their appearance indicated.

INTEGRATION OF RESIDENTS INTO THE COMMUNITY

One of the most detrimental effects of institutional living arrangements is that residents may lose their ability to live productively outside of the institution. Residents may become dependent on the institution to meet their needs, and they sometimes lose contact with friends and family. Consequently, a goal of the deinstitutionalization movement was to place people in homes with access to community resources. As we visited facilities, we noted the extent to which facilities provided *opportunities* for community integration. Overall, we found that:

Community facilities should provide residents with opportunities to participate in community life.

- **Most Rule 36 facilities give their residents considerable freedom to move about the community, usually subject to some schedule restrictions.**

- **Most, but not all, Rule 36 and board and lodging facilities are in locations that provide convenient access to services such as day programs. However, residents' participation in community life may be hindered by lack of bus service, restrictions on telephone use, and unsafe neighborhoods.**

- **Most Rule 36 facilities provide adequate opportunities for learning independent living skills, but the larger facilities provide fewer opportunities for residents to use these skills. In general, Rule 36 facilities provide more opportunities for residents to learn independent living skills than board and lodging facilities.**

As shown in Table 3.3, most Rule 36 facilities we visited are in residential neighborhoods, while board and lodging facilities are more likely to be in downtown commercial areas. We observed that facilities usually "blended in" quite well with surrounding land uses. Although the names of a few Rule 36 facilities were posted by the front entrance, the signs never indicated that the facility was a group home for adults with mental illness.

5 We visited two such facilities in Minneapolis and two in Duluth.

Table 3.3: Types of Neighborhoods in Which Facilities In Our Sample Are Located

	Rule 36	Board and Lodging
Single family residential	10	8
Multi-family residential	10	4
Commercial	2	7
Rural	2	1

Resident Freedom and Access to Outside Resources

Rule 36 residents have considerable freedom to move about in the community, although residents are usually subject to certain schedule restrictions. Of the 24 facilities we sampled, 14 have evening curfews, and the others have no curfews or establish curfews on an individual basis. Staff allow most residents to go outdoors without supervision.[6] Most facilities have evening bed checks, expect residents to be out of bed by a certain time in the morning, and ask residents to take their medications at scheduled times. About half of the facilities we sampled expect all residents to participate in programs, and the other half set individual expectations during the treatment planning process. Rule 36 facilities rarely use restraint and seclusion for treatment or discipline.[7]

A few facilities in rural areas are far from community services.

Some rural Rule 36 facilities are far from community services and have difficulty giving clients complete freedom to set their own schedules. The Riverview facility is on a 168-acre farm that is 30 miles from Duluth and several miles from the town of Brookston. The program staff prefer this setting because of its distance from bad influences (such as illegal drugs), and they said residents "act up" less when they are away from family and friends. However, the facility's distance from community services precludes its staff from admitting clients who need extensive outside services, such as vocational training. Rathjen House is several miles outside of Albert Lea, and its staff like the facility's peaceful, safe setting. However, clients are very reliant on the facility's van service for rides into town. Similarly, St. Francis Home is in a residential neighborhood in Atwater, but clients often need rides from staff because they get most of their services in Willmar, which is 10 miles away.

Table 3.4 shows the means of transportation available to residents in the Rule 36 facilities we visited. About one-third of the facilities are in cities with little or no bus service, although each has a vehicle available for resident transportation. In facilities with access to public bus service, staff often teach residents how to use the transit system and purchase bus cards for their use.

---

6 We visited one facility where one-third of the residents must have staff present on trips outside the facility.

7 We visited one facility that apparently withheld services, money, and coffee from a resident for poor hygiene. This type of "aversive therapy" is not permitted by state law.

We visited a variety of residential facilities across the state. Most of them are in residential neighborhoods, but a few are in rural areas. Many facilities are located in or near downtown areas.

Many of the facilities we visited, such as the ones shown here, were clean and homelike.

However, some facilities were less desirable. They had characteristics such as:

- Poorly-maintained, stark bathrooms
- Bedrooms which provided residents with inadequate space and little privacy

Some Rule 36 facilities have institutional characteristics, such as the hospital-type bed shown above. A few facilities are very large, resembling dormitories or nursing homes.

Table 3.4: Transportation Available to Residents of Rule 36 Facilities Visited by Program Evaluation Division

Facilities with:

Nearby bus service and facility-provided transportation	15
Nearby bus service but no facility-provided transporation	1
Facility-provided transportation but no nearby bus service[a]	8

Source: Program Evaluation Division interviews with staff in 24 Rule 36 facilities, May to August 1989.

Note: "Nearby" bus service is within one mile. "Facility-provided transportation" is a vehicle used at least part of the day by facilities to transport residents.

[a]One of these facilities has door-to-door transit service that staff said provides "sporadic" service.

Transportation, telephone access, and neighborhood safety affect the integration of residents into the community.

Telephone access also affects residents' participation in community life. With the exception of one board and lodging facility, all facilities we visited had resident telephones. However, four Rule 36 and four board and lodging facilities had only pay phones for local calls. Moreover, the number of residents per phone seems excessive in some facilities. We found that:

- **In Rule 36 facilities, the median number of residents per telephone is 14. One Rule 36 facility has one phone for every 52 residents, and one board and lodging facility has only one phone for its 150 residents.**[8]

Finally, the integration of residents into the community is directly affected by neighborhood safety. As noted in Chapter 1, about 40 percent of Rule 36 residents are vulnerable to abuse by others, according to facility staff. Most Rule 36 staff told us that their facilities are in fairly safe neighborhoods. However, many facilities ask their residents to travel in pairs after dark, and staff from facilities in Minneapolis and St. Paul cited cases in which residents have been mugged and verbally abused. One facility recently relocated to a Twin Cities' suburb because residents were assaulted and bothered in Minneapolis.

Opportunities to Learn and Use Daily Living Skills

In order for adults with mental illness to remain in the community after leaving a treatment facility, many need to master basic living skills. Some clients have these skills before entering a facility, while others do not know how to cook, plan menus, maintain good hygiene, do laundry, manage their money, and do other daily tasks. One program director told us that clients usually have good living skills, but they lack the motivation to use them when their mental illness worsens.

8 Some facilities also limit the hours when calls can be made and the length of calls.

We discussed training in daily living skills with program directors at each Rule 36 facility we visited. Although we were unable to make judgments about the quality of training done by facility staff, we found that all Rule 36 facilities offered training in daily living skills (either in classes or one-to-one). In fact, our impression is that training in daily living skills is one of the things Rule 36 facilities do best. However, we also found that:

- **While all Rule 36 facilities offer training in daily living skills, many residents lack the opportunity to put meal preparation skills to use in their daily lives.**

Table 3.5 indicates the proportion of residents that staff said do various tasks in the facilities we visited. Most residents in Rule 36 facilities do not participate in menu planning, grocery shopping, or meal preparation. Usually this reflects lack of opportunities rather than client choices. Some facility staff told us that health regulations preclude them from using residents in kitchens.

We examined whether residents have opportunities to use daily living skills.

Table 3.5: Question For Facility Staff: "How Many Of Your Residents Did the Following Tasks In The Past Month?"

	Number of Facilities Responding:	
Tasks	"None" or "Some"	"Most" or "All"
Grocery Shopping	16	8
Menu Planning	16	8
Meal Preparation	12	12
Laundry	1	23
Housekeeping	1	23
Money Management	11	13

Source: Program Evaluation Division interviews with staff in 24 Rule 36 facilities, May to August 1989.

Resident participation in meal preparation seems partly related to facility size. Small facilities often involve residents in daily kitchen activities, and some residents even have kitchens in their living quarters. The larger facilities hire staff to prepare daily meals in institutional kitchens. They typically have a smaller, homelike kitchen available for instructional purposes, but it is not used for daily meals, and in some facilities it appeared seldom used. One facility's "independent living skills kitchen" is kept locked, has little room for people to work, and was uncomfortably hot when we visited.

Although Rule 36 facilities could provide better opportunities for their residents to participate in daily living skills, they generally do better than board and lodging facilities. Board and lodging facilities often prepare all meals and do most or all laundry for residents. Although some people probably choose to live in board and lodging facilities because of these services, it is likely that others live there because of the lack of other housing options. We have no way of knowing how many board and lodging facility residents are incapable

of daily living skills or uninterested in learning them, but these facilities seem more likely to encourage dependence than the Rule 36 facilities we visited.

Resident Activities Outside Rule 36 Facilities

As noted earlier, most Rule 36 residents live in residential neighborhoods close to community resources, and most have considerable freedom to participate in community life. Because mental illness sometimes manifests itself in a tendency to withdraw and isolate oneself, we wanted to know the extent to which residents have contacts outside the Rule 36 facility. Our findings rely on estimates provided by facility staff.[9]

According to staff,

- Two to three percent of Rule 36 residents stay in their rooms for most of the day.
- 95 percent of residents go outside the facility in the course of a week.
- 84 percent go to a store during a typical week.
- 73 percent have at least one conversation in a typical week with someone outside the facility who is not paid to provide services.
- 84 percent participate in recreation activities inside or outside the facility in a typical week.
- 73 percent have some sort of contact with a family member in a typical month.

In addition, we surveyed more than 60 neighbors of Rule 36 facilities, and about half of them said they have talked to a facility resident at some time. We defined "talking to" residents as more than a passing greeting on the street.

ADEQUACY OF TREATMENT PLANNING AND PROGRAMS

Our review of research literature revealed little consensus on which types of programs work best for people with mental illness. Thus, our evaluation of treatment planning and programs in Rule 36 facilities did not focus primarily on the descriptions of program content and philosophy we obtained from facility staff. Instead, we examined individual client files to determine (1) whether planning is consistent with state rules and accepted standards of professional practice, and (2) whether individual mental health needs of particular clients are addressed in treatment plans. Our sample of files is large enough to be

9 These estimates were obtained in spring and summer months. It is likely that residents' community activities are somewhat less frequent in colder weather.

broadly representative of the 1,700 Rule 36 residents statewide, but it does not necessarily allow conclusions to be drawn about the practices of particular Rule 36 facilities.

Diagnostic Assessments

State law defines a "diagnostic assessment" as a written summary of a client's history, diagnosis, strengths, vulnerabilities, and general service needs.[10] The 1987 Mental Health Act requires providers of residential services to complete a diagnostic assessment for each client within five days of admission. If an assessment has been done in the 90 days preceding admission, the facility need only update the assessment.

Diagnostic assessments are important for several reasons. First, they indicate whether clients have mental illnesses that would qualify them for Rule 36 services. Since counties usually do not screen clients before they enter Rule 36 facilities, the assessment serves this important function. Second, a good diagnostic assessment indicates the current status of a person's illness. This is important because of the cyclical nature of many mental illnesses, with active phases often following periods of remission. Third, the assessment provides a basis for writing a good treatment plan. It should indicate specific behaviors that treatment might address, and it may indicate what has worked or failed in the past with a particular client.

We reviewed 263 client files at Rule 36 facilities. The diagnostic assessment requirements in state law pertain to those residents admitted after the enactment of the 1987 Mental Health Act in August 1987. We found that:

- **Less than one-third of the files of clients admitted after August 1, 1987 had diagnostic assessments that were complete, on time, and up to date at the time of admission.**

Most files lacked evidence of proper client assessments.

Typically, we found some indication of client diagnoses in files, although about one-fourth of the files listed conflicting diagnoses or none at all. Often the diagnoses were done during a hospital stay months or years prior to Rule 36 admission, although we saw many cases where there was no indication who made the previous diagnoses. In some cases, the most recent diagnosis was more than 10 years old.[11] Those cases in which Rule 36 facilities provided updated information on the resident's diagnosis or recent symptoms were the exception, not the rule.

We conclude that Rule 36 facilities are inadequately assessing most clients at admission. Facilities lack baseline diagnostic information that could be used at a later date to gauge a client's progress. They also lack behavioral evidence to indicate whether previous diagnoses (if they were made at all) remain valid. Most important, the lack of diagnostic information indicates that facilities are not focusing on specific behaviors of clients at the time they are writing treat-

10 Minn. Stat. §245.462, Subd. 9.

11 Three of the 24 facilities we visited did their own diagnostic assessments in the months preceding client admission. One facility said that the Department of Human Services Licensing Division had approved this practice, although we saw little evidence that the assessments were then updated when clients were admitted.

ment plans for them. Facilities' heavy reliance on diagnostic assessments done by previous service providers raises the possibility that such assessments will become self-perpetuating and clients will not receive appropriate, individualized treatment.

Timeliness of Treatment Planning

State rules require that residential facilities develop a list of short-term goals for clients within 10 days of admission and an "individual program plan" within 30 days of admission. The plan must contain a list of client strengths and needs, a list of prioritized goals, and objectives that are specific, measurable, and time-limited.

We found that:

- **One-fifth of individual program plans are completed late.**
- **Eight percent of the residents who had been in a Rule 36 facility for at least 30 days did not have plans in their files at the time we conducted our reviews.**

There were 150 cases in which we could clearly determine whether the initial plan was completed within 30 days of admission, and 30 were completed late. There were 235 cases in which clients had been at a facility more than 30 days, and we found no plans in 19 of these files. We also saw several files in which clients had treatment plans that were developed within 30 days, but all target dates for objectives in the most recent plan had lapsed without being updated.

Many treatment plans do not comply with state rules.

Compliance of Plan Elements with State Rules

As we reviewed individual treatment plans, we examined whether they contained elements required by Rule 36. For example, state rules require treatment plans to contain a "strengths and needs list" to ensure that clients are fully appraised in a wide range of life areas. We found that:

- **The strengths and needs list was missing from about 30 percent of the treatment plans we reviewed.**

The rules also require that goals developed in the treatment plan be listed in order of priority. We found that:

- **It is difficult to tell whether facilities list goals in order of priority, and we visited no facilities with plans that routinely indicate *why* certain goals are given higher priority than others.**

Some facilities explicitly indicate the priority of goals listed in treatment plans, usually by a "priority" column next to the stated goal. But most facilities number or list goals with no clear indication of whether this reflects priorities. For example, some of the "number one" goals we saw included the following:

- "Not to consume alcohol," even though this person's diagnosis indicated that his chemical dependency problem was in remission.

- "Will smoke only in designated areas."

- "Compliance in the use of foot cremes."

It was unclear why these goals were listed first since they do not relate to the clients' primary mental health problems. If they were indeed high priorities for these clients, it was not apparent from the treatment plans why such was the case. In some facilities, all residents had similar goals that were listed in the same order with no explicit indication of priority.

State rules also require treatment objectives to be "time-limited." The purpose of this requirement is to provide a realistic, but not open-ended, time frame for progress on various objectives. We found that:

- **Most objectives within a typical client's treatment plan had identical time frames.**

We observed that most clients' objectives were for a three-month period, coinciding with the facility's quarterly meetings to review the plan. More often than not, objectives were then continued without change for another three-month period. We saw some treatment plans that had three-month objectives that had not been changed for several years. While these "three-month" objectives probably satisfy the state requirement for time-limited objectives, they often provide no indication of (1) an overall time frame for a given objective (more or less than three months), and (2) what might signify successful completion of an objective. We think the use of three-month time frames for each objective of each client undermines the notion of "individualized" treatment plans.

Rule 36 also requires that treatment plans contain "the names of community resource personnel, program staff, or other persons designated to assist the resident in implementing the various components of the plan." We found that:

- **Plans usually do not designate specific staff who are responsible for helping clients achieve objectives.**

About 16 percent of plans listed staff names for specific plan objectives. Many other plans merely indicated that "staff" would monitor or assist clients, without indicating particular staff by name. About half of the plans gave little or no mention (even in vague terms) of people responsible for helping clients with their objectives.

In addition, state rules require that residents be actively involved in their plan development (unless otherwise indicated in the plan). The resident's participation must be noted in the plan. However, we found that:

- **The client's personal objectives or preferences for services are seldom noted in treatment plans.**

At most, about one-fourth of the plans we reviewed contained evidence of client input. This includes cases where clients were said to have provided input, even if the nature of their input was not specified. Although there will certainly be clients who are not willing or able to make meaningful contributions to treatment plans, we think the extent of client involvement documented in the plans we reviewed falls far short of state requirements and standards of good practice.

Finally, we examined whether treatment objectives are specific and measurable, as state rules require. We found most objectives to be at least somewhat specific and measurable. For example, a typical objective that we saw was for a resident to attend an independent living skills group each day at the facility. As written, this objective is quite specific and measurable. However, while this objective specifies a measurable level of participation in an activity, we think it is important for objectives to focus on the expected behavioral outcomes rather than attendance *per se*. Thus, while we concluded that facilities could certainly be writing more specific and measurable objectives, we think it is more important for facilities to improve the focus of their objectives, as discussed in the next section.

State licensing reviews have not been very effective in Rule 36 facility oversight.

Our findings of compliance problems in many treatment plans raises questions about the effectiveness of the Department of Human Services Licensing Division. The division visits each Rule 36 facility annually and reviews a sample of client files. The division visited several facilities in our sample within days of our visit. We obtained the division's findings for four of these facilities, and in all but one, the division's findings were minor compared to the problems we observed. Perhaps the Licensing Division reviewed entirely different client files than we did in these facilities. However, the extent of problems we observed throughout the Rule 36 system convinced us that state licensing reviews have not been a particularly effective oversight mechanism for Rule 36 programs.

Do the Plans Meet Residents' Mental Health Needs?

We tried to determine whether residents were receiving all of the services called for in their treatment plans. In many cases, we found that plans were too vague to determine this, or it was difficult to determine which services the resident received. In the cases where plans and services were clearly documented, we found that clients usually received the planned services. This is not particularly surprising, since the facility staff know which services are available in the facility or community, and it would be unusual to plan for services that are entirely unavailable.

Although residents appear to be getting most of their planned services, we observed some serious weaknesses in Rule 36 treatment plans. In particular, we found that:

- **Facility programs often fail to address important symptoms and behaviors of residents' mental illnesses.**

While staff usually make strong efforts to provide social activities and independent living skills training, they often do not directly address the behaviors that led to Rule 36 placement. Here are several examples we observed in client files:

- A resident had a serious problem with aggressive behavior, as evidenced by criminal charges brought against him for property damage. The client's plan contained no goals related to his angry and violent behavior.
- A client who heard voices and had suicidal tendencies had nothing in her plan to address these problems.

Many treatment plans ignore important mental health problems.

- A resident admitted to a Rule 36 facility because of inappropriate sexual and social behaviors had no goals related to these issues. The focus of his plan was independent living skills.
- A resident entered a facility following hallucinations, delusions, and thoughts of suicide. There were no goals addressing these problems. Meanwhile, the resident was convicted of criminal sexual conduct while at this facility, but the facility's assessment said that she has no sexual vulnerabilities.
- A resident had three goals in his plan: developing social, math, and budgeting skills. It was unclear how these goals would address this resident's mental illness, the nature of which was not specified in intake documents.
- The only goals in one resident's plan were to quit smoking and find an activity for summer.

There are probably cases such as these where the facility staff were trying to address the resident's mental health needs but not doing a good job of documenting their efforts. However, we saw too many similar cases to believe the problem is one of documentation alone. While we do not wish to undermine the importance of client social activities and teaching daily living skills, the lack of goals related to serious mental health problems was disturbing. There were many instances in which facility progress notes reported clients with overt symptoms of their mental illness (or even significant deterioration), but subsequent treatment plans did not address these problems.

In many plans, residents' mental health problems were addressed only through the goal of taking medication regularly. Medication is a powerful and useful approach to treating mental illness, and medication compliance is a problem with many clients. However, what seemed to be missing from many plans were efforts by staff to teach and train residents about their illness and ways to cope with symptoms. We saw too much focus on management of the illness through medication compliance and too little focus on building client skills to address problem behaviors.

We also observed that:

- **Treatment plans focus too heavily on client activities rather than client results.**

In particular, plans often called for residents to participate in groups or attend day programs. However, most plans did not indicate what these activities were intended to accomplish. Consequently, plans were often system-oriented, not client-oriented. For example:

Plans often do not indicate what treatment is intended to accomplish.

- A goal in a resident's plan was to engage in one-to-one therapy "for as long as (the person) resides at (the facility)." The plan gave no indication what this therapy was intended to accomplish.

- Toward the goal of "managing mental illness," a resident's objectives were to see her psychiatrist, take medications, and attend a day program. The plan did not discuss the aspects of this client's mental illness that these activities were supposed to address, or how she would know when she achieved her objectives.

- A resident's only mental health goal was: "Behavior will be stable." The plan did not specify particular behaviors or indicate how they would be stabilized.

- A resident's goals included maintaining a job and socializing more. But the plan did not indicate what would be required to achieve these goals and how the facility would help.

Again, it is possible that the problem is inadequate documentation, not inadequate programs. However, our findings were so widespread that they seem to indicate a deeper, systemic problem. Specifically, facility staff seem inadequately skilled in writing treatment plans, and their plans do not contain enough creative strategies that target particular client behaviors.

Finally, as noted in Chapter 2, we have concerns about mental health programming for "maintenance" clients, or those with poor prognoses for rehabilitation. About nine percent of the residents whose files we reviewed had lived in their present facility more than 10 years, and many of their files had no documentation of recent diagnoses. Several had IQ scores below 70, indicating mental retardation. Many long-term or maintenance clients have goals that remain the same year after year, sometimes focusing on physical problems or grooming. Although we think facilities should not have unrealistically high expectations for residents, we question whether the programs for some residents constitute "treatment" and are adequately challenging. Unfortunately for these residents and others with better prognoses:

- **There is no systematic, state-level quality assurance monitoring of Rule 36 facilities.**

State law requires the Commissioner of Human Services to ensure that the mental health system "provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health." We are aware of one facility that was asked by the Department of Human Services to review whether its residents were appropriately placed. In addition, the department's licensing division reviews facility

compliance with state laws and rules. However, no one at the state level reviews the content of client plans to assess whether they adequately address client needs. In contrast, "utilization reviews" (often funded by employers or private insurers) are standard practice for community hospital stays in Minnesota. Given that the state pays for most Rule 36 services and approves facility budgets, we think it is reasonable for the state to play a similar oversight role.

"Programs" in Board and Lodging Facilities

The state human services licensing law defines a "residential program" as a program providing "24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation, or treatment outside a person's own home."[12] Residential programs for five or more persons with a mental illness must have a human services license.[13] Facilities with a board and lodging license from the Department of Health do not need a human services license until July 1990 if they provide services to five or more persons who have refused appropriate treatment.[14]

As noted in Chapter 1, the state currently has no means of enforcing its licensure requirement for programs serving five or more persons with mental illness. Moreover, board and lodging facilities usually have no formal documentation of who has been offered and refused a treatment program, so it is difficult to know which facilities should be excluded from licensure requirements.

During our site visits, we were interested in finding out how the activities available to residents at board and lodging facilities differed from those in Rule 36 facilities. We found that:

- **While most board and lodging facilities do not provide counseling or case management services, several do provide programs comparable to those offered in Rule 36 facilities.**

For example:

- Staff at Stevens House in Minneapolis said their facility is virtually the same as a Category II Rule 36 facility. They develop goal plans with their 24 residents, and all but a few residents attend day treatment programs. Staff provide case management and training in independent living skills, and the facility shares a recreation therapist with a Rule 36 facility.

---

12 Minn. Stat. §245A02., Subd. 14. The use of the word "or" is curious, since it implies that any facility providing ongoing lodging for people has a residential program.

13 Minn. Stat. §245A.095, Subd. 1.

14 Minn. Stat. §245A.03, Subd. 2. It is possible to interpret this statute as allowing facilities to operate without a human services license if they have many clients who have not refused treatment in addition to having five residents who have refused. We suspect that such an interpretation is not what the Legislature intended, and the Legislature should clarify this issue if it extends this statutory exclusion from licensure beyond mid-1990.

- St. Clare House in Duluth has a full-time counselor in addition to staff who assist with in-house art therapy, poetry therapy, and recreation. They are starting a "finishing school" for the 25 residents.

- Arrowhead House in Duluth has the equivalent of a Rule 36 mental health worker and mental health counselor on staff during the day. They offer chemical health, socialization, and recreation groups.

- Whittier Place in Minneapolis has three separate programs for its 60 mentally ill adults. Staff said they provide support, not treatment. The facility employs an independent living skills staff person and six "resident advocates."[15]

If we assume that everyone in these four facilities has refused a treatment program (which is unclear), then present law does not require these facilities to have a Rule 36 license until July 1990. Staff at these facilities often commented that their programs are less rigid or structured than Rule 36 facilities. Staff at St. Clare House said that they do not want Rule 36 licensure because it offers no advantages to staff or residents while imposing unnecessary burdens.

Board and lodging facilities are subject to minimal state oversight.

We observed the programs in both Rule 36 and board and lodging facilities, and it is apparent that similar programs are presently not subject to similar regulation. If board and lodging facilities feel that Rule 36 requirements are too rigid, they may request variances from the Department of Human Services. We are concerned that board and lodging facilities with programs are not required to meet other requirements, such as the state Vulnerable Adults Act or the statutory "patients' bill of rights," nor are they subject to oversight by the Office of the Ombudsman for Mental Health and Mental Retardation. Neither does the Department of Health's Office of Health Facilities Complaints receive or investigate complaints about board and lodging facilities because they are not considered "health facilities."

Other Rule 36 Program Issues

During our site visits and interviews, we encountered other program issues that merit the Legislature's attention. They are (1) the lack of differentiation between Category I and II Rule 36 programs; (2) variations in facility follow-up following resident discharge, (3) abuse and neglect of residents in facilities, and (4) the lack of a useful definition of "treatment." We found that:

- **The programmatic distinctions between Category I and II facilities are sometimes blurred.**

State rules define Category I Rule 36 facilities as emphasizing "services being offered on a regular basis within the facility with the use of community resources being encouraged and practiced." However, we visited two Category I facilities whose residents primarily attend programs outside the facility. Category II facilities are intended to emphasize "securing community resources for most daily programming and employment." However, we visited one Category

15 Each of these four board and lodging facilities are certified by their respective counties to provide services beyond room and board.

II facility in which residents must attend programs at a campus owned by the facility, and community services are generally not used.

Elsewhere in this report, we note other evidence of the lack of differentiation between Category I and II programs. Specifically, staff in both types of facilities usually supervise resident medications, although most Category II facilities lack clear authority to do so. In addition, Chapter 4 notes that staffing levels of Category I and II facilities are not necessarily different, and Chapter 6 notes the same about per diem rates.

We also examined the nature of Rule 36 facilities' contacts with residents following discharge.[16] While it is clear that residents need supportive services after discharge, it is unclear whether these services should be arranged by county case managers or Rule 36 staff. It may be very useful for people who have been through lengthy treatment to discuss their adjustment to community life with facility staff following discharge. On the other hand, it is possible that "aftercare" services provided by a Rule 36 facility could encourage former residents to remain dependent on facility staff.

We found that:

- **Seven of the 24 facilities we visited provide "aftercare" programming for residents following discharge.**

Two of these facilities fund an aftercare staff person, while the other five facilities provide these services informally or use another facility's aftercare staff. Former residents return to these facilities for group or individual meetings with staff.[17] Staff from a Minneapolis facility told us that the addition of aftercare staff allowed them to reduce length of stay by half and move residents into private apartments.

The state should clarify responsibility for aftercare services.

Facilities seem to be providing aftercare for their former residents because this service is not available elsewhere. However, we would prefer that the Department of Human Services clarify responsibility for aftercare so that these services are provided consistently and with proper planning. This would reduce the possibility of clients falling through cracks in the mental health system following discharge from a facility.

Another issue reflecting on program quality is the extent of abuse and neglect in facilities. We reviewed the most recent data and analyses on file with the Minnesota Office of the Ombudsman for Mental Health and Mental Retardation. The office has compiled comparative data on community facilities licensed by the Department of Human Services to serve adults with mental illness, mental retardation, and chemical dependency. The office does not have information on board and lodging facilities.

- **The ombudsman reports that the number of abuse or neglect reports per bed filed on behalf of Rule 36 residents is about the**

16 Staff from all but two facilities in our sample said that they try to contact residents six months after discharge to obtain information on their current living arrangements, employment, and recent hospitalizations.

17 One facility said that it stores medications for some former residents.

same as in other residential facilities, although counties substantiate a somewhat higher percentage of Rule 36 reports.

During 1987 and 1988, the staff from the ombudsman's office visited facilities with 1,400 Rule 36 beds, or more than 80 percent of the state's total. They found 139 reported cases of abuse or neglect.[18] Counties substantiated 36 reports, found 41 false, and deemed the rest inconclusive. Overall, about one case of abuse or neglect was reported for every 10 Rule 36 beds, which was similar to the rate in community facilities of other types. One-fourth of the Rule 36 reports were verified, compared with 17 percent in other types of facilities. The ombudsman's office also reported that there were seven deaths in 1987--including two suicides--in the Rule 36 facilities it visited.

The Department of Human Services has not adequately defined "treatment."

Finally, we think it is necessary for the Department of Human Services to clarify what distinguishes a treatment facility from other facilities. In 1987, the Legislature asked the department to develop rules that define treatment, but it has not yet done so.[19] The lack of a treatment definition allows some Rule 36 facilities to provide minimal structured programming, sometimes less than the programming provided by board and lodging facilities that do not have Rule 36 licenses. Although most Rule 36 residents can select from various scheduled activities at a facility, such as groups or social events, we visited one large facility that offers no structured activities. This facility's staff insist that structured activities are not in keeping with "individualized" treatment, but some current and former residents of this facility expressed concern to us about this approach. One said that residents "sit around and vegetate," while another said that "it could have been easy to get comfortable with a nonproductive lifestyle" at this facility. Our mental health consultant suggested that some minimal level of optional, scheduled activities are appropriate for treatment facilities, given the difficulty that many clients have organizing their lives and taking initiative.

MEDICATIONS

The development of psychotropic medications in the mid-1950s revolutionized treatment of persons with mental illness. These drugs affect the central nervous system and modify behavior, emotions, and thinking. They have permitted many previously institutionalized people to live in the community. Common psychotropic drugs include thorazine, haldol, prolixin, mellaril, prozac, lithium, and stelazine.

---

18 These are cases filed with counties pursuant to the state Vulnerable Adults Act.

19 Minn. Stat. §245A.095, Subd. 2. The department's draft revisions of Rule 36 have not included a definition of treatment that could be used to determine whether board and lodging facilities are treating their residents. The draft has also not indicated whether treatment implies a minimal amount of "structure," or scheduled activities.

In 1988, Rule 36 facility staff statewide reported to the Department of Human Services that 70 percent of their residents were on psychotropic medications.[20] Our visits to 24 facilities indicated that medication usage is even higher. We found that:

- **According to staff estimates, 90 percent of current Rule 36 residents are on psychotropic medications. Our review of client files indicated that as many as 95 percent of residents may be on psychotropic medications.[21]**

These medications are prescribed by private psychiatrists, not by facility staff. Although many Rule 36 staff reported close working relationships with doctors, others said that doctors provide little indication of what the prescribed medications are intended to do. Also, some doctors prescribe that medications be taken "as needed," without specifying circumstances that may justify these drugs.[22]

Nearly all Rule 36 residents take medications for their mental illnesses.

State Regulation of Medication Supervision

Prior to our site visits, we consulted state laws and rules to determine restrictions on medication supervision in various types of facilities. For the most part, medication regulations are contained in the state's health licensure rules rather than human services rules. Figure 3.1 summarizes rules on medication handling for the three types of facilities serving mentally ill adults. We found that:

- **Existing rules and 1989 legislation regarding the handling and monitoring of medications in various facilities are vague and incomplete.**

First, the rules do not define various types of medication handling and specify which are permissible in supervised living facilities and boarding care homes. For example, it is unclear whether staff in these facilities are authorized to remove medications from containers for residents, or whether residents are supposed to do this for themselves under staff supervision. Second, the rules for supervised living facilities do not indicate the training (if any) required by staff who handle medications. Third, it is unclear whether residents capable of self-medication may store their medications in their rooms or if medications must be stored centrally. Fourth, supervised living facilities are required to record adverse reactions to medications, but boarding care homes have no such requirement.

---

20 Department of Human Services, Mental Health Division, *Report to the Legislature: Grants to Counties for Adults with Serious and Persistent Mental Illness*, January 1989, p. 61.

21 Of the files we reviewed, only 5 percent of clients were definitely not on medications, although there were other cases in which the situation was unclear.

22 Some facilities have close working relationships with doctors because most or all clients in a given facility see the same doctor. We did not try to determine the extent to which residents make their own choices of doctors, but some mental health advocates we talked with believe that resident choices are constrained in certain facilities.

State medication rules are vague.

Figure 3.1: Medication Handling Rules for Various Types of Facilities

	Boarding Care Home	Supervised Living Facility	Board and Lodging Facility
Do state rules give clear authority to store medications?	YES	YES	NO[a]
Do the rules indicate training required by staff handling medications?	YES[b]	NO	NO
Do the rules indicate minimum qualifications for supervisors of medication handling in facilities?	NO	NO	NO
Do the rules indicate whether staff may, in any circumstances, remove medications from containers for residents?	NO	NO	NO
Do the rules require facilities to keep records of medications taken?	YES	YES	NO
Do the rules require side effects monitoring?	NO	See Footnote C	NO

Source: Minnesota Rules Chapters 4665 and 4655.

[a]Minn. Laws (1989), Ch. 282, Art. 2, Sect. 49 authorizes rules that allow for medication storage in board and lodging facilities. Rules have not been developed yet.

[b]Must be a nurse or have completed a medication administration training program in a Minnesota post-secondary educational institution.

[c]"Adverse reaction to a medication and the report to the physician of the same shall be recorded."

At the time of our site visits, state rules did not authorize facilities with board and lodging licenses to handle medications. However, the 1989 Legislature asked the Department of Health to adopt rules by July 1990 that would allow certain board and lodging facilities to provide "assistance in the preparation and administration of medications..."[23] Between September 1, 1989 and the time these rules are promulgated, board and lodging facilities may assist with medications only if a licensed nurse is on site at least four hours per week. As with the rules for boarding care homes and supervised living facilities, the legislation for board and lodging facilities does not clearly specify how medications may be handled by staff.

---

23 Minn. Laws (1989), Ch. 282, Art. 2, Section 49.

Facility Medication Handling Practices

We conducted all site visits between May and August 1989. In each facility, we discussed medication procedures with staff and examined medication storage and record-keeping. Lacking clear rules and statutes, we adopted three working definitions which constitute a continuum of medication handling procedures from least to most restrictive. We defined "self-administration" to be those instances in which residents keep medication in their rooms and ingest it without staff's personal supervision. Residents on "supervised" medications have their medications stored by facility staff, remove pills from the containers themselves, and take the pills while staff watch. Finally, residents with "administered" medications take pills that are stored and removed from containers by staff, and staff watch while pills are ingested.

We found that:

- **Slightly more than half of the Rule 36 residents take medications which are administered by staff, and about 10 percent administer their own.**

Current medication practices probably encourage residents to be too dependent on staff.

We think that current medication procedures probably encourage more dependence among residents than necessary. Many residents whose medication is administered are probably capable of removing pills from containers, given minimal training and prompting. In addition, we learned that some staff at Rule 36 facilities prevent residents from keeping medications in their rooms for self-administration because they believe this would violate health department regulations. We were unable to find any such prohibition in state rule. Several facilities had no locked spaces in resident rooms for medication storage.

We also found that:

- **Nine Rule 36 facilities we sampled were supervising or administering medications although they were not authorized to do so (they are licensed as board and lodging facilities), and four of these had no regular nursing staff.**

It is likely that these rule violations have been encouraged by inadequate or inconsistent enforcement of medication regulations by health department officials. We saw an example of inconsistent enforcement in St. Paul, where a Category II Rule 36 facility obtained a supervised living facility license because staff believed the Department of Health would not allow them to supervise medications without this license.[24] However, two miles away, most residents of a Category II facility with a board and lodging license have their medications administered by staff, apparently without objection by health regulators.

We also found that board and lodging facilities that do not have human services licenses often administer or supervise medications. Specifically:

---

24 Most Category II facilities have board and lodging licenses, whereas all Category I facilities have at least a supervised living facility license.

- **Fourteen out of 19 board and lodging facilities in which we inspected medication distribution either supervised or administered medications, in violation of state rules.**

One board and lodging facility kept resident medications in an unlocked kitchen cabinet, and several facilities did not have locked spaces in residents' rooms to permit secure self-storage of medications. A few facilities recorded whether residents took their medications, but most did not.

Side Effects Monitoring

Psychotropic medications can have strong side effects.

The positive effects of psychotropic medications are often powerful, but negative effects can be powerful, too. Tardive dyskinesia is the most common problem. This disorder is characterized by involuntary movements, such as tics, lip smacking, tongue thrusting, and grimacing. Besides being functionally disabling and irreversible in some cases, these symptoms often contribute to low self-esteem. Some symptoms are "masked" and do not show up in clients until they stop taking their medication. Presently, there is no reliable, effective treatment for tardive dyskinesia.[25]

Our literature reviews and discussions with medication experts indicated that tardive dyskinesia and other side effects should be monitored with standardized evaluation methods for all people taking psychotropic medications.[26] We found that:

- **Minnesota's regional treatment centers and community facilities for mentally retarded adults are required to monitor medication side effects, but community facilities for adults with mental illness are not.**

According to Department of Human Services policy, residents of regional treatment centers on specified psychotropic drugs "shall be regularly and systematically assessed and evaluated for tardive dyskinesia."[27] The centers must assess residents at least twice a year and forward the results to the patients' physicians. In 1988, the department developed a side effects monitoring checklist and reference manual for community facilities for mentally retarded adults, and the department's licensing division now reviews medication monitoring during regular facility inspections.[28] About 20 percent of residents in community facilities for adults with mental retardation take psychotropic medications. In contrast, although at least 90 percent of Rule 36 residents take

---

25 John E. Kalachnik and Kenneth M. Slaw, "Tardive Dyskinesia: Update for the Mental Health Administrator," *Journal of Mental Health Administration*, 1986, no. 2, pp. 1-8.

26 The most common instruments are the Dyskinesia Identification System (DISCUS), Monitoring of Side Effects Scale (MOSES), and Abnormal Involuntary Movement System (AIMS).

27 Department of Human Services Residential Facilities Manual, Policy 6620.

28 DHS Licensing Division, *Psychotropic Medication Monitoring Checklist and Manual for Rule 34 Facilities*, September 1988. This was developed in response to *Welsch v. Gardebring* Negotiated Settlement, 1987, Section VB5-6 (United States District Court, District of Minnesota, Fourth Division No. 4-72, Civ. 451).

medications, there are no rules or policies that explicitly require Rule 36 facilities to evaluate side effects.

Despite the lack of state policy on medication monitoring, we thought that Rule 36 staff might recognize the importance of regular monitoring. During our site visits to facilities, we looked for evidence of side effects monitoring in resident records and found that:

- **Rule 36 facility staff assessed medication effects with a standardized instrument for only 11 percent of the residents on medication. We found no evidence of monitoring (including informal notes) for more than half of the residents on medication.**

There is inadequate monitoring of medication side effects.

Many of the files that contained evidence of structured monitoring had just one assessment, meaning there had been no ongoing tracking of "baseline" measures of medication effects. Some facilities' staff said that residents were being assessed for side effects by other providers (such as mental health clinics), but we rarely found records of this in the Rule 36 files.

In contrast to the lack of medication monitoring among residents of Rule 36 facilities, a recent study by the Office of the Ombudsman for Mental Health and Mental Retardation concluded that 94 percent of clients taking psychotropic medications in community facilities for adults with mental retardation are monitored for side effects using a standarized method.[29] Thus, although psychotropic medications are a less common form of treatment for mentally retarded than mentally ill adults, they seem to be monitored more closely.

We also interviewed staff at board and lodging facilities and found that:

- **Board and lodging facilities do virtually no systematic monitoring of medication side effects, nor do most keep even informal records of side effects.**

This is not surprising, given that these facilities often keep few resident records of any kind.

Prescription Monitoring

From our discussions with experts in the field of psychotropic medication, we learned that some generally accepted standards for prescriptions have evolved within the medical profession. For example, there is general agreement that dosages of particular drugs should fall within certain ranges, and that some drugs do not work well in combination with others. Exceptions to these general rules are sometimes appropriate, but they should be justified by the prescribing doctor.

During our site visits, our mental health consultant reviewed the medication files of more than 100 residents. Although the purpose of this review was pri-

---

29 Office of the Ombudsman for Mental Health and Mental Retardation, *A Survey of Psychotropic Medication Usage in Community Rule 34 Facilities in Minnesota*, August 1989, p. 5.

marily to review facilities' medication monitoring practices rather than to compare systematically the prescriptions against a set of standards, she observed several cases in which residents were on multiple antipsychotic drugs or unusually high dosages, without written justification from a doctor. This is noteworthy because:

- **There is no systematic process for independent review of prescriptions.**

As a result, it is usually up to clients or facility staff to raise any concerns they have about medications with the prescribing doctor. If the doctor does not change a prescription that the client thinks is inappropriate, the client's main recourse is to change doctors.

DISCHARGE PRACTICES

We discussed Rule 36 facilities' discharge practices with the 24 providers we visited, county mental health staff, and mental health advocates. We did not review specific cases to try to determine whether individual decisions were appropriate, but we tried to determine whether there are widespread practices that are clearly discriminatory or arbitrary.

The people we interviewed expressed two primary concerns about Rule 36 discharge practices, namely that: (1) residents can stay at some facilities only for a limited time, and (2) too many residents are moving from one Rule 36 facility to another because staff do not tailor programs to individual needs.

Limits on Length of Stay

We reviewed data on residents' average length of stay in Rule 36 facilities and found that:

- **The average length of stay of current Rule 36 residents is declining, apparently because facilities have been discharging some of their longer-term residents.**

The average length of stay in Rule 36 facilities is 11 months.

Table 3.6 shows recent trends in the number of residents with various lengths of stay. The only significant change has been a reduction in the number of residents who have been in facilities for one to two years. We also found that the average length of stay of discharged residents is higher now than it used to be. On average, residents discharged from Rule 36 facilities in 1988 had been there for 10.7 months. By comparison, the average length of stay for residents discharged in 1986 was 8.6 months, and in 1984 it was 7.1 months.[30]

Neither state law nor rules limit the time that people may stay in a Rule 36 facility. However, during the past three years, there have been concerns within the Department of Human Services that some Rule 36 residents have been in

30 Department of Human Services biennial Rule 36 reports to the Legislature, 1985, 1987, 1989.

Table 3.6: Length of Stay For Rule 36 Residents

Number of residents that have lived in a facility for:	1986	1987	1988
Less than 1 year	754	750	910
1 to 2 years	374	263	238
2 to 3 years	139	154	137
3 to 5 years	141	174	137
5 or more years	169	158	170

Source: Department of Human Services, as reported by Rule 36 facilities.

Note: The Table represents the number of clients in Rule 36 facilities on June 30 of 1986, 1987, and 1988.

State law requires that length of stay be governed solely by client need.

treatment facilities longer than necessary. In February 1988, the department asked counties seeking state funds for Rule 36 facilities to "provide a statement of the facility's efforts to reduce residents' length of stay." Many Rule 36 staff told us that the department encouraged a two-year limit on treatment programs, although this was not a written policy. A May 1989 departmental draft of revised Rule 36 proposed limiting Rule 36 stays to one year unless a resident's treatment team justifies a longer stay.[31] The 1989 Legislature mandated that the Rule 36 rewrite "shall assure that length of stay is governed solely by client need and shall allow for a variety of innovative and flexible approaches in meeting residential and support needs of persons with mental illness."[32]

People in favor of limiting length of stay argue that such limits are socially, medically, and fiscally responsible. They suggest that "active" treatment should show results within a reasonable time period and should be changed if it is not working. Opponents of time limits argue that mental illness often lasts a lifetime, and treatment plans must be flexible enough to meet ongoing, long-term needs.

During our interviews with Rule 36 staff, we learned that:

- **In practice, 5 of the 24 facilities we visited impose time limits on length of stay.**[33]

Staff at four of these facilities attributed their time limits to county actions, and at the fifth, staff said limits were required by both the state and county. The other 19 facilities have either not been pressured to impose time limits, ig-

31 The draft says longer stays might be necessary when (1) discharge would constitute a neglectful act under the Vulnerable Adults Act, (2) the resident has continuing delusions or disorientation, or (3) the resident exhibits grossly disruptive or potentially harmful behavior.

32 Minn. Laws (1989), Ch. 282, Art. 4, Section 61.

33 The time limits for these five facilities were 60 days (in a respite facility), one year (two facilities), 18 months, and two years.

nored limits sought by the state or counties, or used suggested limits only as guidelines.

Our review of files indicated that many residents receive treatment that is not very "active," that is, designed to return residents to more independent living arrangements. Many residents' mental health needs are only indirectly addressed by facilities, and we think treatment plans should be more creative. However, we have not seen research indicating that it is reasonable to expect appropriate treatment to show positive results in all clients in a specified period, so we cannot endorse strict time limits on treatment stays.[34] It is possible that some clients will take a long time to respond to appropriate treatment or may not respond at all. The department's draft revision of Rule 36 does not contain the strict time limits that some facility staff feared, and we think it is appropriate for the department to request justification for long stays. At the same time, we think that "active" treatment can be encouraged by other means, as discussed in our recommendations at the end of this chapter.

Movement of Residents Between Rule 36 Facilities

Some mental health advocates believe that too many adults with mental illness move from one Rule 36 facility to another. Their concern is that facilities will not be flexible to meet residents' needs, and such moves result in additional stress for the clients. We found that:

- **In 1988, 12 percent of Rule 36 discharges were to another Rule 36 facility, up from 10 percent in 1986 and 1987.**

Residents of Rule 36 facilities in the seven-county Twin Cities metropolitan area are twice as likely to be discharged to another Rule 36 facility as residents outside the metropolitan area. Table 3.7 shows these rates of discharge to other Rule 36 facilities. The high rate in Hennepin County largely reflects the presence of two "respite" Rule 36 facilities. These facilities usually accept residents for periods of less than two months, and then arrange longer-term living arrangements (often in another Rule 36 facility). The program director at one respite facility told us that community hospitals now do inadequate discharge planning for patients, so the respite facilities are taking over this function while providing temporary housing for clients.

Some Rule 36 staff told us that moves from one facility to another often are done to increase or decrease supervision for residents. Thus, residents from Category I Rule 36 facilities (which have high staffing levels) might move to Category II facilities (with less staffing). However, we reviewed placement information on individual facilities and found that:

---

34 A possible exception is clients served in crisis or respite facilities, which are intended to provide short-term treatment.

Table 3.7: Percentage of Clients Discharged From Rule 36 Facilities in 1988 Who Went Directly To Another Rule 36 Facility

Discharges From Facilities	Percent
In Hennepin County	18.7
In Ramsey County	10.8
In Counties Outside the Twin Cities Metro Area	6.8
Statewide	11.9

Source: Program Evaluation Division analysis of Fiscal Year 1988 data from the Department of Human Services.

- **About 47 percent of moves between Rule 36 facilities do not result in significantly increased or decreased levels of supervision for the residents.**[35]

We also found that moves between Rule 36 facilities may occur for reasons other than changes in supervision. For example, clients may want to move to a different place, perhaps to be closer to family. Also, staff sometimes find that their programs are not effective with certain residents, despite their best efforts.

Some Rule 36 facilities are more tolerant of difficult clients than others.

It is likely that staff at some Rule 36 facilities are more tolerant of difficult clients than others. In fact, a few Rule 36 staff told us that other facilities are unwilling or unable to tailor their programs to meet residents' needs. In five facilities we visited, about 30 percent of discharges are due to residents' "problem behavior." In contrast, a Minneapolis facility that specializes in difficult, assaultive residents discharged no one in 1988 for behavior problems.[36]

There are also significant differences in the extent to which residents complete the programs at various facilities. Among Rule 36 facilities, the portion of residents discharged in 1988 who completed their program ranged from 0 to 80 percent.[37] Statewide, 48 percent of residents completed their programs. The extent of program completion is only partially dependent on facility policies and practices. For example, residents are free to leave programs when they wish, and acute episodes of mental illness requiring resident hospitalization are sometimes beyond a facility's control.

We asked staff from hospitals around the state that place mentally ill patients in the community to assess whether Rule 36 staff adequately tailor their programs to meet client needs. Among the 19 hospitals answering this question,

35 Moves from one Category II facility to another are more common than moves from one Category I facility to another. Our finding assumes that supervision levels in all Category II facilities are relatively similar (likewise for Category I facilities), although Chapter 4 notes that staffing can vary quite a bit.

36 To some extent, facilities' ability to handle difficult clients depends on staffing levels. For example, some facilities have at least two staff people on duty during late evening hours, but most have just one.

37 Program Evaluation Division analysis of discharges, as reported by Rule 36 facilities to the Department of Human Services.

six responded that Rule 36 facilities "usually or always" tailor services appropriately, six said "often," six said "sometimes," and one said "rarely." Staff from regional treatment centers and hospitals in the Twin Cities metropolitan area voiced more concerns than staff from community hospitals outside the metropolitan area.

In our view, the summary data do not clearly indicate whether too many residents move from facility to facility. A judgment would require a case-by-case review, involving interviews with clients and facilities. However, the concerns expressed to us by mental health advocacy groups and hospital placement staff indicate some problems with discharges, and it probably makes sense to ask Rule 36 facilities to justify transfers to other Rule 36 facilities.

RECOMMENDATIONS

We think that high quality, individualized treatment plans should be the foundation of a comprehensive mental health system. The quality of facilities' programs are best evaluated by examining the needs of individual residents and facilities' programmatic responses to these needs. We found that treatment plans too often sidestep important mental health issues, and we recommend that:

- **The Department of Human Services should develop a treatment planning handbook for staff in community facilities (and improve their handbook for case managers, as discussed in Chapter 2). The handbook should identify characteristics of good plans, behaviors characteristic of various mental illnesses, and possible service strategies for various types of clients.**

- **The Department of Human Services and the Office of the Ombudsman for Mental Health and Mental Retardation should more closely monitor the quality of treatment plans and community support plans. This may require additional resources.**

Minnesota needs better state-level quality assurance efforts.

State law requires both the Department of Human Services and ombudsman's office to ensure that clients receive high quality services, and both need to improve their quality assurance efforts. Presently, neither agency regularly reviews the quality of client treatment plans. Since the department is the principal funding and regulatory agency for Minnesota's mental health services, we think it makes sense for the department to play the lead role in (1) helping service providers write better treatment plans, and (2) conducting ongoing quality assurance reviews. The department expressed to us a willingness to reorder existing priorities to develop the capacity for such reviews. The ombudsman's office could periodically assess the department's efforts through similar, but less extensive, quality assurance reviews. In this role, the ombudsman would provide further assurance that high quality services are being provided to clients. We have not reviewed the budgets, workloads, and priorities of either agency in sufficient detail to know whether increased quality assurance can be accomplished with current budget levels.

We envision quality assurance reviews that assess whether plans are consistent with clients' mental health needs and contemporary professional standards. Such reviews need not be done for all clients or even a representative sample. In fact, it is possible that a careful review of even a single plan in a facility could result in improved plans for other residents of this facility. Because we think more mental health services should be provided to clients who do not live in treatment facilities, and because Chapter 2 noted weaknesses in community support plans developed by case managers, we think that both community support plans and treatment plans should be subject to periodic state quality assurance reviews.

We examined the files of many Rule 36 residents whose treatment is not particularly active or challenging. This may be appropriate for certain residents. We think the state should more carefully consider how to serve these residents while ensuring that they are not labeled, "warehoused," or served without periodic review. We recommend that:

- **The department's treatment planning handbook should suggest possible strategies and resources for serving residents who do not respond well to active treatment. The department should consider assembling a team that can provide timely clinical assistance on difficult cases at the request of facilities.**

To improve medication practices in facilities, we recommend:

- **The Department of Health should clarify its medication rules for various types of facilities, specifying requirements for staff training and supervision, allowable medication handling procedures, and record-keeping. Clients should be allowed and encouraged to self-medicate if their doctors and facility staff believe they are capable.**

Standardized assessments of medication side effects should be mandatory.

- **The Department of Health should ensure consistent enforcement of medication rules in various types of facilities.**

- **The Legislature should mandate that county case managers arrange for standardized assessments of side effects for all their clients on psychotropic medications.**

These assessments must be conducted by qualified professionals. Facilities that store medications for their residents should arrange or conduct side effects assessments for any of their residents who do not have case managers. The results of these assessments should be documented in case management or facility records, and results should also be forwarded to physicians. The Department of Human Services should develop a medication monitoring manual for facilities, and the Licensing Division should routinely review Rule 36 medication practices.

- **The Departments of Health and Human Services should consider the merits of periodic "prescription audits" in facilities that serve clients on psychotropic medications.**

Such audits would assess whether the types, dosages, and justifications for client medications meet acceptable standards. The departments should also develop guidelines for "minimal effective dosage" programs for community facilities.

Effective July 1990, facilities may not house more than five adults with mental illness unless they have a human services program license. We think this statute will be difficult and expensive to enforce. Moreover, people with mental illness have a right to live in the place of their choice, and this law may limit their choices. We think the Legislature should regulate the activities of board and lodging facilities, rather than the number of people with mental illness who live in them. The Legislature took a step in this direction in 1989 when it required that board and lodging facilities providing "health supervision" and "supportive services" be subject to health department rules (yet to be developed). However, the distinction between these services and Rule 36 "treatment programs" remains unclear. We recommend that:

- **The Department of Human Services should develop a definition of "treatment" that Department of Health inspectors can use to determine whether board and lodging facilities require human services licensure. Once this is done, the Legislature should repeal its requirement of human services licensure for board and lodging facilities with five or more adults with mental illness.**

The state should oversee board and lodging facilities more closely.

As a result of this change, state human services licensure would be contingent on services offered by the facility, not the number of adults with mental illness living there. But we think that even the board and lodging facilities that do not provide treatment services should be subject to more state oversight. We recognize that this additional oversight should not be based solely on the needs of residents with mental illness, since many people without mental illness also live in these facilities. Presently, the departments of health and human services are conducting a joint study of state regulation of board and lodging facilities, to be completed in early 1990. That study will recommend regulatory changes for all such facilities, not just those serving adults with mental illness. However, based on our study of board and lodging facilities serving adults with mental illness, we recommend:

- **The Legislature should extend relevant portions of the Vulnerable Adults Act and patients' bill of rights to residents of board and lodging facilities with "health supervision" and "supportive services" licenses.[38] Board and lodging facilities should annually report the number of residents for whom they store psychotropic medications, and the Ombudsman for Mental Health and Mental Retardation should be authorized to review quality of service for people whose medications are stored by these facilities.**

- **The Legislature should authorize the Office of Health Facility Complaints to accept and investigate complaints from residents in all board and lodging facilities, even though these facilities are technically not considered "health care" facilities.**

---

38 For example, abuse and neglect of residents should be systematically reported and investigated, although it may not be practical for such facilities to develop vulnerable adults plans for each of their residents. Such plans are presently required for residents of health care facilities.

- **The Department of Human Services should develop rules regarding privacy and space requirements in negotiated rate facilities.**

Negotiated rate facilities (discussed more fully in Chapters 1 and 6) are those in which the state pays for most room and board costs using General Assistance or Minnesota Supplemental Aid. All Rule 36 facilities and many board and lodging facilities are negotiated rate facilities. We think that if the state continues to pay for residents' room and board in these facilities, it should have at least minimal expectations about the physical characteristics of these buildings.

To help ensure that clients are not required to move more often than necessary, we recommend:

- **State rules should require Rule 36 facilities to justify resident transfers to other Rule 36 facilities.**

To help ensure more consistent delivery of services after clients leave Rule 36 treatment, we recommend:

- **The Department of Human Services should clarify the respective responsibilities of county case managers and Rule 36 facility staff for aftercare service to discharged Rule 36 clients.**

We think that community facilities should be small and homelike, but nearly one-third of Rule 36 clients are in facilities with more than 80 beds. We recommend:

- **The Department of Human Services should require large Rule 36 facilities to reduce their populations in the next few years to levels commensurate with other facilities.**

Three facilities (Andrew Care Home, Hoikka House, and Guild Hall) have large numbers of residents in single buildings. We think the living environments in these facilities are too institutional and contrary to the Legislature's preference for "small homelike settings."[39] The other large Rule 36 facility (Familystyle Homes) presents a more difficult issue. It houses 112 residents on a "campus" of 15 buildings. Individual buildings are small and homelike, but the facility has more institutional qualities than the other small facilities we visited.

---

39 Minn. Laws (1989), Ch. 282, Art. 4, Section 61.

RULE 36 STAFFING AND SALARIES

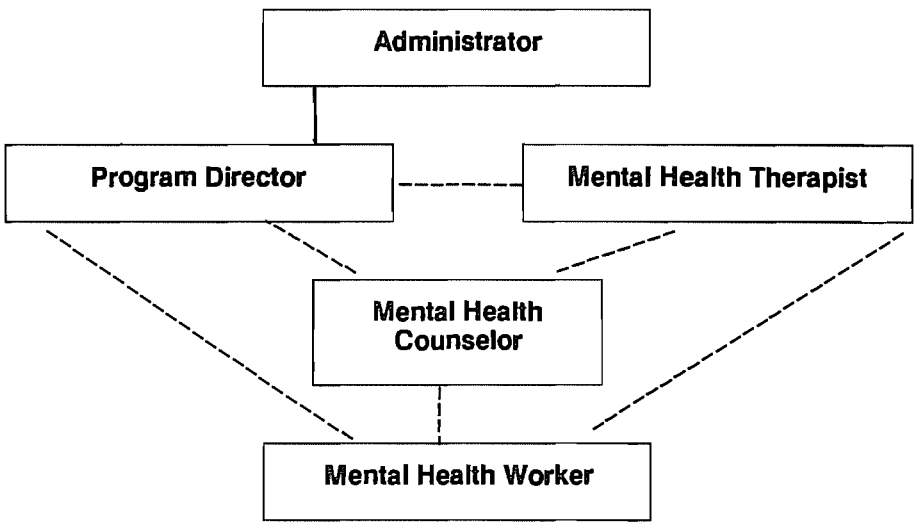
Chapter 4

The quality of Rule 36 treatment programs depends largely on the quality of staff that facilities attract. In addition, most mental health professionals agree that people with mental illness should have continuity of care, so it is important for facilities to keep staff turnover as low as possible. We heard legislators, Department of Human Services staff, and facility staff raise concerns about salary and staffing levels in community facilities, so we asked:

- **How do Rule 36 salaries and benefits compare to those of comparable staff employed in the state's regional treatment centers?**
- **How much does the number of direct care staff vary from one Rule 36 facility to the next?**
- **Is turnover a problem in community facilities?**

Figure 4.1 shows the lines of authority for a typical Rule 36 facility. The "administrator" is responsible for the overall operation of the facility, including maintenance and upkeep. State rules do not specify minimum qualifications

Figure 4.1: Staff Organization in Rule 36 Facilities



Source: Based on lines of authority identified in Minn. Rules Ch. 9520.

for administrators, and many facilities do not have full-time administrators.[1] Sometimes the administrator is also the facility's "program director." The program director implements and oversees the facility's direct services to residents.

State rules specify staffing ratios for mental health therapists, counselors, and workers. In Category I Rule 36 facilities, these direct care employees must together comprise at least one full-time-equivalent staff person for every five residents. In Category II facilities, there must be at least one staff person for every 10 residents. All facilities must have staff on duty 24 hours a day. The Department of Human Services' most recent draft of staffing rule revisions proposes that facilities have at least one full-time-equivalent staff person per 10 residents "during the hours that residents are awake" (similar to the current Category II staffing requirement).

METHODS

We used a study by the Department of Employee Relations (DOER) as a model for our research on staffing issues in Rule 36 facilities. The 1988 Legislature asked DOER to examine salaries, benefits, and turnover in community facilities for adults with mental illness. The department's study found that these facilities pay their direct care employees about 60 percent of regional treatment center (RTC) wages for comparable positions. It concluded that the lower wages resulted in higher turnover in community facilities.[2] We surveyed all Rule 36 facilities in June and July 1989. The 63 facilities that responded have about 85 percent of the state's Rule 36 beds. We asked facilities to report information on their current number of staff and the extent of turnover in 1988.

We also sent Rule 36 administrators a list of regional treatment center job descriptions and asked them to identify the RTC job or jobs most similar to each of their employees' jobs. If a Rule 36 job did not correspond entirely to a single RTC job, the administrator could identify a second RTC job that closely matched the job's other duties. The administrator then estimated the portion of the employee's time spent doing tasks consistent with each of the two specified jobs.[3] Rule 36 staff provided information on current wages, benefits, and minimum qualifications for each employee. If Rule 36 staff reported that 80 percent of an employee's job corresponded to a "human services technician" at an RTC and 20 percent corresponded to a "skills development specialist," then we estimated this person's comparable RTC salary by adding 80 percent of the average human services technican's wages and 20 percent of the average skills development specialist's wages. We compared Rule 36 and RTC turnover in a like manner.

---

1 We visited one facility with a full-time administrator who had no knowledge of her facility's budget.

2 Department of Employee Relations, *Study of Employee Wages, Benefits and Turnover in Minnesota Direct Care Facilities Serving Persons with Developmental Disabilities*, January 1989.

3 We received information on 777 Rule 36 employees. Rule 36 staff were able to match 64 percent of these to RTC jobs. In the remaining cases, staff said that their employees' jobs were not comparable to any of those at the RTCs.

To help us make comparisons between Rule 36 facilities and RTCs, we identified 22 RTC job titles that Rule 36 staff most frequently matched to their jobs. We asked RTC staff to provide us with information on qualifications and turnover for these positions, and we obtained statewide averages of current RTC salaries from the Department of Employee Relations.

In addition to the staffing and salary survey, we interviewed staff in the 24 Rule 36 facilities that we visited about turnover and staffing patterns.

FACILITY STAFFING

In the facilities we visited, employee salaries and benefits were about 59 percent of total expenditures in 1988.[4] We found considerable variation in facilities' staffing approaches. One Category II facility (Hiawatha Hall, Winona) has a live-in family of two adults and three children, and the adults are facility employees. We visited two multi-building facilities (Bristol Place in Minneapolis and Familystyle Homes in St. Paul) that do not have staff specifically assigned to each of their buildings. We found that about two-thirds of the facilities have nursing staff, and the rest do not. A few facilities have specialists in vocational training, but most facilities refer residents to community vocational services. All but a few facilities have only one staff person on duty after midnight, and this makes some administrators reluctant to admit too many residents with histories of problem behavior.

Most facilities' staffing levels appear to meet state requirements.

We asked facility staff to provide us with information on their "direct care" employees and found that:

- **There are an average of 2.2 beds per full-time-equivalent direct care staff member in Category I facilities and 3.2 beds in Category II.**

The resident-to-staff ratios mandated by state rules (5:1 for Category I and 10:1 for Category II) apply only to the facilities' total number of mental health therapists, counselors, and workers. For our survey, we chose to let facilities report information on other staff who, in their view, also provide direct care. Some facilities included administrators, program directors, nurses, and others in their estimates of direct care staff. Because of this, we were unable to precisely assess facilities' compliance with state staffing ratios, although it appears that most facilities are well within state requirements.

Nevertheless, we did find one case in which a facility's self-reported staffing clearly does not meet state requirements. Hoikka House, a Category I facility in St. Paul, reported that it has 18 full-time-equivalent staff for its 108 residents. This ratio of six beds per staff exceeds the required ratio of five beds per staff.[5]

4 In the facilities we visited, salaries and benefits ranged from 34 to 76 percent of total expenditures. The facility that spent the lowest portion of its budget on employee salaries and benefits spent a larger portion of its budget on contract services than any other facility, so it appeared to be substituting contract services for regular employees.

5 Hoikka's 18 staff include a full-time administrator, program director, and director of nursing, and a portion of their time is probably administrative in nature. Thus, for purposes of judging compliance with state rules, Hoikka's actual staffing is between 15 and 18 full-time-equivalents.

We found considerable variation in facility staffing levels. The programs with very high staffing levels usually are more specialized, such as those serving clients in crisis or clients with impairments other than their mental illness. We also noticed that:

- **The facilities with the most beds tend to have very low staffing levels compared with other facilities.**

Table 4.1 shows the facilities with the highest and lowest reported staffing levels. It is worth noting that Minnesota's four largest facilities, which account for nearly one-third of the state's Rule 36 beds, all have low staffing levels relative to other facilities. It is also interesting--and indicative of the lack of differentiation between categories--that some Category II facilities are more highly staffed than some Category I facilities.

Some Category II facilities are more highly staffed than Category I facilities.

Table 4.1: Rule 36 Facilities With the Highest and Lowest Direct Care Staffing Levels

Category I Facilities	Beds Per FTE
Journey House (Plymouth)	0.45
Temporary Residence (Willmar)	0.88
Theodore I (Inver Grove Heights)	0.90
Broadway Center (Winona)	2.34
Andrew Care Home (Minneapolis)	3.27
Hoikka House (St. Paul)	6.00
Category II Facilities	**Beds Per FTE**
Welcome Home (Eden Prairie)	1.61
Passageway (Minnetonka)	1.64
Northwest Residence (Brooklyn Center)	1.68
Familystyle[a] (St. Paul)	4.87
Bristol Place/Groveland (Minneapolis)	5.10
Guild Hall (St. Paul)	5.52
Parkside Homes (Soudan)	7.00

Source: Program Evaluation Division staffing survey, June-July 1989. Data on number of beds is from Department of Human Services, January 1989.

[a]Familystyle has 112 beds, of which 21 are Category I, and 91 are Category II.

Although most facilities appear to comply with state staffing requirements, we think the existing requirements are quite minimal. For example, we visited one facility that is well within the staffing requirements but has only one direct care staff member on duty 24 hours a day.[6]

6 For two of its residences, Bristol Place in Minneapolis has a total of about 4.2 full-time-equivalent staff serving 21 beds, which barely provides continual staffing for a 168 hour week.

We have particular concerns about the low staffing levels in some facilities given the minimal qualifications required of some direct care workers. For example, staff at a Willmar facility told us that none of the direct care staff, except for one nurse, have degrees from a four-year college. Also, we learned that a program director for a St. Paul facility does not have a college degree.[7]

We examined staff education and experience in the largest Rule 36 job class, staff comparable to RTC human services technicians, and did not find significantly different qualifications between RTC and Rule 36 staff. However, given that RTCs have more professional staff available for employee supervision and given the need for more creative services in community facilities, it might be reasonable to expect higher qualifications among Rule 36 staff.

SALARIES

Our survey of Rule 36 administrators allowed us to compare the wages of 500 Rule 36 employees to their counterparts in Minnesota's regional treatment centers. As described earlier, the administrators reviewed RTC job descriptions and identified those most comparable to Rule 36 jobs. We found that:

Rule 36 salaries are much lower than regional treatment center salaries.

- **On average, Rule 36 salaries are 36 percent less than those of RTC employees having comparable duties.**

Table 4.2 shows salary comparisons for specific jobs. Rule 36 salaries are consistently lower than RTC salaries, although Rule 36 nurses and social workers have wages slightly closer to RTC wages than do other staff. Rule 36 staff in the Twin Cities metropolitan area usually have higher wages than staff in other parts of the state, but their wages are still significantly lower than RTC wages. For example, for the single largest group of Rule 36 workers, those with jobs comparable to RTC human services technicians, the staff salaries at Twin Cities area Rule 36 facilities are 30 percent lower than RTC salaries. In contrast, human services technicians from Rule 36 facilities in the northwestern and north-central parts of the state receive wages that are about 50 percent below their RTC counterparts.

There are many possible explanations for the wage differences between Rule 36 facilities and RTCs. First, RTC staff are unionized, unlike most Rule 36 staff. Second, in the past decade the Department of Human Services spent most of its new Rule 36 funding on expansion of facilities, rather than augmenting the budgets of existing facilities.[8] Third, although we did not collect information on employees' tenure in their current jobs, it is likely that RTC staff have more years of experience than Rule 36 staff, given the recent development of most community facilities. However, if indeed RTC staff have longer average tenure, it is unclear whether this is a **cause** or **result** of the

7 This is a violation of state rules, and the facility (Familystyle Homes) was recently cited by the Licensing Division of the Department of Human Services.

8 Most Rule 36 facilities have received annual budget increases averaging three percent or less.

Table 4.2: RTC, Rule 36 Salaries for Comparable Jobs

Job Class[a] (Number of Rule 36 employees shown in parentheses)	Rule 36 Average Hourly Wage	RTC Average Hourly Wage[b]	Rule 36 Wages/ RTC Wages
Work Therapy Technician (5)	$5.76	$9.81	.59
Human Services Technician (218)	6.08	9.75	.62
Structured Program Assistant (36)	6.20	11.10	.56
Recreation Therapist and Program Assistant (41)	6.44	11.36	.57
Skills Development Specialist (23)	7.14	12.23	.58
Social Worker (34)	8.89	11.70	.76
Licensed Practical Nurse, Registered Nurse (42)	9.06	11.78	.77
Group Supervisor and Assistant (23)	10.94	18.04	.61
Psychologist, Psychologist Supervisor (10)	11.92	18.16	.66
Residential Supervisor, other supervisory positions (64)	12.59	19.77	.64
TOTAL	$7.79	$12.25	.64

Source: Program Evaluation Division survey of Rule 36, RTC administrators, June - July 1989.

[a]RTC job titles are listed. The Rule 36 staff whose wages are shown in each job class are those whose jobs predominantly match the various RTC job classes (that is, 50 percent or more of an employee's job matches the RTC class shown).

[b]The wages shown are based on actual RTC wages, but we constructed hypothetical RTC wages that directly correspond to the job duties of each Rule 36 employee.

There are many possible explanations for salary differences.

higher wages. The Department of Employee Relations' study of wages in community facilities for mentally retarded adults and regional treatment centers concluded that wages have a significant impact on staff turnover in both settings.[9] Fourth, RTC employees may have higher qualifications than Rule 36 employees. We asked Rule 36 and RTC staff to tell us the minimum education and experience needed for each position. We were unable to tell whether facilities reported their formal requirements or the actual qualifications of job incumbents. In any case, the requirements for a given job vary considerably from one RTC to the next and from one Rule 36 to the next, so we could not determine conclusively whether wages are related to qualifications. Finally, it is possible that the number and backgrounds of mental health staff in various labor markets affect facility wage levels. Although we documented regional differences in Rule 36 salaries, we did not analyze the supply of potential job-seekers in particular labor markets.

9 Department of Employee Relations, *Study of Employee Wages, Benefits and Turnover in Minnesota Direct Care Facilities Serving Persons with Developmental Disabilities*, January 1989, pp. 22-23.

A final salary issue we examined is administrative salaries. During our visits to Rule 36 facilities, we obtained salaries for administrators and program directors. Most facilities do not have a full-time administrator, so we calculated full-time-equivalent salaries. We found that the median salary for administrators is $35,000, with a range from $25,000 to $62,000.[10] The median program director salary is $30,000, with a range from $21,000 to $54,000.[11]

EMPLOYEE BENEFITS

As noted in the previous section, it is possible that differences in Rule 36 and RTC salaries result partly from differences in employee tenure. However, we would not expect tenure to affect whether an employee has basic benefits, such as health insurance, paid days off, and pensions. We examined whether RTC and Rule 36 employees have these benefits, although we did not determine the value of benefits received.

All RTC mental health staff, full-time and part-time, receive the three benefits listed above. We found that:

- **Rule 36 employees have fewer employee benefits than RTC employees.**

Most full-time Rule 36 staff do not have pension benefits.

The facilities responding to our survey have 443 full-time and 334 part-time employees. Table 4.3 shows how many Rule 36 employees have each type of basic benefit, and Figure 4.2 compares the percentages of Rule 36 and RTC staff who receive all three types of benefits we examined. Rule 36 employees usually do not have pension benefits, and part-time employees often lack health insurance and paid days off.

Table 4.3: Percent of Rule 36 Employees With Various Types of Benefits

	Health Insurance	Paid Days Off	Pension
Full-time	98%	100%	39%
Part-time	31	57	21

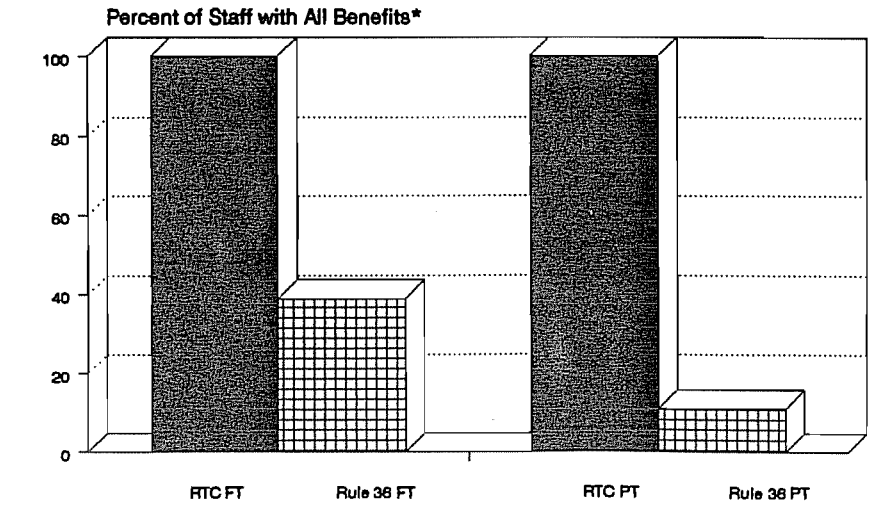
Source: Program Evaluation Division survey of Rule 36 facilities, June - July 1989.

For health benefits and paid days off, we did not find significant differences in benefit availability between Twin Cities area Rule 36 facilities and those elsewhere in the state. However, for both part-time and full-time employees, we

10 The administrator with the highest salary said that 10 percent of his salary is paid by the facility we visited.

11 Large facilities have more than one program director, and we did not verify whether all staff described as "program directors" had the state-required qualifications. The facility with the highest paid program director has three other program directors who report to this person.

Figure 4.2: Benefits of Rule 36 and RTC Full-Time and Part-Time Employees



Source: 1989 OLA Salary Survey

*Health care, pensions, paid days off

found that Twin Cities Rule 36 facilities are less likely to pay pension benefits than facilities elsewhere. For example, 24 percent of full-time Rule 36 employees in the Twin Cities area receive pension benefits, compared to 68 percent in other parts of the state.

TURNOVER

Most mental health professionals think that adults with mental illness should have as much continuity in their caregivers as possible. Many clients have difficulty establishing social relationships, so they strongly value good relationships with treatment staff. Clients often grow close to staff and experience stress when staff leave.

We surveyed Rule 36 and RTC facilities about the extent of staff turnover in 1988. We defined "turnover" as the number of staff leaving a job class compared to the total number of incumbents in this job class. Our survey allowed us to examine reasons why staff left facilities, and we focused on those staff who resigned.[12]

We found that:

- **The turnover rate in Rule 36 jobs is five times as high as in comparable RTC jobs.**

12 The other reasons for leaving a job class include promotion, demotion, firing, and retirement. More than three-fourths of people leaving job classes left due to resignation.

The number of Rule 36 staff who resigned in 1988 was about half the number of people currently holding these jobs. In contrast, the number of resignations in RTCs was about one-tenth the number of incumbents.

Table 4.4 shows the turnover rates for various RTC and Rule 36 job classes. All Rule 36 jobs have substantially higher turnover than comparable RTC jobs.

Table 4.4: RTC, Rule 36 Turnover Rates For Comparable Jobs

	1988 Resignations/Current Staff	
Job Class[a]	Rule 36	RTC[b]
Work Therapy Technician	.167	0
Human Services Technician	.522	.127
Structured Program Assistant	.694	.045
Recreation Therapist and Program Assistant	.902	.056
Skills Development Specialist	.480	.009
Social Worker	.517	.165
Licensed Practical Nurse, Registered Nurse	.381	.110
Group Supervisor and Assistant	.318	.032
Psychologist, Psychologist Supervisor	.444	.025
Residential Supervisor, other supervisory positions	.254	.023
TOTAL	.503	.090

Source: Program Evaluation Division survey of Rule 36, RTC administrators, June-July 1989.

[a]RTC job titles are listed. The Rule 36 staff represented in each job class are those whose jobs predominantly match the various RTC job classes (that is, 50 percent or more of an employee's job matches the RTC class shown). The job classes are listed in ascending order of Rule 36 wage levels.

[b]The turnover shown is based on actual RTC turnover, but we constructed hypothetical RTC turnover rates that directly correspond to the job duties of each Rule 36 employee. For example, if 80 percent of a Rule 36 job consists of duties comparable to a Human Services Technician and 20 percent to a Social Worker, we estimated comparable RTC turnover for this position by adding 80 percent of the RTC Human Services Technician turnover rate and 20 percent of the RTC Social Worker turnover rate.

Turnover rates are much higher in Rule 36 facilities.

We reviewed the three largest Rule 36 job classes to determine whether there are regional turnover patterns. Facilities in the Twin Cities metropolitan area have relatively high turnover in each of these three job classes even though their wages are also higher. This probably reflects the metropolitan area's more competitive job market and lower unemployment rate. The turnover data do not indicate other clear regional patterns.

Despite Rule 36 facilities' relatively high turnover compared to RTCs, staff in only three of the 24 facilities we visited said that turnover among full-time direct care staff is a "serious" problem. Staff in eight other facilities said turnover is "somewhat" of a problem. Most administrators said they have difficulty retaining good part-time staff.

CONCLUSIONS

Our interviews with Rule 36 residents indicated that they often have considerable insight into their illnesses and treatment programs. When programs do not meet their needs, they may become bored and frustrated, and some decide that no treatment is better than the treatment they are receiving.

Because of this, it is critical that providers of mental health services be good observers, listeners, communicators, and teachers. Especially in residential programs, staff should be familiar with the nature of mental illness and its treatment, and they should be able to creatively tailor services to meet individual needs. As the previous chapter indicated, there is too little creativity and teaching evident in Rule 36 plans, which leads us to question whether facilities are attracting highly qualified staff and supervisors. Higher wages are no guarantee of better staff, but the Legislature should use the information provided in this chapter to help determine the adequacy of salaries and benefits.

In addition, we think the Department of Human Services should reconsider the adequacy of staffing levels required by state rules, although it is difficult for us to make recommendations until the department clarifies the purpose of Rule 36 treatment facilities. In general, we think that current and proposed staffing ratios are inadequate if the department wants facilities to (a) offer active, intensive treatment to residents, or (b) provide alternatives to hospitalization for unstable clients or those needing extensive supervision. The low staffing that some facilities have is appropriate for certain clients, but we question whether *this* level of support should be tied to residence in a facility. Residents who need only minimal staffing support should be able to receive it outside of residential treatment facilities.

EFFECTIVENESS OF COMMUNITY PROGRAMS

Chapter 5

Research indicates that many mental illnesses might be genetically-based, in which case the notion of "curing" mental illness is not particularly useful. However, research also indicates that even severe mental illnesses are not necessarily disabling, and the prognosis for improvement is better than once believed. Most treatment programs try to alleviate, if not cure, symptoms of mental illness so that clients can participate more fully in society and live in the least restrictive settings possible. We think it is important to consider whether programs have an impact on residents' lives. We asked:

- **What does research literature indicate about the effectiveness of community mental health programs?**
- **What impact do Rule 36 facilities have on their residents' hospitalization rates, living arrangements, and employment?**
- **Are Rule 36 residents satisfied with the services they receive?**
- **Do facilities have appropriate means of monitoring residents' progress?**

Mental health is hard to measure, and good treatment does not always produce client improvements.

Assessing the outcomes of mental health programs is an extremely difficult task. Mental health is hard to measure, and good treatment does not always produce improvements. Moreover, it is difficult to separate the effects of treatment programs from those of other influences on the client, such as psychotropic drugs and the client's social environment. Because of these difficulties, this chapter tries to summarize what is known about the outcomes of community treatment programs from several perspectives, and it suggests some ways the state might improve its measures of outcomes and service needs.

LITERATURE REVIEW

The deinstitutionalization movement was based on a belief that hospital settings are inappropriate long-term living arrangements for most people with serious mental illnesses. When the movement began, hospitals often provided little more than custodial care, causing patients' social and vocational abilities to deteriorate.

The proper mix of hospital and community treatment remains a topic of debate.

Hospitals continue to play a role in the care and treatment of people with mental illness, but it is a more limited role today than 40 years ago. Patients do not usually stay in the psychiatric wards of community hospitals for more than three weeks, and stays in regional treatment centers are typically measured in months, not years. Still, there continue to be questions about the proper mix of hospital and community treatment. Some observers believe that too many people have been discharged from hospitals to the community. Also, the 1989 Legislature instructed the Department of Human Services to develop proposals by February 1990 for renovation or reconstruction of four regional treatment centers that serve adults with mental illness. This indicates the Legislature's willingness to consider the possibility of large capital investments in inpatient care.

We reviewed what studies have found about the effectiveness of hospital care versus alternatives. In general, given the size and importance of the deinstitutionalization movement, we found fewer landmark studies of mental health outcomes and program effectiveness than we expected. In addition, the available studies often provide only general descriptions of the programs and clients they are evaluating, hindering useful interpretation.

Fortunately, two reviews of past research have isolated the more rigorous research, particularly studies which randomly assigned clients with mental illness to hospitals or alternative forms of treatment.[1] These literature reviews agree that:

- **No studies comparing hospitalization with alternative care have found hospitalization to yield more favorable client outcomes.**

These studies examined a wide range of alternative treatments, ranging from group homes to outpatient services to home care. They also used a variety of outcome measures, including psychiatric evaluations, employment, hospitalization rates, and living arrangements.

There remains some question about how long the positive effects of community treatment last. Many studies have reported that the best predictor of a client's future hospitalization is that client's incidence of past hospitalization.[2] Thus, helping a person avoid a hospital stay now may also reduce the likelihood of future hospitalization. However, several studies also report that the positive outcomes of community programs are not sustained after the community program ends, perhaps suggesting a need for ongoing supportive services.[3]

---

1 Charles A. Kiesler, "Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients," *American Psychologist*, April 1982, pp. 349-360; Peter Braun, et al., "Overview: Deinstitutionalization of Psychiatric Patients, A Critical Review of Outcome Studies," *American Journal of Psychiatry*, June 1981, pp. 736-749.

2 Kiesler's summary of the "best" studies concludes that "there is clear evidence here for the causal sequence in the finding... that the best predictor of hospitalization is prior hospitalization." (p.358) This may be related to the difficulty of teaching coping skills to clients in hospital settings that can be transferred to community living arrangements.

3 Braun, et al., "Overview: Deinstitutionalization of Psychiatric Patients," p. 744; Jeraldine Braff and Monroe M. Lefkowitz, "Community Mental Health Treatment: What Works for Whom," *Psychiatric Quarterly*, 1979, no. 2, p. 121; Mary A. Test and Leonard I. Stein, "Community Treatment of the Chronic Patient: Research Overview," *Schizophrenia Bulletin*, 1978, no. 3, pp. 350-364.

Although studies generally indicate positive results from community-based programs, we also found that:

- **Existing evidence does not clearly indicate which alternatives to hospital care are most effective.**

Many studies do not adequately document program content, and it is difficult to attribute client progress to particular elements of treatment, such as drug therapy or psychotherapy. Most community programs that have been the subject of study are "model" programs, and they may not reflect the content of community programs used in Minnesota. However, the important finding from the research literature is that community-based programs have well-documented *potential* for providing effective services to clients.

Community-based programs have well-documented potential for providing effective services.

Although most mental health practitioners now agree that "community integration" is a desirable goal for clients, there continues to be debate in mental health literature about appropriate expectations for client outcomes. As noted in Chapter 1, the results of long-term research suggest that most people with serious mental illness achieve some level of recovery over the course of their lives. However, some practitioners believe that residents who do not respond to rehabilitation programs sometimes do best in inactive, pressure-free settings. They argue that asylum from the demands of daily life (without expectations of independent living) should be available for such people in community settings.

EFFECT OF RULE 36 TREATMENT ON HOSPITALIZATION RATES

The most widely used measure of mental health program performance is hospitalization. Hospitalization usually occurs when mental health symptoms overwhelm clients' coping abilities. Treatment programs may be unable to prevent the onset of symptoms (although some can), but it is reasonable to expect treatment to provide clients with coping mechanisms, outlets for anger or anxieties, and links to community resources. Reduction in client hospitalization rates, but not complete elimination of hospitalization, is a realistic goal of treatment programs.

Previous Studies

The Department of Human Services collects data on hospitalization before, during, and after Rule 36 facility stays. Reports to the Legislature during the past three bienniums have concluded that Rule 36 programs are effective in reducing client hospitalization. The department reported that 64 percent of the residents discharged from a Rule 36 facility in 1988 had been hospitalized for their mental illness sometime during the year prior to Rule 36 admission, and 15 percent entered a hospital during their Rule 36 stays (which averaged 11 months). Contacts made by Rule 36 staff during 1988 with discharged clients indicated that 34 percent had been in the hospital during the six months following discharge.

Unfortunately, there are serious weaknesses in the department's data on hospitalization. First, it is based on client recollections, sometimes from several years ago, and the data does not distinguish psychiatric hospital stays from nonpsychiatric stays. Second, the clients from whom the department collects six-month follow-up data are not necessarily the same clients from whom the department collects hospitalization data before and during Rule 36 stays.[4] Third, it is inappropriate for the department to compare hospitalization rates during the six months following discharge with those from the 12 months preceding admission without adjusting for the unequal time periods. If we assume that the number of clients hospitalized during the 12 months following discharge is twice the number hospitalized during the first six months following discharge, and then we compare the "before" and "after" hospitalization rates reported by the department, we find that Rule 36 stays have no apparent effect on resident hospitalization.[5]

In 1986, Hennepin County conducted a study of Rule 36 outcomes using data similar to that used by the Department of Human Services.[6] However, county staff made adjustments in the data so that hospitalization rates before and after Rule 36 stays were compared for like time periods. The county found that clients had more hospitalizations following Rule 36 stays than before. However, Hennepin County staff also reviewed the number of days spent in the hospital and found that Rule 36 stays reduced the average client's days per month in the hospital from 5.7 to 3.6. A more recent study of Hennepin facilities reported that clients spent half as many days per month in the hospital following discharge as they did prior to admission.[7]

Program Evaluation Division Analysis of Hospitalization

For our review of client hospitalization rates, we decided not to rely on client hospitalization data reported by Rule 36 facilities. We preferred data that were not based on client recollections, and we wanted to assess only those hospital visits related to psychiatric illness. In our visits to Rule 36 facilities we collected identifying information on about 300 people discharged between July 1 and December 31, 1987. We used the identifiers to obtain Department

4 The "before" and "during" Rule 36 data are from clients discharged between July 1987 and June 1988. The six-month follow-up data are from clients discharged between January 1987 and December 1987. The department is currently improving its ability to track the outcomes of individual clients over time.

5 It is reasonable to expect that more people will be hospitalized in 12 months than six months, although there are no data to confirm that there will be exactly twice as many.

6 Hennepin County Community Services Department, Mental Health Division, *Residential Programs for Mentally Ill Adults: A Report on Clients, Costs, and Outcomes*, May 1986.

7 Touche-Ross International, *Hennepin County Financial and Programmatic Review of Rule 36 Programs, 1985-1988: Final Report*, June 1989, pp. 38-40. Touche-Ross examined hospitalization in the 12 months prior to Rule 36 admission and six months following discharge.

of Human Services data for these clients indicating regional treatment center stays and community hospital stays paid by Medical Assistance.

Appendix D provides more information on our methods. Our goal was to make comparisons between hospitalization rates for the six months before and after Rule 36 stays, as well as during the Rule 36 stay itself. For the average client, we examined hospitalization over a 22-month period, including an average Rule 36 stay of 10 months. During these "before," "during," and "after" time periods, we found that 31 percent of the clients had been in a regional treatment center and 35 percent had publicly funded psychiatric hospitalizations in community hospitals. About 58 percent of clients had been hospitalized in a regional treatment center or community hospital during these periods, according to records we reviewed. The fact that so many clients (42 percent) were not hospitalized suggests that hospitalization rates are a crude measure of mental health, and many clients enter treatment programs without having a recent hospitalization.[8]

Hospitalization rates are a crude measure of mental health.

As shown in Table 5.1, we found that:

- **On average, clients spent about half as much time in the hospital in the six months following Rule 36 discharge as in the six months preceding admission.**

This was true for stays in both regional treatment centers and community hospitals. Overall, the clients whose files we reviewed spent 7,674 days in the hospital during the six months preceding admission, compared to 3,746 days following discharge. We also found that:

- **The reduction in hospitalizations following Rule 36 discharge is somewhat greater for Category I than Category II facilities.**

Category I clients were in the hospital 55 percent fewer days following Rule 36 discharge than prior to admission. Category II clients were in the hospital 44 percent fewer days after their Rule 36 stay than before.

We also tried to identify clients who completed their Rule 36 program and compare their hospitalization rates with the rates of those who did not. It is not unusual for clients to be discharged from a Rule 36 facility at the time they are hospitalized, so we would expect to find higher hospitalization rates among the clients who did not complete their Rule 36 program. Indeed, we found that program completers' hospitalization days declined 93 percent following treatment (from 2,158 to 154), whereas the non-completers' days declined 31 percent (from 4,756 to 3,287).

Finally, we examined the relationship between hospitalization rates and length of stay in Rule 36 facilities. We found that clients in treatment for 30 days or less actually spent more days in the hospital after treatment than be-

8 The low hospitalization rates may reflect data problems described in Appendix D, but our findings are consistent with those reported by facilities to the department. In 1988, facilities reported that only 64 percent of discharged Rule 36 clients had been in the hospital during the year prior to Rule 36 admission.

Table 5.1: Hospitalization Rates Before, During, and After Rule 36 Stays

The hospitalization rates of people dropped significantly after treatment.

	Total Hospital Stays[1]		
	In Community Hospitals	In Regional Treatment Centers	Total Hospitalizations
Before Rule 36 Stay (6 mos.)	107	62	169
During Rule 36 Stay (average: 10 mos.)	60	1	61
After Rule 36 Stay (6 mos.)	56	43	99

	Total Hospital Days		
	In Community Hospitals	In Regional Treatment Centers	Total Days In Hospital
Before Rule 36 Stay (6 mos.)	1,354	6,320	7,674
During Rule 36 Stay (average: 10 mos.)	567	37	604
After Rule 36 Stay (6 mos.)	680	3,066	3,746

Source: Program Evaluation Division analysis of Medical Assistance and regional treatment center records for 243 clients admitted to Rule 36 facilities after June 1984 and discharged in the last six months of 1987.

[1]The table defines a "stay" as any continuous period of hospitalization during the intervals shown. If, for example, the client's hospitalization began seven months prior to Rule 36 admission and ended five months prior to Rule 36 admission, this would count as one stay in the "before" interval, and 30 days of this hospital stay would be counted in the before interval.

fore. Clients staying longer than 30 days in Rule 36 facilities averaged fewer hospital days following Rule 36 treatment than before treatment, and the largest reduction in hospitalizations was for clients who were in Rule 36 facilities for 6 to 12 months.[9]

Although these findings are encouraging, it is important to be cautious about the reductions in hospitalization reported here. Since we were not able to isolate other factors influencing clients' mental health, we cannot say that Rule 36 treatment causes reductions in hospitalization. Also, the placement of many clients in Rule 36 facilities following mental health crises leads us to expect higher hospitalization rates in the months immediately preceding Rule 36 admission than in the months following discharge. Finally, it is unclear from

9 The "before" and "after" hospital days for various lengths of Rule 36 stays were: 796/968 for Rule 36 stays of 30 days or less; 982/628 for Rule 36 stays of 31 to 90 days; 1,212/733 for 91 to 180 day stays; 1,511/275 for 181 to 365 day stays; 1,879/852 for one to two year stays; 1,294/290 for stays longer than two years.

our analysis whether clients are able to sustain lower hospitalization rates over the long term.

CLIENT LIVING ARRANGEMENTS AND EMPLOYMENT

Rates of hospitalization reflect clients' psychiatric well-being, but we think it is also important to monitor the extent to which programs move clients toward independence. While independent living is not a realistic goal for every client in Rule 36 programs, and most seriously ill clients need ongoing support, programs should show cumulative evidence of helping their client population live more productive, independent lives.

Unfortunately, there are some problems with data on client outcomes other than hospitalization collected by the Department of Human Services. Most important:

- **Aside from the data on hospital stays, there is no reliable information on outcomes beyond the day clients leave a Rule 36 facility, which precludes an assessment of long-term effectiveness.**

There is too little follow-up data on discharged Rule 36 clients.

Facilities provide the department with information on the living arrangements, employment status, and income sources of clients at the time of discharge. The department has asked facilities to update this information six months after discharge, but it appears that facilities are either unable to contact most of their former residents or do not make an effort to do so. In 1988, the department received follow-up information on 780 former Rule 36 residents, which is only about one-third of the residents discharged in a typical year.

In addition, the department's data do not distinguish the outcomes of clients who completed their treatment programs from those who did not.

Living Arrangements

Based on data submitted annually by facilities to the Department of Human Services, we found that:

- **On average, Rule 36 clients are discharged to more independent living arrangements than those from which they were admitted.**

Table 5.2 shows the "before" and "after" living arrangements of clients discharged in 1986 to 1988. Clients are more likely to live in independent or semi-independent living settings following discharge, and they are less likely to live in hospitals.

As with our analysis of client hospitalizations, this finding is encouraging but not entirely unexpected. Many people enter Rule 36 facilities following a cri-

Table 5.2: Percentage of Rule 36 Residents Admitted From and Discharged to Selected Living Arrangements

	Clients Discharged In:		
	1986	1987	1988
Independent living prior to admission	10.0	23.2	14.0
Independent living following discharge	29.5	35.0	28.1
Semi-independent living prior to admission	0.7	1.8	1.7
Semi-independent living following discharge	5.3	4.6	4.9
Regional treatment center prior to admission	24.1	15.7	18.4
Regional treatment center following discharge	9.8	8.3	8.6
Community hospital prior to admission	25.3	25.1	25.6
Community hospital following discharge	9.8	8.3	8.6

Source: Department of Human Services data, as reported by Rule 36 staff.

sis, often one requiring hospitalization. Thus, it is not surprising to see that fewer people are hospitalized following discharge from a treatment program than were hospitalized just prior to admission. The more important question is whether Rule 36 facilities build client skills and capabilities to allow for more independent living arrangements over the long term, and data now collected by the state provide no basis for determining this.

Employment and Income Sources

Mental health experts disagree about the employability of clients with serious mental illness. We asked staff in 24 Rule 36 facilities to estimate the number of their residents who might someday be competitively employed in full-time jobs, given proper vocational services. They estimated that only one of every four current residents have the potential for such employment.

In contrast, we visited a non-Rule 36 program in Minneapolis (Tasks Unlimited) that takes a more optimistic view of clients' employment potential. Clients live together in houses they rent from the program, and they receive

virtually all of their income from competitive employment (for which the program trains them). The program's staff believe that these residents are no less ill than Rule 36 residents and that Rule 36 staff are too pessimistic about the employment potential of clients with serious mental illness. Similarly, some academic researchers insist that the positive outcomes of rehabilitation programs for the most seriously ill clients should cause mental health staff to "adopt hope as our central and guiding value" in programs for people with mental illness.[10]

A few of the Rule 36 facilities have vocational staff, but most do not. Residents who need vocational services usually receive them in programs outside the facility. We reviewed employment data and found that:

- **Rule 36 residents are more likely to be working when they leave a facility than when they enter it, although the increase in full-time competitive employment is small.**

Table 5.3 shows that the unemployment rates of Rule 36 residents are five to fifteen percentage points lower at discharge than at admission. Table 5.4 shows that Rule 36 stays do not appear to change the number of clients who rely on welfare programs as their primary income source, although there are small increases in the number of clients who report that job earnings are their main income source.

Table 5.3: Employment Status of Rule 36 Residents at Admission and Discharge

	Clients Discharged In:		
	1986	1987	1988
Unemployed at admission	77.2	67.7	78.1
Unemployed at discharge	61.9	62.9	67.4
Full-time competitive employment at admission	1.8	4.9	4.8
Full-time competitive employment at discharge	4.9	7.2	6.3
Part-time competitive employment at admission	2.2	3.6	3.5
Part-time competitive employment at discharge	5.9	6.1	6.0

Source: Department of Human Services data, as reported by Rule 36 staff.

The effects of community treatment on employment are positive but small.

In sum, the effects of Rule 36 facilities on employment appear to be positive but relatively small. It is difficult to know whether Rule 36 facilities could have significantly larger vocational effects, although Chapter 2 noted that many residents have difficulty getting appropriate vocational services. It is worth noting that the percentage of Rule 36 clients working competitively at discharge (11 to 13 percent) is far below the percentage of current clients who

10 See Anthony M. Zipple, Paul J. Carling, and James McDonald, "A Rehabilitation Response to the Call for Asylum," *Schizophrenia Bulletin*, 1987, no. 4, pp. 543.

Most clients remain dependent on public assistance payments following treatment.

Table 5.4: Primary Source of Income of Rule 36 Residents at Admission and Discharge

	Clients Discharged In:		
	1986	1987	1988
Public assistance[1] at admission	80.9	78.4	77.0
Public assistance[1] at discharge	79.8	78.5	77.4
Job earnings at admission	2.9	6.3	6.1
Job earnings at discharge	6.2	9.4	7.4

Source: Department of Human Services data, as reported by Rule 36 staff.

[1]Public assistance includes Supplemental Security Income, Minnesota Supplemental Aid, General Assistance, Social Security Disability Income, Veterans Administration assistance, and Aid to Families with Dependent Children.

Rule 36 staff think have potential for full-time competitive employment (26 percent).

CLIENT SATISFACTION

Because changes in mental health are often subtle and hard for researchers to measure, the clients themselves are in a unique position to evaluate facility effectiveness and quality. Our conversations with residents were valuable, and we found that residents have considerable insight into their illnesses and treatment programs.

Previous Studies

The largest survey of Rule 36 clients was done in December 1987 by the Association of Mental Health Residential Facilities, which represents most of the state's Rule 36 facilities. The association heard from more than 700 Rule 36 residents, and it also surveyed patients at Minnesota's regional treatment centers. The association's efforts are valuable but should be interpreted with caution since clients might make guarded responses in surveys conducted by providers. Also, we do not know the views of the 58 percent of Rule 36 residents who did not complete the survey.

In the association's survey, most Rule 36 residents spoke favorably about their living arrangements and services. The responses of Rule 36 residents were almost always more positive than the responses of regional treatment center res-

idents to the same questions. Table 5.5 shows residents' overall satisfaction with facilities. Eleven percent of Rule 36 residents said their present living arrangement was "not satisfactory." Table 5.6 highlights those responses that reflect Rule 36 residents' overall outlook and confidence in the Rule 36 program.

Rule 36 residents expressed more satisfaction than regional treatment center residents.

Table 5.5: Overall Satisfaction With Present Living Arrangement

Rating	Percent of Rule 36 Respondents (N=745)	Percent of Regional Treatment Center Respondents (N=348)
Very Good	27	16
Good	35	26
Fairly Good	27	33
Not Satisfactory	11	26

Source: Minnesota Association of Mental Health Residential Facilities survey, December 1987.

Table 5.6: Selected Rule 36 Provider Survey Responses

	Percent of Residents Responding:		
	Yes/True	No/False	Other[1]
There is a program here that is helping me to prepare to be more independent and ready to live in the community.	77	17	6
There are enough opportunities available to me for leisure and recreation activities.	78	19	3
I feel confident that my goals will be reached.	75	17	8
My life is enjoyable.	68	23	9
I feel good about myself as a person.	75	18	7
I feel discouraged.	32	58	10
I feel that I control my own life.	65	27	8
I feel that others are in control of my life.	37	54	9

Source: Minnesota Association of Mental Health Residential Facilities survey, December 1987.

[1]745 Rule 36 residents took the survey, but some did not answer all questions. We subtracted the total number of "yes" and "no" answers for each question from 745 to determine the number of people who provided other or no responses.

In 1988, the Department of Human Services contracted with a firm to assess housing needs for people with mental illness.[11] As part of this study, the firm surveyed more than 200 people living in Rule 36 facilities and other places in the community. Unfortunately, the final report does not distinguish the responses of Rule 36 residents from the others. However, 55 percent of the respondents were Rule 36 residents, and it is interesting that only 20 percent of respondents said that the "best living situation" for them at the time of the survey would be a Rule 36 facility. Most respondents wanted to be living in a living arrangement with less supervision.

Program Evaluation Division Analysis of Client Satisfaction

During our visits to 24 Rule 36 facilities, we conducted informal face-to-face interviews with about 70 current residents. We discussed residents' program and housing preferences, as well as their level of participation in important decisions. Usually we approached residents who were in the facility at the time of our visit, but we sometimes asked facility staff to suggest people who might be willing to talk with us.[12]

From our discussions with current residents, our impression is that:

- **Most residents liked the treatment facilities or at least preferred them to other available options.**

We talked to 70 current and 23 former Rule 36 facility residents.

Figure 5.1 paraphrases some of the residents' comments. We found that residents often complimented staff, although many were bored by the facility's programs or lack of programs. Most residents told us they preferred their current living arrangement to a hospital or other Rule 36 facilities they had been in. Many said they were grateful to have a clean place to live with decent meals, but they wished they had more spending money. Most residents told us the facility was at least somewhat helpful in meeting their needs, and many appreciated the organized social activities.

We also thought it would be useful to hear from clients no longer in Rule 36 facilities, so we surveyed clients who were discharged during the last half of 1987. For the 300 clients discharged from the facilities we visited, we found 125 cases where the facility had a complete forwarding address.[13] We sent surveys to clients at these addresses and received 23 replies.[14]

Appendix E contains the survey responses, and Figure 5.1 lists some former residents' comments about facilities. We found that:

---

11 Ernst and Whinney, *Final Report on the Housing and Support Service Needs for Minnesotans with Severe and Persistent Mental Illness* (Minneapolis, February 1988).

12 Interviews were based on a standard list of questions, but we found that it was useful to structure the interviews informally. Thus, our questions differed somewhat from one client to the next.

13 This does not include cases where the forwarding address was a hospital or corrections facility.

14 In 35 cases, the client was no longer living at the address and had no forwarding address. Thus, our best estimate is that 23 of 90 people who received surveys responded.

Figure 5.1: Selected Client Comments About Rule 36 Facilities

Current clients:

"I really appreciate the efforts of staff. They've put me at ease and given me time to adjust. The best part of my program here has been my medications. This place has been a blessing to me."

"I don't want to live here too long. It's boring. I have more freedom here than I have had in other places, but you have to stand in line for everything here. Dancing class is the best thing here."

"I like the fact that there are people here to talk to every day. Some of the groups we have to attend last too long."

"I would like more informal activities, like coffee hour and social activities. Otherwise, we have to kill a lot of time. The programs that work best are the ones with activities."

"I've been here for four years, although I thought I was only going to be here for a couple months. I'd be willing to stay here until I die, but staff doesn't want this for me. Unfortunately, housing for poor people is hard to find."

"Living here is like living in a bubble--it's safe and comfortable."

"The food is the best part of this program, and meeting new people is the worst part. Staff here are helpful, and I can talk about my problems with them."

"This place gives me independence and is changing my behaviors. I used to have angry outbursts, but I'm doing better now. I have more appreciation for what people do for me and have grown closer to my father. Most people here are friendly, and I've made lifetime friends."

"This program has been good for me, but some mental health programs can make you worse. They give me a lot of attention, but some other people here don't get as much attention as they need."

Discharged clients:

"The staff and most residents seemed to accept me as I am."

"Evidently Minnesota has some laws on the books that prevent residents from working. I could have cleaned a lot more and taught others to do so, but I was prevented by staff."

"Staff was condescending and sometimes arrogant. Some residents were disruptive and too imbalanced. There was no privacy, and staff searched the rooms of my friends."

"One-on-one help was available when needed. I got direction and help with future plans when I was ready to go on. Facing this alone would have been overwhelming."

"Living conditions upstairs were not nice like downstairs that the public sees. We had three to a room. This perpetuated my loss of self-worth feeling."

Source:Program Evaluation Division interviews with current clients and surveys of discharged clients from 24 Rule 36 facilities.

- **Most former residents said that the facility they had been in was "somewhat helpful" in enabling them to deal with the symptoms of their illness, and most received as much help as they had expected. Several residents expressed concern about lack of privacy, disrespectful treatment, and the lack of services following discharge.**

As with our interviews of current residents, the former residents often had good things to say about staff. However, many were less complimentary about the facility's program or its atmosphere. Several former residents provided us with specific suggestions for the Legislature, such as improving employment opportunities at Rule 36 facilities and segregating clients by the severity of their illness.

FACILITIES' MEASURES OF CLIENT PROGRESS AND SERVICE NEEDS

State rules require Rule 36 facilities to monitor client outcomes in two ways. First, treatment plans must contain notes that indicate progress toward goals and objectives. Second, each program must develop an outcome-based program evaluation system that includes summary data on client characteristics and outcomes. "(F)or the purpose of examining the program's impact," each facility must assess residents every three months using "uniform level of functioning scales" developed by the Department of Human Services.[15] Facility staff must work with county staff to assess the evaluation results. The program evaluation results must be summarized in the facility's annual report. This section examines existing measures of client outcomes and service needs.

Progress Notes

Most facility staff make regular progress notes on clients.

During our reviews of client files in 24 Rule 36 facilities, we found that staff in most facilities make regular notes about client progress. However, staff in one facility made virtually no progress notes for any of the seven residents whose files we reviewed, a violation of state rules.[16]

As we reviewed progress notes, we tried to determine whether they were linked to client treatment plans. In our judgment:

- **Progress toward goals and objectives was not clearly documented for about one-third of the clients who had plans.**[17]

These were cases in which progress notes were vague or did not specifically relate to client objectives. In contrast, a few facilities encouraged staff to write

15 *Minn. Rules* Ch. 9520.0580.

16 The Department of Human Services Licensing Division reviewed files in this facility the same month we did, and their review makes no mention of problems with progress notes.

17 In another 40 percent of the cases, we judged that facilities documented progress for most, but not all, objectives.

progress notes directly in the applicable portions of the treatment plans, making an overview of client progress much easier.

Functional Assessments

"Functional assessments" of clients help service providers to develop treatment plans and monitor resident behaviors and skill levels over time. State rules require county mental health case managers to conduct "functional assessments" of their clients, evaluating: mental health symptoms and needs, use of drugs and alcohol, vocational and educational functioning, social functioning, self care and independent living capacity, interpersonal functioning, medical and dental health, financial assistance needs, and housing needs.[18]

County case managers are required to assess the functioning levels of clients.

State rules also require the Department of Human Services to develop a "uniform" level of functioning scale for use by all Rule 36 facilities, but this has not been done.[19] The department developed a prototype scale that some facilities use, but other facilities prefer their own measurement devices. Lacking consensus on an assessment instrument, the department has allowed facilities to select their own level of functioning measures. During our site visits, we found that:

- **A few facilities use no level of functioning measures, and most program directors reported that they do not find level of functioning measures very useful.**

Most Rule 36 files we reviewed did not contain ongoing level of functioning assessments.[20] We heard comments from program directors such as the following:

- "The state never used our level of functioning data, so we stopped collecting it."
- "We measure level of functioning at admission, but we haven't found it useful to measure ongoing progress."
- "We used to use a simple functional assessment, but everyone on our staff filled it out differently. We went to a complex behavioral assessment, but we found this too burdensome. Now we're back to using the simple one. We don't use the information, but it satisfies state requirements.
- "We would like the Department of Human Services to settle on one instrument."

---

18 Minn. Rules Ch. 9505.0477. The current draft of the department's Rule 36 revision requires Rule 36 staff to do this assessment if their residents do not have a case manager.

19 Minn. Rules Ch. 9520.0580.

20 In addition, residents' diagnostic assessments usually did not contain functional assessments, also known as "Axis 5" assessments.

Some facilities, most notably the nine facilities owned by the Hecla Corporation, build level of functioning measures into a program evaluation system. For example, based on the types of clients served in the past, Hecla administrators estimate the percentage of residents whose level of functioning scores they expect to improve in each facility. Administrators compare these expectations to actual facility performance every three months.

Functional assessments are not very useful in providing statewide data on client outcomes.

Based on our discussions with facility staff and our review of literature on outcome measures, we reached two conclusions about functional assessments. First, functional assessments should be used primarily to help plan and improve services to clients, rather than to generate outcome data for state officials. There are too many problems with data reliability for the state to analyze client outcomes using a uniform functioning scale.

In contrast, we think that functional assessments could provide state and county staff with an indication of services clients need to live in the community. We are not convinced that the functional assessments mandated by Minnesota's case management rules do this. The rules require case managers to assess clients' "mental health needs," but this requirement is vague and might not inspire case workers to think about clients' specific service needs. We prefer the approach taken in Madison, Wisconsin, where clients are assessed on characteristics related to services required: (1) willingness to come in for services, (2) medication compliance, (3) need for structured daily activities, (4) ability to self-monitor, (5) frequency of crises, (6) need for professional psychological support, and (7) degree of case management services required.[21]

Second, it is important for the Department of Human Services to provide adequate technical assistance to facilities' assessment staff. Whether assessments are being done to measure client outcomes or service needs, staff should understand the purpose of assessment and proper approaches. As a recent research summary concluded:

> (I)t is the focus and conduct of the assessment process, rather than the assessment instruments, that are the foundation for a valid assessment.... Without a skilled practitioner, assessment can revert to a simple checklist of client functioning, seemingly independent of the client's high-priority goals and the specific requirements of the client's own environment.[22]

---

21 Leonard I. Stein and Ronald J. Diamond, "A Program for Difficult-to-Treat Patients," ed. Stein and Mary Ann Test, *New Directions for Mental Health Services* (San Francisco: Jossey-Bass, June 1985), no. 26, pp. 30-1. Although some elements of Minnesota's functional assessments are similar to Madison's, Minnesota's approach seems to emphasize describing the client rather than identifying specific service needs.

22 William A. Anthony, Mikal Cohen, and Patricia Nemec, "Assessment in Psychiatric Rehabilitation," ed. Brian Bolton, *Handbook of Measurement and Evaluation in Rehabilitation* (Baltimore: Brookes, 1987), p. 311.

RECOMMENDATIONS

The best available studies indicate that community mental health programs have the potential to improve their residents' mental health, apparently more so than hospital-based programs. However, just as the quality of inpatient treatment programs varies, the quality of community programs also varies. As a result, it is important for state policy makers and treatment providers to examine programs for evidence of effectiveness and identify program elements associated with good client outcomes. To improve effectiveness measurement, we recommend:

- **The Department of Human Services should examine the possibility of having county case managers, rather than Rule 36 staff, track clients and report follow-up data after discharge from Rule 36 facilities.**

County case managers are in a better position than Rule 36 staff to track clients after discharge from treatment.

County case managers are supposed to have ongoing contacts with seriously ill clients regardless of their living arrangements, so they should be in a better position than treatment providers to track client whereabouts, living arrangements, and hospitalizations. They are also in a better position to provide this information to the state for longer than a six-month follow-up period.

We recognize that precise measurement of client outcomes is a difficult task, one that is probably beyond the means of most facilities. Because of this, we think the department should seek whatever help it can get to conduct ongoing research. We recommend that:

- **The Department of Human Services should encourage study of the quality and outcomes of its mental health programs by academic researchers.**

For example, the department may wish to establish closer ties to researchers in the University of Minnesota's departments of psychiatry and social work.

The Department of Human Services lacks information about the types of services clients need and the availability of these services. Because this hinders the department's ability to plan and fund services, we recommend:

- **The department should provide case managers with more specific guidelines for their functional assessments of clients' "mental health needs." The department should consider improvements in functional assessments that (1) help case managers identify client service needs, and (2) help state officials conduct system-wide planning for services. If functional assessments are to be used by the state to plan services, counties will need to summarize and report service needs to the state.**

To improve measurement of Rule 36 effectiveness, we recommend that:

- **The department should develop better ways to assess the effect of treatment on client hospitalization rates by using the tracking system implemented in 1989.**

FINANCIAL ISSUES

Chapter 6

The state has two primary financial responsibilities for adults with mental illness in community residential facilities. First, it pays for most on site programs at these facilities, as well as many community support services. Second, the state helps many adults with mental illness pay for food and shelter through General Assistance and Minnesota Supplemental Aid. We asked:

- **What effect does a client's choice of living arrangement have on the state's subsistence payments to that person?**
- **How do program expenditures vary from one Rule 36 facility to the next, and does the state adequately oversee these expenditures?**
- **Does the state finance facilities' property costs in an appropriate way?**
- **Are community residential treatment facilities cost-effective?**

We found little accountability for client room and board costs, which counties negotiate but the state largely pays. We also think room and board payments are inequitable because they differ depending on where clients live. In addition, we think state rules governing Rule 36 expenditures need to be rewritten, and there should be more state oversight of expenditures.

STATE PAYMENTS FOR ROOM AND BOARD

Many adults with mental illness receive state GA or MSA payments.

Many people with mental illness are unemployed and receive assistance payments from the state and federal governments. The two primary state assistance programs are (1) Minnesota Supplemental Aid (MSA), which provides assistance to elderly and disabled persons beyond that provided by the federal Supplemental Security Income (SSI) program, and (2) General Assistance (GA), which provides grants to individuals with low incomes. State law authorizes counties to contract with board and lodging facilities to provide living quarters for GA and MSA recipients. Counties negotiate monthly rates with facilities at which GA or MSA will pay for room and board costs. The Legisla-

ture froze these rates in 1985, permitting only annual adjustments for inflation. In 1989, negotiated rates could not exceed $920 per client per month.[1] All Rule 36 facilities are "negotiated rate facilities," as are many of the state's board and lodging facilities that do not have human services licenses.

We found that:

- **Individuals living in negotiated rate facilities usually receive larger state payments for room and board than individuals living elsewhere. In our view, this is inequitable.**

Table 6.1 shows state and federal income assistance payments to six hypothetical individuals in various living arrangements. In general, the state provides larger assistance payments to people living in negotiated rate facilities than it does to people living independently. The only exceptions are SSI/MSA recipients living in negotiated rate facilities with very low rates ($400, in this example). A 1988 study reported that the state's average MSA payment to residents of negotiated rate facilities is $430 per month, meaning that facilities tend more toward the higher rates shown in the chart than the lower rates.[2]

Within a given negotiated rate facility, the state pays higher subsidies to GA recipients than MSA recipients, as shown. The state pays a maximum of nearly $1,000 per month in room and board for GA recipients in these facilities, compared to a maximum of about $600 for MSA recipients. This difference is made up by federal assistance payments available to MSA recipients. According to state officials we interviewed, there are probably many GA recipients who qualify for MSA but have not applied for the program. The Department of Human Services attempts to assist clients in obtaining MSA and SSI, and has provided training in this process to Rule 36 staff. About 15 percent of people admitted to Rule 36 facilities report GA as their primary income source at the time of admission, compared to only 6 percent of people who have lived in Rule 36 facilities for more than a year. This indicates some movement of clients to the less expensive MSA program during their Rule 36 stays.

There is no reason to assume that residents of negotiated rate facilities are more disabled than mental health clients living on their own.

The fundamental question raised by Table 6.1 is: why does the state pay residents of negotiated rate facilities more for room and board than it pays people living independently? A possible explanation is that residents of negotiated rate facilities are more disabled than GA or MSA recipients who live independently, thus warranting residential services that people living independently do not need. However, we see no reason to assume this is the case. First, most counties have no formal screening process to direct adults with mental illness to one living arrangement or another. Second, even if counties screen residents, residents are free to choose where they want to live (unless committed by the courts to a treatment program). Third, state law does not authorize negotiated rates to pay for services beyond basic subsistence. Negotiated rates may cover "shelter, fuel, food, utilities, household supplies, and other costs necessary to provide room and board," but they may not cover

1 Counties entering new negotiated rate agreements now may not set rates higher than 90 percent of the statutory maximum.

2 Department of Human Services, *Rate Limits for Negotiated Rate Facilities in the Minnesota Supplemental Aid Program: A Report to the 1988 Legislature*, February 1988, p. 2.

Table 6.1: Assistance Payments To Individuals In Various Living Arrangements

	Living Arrangement and Program Eligibility	Federal Assistance Payments	State Assistance Payments
CLIENT A	Lives in facility with a negotiated rate of $400		
	Is on SSI/MSA	$368	$99
CLIENT B	Lives in facility with a negotiated rate of $400		
	Is on GA	$0	$447
CLIENT C	Lives in facility with a negotiated rate of $900		
	Is on SSI/MSA	$368	$599
CLIENT D	Lives in facility with a negotiated rate of $900		
	Is on GA	$0	$947
CLIENT E	Doesn't live in a negotiated rate facility		
	Is on SSI/MSA	$395	$63
CLIENT F	Doesn't live in a negotiated rate facility		
	Is on GA	$99	$203

Source: Department of Human Services Assistance Payments Division.

Note: Calculated for single person in Hennepin County with no other income sources. Includes food stamps for clients E and F.

State assistance payments differ considerably, depending on where recipients live.

nursing, medical, program, or social service costs.[3] The only reason that room and board costs for clients in negotiated rate facilities might be higher than costs for other clients is that most negotiated rate facilities have staff who prepare meals for residents.

The 1989 Legislature required the Department of Human Services to establish a comprehensive statewide system of rates for negotiated rate facilities by 1992. This should address disparities in counties' rate-setting practices. Also, by allowing the state to set room and board rates that it pays, this change will improve accountability. However, it is not clear to us that the new system will address the larger inequities caused by providing subsistence payments to residents of negotiated rate facilities that are different from those given to people who do not live in these facilities.

3 *Minn. Laws* (1989), Ch. 282, Art. 5, Section 117.

It is likely that some of the negotiated rate facilities have high rates because they provide services that facilities with lower rates do not provide. These services might include laundry service, more hours of staff supervision, or formal programs for residents. While many of the residents may need such services, present state law does not authorize GA and MSA to pay for them. As recommended at the end of this chapter, the Legislature needs to reconsider the way it pays for room, board, and supportive services to adults with mental illness.

ANALYSIS OF RULE 36 EXPENDITURES

Expenditures in Rule 36 facilities totaled about $29 million in 1989.

As Table 6.2 shows, Rule 36 facility expenditures totaled over $28.5 million in 1989. Of that total, about 68 percent was funded by the state, 13 percent by the county, and 19 percent by other sources (including federal Supplemental Security Income funds). We reviewed Rule 36 costs using budgets and expenditure reports submitted by counties to the Department of Human Services. We also spoke with Rule 36 administrators and county staff about the budget process. Overall, we found:

- **It is difficult to analyze Rule 36 facility costs because definitions of facility cost categories are not meaningful.**

- **The lack of clear boundaries for costs makes it more difficult for the state to control "program" costs.**

Table 6.2: Estimated 1989 Rule 36 Funding

Funding Source	State	County	Federal	Other	Total
Rule 12	$10,844,000	$0	$0	$800,000	$11,644,000
Community Social Services Block Grant	417,909	1,820,378	361,712	0	2,600,000
General Assistance	2,625,000	875,000	0	0	3,500,000
Minnesota Supplemental Aid	5,525,000	975,000	0	0	6,500,000
Supplemental Security Income	0	0	4,300,000	0	4,300,000
TOTAL	$19,411,909	$3,670,378	$4,661,712	$800,000	$28,544,000

Source: Mental Health Division, Department of Human Services (December 1988 estimate of Calendar Year 1989 funding).

There is little state scrutiny of community treatment expenditures.

Although the Department of Human Services does some budget analysis when reviewing applications for Rule 12 funds, there is no cost auditing or scrutiny of actual costs comparable to what exists for community facilities for adults with mental retardation.[4] Consequently, it is difficult to determine whether Rule 36 facilities' expenditures are reasonable, or to be sure what state dollars are buying.

Variations in Rule 36 Costs

Table 6.3 lists the highest and lowest per diems (cost per patient per day) for Category I and Category II facilities.[5] On average, Category I facilities have higher per diems. To a large extent, Rule 36 facilities' per diems are driven by salary and benefit costs, which average about 59 percent of total expenditures. Since Category I facilities are required to have higher staffing levels than Category II facilities, they usually have higher per diems.[6] However, in some cases, Category II facilities have per diems considerably higher than the average for Category I facilities. For example, one Winona Category II facility (Hiawatha Hall) has a per diem that is about $20 higher than the average for Category I facilities. One reason for this is that the Department of Human Services provides Rule 12 funding for this facility's day programming and vocational rehabilitation, but it does not fund these services in most other facilities.

Table 6.3: Variation in Per Diem Costs for Residents in Rule 36 Facilities

Treatment per diems vary considerably.

	Category I	Category II	Nonprofit	For-Profit
Highest	$255.63	$80.77	$255.63	$88.96
	145.81	73.40	145.81	84.40
	117.45	70.41	117.45	78.66
Mean	$61.35	$45.84	$55.24	$51.66
Lowest	$45.54	$32.04	$42.48	$36.76
	42.90	27.02	36.20	32.04
	37.96	26.88	26.88	27.02

Source: Mental Health Division, Department of Human Services.

4 Intermediate care facilities for mentally retarded adults submit a very detailed annual report to the Department of Human Services. Facilities or chains of facilities with more than 48 beds must have certified audits performed, and other facilities must have audited statements. In addition, DHS staff perform periodic desk or field audits of these facilities.

5 Per diems include two parts; (1) room and board per diems, which are generally (but not always) equal to the GA and MSA negotiated rates, and (2) program per diems, which are costs generally paid with Rule 12 funds.

6 We noted that Ramsey County facilities have very low per diems. Of 11 Ramsey County facilities, 7 are below average for their category, and 3 are only slightly above average.

Facilities with low salary and benefits expenditures do not always have low per diems, however. In some cases, facilities appear to substitute contract services for staff. That is probably an efficient use of resources, especially for smaller facilities. In other cases, facilities with high per diems, but low salary and benefit costs, are spending above average amounts on such things as overhead, occupancy costs, or equipment. These are not obvious substitutes for staff, and are harder to explain.

We also compared the expenditures of nonprofit facilities with those of for-profit facilities. We found that nonprofit facilities have slightly higher average per diems than for-profits, as shown in Table 6.3. This is partially explained by the fact that nonprofit facilities are more likely to be Category I than are for-profit facilities.

Lack of Clear Expense Categories

We looked at expenditures in more detail in an attempt to rationalize the variations in per diems. We found that there are wide variations in costs for particular activities from one facility to the next, but poorly-defined expense categories make it difficult to evaluate cost differences conclusively. Although the wide variation in expenditures, as well as the level of expenditures in some cases, should be causes for closer scrutiny by the Department of Human Services, we found that:

- **Facilities' reports of their expenditures are apparently accepted at face value by department staff.**

Table 6.4 shows the range of expenditures reported for some cost categories. It appears that some of the variation occurs because there are no guidelines for what expenses belong in each category. We found, for example, that facilities differ in their interpretation of "overhead" expenses. Expense reports show that 49 facilities reported no overhead expenses, while 11 had overhead costs of over $2,000 per bed. All of the facilities owned by the Hecla Corporation reported "overhead" in their costs. In 1988, $433,000 in administrative and central office costs were included in the overhead categories of Hecla's nine facilities, according to staff.

Facility costs vary widely even in categories that seem more well-defined. For example:

- Spending for "food and supplies" ranged from 4 cents per patient day to more than $11 per patient day.

- In 1988, a facility spent more than $100,000 on "equipment." This was 24 percent of its expenditures, compared to the statewide average of 3 percent.

- One facility spent over $45,000 in 1988 on "staff travel." The next highest facility reported spending about $14,000.

- Another facility spent $1,305 per staff person for staff travel in 1988.

Table 6.4: Variations In Selected Rule 36 Cost Categories

	Category I Range	Category II Range
Salary and Benefits Per Patient Day	$0 - 285.35	$7.31 - 44.40
Staff Travel Per Staff Per Year	$0 - 514.23	$0 - 1,305.09
Occupancy Costs Per Bed Per Year	$109.20 - 8,080.33	$0 - 4,586.63
Supplies and Food Per Patient Day	$0.04 - 11.28	$0.17 - 8.98
Other Operating Costs Per Bed Per Year	$0 - 11,985.67	$31.80 - 3,301.08
Overhead Per Bed Per Year	$0 - 16,655.30	$0 - 285.10
Percent Profit	0% - 16.3%	0% - 9.9%

Source: OLA Analysis of Rule 36 Expenditure Reports.

The expenditures in each of these examples may be correct and reasonable. However, we are concerned that they apparently raise no "red flags" with the department.

Existing reports of facility profits are not useful.

There also appear to be varying interpretations of "profit." Facilities usually make profits by (1) keeping more beds filled than assumed by the Department of Human Services, and (2) accumulating equity in property. Typically, counties also grant for-profit facilities a percentage of their total budgets as profit. But Ramsey County staff told us that "profits" reported in expenditure reports are not really profits.[7] For example, one Ramsey County facility's 1988 expenditure report showed a $101,000 profit, but facility and county staff told us that this represents the interest payment on a contract for deed, and not profit. In other counties, we found cases where for-profit facilities showed a profit in their expenditure reports, even though their expenditures exceeded revenues. Two non-profit facilities reported profits of 3 percent and 10 percent.[8]

- **Overall, the lack of consistent definitions make reports of facility profitability meaningless to state policy makers.**

7 Ramsey County lets most facilities have a "return to agency" in the budget, which is an undesignated fund usually representing six to eight percent of total expenditures. County staff said they consider this a cushion, not a profit.

8 Intermediate care facilities for persons with mental retardation may not show profit as a line item in their budgets.

Program vs. Room and Board Costs

Counties categorize all Rule 36 facility expenditures into either "room and board" or "program" costs. As previously discussed, the state pays most room and board costs for residents of Rule 36 facilities through either the Minnesota Supplemental Aid program or General Assistance, and the Legislature froze room and board payment rates for Rule 36 facilities (and other negotiated rate facilities) in 1985. Program costs within Rule 36 facilities are funded by Rule 12 grants. We found that:

- **There is no clear distinction between "program" and "room and board" costs.**

Given fixed annual increases in both categories, facilities and counties adjust their budgets to fit the available funds. A Hennepin County report describes the process facilities go through in preparing their budgets:

> ...programs must "adjust" their allocation process so the room and board expenses reported in the Rule 12 application will "match" the frozen level of room and board revenue they are allowed to collect. The remaining expenses become "program" expenses.[9]

Some counties fund program activities with room and board funds because Rule 12 funds were not originally intended to replace program funds already being spent by counties. Thus, some facilities that funded certain program activities with GA and MSA funds prior to the availability of Rule 12 funds in the early 1980's still support programs with these funds.[10] In newer facilities, comparable activities are funded with Rule 12 funds.

State "room and board" payments pay half of some facilities' salaries.

The clearest example of the lack of distinction between program and room and board costs is in funding for salaries. We found that the percent of salaries funded by room and board payments in various facilities ranged from 0 to 51 percent in 1988. At one facility we visited, all "mental health workers" salaries are categorized as room and board costs, even though these are the staff who work most directly with residents and conduct most of the programming.

Overall, program and room and board costs are often defined to maximize revenue, not to place expenditures in rational categories. Requiring counties and facilities to split costs into these categories increases paperwork but does not provide the state with meaningful cost information.

Counties' Share of Rule 36 Costs

State law provides that the state will pay 75 percent of the cost of expanding or providing services to adults with mental illness.[11] The law implies that

---

9 Touche Ross Incorporated, *Financial and Programmatic Review of Hennepin County Rule 36 Programs, 1985-1988, Final Report* (Minneapolis, June 1989), p. 16.

10 These are referred to as "previously funded" activities.

11 *Minn. Stat.* § 245.73, subd. 3.

counties will provide other revenues needed to operate the program, although the law does not require these matching revenues to be county tax dollars. Most counties with Rule 36 facilities use Community Social Services block grant funds or county dollars to pay the local match. However, we found that:

- **27 Rule 36 facilities use GA and MSA (comprised mostly of state funds) to pay the "local share" of Rule 36 program costs.**

The "local share" of Rule 36 costs sometimes includes few local dollars.

Apparently, some facilities' negotiated GA and MSA rates are high enough to cover all room and board costs, as well as some program costs. Thus, these facilities use MSA or GA payments as the "local share" of program costs, even though MSA and GA are primarily state-funded. The Department of Human Services has permitted this practice as a way of expanding the number of Rule 36 facilities statewide. The use of GA and MSA funds to pay program costs may create some undesirable incentives. Facilities using GA or MSA for the local share of program costs require no other local match, while other facilities require local matches of up to $36 per day per client. When counties' costs are lower, they have less incentive to scrutinize the reasonableness of facilities' expenditures. Varying county shares may also induce counties to "price shop" among facilities, rather than attempting to place clients where they would be best served.

STATE PAYMENT OF FACILITY PROPERTY COSTS

One of the chief costs of operating a group home is the purchase or rent of the property. Reimbursements for property costs are also a primary source of profit for the owners of group homes.[12] An effective facility payment system would reimburse property costs at a rate high enough to attract enough providers and encourage adequate property maintenance, while avoiding overcompensation of property owners.

This section reviews existing and alternative means of paying for property costs. We found that the state's payment system for Rule 36 property costs lacks adequate accountability and safeguards. It also creates incentives for owners to sell facilities.

Basis for Payment of Rule 36 Property Costs

Rule 36 facilities receive separate funding for "program" and "room and board" costs. Counties negotiate room and board per diems with facilities, and the state negotiates with facilities to determine the amount of its Rule 12 program grants. The state finances the vast majority of both program and room and board rates.

12 About two-thirds of Rule 36 facilities are for-profit and one-third are non-profit, according to Department of Human Services budget data. In about three-fourths of the facilities we visited, the property owners are also program employees or they oversee program operations.

We found that:

- **State officials do not scrutinize the property costs of Rule 36 facilities, nor are there state guidelines for counties to do so. This suggests a lack of accountability for property costs (and room and board costs in general), since the state pays most of these costs.**

Neither state rules nor laws explicitly authorize Rule 12 funds to pay for property costs, so Department of Human Services staff assume that county-negotiated room and board per diems pay for them.[13] However, there are no state rules governing property payments in negotiated rate facilities (including Rule 36 facilities). The rules governing the state's Rule 12 grants require counties applying for funds to submit budgets for all their costs (including costs not eligible for Rule 12 funding). The rules specify that straight-line depreciation "may" be included in counties' proposed Rule 36 budgets. They do not authorize or prohibit the inclusion of other types of property expenses in the budget (such as mortgage interest and rent), and they do not ensure full reimbursement of depreciation.[14] In contrast to the absence of rules governing Rule 36 property costs, the rules governing community facilities for adults with mental retardation specifically authorize payment of depreciation, interest on capital debt, and rent payments, and there are detailed guidelines for calculating property payment rates.

There is little accountability for property costs.

The lack of accountability for property costs is also caused by the lack of adequate reporting on these costs. We found that:

- **The state collects little useful information on Rule 36 property costs, which precludes effective oversight and management of these costs.**

The Department of Human Services receives county reports of Rule 36 expenditures in vague categories, such as "occupancy" and "profit." As noted in the previous section, there are no formal state definitions for these categories. Facilities do not systematically report to the state whether their property "expenditures" are real cash outlays (such as rent, or interest on a mortgage) or paper outlays (such as depreciation). We asked 17 facilities to provide us with information on their annual principal and interest (or rent) payments and found that, in most facilities, these payments are about half of the reported "occupancy" expenditures. Apparently, this is because most facilities receive compensation for both depreciation and mortgage interest. In addition to lacking information on the types of property costs funded, the state lacks documentation on the following items:

- facilities' accumulated equity in capital assets;

---

13 Rule 36 expenditure reports in the facilities we visited showed that 80 percent of "occupancy" costs are paid by room and board revenues. In fact, Rule 36 facilities combine revenues from several sources, and it is not possible to trace a given expenditure to a particular revenue source.

14 More than two-thirds of the Rule 36 programs we visited own their buildings, and the remainder lease space.

- interest rates being paid by facilities;
- the time period over which assets are being depreciated;[15] and
- asset value (such as the purchase price of a building, which is the basis for depreciation).

Department of Human Services staff told us that most Rule 36 facilities receive payments for their depreciation and interest, although some only receive payments for depreciation. We think there are several problems with the use of depreciation as the basis for property payments. First, most Rule 36 facilities are in cities where real estate is appreciating in value, which undermines the rationale for "depreciation" payments. Second, owners typically depreciate buildings over a 20 to 30 year period, but most buildings are usable for longer than this. Third, and most important, although property owners can accumulate equity in property at the same time the state is paying their depreciation and interest, owners have no obligation to repay the state for its investment at the time of sale. In addition, the state might end up paying this facility's property costs for a second time (to the new owners).

The state pays most property costs, but property owners accumulate the equity.

State officials addressed this latter problem in reimbursement systems for nursing homes and community facilities for adults with mental retardation by requiring that depreciation payments be "recaptured" by the state up to the level of the asset gain resulting from a sale. Similarly, a recent review of Hennepin County Rule 36 reimbursement suggested that the Legislature consider a "shared equity" approach in which facility owners would pay the state and county a portion of the increase in equity at the time of facility sale or refinancing.[16]

Researchers suggest that depreciation-based payment systems encourage frequent sales of facilities.[17] During the first half of a facility's depreciable life (when depreciation exceeds principal payments), owners receive property payments in excess of their regular mortgage payments. But in later years, principal payments exceed depreciation payments and owners have an incentive to sell. The Department of Human Services has implemented safeguards in reimbursement systems against frequent sales of some facilities. For example, state rules require facilities for adults with mental retardation to set aside a portion of their depreciation payments to meet future principal payments. Also, facilities for mentally retarded adults and nursing homes are not allowed to increase their property payments following sales. In contrast, we found that:

- **State laws and rules do not provide strong disincentives to Rule 36 facility sales.**

---

15 For depreciation purposes, state rules for facilities for mentally retarded adults specify the useful life of new capital assets; there are no comparable guidelines for Rule 36 facilities.

16 Touche-Ross International, *Hennepin County Financial and Programmatic Review of Rule 36 Programs, 1985-1988: Final Report* (Minneapolis, June 1989), pp. 59-60.

17 Joel Cohen and John Holahan, "An Evaluation of Current Approaches to Nursing Home Capital Reimbursement," *Inquiry*, Spring 1986, pp. 23-39; Eileen Tynan, et al., *Nursing Home Reimbursement: A Synthesis of Findings from Health Services Research and Demonstration Projects* (Washington, D.C.: National Center for Health Services Research, March 1981), pp. 34-43.

Of the 24 Rule 36 facilities we visited, only one has changed owners recently. Thus, there is little indication of facility turnover so far. However, most Rule 36 facilities are less than seven years old, so it may be too early to tell if frequent sales of Rule 36 facilities will be a problem.

Finally, although we have confined our discussion here to Rule 36 facilities, our concerns apply to all negotiated rate facilities. Counties negotiate room and board payments with hundreds of these facilities statewide, but there are no state guidelines for allowable property costs.

An Alternative Property Payment Method

The state could improve its oversight of property payments if it adopted some of the safeguards discussed in the previous section. The Legislature and Department of Human Services might also consider more fundamental changes in the state's approach to property payment.

One alternative is the "fair rental" approach used in Minnesota's nursing home reimbursement system. Under this approach, the state pays nursing home owners a simulated rent for their property based on periodic appraisals of facility value.[18] The fair rental approach decreases owners' incentives to sell facilities and eliminates the possibility that the state will pay for the same facility twice. Department of Human Services staff told us that appraisals costing about $700 each will be done in all nursing homes at least once every seven years. There may also be state litigation costs in cases where nursing home owners disagree with the appraisals.

Minnesota's nursing home system uses a "fair rental" approach.

A recent review of various approaches to capital reimbursement concluded that the fair rental approach:

> permits the state to recognize the increasing value of capital assets in an inflationary economy without requiring sales, refinancing, or leases. The state does not have to calculate depreciation payments in an appreciating asset. It provides incentives for owners to seek efficient financing arrangements. It encourages continued ownership, which should have a positive impact on quality of care.[19]

The authors note that fair rental approaches have the potential to be more expensive than other approaches, but state policies on appropriate rates of return should be able to control property payments. Although the Department of Human Services is not certain that a fair rental approach would be appropriate in the mental health system, staff acknowledge the need to consider a property payment system that more closely approximates actual costs.

---

18 The state pays about 5.7 percent of the equity portion of the property's appraised value.

19 Cohen and Holahan, "An Evaluation of Current Approaches to Nursing Home Capital Reimbursement," p. 38.

COST-EFFECTIVENESS OF COMMUNITY TREATMENT FACILITIES

Policy makers backed deinstitutionalization primarily because of concern about clients' quality of life, not because of concern about costs of care. Mental health advocates felt that people with mental illness should be served in the least restrictive environment possible, preferably close to friends, family, and community services. However, some people also suggest that community programs are less expensive than state hospitals, so this section reports what is known about the cost-effectiveness of community treatment relative to regional treatment centers.

It is difficult to conclusively evaluate the cost-effectiveness of community facilities.

In general, we think there is too little information available to conclusively judge the relative cost-effectiveness of treatment settings in Minnesota, and there are several difficulties with such comparisons. First, there are no standardized measures of mental health that allow routine comparison of client outcomes. It is relatively easy to compare the cost of client stays in Rule 36 facilities and regional treatment centers, but it is difficult to gauge client benefits. Second, the clients in inpatient settings may be different than those in community settings, thus hindering direct comparisons. Hospitals often treat unstable individuals who are experiencing acute mental health crises, whereas community programs usually prefer treating clients who are no longer experiencing a crisis. Third, as discussed below, it is difficult to estimate the cost of some community services provided outside of Rule 36 facilities. Fourth, the cost of care depends largely on salary levels, which vary considerably among care settings.

Research Literature

We reviewed research literature to determine what is known about the cost-effectiveness of community treatment programs for adults with mental illness.[20] Most of the studies have examined the cost-effectiveness of single programs, not entire systems of community care. We found that:

- **Most comparisons of community and inpatient treatment programs have concluded that community programs are at least as effective and no more costly than hospital treatment. However, the studies seem less conclusive about the cost findings than the effectiveness findings.**

---

20 Reviews of cost-effectiveness findings are reported in: Charles Kiesler, "Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients," *American Psychologist*, April 1982, pp. 349-360; Sari R. Gilman and Ronald J. Diamond, "Economic Analysis in Community Treatment of the Chronically Mentally Ill," *The Training in Community Living Model: A Decade of Experience*, ed. Leonard I. Stein and Mary Ann Test (San Francisco: Jossey-Bass, 1985), pp. 77-84; and Leonard I. Stein, "Funding a System of Care for Schizophrenia," *Psychiatric Annals*, September 1987, pp. 592-598.

The cost-effectiveness study with the most rigorous cost methodology concludes that community treatment is about 10 percent more expensive than short-term inpatient care combined with traditional aftercare services.[21] This study also concludes that the higher costs are more than offset by better client outcomes.

There has been virtually no controlled testing of the cost-effectiveness of the type of supported housing approaches recommended in Chapter 2. The primary impetus behind the supported housing approach in many states has been the desire to give clients choices about their living arrangements, not a desire to reduce costs.

Comparison of Rule 36 and Regional Treatment Center Costs

Table 6.5 compares the costs of regional treatment centers and Rule 36 facilities per day and per client stay. Unfortunately, the per diems of these facilities are not calculated in exactly the same manner. For example, regional treatment centers calculate their property costs differently than Rule 36 facilities, and Rule 36 per diems do not reflect state administrative costs (unlike the RTC per diems).[22]

On average, community facilities appear to cost less than RTCs.

Table 6.5: Costs Per Day and Per Stay in Community and Inpatient Facilities

	Cost Per Day Of Services At Facility	Other Costs Per Day[b]	Total Costs Per Day	Average Length Of Stay	Average Total Cost Per Stay
Rule 36	$55.79	$23.69	$79.48	10.7 months	$25,513
Regional Treatment Center[a]	169.10 to 262.50	5.14	174.24 to 267.64	7.6 months[c]	46,000[d]
Community Hospital	452.97	5.14	458.11	19 days	8,704

Source: Cost data are 1990 estimates from the Department of Human Services. Sources for length of stay data are: Rule 36 facility reports on clients discharged in 1988; Department of Human Services Residential Program Management Division data for patients discharged from RTCs in 1989; and Program Evaluation Division survey of community hospitals, June 1989.

[a]RTC per diems range from $169.10 at St Peter to $262.50 at Fergus Falls.

[b]Other costs include day treatment, case management, outpatient mental health services, community support services, and an allowance for living expenses.

[c]Does not include adolescent and geriatric stays in Willmar and Brainerd RTCs.

[d]Assumes a $200 per diem for 230 days.

21 Burton Weisbrod, "A Guide to Cost Benefit Analysis, As Seen Through a Controlled Experiment in Treating the Mentally Ill," in *Social Policy Evaluation: An Economic Perspective*, ed. Elhanan Helpman (New York: Academic Press, 1983), pp. 5-42.

22 As noted earlier in this chapter, there are no consistent statewide practices for reimbursing Rule 36 property costs, so there appear to be variations from one county to the next. The property costs in regional treatment centers' per diems are based on depreciation of the facilities' 1967 appraised value, plus subsequent remodeling costs.

In addition, Rule 36 per diems do not include the costs of many services that clients get in the community. Table 6.5 includes the Department of Human Service's best estimate of the cost ($23.69 per day) of community mental health services beyond Rule 36 per diems, but staff told us that the estimate is rough. However, even if the estimates of community service costs are significantly more than shown in Table 6.5, it appears that total costs per day are less for Rule 36 residents than for patients in regional treatment centers. Much of the difference reflects salary differences between these providers (described in Chapter 4) and the regional treatment centers' higher staff to patient ratios.

An average Rule 36 stay costs about $25,000.

Table 6.5 also indicates that Rule 36 costs are substantial over the course of the average client's stay, probably around $25,000. At this level, they are on par with the cost of a patient who stays in a regional treatment center for five months. The average length of stay of patients discharged from the regional treatment centers in 1989 was more than seven months. Thus, on average, Rule 36 costs per stay are less than regional treatment center costs.

If the Legislature increases case management services, home-based supportive services, and Rule 36 staffing levels (as recommended in this report), it is possible that community mental health services will actually be more expensive than current RTC or Rule 36 services over the long term. In fact, perhaps we should expect that services provided to people in the residence of their choice will have fewer economies of scale than services to these same people in group or institutional living arrangements. Nevertheless, our report recommends that the Legislature provide stronger financial support for community services in light of:

- the research supporting the efficacy of community programs (see Chapter 5),
- the legal right of most clients to live where they choose,
- the apparent preference of clients for community-based rather than institution-based services (see Chapter 5's discussion of client satisfaction), and
- the evidence that many clients living in the community do not receive adequate supportive services (see Chapter 2).

Despite the increased legislative focus on community mental health services in the past decade, we found that:

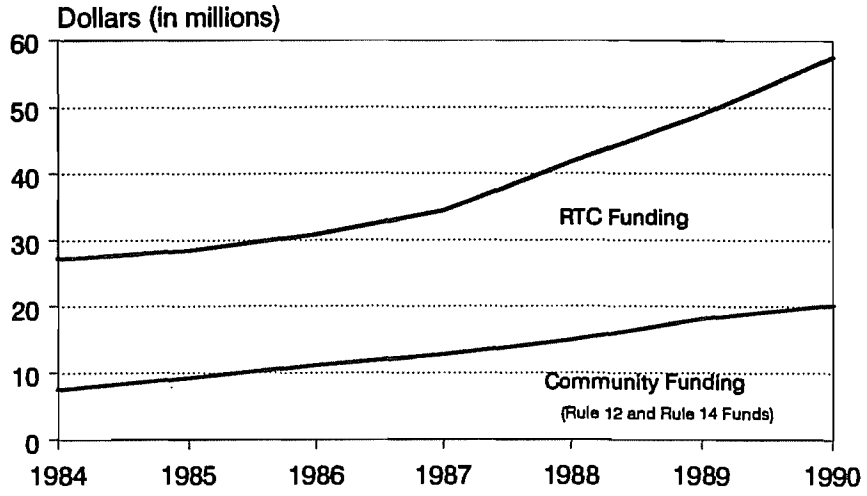
- **Funding for mental health services in regional treatment centers has continued to grow rapidly, and the most recent RTC funding increase was greater than the funding increase for community mental health programs.**

Figure 6.1 shows RTC and community funding between 1984 and 1990, during which time there was a reduction of about 200 RTC residents. Community funding increased significantly during this time, but RTCs still receive most of the state's mental health budget. Estimates prepared for the Department of Human Services indicate that between 22,000 and 30,000 Minnesotans have a

"chronic" mental illness.[23] RTCs have about 1,100 residents, while community programs serve the remainder of Minnesota's population with mental illness.

RTCs still account for most state mental health funding.

Figure 6.1: State Funds in RTCs and Community Programs



Source: Mental Health Division, Department of Human Services

It is important to reiterate that comparisons between hospital and community services costs must be made with caution, since the types of care provided in these settings often differ. There are some circumstances where community mental health services could be substituted for hospital care, but there are probably other cases where this is not true. Nevertheless, we think that the Legislature should consider whether its allocation of resources between RTCs and community programs is appropriate, especially as it considers additional funding for community services.

RECOMMENDATIONS

We think the Legislature needs to reconsider the way it makes subsistence payments to people enrolled in the state's General Assistance and Minnesota Supplemental Aid programs. Currently, most of these recipients get larger state subsidies if they live in a "negotiated rate facility." Given the freedom of most adults with mental illness to live where they choose, we think that the state's subsidization of room and board should not depend on where a person lives. While some negotiated rate facilities are providing supportive services beyond room and board, state payments for these services should also not depend on a person's living arrangement. We recommend that:

---

23 Rama S. Pandey and Soonhae Kang, "Prevalence Estimates of Mental Disorders for Minnesota Counties," September 1987.

- **The Legislature and Department of Human Services should consider replacing the negotiated rate facility system with vouchers that GA and MSA recipients could use to obtain room and board.**

A voucher system for room and board should be considered.

If recipients of the vouchers require supportive services, these services should be available regardless of where clients choose to live (within reasonable limits). This would probably require comprehensive screening systems to determine need and eligibility for supportive services, which most counties do not have in place now.

According to Department of Human Services staff, it is possible that federal regulations restrict the use of vouchers for MSA recipients. This requires further investigation by department staff.[24] If, instead of a voucher system, the Legislature favors proceeding with the currently-mandated rate-setting system for negotiated rate facilities, then we recommend that:

- **The Department of Human Services should consider standardizing the way it pays for property costs in negotiated rate facilities. The department should consider the merits of a fair rental payment system.**

- **At a minimum, the department and Legislature should consider recapturing state depreciation payments to Rule 36 facilities at the time of sales, as well as prohibitions on increased property payments resulting from facility sales.**

Currently, there is little accountability for room and board costs, which counties now negotiate but the state pays. State officials do not scrutinize facility property costs (even in Rule 36 facilities), but these are a potential source of profit for facility owners and should be regulated more closely. State room and board payments often pay for programmatic expenses, which we think is inappropriate.

We also think the state needs better oversight of Rule 36 expenditures, which vary widely. We recommend that:

- **The Department of Human Services rewrite Rule 12, outlining allowable costs more explicitly. The department may wish to consider flat rates for certain routine expenditures. To the extent possible, the Department of Human Services should standardize the services eligible for funding. The department should also evaluate the feasibility of periodic audits of Rule 12 expenditures.**

- **The Legislature should repeal statutory references to "previously-funded activities," an outdated provision of present law.**

- **The Legislature should require Rule 36 owners to provide the state with documentation of: (1) the types and extent of their property costs, (2) accumulated equity in capital assets, (3) financial**

---

24 Vouchers are not considered state supplementary payments under federal regulations. This could present a problem, since Minnesota is required to show the federal government that it is not reducing its total MSA expenditures from one year to the next.

arrangements (including interest rates) for capital facilities, (4) a depreciation schedule, and (5) asset values.

- **The department should continue improving its mental health information system so that it can assess the complete cost of services to Rule 36 residents.**

NEIGHBORHOOD ACCEPTANCE OF RESIDENTIAL FACILITIES

Chapter 7

Deinstitutionalization shifted people with disabilities from isolated hospital settings into residential neighborhoods, and the siting of some Rule 36 facilities has sparked debate and legal action. Mental health advocates often suggest that community opposition to group homes reflects prejudice toward people with mental illness, while neighborhood groups contend that their opposition results from legitimate concerns about neighborhood quality of life.

Whatever the case, such resentment undermines the goal of helping residents become an integrated part of community life. One study found that nothing contributes more to the social integration of facility residents than having neighbors who invite them into their homes and talk with them.[1]

We asked:

- **How do current laws affect the location of facilities for adults with mental illness?**
- **What do people who live near Rule 36 facilities think of them?**

STATE LAW

According to Minnesota law, persons in residential programs "shall not be excluded by municipal zoning ordinances or other land use regulations from the benefits of normal residential surroundings."[2] For zoning purposes, a state-licensed residential facility serving less than seven people must be considered a permitted single family residential use, meaning it may locate anyplace that single family homes are authorized to locate. Facilities serving 7 to 16 people are considered permitted multi-family residential uses. Local zoning authorities may impose conditions on facilities with more than seven residents to assure proper maintenance and operation of the program.[3]

---

1 Steven P. Segal and Uri Aviram, *The Mentally Ill in Community-Based Sheltered Care: A Study of Community Care and Social Integration* (New York: John Wiley and Sons, 1978), pp. 170-171.

2 *Minn. Stat.* §245A.11, Subd. 1.

3 *Minn. Stat.* §245A.11, Subd. 3.

The Legislature has tried to limit the concentration of residential facilities.

The Legislature has tried to limit the number of group homes that locate in particular neighborhoods. First, in cities of the first class, state law prohibits licensure of new programs that are within 1,320 feet of existing residential programs (unless authorized by the city). Second, if more than 0.5 percent of the population of cities or local planning districts lived in residential facilities in January 1985, no new programs serving seven or more residents may be located in these areas. The Legislature has asked counties with areas of group home concentration to promote the dispersal of these residents and to plan new facilities in areas that are not concentrated.[4] These laws pertain to Rule 36 facilities as well as community facilities for mentally retarded and chemically dependent adults. They do not pertain to residential correctional facilities, adult foster care homes, or "board and lodging" facilities without human services licenses.

Recent federal legislation and regulations have raised questions about the legality of Minnesota's facility siting requirements. Congress passed the Fair Housing Amendments Act of 1988 to prohibit housing discrimination and allow disabled people to choose where they live.[5] According to an analysis by a mental health legal advocacy group, the law and subsequent federal regulations prohibit distance requirements between group homes, facility dispersal requirements, and local requirements for conditional use permits for group homes.[6]

SURVEY OF ATTITUDES AMONG FACILITY NEIGHBORS

Although it is likely that federal actions and court decisions will guide future facility siting decisions, we felt it would be useful to document the attitudes of people who live near group homes. In an effort to get neighbors' impressions of Rule 36 facilities, we surveyed 65 people who live within one block of facilities we visited.[7] We conducted face-to-face interviews with neighbors who were home when we visited, and we left survey forms for people who were not home.

We found that:

- **Neighbors generally have good or neutral impressions of Rule 36 facilities.**

---

4 *Minn. Stat.* §245A.11, Subd. 5. The Legislature has not appropriated money specifically for the purpose of deconcentration, and most people we talked to said that the Legislature's "dispersal planning" requirements have had little impact on facility concentration.

5 Public Law 100-430.

6 Mental Health Law Project, "How the New Federal Fair Housing Law Affects Local Land-Use Rules," March 7, 1989.

7 We surveyed neighbors living near 21 of the 24 facilities we visited; three facilities did not have immediate neighbors. To minimize bias in our sample, our findings are only for neighbors with whom we initiated contact and do not include the comments of several neighbors who contacted us with complaints about facilities.

As shown in Figure 7.1, three-fourths of respondents said the Rule 36 facility has been a good neighbor. Many people said they felt initial apprehension about facilities but have not experienced significant problems. About one-fourth of the neighbors said they would prefer to have a smaller facility or no facility at all in the neighborhood, but the facilities appeared to have relatively little effect on neighbors' likelihood of moving.

We surveyed people who live near Rule 36 facilities.

Figure 7.1: Summary of Comments From People Who Live Near A Rule 36 Facility

- 74 percent said the facility is a good neighbor, 13 percent said it is "somewhat" of a good neighbor, and 11 percent said it is not a good neighbor.
- 60 percent said the facility is the right size for the neighborhood, while 10 percent preferred a smaller facility and 16 percent preferred not having a facility in the neighborhood.
- 27 percent said there have been facility-related problems or incidents in the past two years. Of these neighbors, 44 percent said the facility staff have been very willing to listen to the neighborhood's concerns.
- 14 percent said the facility makes them more likely to move out of the neighborhood, and 82 percent said the facility does not.

Source: Program Evaluation Division interviews and surveys, May to August 1989.

Note: 65 neighbors were interviewed or completed the survey. On each question, a few neighbors did not respond or were not asked the question, and we have not included these cases in survey calculations.

Some of the positive comments we heard about facilities included the following:

- "Because there are many problem areas in the city, I'm happy to have this residence making good use of a big house and providing a service to the clients. They are basically quiet and present no problems that I know about. They keep the outside neat. I'm pleased with their location in this area."
- "We make it a point to visit the facility because we like to know what's going on there. We're glad the facility is there. The previous owner didn't keep the place up real well. The residents at [this facility] stay to themselves most of the time. Sometimes they get lost and approach neighbors to ask directions, which is fine."
- Noting that there have been only minor problems, one neighbor said that if the facility's properties were sold, "we could have much worse neighbors, especially if there were absentee landlords."
- "Sometimes the residents behave strangely. But these people have to live somewhere and have to learn to deal with life."

Several facilities have neighbors on their advisory boards and some have public open houses, but our impression is that facility contacts with neighbors are

minimal. Many Rule 36 administrators try to keep a low profile in the neighborhood.

While relatively few of the neighbors we surveyed expressed negative feelings about Rule 36 facilities, there were some noteworthy exceptions. These included comments such as the following:

We heard relatively few negative comments from Rule 36 facility neighbors.

- "There are some problems with noise in the summer, and one resident was urinating off the deck last summer. We probably wouldn't have built our house here if we'd have known [the facility] was going to move in right after we built."

- "The residents are always walking the neighborhood streets unescorted. Some days I see the same person walk by as many as 10 times. The small children in the neighborhood are sometimes frightened by their unkempt appearance. I have come home some nights after 10 p.m. and one or two of the residents are just standing around at the street corner in the dark, which especially disturbed my children."

- "Residents play ball in the street because they don't have room for recreation in the yard. Residents are out after curfew. The neighborhood became more transient after [this facility] moved in. The facility might be alright in a residential area on a main traffic artery, but not here."

- "The residents litter the neighborhood with fast food garbage and cigarette butts. It's difficult to live in an area with such turnover of residents. The place just isn't a normal next-door neighbor. It's too big, the people stare at me, and they repeat the same comments to me over and over."

Staff at one facility noted that one of their former residents sexually abused a neighborhood child while living at the facility. This was the only confirmed incident of serious criminal activity we learned about from staff or neighbors.

Overall, Rule 36 facilities receive mixed, but mostly positive, reviews from neighbors. Given the nature of residents' illnesses and their legal right to move freely in the community, neighbors are likely to see instances of strange behavior occasionally. We do not think the problems noted by some neighbors should be taken lightly by facility staff or state policy makers. To the extent that neighbors' concerns relate to policy issues, such as facility supervision or size, they should be heard by state officials that work on these issues. To the extent that they reflect neighbors' misunderstandings about mental illness or the purpose of a particular facility, Rule 36 staff should try to educate and inform neighbors. But we think it would be inappropriate to mandate restrictions for Rule 36 residents that do not govern other members of society, unless such restrictions are court-ordered or done with the residents' consent.

For the purpose of improving communication between neighbors and policy makers, we recommend:

- **Each Rule 36 facility should be required to develop a resource list for the community representative(s) of its advisory committee, including contacts in the Department of Human Services, county mental health advisory board, and mental health advocacy groups.**

The resource list should provide neighbors with some possible outlets for their concerns and names of people who can provide answers to mental health questions. It is also possible that neighbors will be able to bring issues affecting quality of care to the attention of advocates or policy makers that they would otherwise not be aware of.

FACILITIES VISITED BY PROGRAM EVALUATION DIVISION, MAY TO AUGUST 1989

Appendix A

RULE 36 FACILITIES:

New Foundations (St. Paul)
Hiawatha Hall (Winona)
Wellspring Therapeutic Community (Minneapolis)
Northway Group Home (St. Cloud)
White Shell Group Home (Little Falls)
Community Options (Fridley)
Bristol Place (Minneapolis)
Andrew Care Home (Minneapolis)
Passageway (Minnetonka)
Familystyle Homes (St. Paul)
Nova Home (New Ulm)
Willmar Health Care Center (Willmar)
St. Francis Halfway House (Atwater)
Janus Treatment Residence (Bloomington)
Spruce Woods (Bemidji)
Northwestern Apartments (Crookston)
Oak Grove Care Center (Minneapolis)
Reentry House (Minneapolis)
Riverview Homes (Brookston)
Hoikka House (St. Paul)
March House (Minneapolis)
Wilson Center houses (Faribault)
Rathjen House (Albert Lea)
Guild Hall (St. Paul)

BOARD AND LODGING FACILITIES:

Maxwell Guest House (Rochester)
Civic Inn (Rochester)
Quinlan Home (St. Paul)[1]
Armstrong Board and Care (St. Paul)
Pursuit Hometel (Minneapolis)
Starlight Manor (Minneapolis)
Harbor Lights (Minneapolis)
Stevens House (Minneapolis)
Country Meadows (Buffalo)
St. Elizabeth Home (St. Cloud)

---

1 Quinlan Home is licensed as a "boarding care" facility.

Brott's Lodging House (Waite Park)
Sunshine House (Madison Lake)
Ammarilla House (Pine River)
Armstrong House (Bemidji)
St. Clare House (Duluth)
Miketin's Central (Duluth)
Arrowhead House (Duluth)
Miketin's (Two Harbors)
Whittier House (Minneapolis)
Medallion Manor (Minneapolis)

OTHER RESIDENCES:

Tasks Unlimited Fairweather Lodge (Minneapolis)
Vail Place (Minneapolis)
Safe House (St. Paul)
People's Apartment Network (St. Paul)

HOSPITAL PLACEMENT SURVEYS

Appendix B

Please complete **and return one** copy of this survey that best represents the views of your hospital's staff involved in discharge planning for mentally ill adults. You may wish to complete this survey during a staff meeting in order to reach a consensus position on these questions. Please return this survey **by June 23, 1989.** (Note: 22 hospitals responded.)

1. How many of your mentally ill patients are you able to discharge to living arrangements that provide them with supervision and support that you feel is appropriate?

31.8%	☐	(a) More than 75 percent
36.4	☐	(b) 50 to 75 percent
22.7	☐	(c) 25 to 49 percent
9.1	☐	(d) Less than 25 percent

2. If the Legislature expanded the services or living arrangments available for patients that you discharge, which of the following would be your hospital's first, second, and third priorities? (Indicate by letter below.)

   (a) More regional treatment center beds.

   (b) Additional Rule 36 beds with higher staffing levels than current Rule 36 facilities have.

   (c) Additional Rule 36 beds with programs and staffing levels comparable to those in existing facilities.

   (d) More living arrangements that provide some supervision but are not linked to a treatment program.

   (e) More community support services for clients living independently.

   (f) More affordable, independent housing (not linked to a treatment program or to supervision).

   First choice: B (40.9%) Second choice: C (31.8%) Third choice: C (40.9%)

3. Making appropriate community placements of seriously and persistently mentally ill clients is:

9.1%	☐	(a) Easier than it was two years ago
27.3	☐	(b) About the same as it was two years ago
59.1	☐	(c) More difficult than it was two years ago.
4.5	☐	(d) Not sure

4. Is the typical length of stay for your hospital's psychiatric patients enough time to stabilize the client and make appropriate living arrangements in the community?

9.1%	☐	(a) Rarely or never
50.0	☐	(b) Sometimes
18.2	☐	(c) Often
27.7	☐	(d) Usually or always
0.0	☐	(e) Not sure

5. Do Rule 36 staff adequately tailor their programs to the needs of their clients?

- 4.5% ☐ (a) Rarely or never
- 27.3 ☐ (b) Sometimes
- 27.3 ☐ (c) Often
- 27.3 ☐ (d) Usually or always
- 13.6 ☐ (e) Not sure

6. Of the clients you discharge who are capable of living in the community, are Rule 36 facilities willing to take your most difficult cases?

- 22.7% ☐ (a) Rarely or never
- 54.5 ☐ (b) Sometimes
- 9.1 ☐ (c) Often
- 13.6 ☐ (d) Usually or always
- 0.0 ☐ (e) Not sure

7. Are clients discharged to settings with more services than necessary because settings with fewer services (e.g., SILS) are unavailable?

- 40.9% ☐ (a) Rarely or never
- 54.5 ☐ (b) Sometimes
- 0..0 ☐ (c) Often
- 4.5 ☐ (d) Usually or always
- 0.0 ☐ (e) Not sure

8. Some client subgroups are more difficult to place in community settings than others. Based on the number of people in these subgroups and the difficulty you have making placements, mark the three subgroups that you find most difficult to place in acceptable living arrangements: Clients with (check three):

- 0.0% ☐ (a) Mobility impairments
- 0.0 ☐ (b) Hearing impairments
- 63.6 ☐ (c) Dual diagnoses of CD and MI
- 40.9 ☐ (d) Dual diagnoses of MR and MI
- 13.6 ☐ (e) Low motivation
- 31.87 ☐ (f) Histories of self-abuse
- 68.2 ☐ (g) Histories of violence or abuse of others
- 0.0 ☐ (h) Bipolar personalities
- 9.1 ☐ (i) Positive HIV or AIDS
- 40.9 ☐ (j) History of fire setting
- 27.3* ☐ (k) Other (please specify) _____

***"Other" responses included Alzheimers, borderline personalities, elderly, non-English speaking.**
Note: Percentages sum to more than 100 because respondants selected three responses.

9. Clients in which one of the following age groups are the most difficult to find appropriate placements for?

22.7% ☐ (a) 18-24
4.5 ☐ (b) 25-34
9.1 ☐ (c) 35-64
27.3 ☐ (d) 65 and older
36.4 ☐ (e) none is more difficult than others

10. Please note specific counties or regions of the state where you have particular difficulty finding suitable placements for mentally ill people.

Taken together, the regions and counties mentioned here cover the entire state.

11. Please use the space below to express any other general concerns that placement staff at your hospital have about the adequacy of community services for the mentally ill.

Selected comments:

Not enough choices in some counties, and nothing in some counties.

Metro counties, especially Hennepin, expect clients to be placed without county assistance.

Need more timely, consistent response by counties to mandated services.

Concerned that new Rule 36 requirements will move away from diversity, when what is needed is more alternatives with less structure.

Rule 14 is helping to improve community services.

The funding process needs streamlining so there are not delays in moving patients from one agency to another.

Facilities, including RTCs, see the survival of their programs as more important than service to clients.

It is hard to find placements close to patients' homes, especially in suburbs.

Getting into a Rule 36 is more difficult than getting into an Ivy League college.

Thank you for your cooperation. If you have any questions about this form, please call Kathi Vanderwall at (612)297-3499.

CLIENT PLACEMENT SURVEY

Please complete this form for ***each*** psychiatric patient discharged from your hospital **between June 5 and June 18.**

NAME OF PERSON COMPLETING THIS FORM: _____

NAME OF HOSPITAL: _____

COUNTY WHERE CLIENT WAS PLACED: _____

NUMBER OF DAYS CLIENT WAS IN THE PSYCHIATRIC UNIT: 24 days (average)

1. How many Rule 36 residences if any did you contact to inquire about possible placements for this client: _____
   N = 450 0 - 76.3% 1 - 8.9% More than 1 - 7.6%

2. Did the client have any characteristics that made placement more difficult than usual?

   N = 410 30.3% Yes 54.2% No

   2a. If you marked Yes, please note these characteristics below:

   _____

   _____

3. Where was the client placed?
   N = 462

   12.0% ☐ a. Residential treatment facility (Rule 36)
   3.1 ☐ b. Boarding house
   8.2 ☐ c. Nursing home
   4.1 ☐ d. Regional Treatment Center
   1.9 ☐ e. Correctional Facility
   0.6 ☐ f. Foster care
   11.3 ☐ g. With parents or relatives
   39.2 ☐ h. Independent living
   14.8 ☐ i. Other (please specify) _____

4. If the client was placed in a residential facility (choices a, b, c, d, and e above), what is the name of the facility?

   N = 177 _____

   4a. Have you ever visited this facility? 15.3% Yes 20.0% No

5. To what extent was the client satisfied with the placement?
   N = 382

   49.1% ☐ a. Very satisfied
   23.1 ☐ b. Somewhat satisfied
   6.6 ☐ c. Dissatisfied

6. Did your hospital postpone the client's discharge temporarily due to problems finding acceptable living arrangments?
   N = 454

   9.3% Yes (how many additional days: 18) 84.3% No

7. Did the client move to a *temporary* living arrangement until a more appropriate placement becomes available?
N = 437

8.5% Yes 81.6% No

7a. If YES, how long do you think this client will need to wait until the more appropriate living arrangement becomes available?
N = 42

61.0% ☐ (a) Less than two months
14.6 ☐ (b) Two to six months
2.4 ☐ (c) More than six months
24.4 ☐ (d) Not sure

8. To what extent does this client need the following services after discharge? (Please circle the appropriate answer)

		Not important	Somewhat important	Very important	Don't Know
N = 410	**Advocacy services** (legal assistance, case management)	21.6%	23.1%	35.7%	4.1%
N = 430	**Interpersonal services** (socialization, recreation, support groups, group psychotherapy)	5.4	23.3	57.5	2.5
N = 408	**Family services** (parenting, family planning, family psychotherapy)	30.5	24.5	24.5	4.5
N = 404	**Vocational development** (job placement, education and training)	33.6	23.7	22.5	3.5
N = 426	**Medication monitoring**	15.9	18.1	50.7	3.1
N = 402	**Skill development for meeting basic daily needs** (finding housing, buyingand preparing food, finances)	39.4	21.0	19.4	3.1
N = 406	**Substance abuse services**	44.5	11.1	22.7	5.4

8a. Please mark any services that you consider very important for this client (those with a rating of 3) that the client will probably NOT have adequate access to in the new living setting:

19.1% ☐ Advocacy services
14.3 ☐ Interpersonal services
24.4 ☐ Family services
32.1 ☐ Vocational development
19.1 ☐ Medication monitoring
26.6 ☐ Skill development for meeting basic daily needs
38.2 ☐ Substance abuse services

9. As you consider the living arrangement that would **best** suit this client, how satisfied are you with the living arrangements this client now has?
N = 445

44.7% ☐ (a) Very satisfied
25.8 ☐ (b) Somewhat satisfied
7.8 ☐ (c) Very unsatisfied
7.2 ☐ (d) Somewhat unsatisfied
6.2 ☐ (e) Neither satisfied nor dissatisfied

10. The location of the client's new residence is:
N = 389

5.6% ☐ (a) Too far from family, friends, or community resources
61.9 ☐ (b) An appropriate distance from family, friends, and community resources.
12.8 ☐ (c) Other (please specify) _____

11. The client's new living arrangement:
N = 394

0.8% ☐ (a) Provides more supervision and care than the client needs.
16.3 ☐ (b) Provides less supervision and care than the client needs.
57.7 ☐ (c) Provides the right amount of care and supervision.
6.0 ☐ (d) Other (please specify) _____

IN THE SPACE BELOW, PLEASE BRIEFLY DESCRIBE THE EFFORTS YOU MADE TO FIND APPROPRIATE LIVING ARRANGEMENTS FOR THIS CLIENT AND ANY PROBLEMS YOU ENCOUNTERED:

Please answer the remaining two questions if you initially hoped to place the client **in a particular community residential facility** (Rule 36 or board-and-lodging house) but were unable to make this arrangement:

What was the reason for not being able to place the client in the setting you initially preferred?
N = 49

18.4% ☐ (a) The facility did not have an available slot.
20.4 ☐ (b) The client did not meet the facility's admission criteria.
36.7 ☐ (c) The client refused to be placed in this facility.
4.1 ☐ (d) The client's family did not agree to this facility.
20.4 ☐ (e) Other (please specify): _____

In your judgment, the new living arrangement will probably:

34.7% ☐ (a) Help this client's mental health as much as the initially preferred living arrangement would have.
20.4 ☐ (b) Help this client's mental health, but not as much as the initially preferred living arrangement would have.
12.2 ☐ (c) Neither help nor harm this client's mental health.
32.7 ☐ (d) Result in deterioration of the client's mental health.

Thank you for your cooperation. If you have any questions about this form, please call Kathi Vanderwall at (612)297-3499.

FACILITY NAME: _____

Page _____ of _____

STAFFING ROSTER
(Direct Care Positions)

	A	B	C	D	E	F	G	H	I
	Facility Job Titles	Job Match Code	Qualifications Code	FT/PT	Average Hrs/Wk Scheduled	Hourly Pay	Health Benefits	Pension Plan	Paid Benefit Days Available
1.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
2.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
3.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
4.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
5.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
6.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
7.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
8.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
9.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
10.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
11.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
12.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
13.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
14.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
15.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
16.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
17.	_____	__-__% __-__%	___	_	____	__.__	_	_	_
18.	_____	__-__% __-__%	___	_	____	__.__	_	_	_

APPENDIX C

INSTRUCTIONS FOR COMPLETING STAFFING ROSTER

This part asks you to separately list each of your *direct care* employees by job title and identify their salary and benefit options. *Photocopy additional sheets of the staffing roster as necessary.*

Column A: Identify each job, vacant or filled, by the job title you use in your facility. If you have more than one employee within a job title, *list each job separately*. For example, if you employ three "social workers," each should be reported separately on the Staffing Roster.

Column B: The attached Job Match List describes mental health jobs at regional treatment centers (RTCs). Review the Job Match List and find the job description which *best* fits the duties and responsibilities of each Rule 36 position; enter the job code in the first two blanks of Column B.

If the RTC job matches this job completely, enter 99 in the third and fourth blanks.

If the jobs do not match completely (as in a multi-function job), indicate the percent of the Rule 36 job that matches the RTC job you listed. Then, in the next two blanks, write the code of the RTC job that best correspondends to the remaining duties of this Rule 36 job, and indicate the percentage of the Rule 36 job that matches this RTC job. Please note that you can match your Rule 36 jobs to *at most* two RTC jobs, and your percentages should add to 99 or 100.

If you can find no match for a particular job or part of a job please use code 75, "Other", and send in a job description for that job title with your survey.

Here are some examples:

a. You match your full-time job to Occupational Therapist, Job Match Code 24. Fill in Column B: 24 - 99% 00 - 00%, indicating that your job matches, or nearly matches, the state job title Occupational Therapist.

b. You match your part-time job to Occupational Therapist, Job Match Code 24. Fill in Column B: 24 - 99% 00 - 00%, indicating that your job matches, or nearly matches, the state job title Occupational Therapist. Note that even though your job is less than full-time, you should indicate that all of your job can be matched to the state job title Occupational Therapist.

c. You match your job to two state job titles--Occupational Therapist, Job Match Code 24, and Behavior Analyst 1, Job Match Code 03. You have determined that 75 percent of your job matches the Occupational Therapist and 25 percent matches the Behavior Analyst 1. Column B should be filled in: 24 - 75% 03 - 25%.

Column C: Review the Qualifications Scale (attached) and identify the level of training and experience you ***require*** for this position. List the qualifications code number in Column C.

Column D: Indicate whether this position is full-time or part-time. Enter an "F" if the position is full-time and a "P" if it is part-time.

Column E: Write the average number of hours per week you *schedule* for the employee in this position.

Column F: Write the current hourly wage rate paid to the employee occupying this position. Dollars are indicated to the left of the decimal point and cents are indicated to the right of the decimal point.

Columns G, H, and I: Place a check "X" if the employee in this position is eligible for health benefits, a pension plan to which the employer contributes, or paid benefits days (e.g., holidays, personal, vacation, sick).

Please return completed Parts A and B in the enclosed postage-paid envelope ***by June 16, 1989*** to:

Office of the Legislative Auditor
122 Veterans Service Building
St. Paul, MN 55155

RESEARCH METHODS FOR REVIEW OF RULE 36 HOSPITALIZATION RATES

Appendix D

We reviewed hospitalization rates for Rule 36 clients discharged between July 1 and December 31, 1987. Nineteen of the 24 facilities we visited had clients who were discharged during this period. We selected this period because we wanted to examine hospitalization in the six-month period following discharge (through June 1988 for some clients), and hospitals reimbursed for clients in the Medical Assistance program have up to one year to submit reimbursement claims to the Department of Human Services (through June 1989).

Of the 299 residents discharged from these Rule 36 facilities during this period, we found 266 with Social Security numbers in their files. We matched Social Security and Medical Assistance (MA) identifiers against state data files that indicated MA-reimbursed hospital stays dating back to 1984. We also matched client identifiers against Department of Human Services data on hospitalizations in regional treatment centers since 1984. Of our 266 cases, we eliminated 26 because the discharged clients' Rule 36 stay started prior to July 1984, which did not provide us with six months of hospitalization data prior to the Rule 36 admission.

Once we obtained MA hospitalization information on clients, we had to determine whether their hospitalizations were related to their mental illness. If the primary or secondary diagnosis code associated with the hospitalization was not a mental health diagnosis (according to the International Classification of Diseases, 9th revision, 3rd edition, Clinical Modification), we eliminated this hospitalization from our analysis.

Not all of the "before" and "after" hospitalizations were entirely contained in the six months preceding Rule 36 admission and following Rule 36 discharge. If a client was in the hospital at the time the six month "before" period started, we counted this hospitalization as one stay in the "before" period. Similarly, if the client was in the hospital at the time the six month "after" period ended, we counted this hospitalization as one stay in the "after" period. However, when calculating the number of "before" and "after" days spent in the hospital, we only included the number of hospital days that fell in the six-month intervals.

There are some caveats to our analysis. First, we were able to identify community hospital stays that were publicly reimbursed, but some client hospitalizations might have been privately paid. The vast majority of Rule 36 clients qualify for public assistance, including MA. However, it is possible that clients or their families paid for some hospital stays with private insurance. Second, some clients' MA numbers may change when they move to a different county,

and this made it more difficult for us to track hospitalizations on the basis of identifiers contained in the Rule 36 files. Because of this problem, we used Social Security numbers for all of our regional treatment center hospitalization analysis and for our assessment of MA-reimbursed hospitalizations since mid-1986. However, the nature of the state's MA hospitalization data required us to use MA numbers as client identifiers for data from 1984 to mid-1986, so it is possible that we did not identify some hospitalizations from this period if clients' MA numbers changed. Third, we looked at "before" and "after" hospitalization for a single Rule 36 stay, but it is possible that clients were in a Rule 36 facility during either of these periods (which might influence hospitalization rates). Finally, our data does not include any psychiatric hospitalizations outside the state of Minnesota.

SURVEY OF FORMER RULE 36 RESIDENTS

Appendix E

We received surveys from 23 people discharged from Rule 36 facilities in the last half of 1987. Their responses are summarized below.

1. During the time you lived at the facility mentioned above, did you learn things that helped you deal with the symptoms of your illness?

4	☐	(a) Yes, the facility was **very helpful.**
14	☐	(b) The facility was **somewhat helpful.**
3	☐	(c) No, the facility was **not very helpful.**
2	☐	(d) Other_____

2. During the time you lived at this facility, did you learn how to do things better for yourself? (These might include skills such as cooking, money management, how to use the bus system, how to look for a job, taking medications on your own, etc.)

5	☐	(a) Yes, I learned **many** useful independent living skills.
9	☐	(b) I learned **some** useful independent living skills.
6	☐	(c) No, I did not learn useful independent living skills.
3	☐	(d) Other:_____

3. Were you treated with respect while at the facility?

16	☐	(a) Yes
4	☐	(b) Sometimes
2	☐	(c) No
1	☐	(d) Other:_____

4. When you were at the facility, were the staff willing to listen to your ideas and suggestions about your mental health treatment?

14	☐	(a) Yes
5	☐	(b) No
4	☐	(c) Other:_____

5. Did you understand the purpose of your treatment at the facility?

17	☐	(a) Yes
3	☐	(b) No
3	☐	(c) Other:_____

6. When you were at this facility, did staff and residents respect your privacy, and did you have a place to be alone if you needed it?

14 ☐ (a) Yes
5 ☐ (b) No
4 ☐ (c) Other:_____

7. When you started living at this facility, you probably had some expectations about how much help this facility could give you. Looking back, which of the following statements best describes the help you received?

6 ☐ (a) The facility helped me **more** than I thought they could.
10 ☐ (b) The facility gave me about as much help as I had expected.
6 ☐ (c) The facility helped me **less** than I thought they could.
1 ☐ (d) Other:_____

8. Since leaving this facility, have you been able to get services that you need? (These services might include counseling, job training, help finding a job, help with medications, or others.)

13 ☐ (a) Yes, I have been able to get most of the services that I need.
5 ☐ (b) I have been able to get some services that I needed, but I have been unable to get others.
5 ☐ (c) No, I have been unable to get the services that I need.
0 ☐ (d) Other:_____

9. Please mark (X) any of the following services that you wanted after you left the facility but were **unable to get**:

2 ☐ Help from a county case manager or social worker.
4 ☐ Job training or school.
4 ☐ Treatment programs, therapy, or counseling.
3 ☐ Help with medications.
1 ☐ Help with basic needs, such as hygiene, budgeting, or meal preparation.
4 ☐ Help finding decent, affordable housing.
6 ☐ Help finding a decent job.

10. What did you like most about the facility?

- **The staff and most residents seemed to accept me as I am.**
- **The staff did respect the residents.**
- **The freedom relative to other facilities. Handy to downtown, etc.**
- **The way they seemed to care about us.**
- **Church services downstairs, able to attend weekly.**
- **Air conditioning in the lounges--bedrooms had no air conditioning and were too hot.**
- **The professionalism of the staff.**
- **I could work there and earn some extra spending money.**
- **The fellow residents and the helpful staff people.**
- **I feel the facility was very good. I learned a lot. The thing I liked the most was the special times I had with the staff. I learned an awful lot. I feel it was run pretty good.**
- **It was a very clean and organized facility. I was very pleased. I wish I found out about it earlier than I did.**
- **The house parents were the most help.**
- **It had girls that really do like me.**
- **My therapist and I had a special relationship which helped me to become more able to trust and listen.**

- **Staff.**
- **You could brew hot coffee in your room.**
- **A room by yourself.**
- **Help available, one-on-one when needed. Direction and help with future plans when ready to go on, facing this alone would have been overwhelming.**
- **I liked the sense of freedom.**

11. What did you like least about the facility?

- **Having to rely on others for meds.**
- **I didn't like being described as vulnerable, though I was.**
- **The way that they expected me to behave in relation to their questions.**
- **Menu repeated after three weeks. Staff was condescending and sometimes arrogant. No privacy. Some residents were disruptive and too imbalanced. Staff searched rooms of my friends.**
- **Nothing.**
- **No privacy; constant counseling--not being allowed to work because of scheduling which didn't allow for work and group attendance.**
- **Lack of privacy. Also the food.**
- **The day treatment program wasn't as challenging as I would have liked it.**
- **Not enough control over my money. Only $25 per month spending given from my account.**
- **Sometimes people that were mean were left there, and I feel they wasted a lot of money on things we didn't need. I guess I just don't believe in spending that much on fun things.**
- **People leaving this facility knowing that they need assistance to live independently or are disabled should receive enough money for housing and food, etc.**
- **Living conditions upstairs were not nice like downstairs that the public sees. 3 to a room. Loss of self-worth feeling perpetuated.**
- **The way that they answered me--they argued my fine points.**
- **I became so tight (close) to my peers, but when they left as I also did--I wasn't able to keep in touch. There's a beautiful world living in a family with so much openness.**
- **Old building.**
- **They kicked me out.**
- **The residents, all they do is sit around, I'm an active person and it (the home) was a mistake.**
- **It would have been easy to get comfortable with a non-productive life style, a feeling of being taken care of, being around people like this, sometimes made it hard to find work and go every day when you do.**
- **The lack of cleanliness, lack of privacy.**
- **Nothing, the facility was very helpful for me.**

SELECTED PROGRAM EVALUATIONS

Insurance Regulation, January 1986	86-01
Tax Increment Financing, January 1986	86-02
Fish Management, February 1986	86-03
Deinstitutionalization of Mentally Ill People, February 1986	86-04
Deinstitutionalization of Mentally Retarded People, February 1986	86-05
Management of Public Employee Pension Funds, May 1986	86-06
Aid to Families with Dependent Children, January 1987	87-01
Water Quality Monitoring, February 1987	87-02
Financing County Human Services, February 1987	87-03
Employment and Training Programs, March 1987	87-04
County State Aid Highway System: Follow-Up, July 1987	87-05
Minnesota State High School League,* December 1987	87-06
Metropolitan Transit Planning, January 1988	88-01
Farm Interest Buydown Program, January 1988	88-02
Workers' Compensation, February 1988	88-03
Health Plan Regulation, February 1988	88-04
Trends in Education Expenditures,* March 1988	88-05
Remodeling of University of Minnesota President's House and Office, March 1988	88-06
University of Minnesota Physical Plant, August 1988	88-07
Medicaid: Prepayment and Postpayment Review - Follow-Up, August 1988	88-08
High School Education,* December 1988	88-09
High School Education: Report Summary, December 1988	88-10
Statewide Cost of Living Differences, January 1989	89-01
Access to Medicaid Services, February 1989	89-02
Use of Public Assistance Programs by AFDC Recipients, February 1989	89-03
Minnesota Housing Finance Agency, March 1989	89-04
Community Residences for Adults with Mental Illness, December 1989	89-05
Local Government Lobbying, Forthcoming	
School District Spending, Forthcoming	
Charitable Gambling, Forthcoming	
Local Government Spending, Forthcoming	

Evaluation reports can be obtained free of charge from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

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