MANDATE FOR ACTION

Recommendations of the Governor's Mental Health Commission
February 3, 1986
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Preparation by:
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THE CONTEXT

The Governor's Commission on Mental Health

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

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

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

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

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

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

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

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

Definitions and the Needs of People with Mental Health Problems

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

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

Definitions

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

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

(p. 363)

Clinically significant mental disorders affect an individual's ability to function in important areas of daily living. Because of disruptions or distortions of emotional or cognitive mental processes, the person may have an increased difficulty dealing with personal relationships, living arrangements, work, recreation, mobility within the environment, and achieving a reasonable level of productivity.
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Clinically significant mental disorders affect an individual's ability to function in important areas of daily living. Because of disruptions or distortions of emotional or cognitive mental processes, the person may have an increased difficulty dealing with personal relationships, living arrangements, work, recreation, mobility within the environment, and achieving a reasonable level of productivity.
order to identify people who are in need of mental health services in the population, a definition of "person with mental illness" is necessary. Current definitions of mental illness require, in addition to descriptions of individual's behavior, specifying co-existent physical illnesses, the degree and severity of social stressors, and recognition of the level of functioning attained by the individual in the past. A mental illness may be a lived experience (acute) or of long duration (onset), but "the real difference between acute and chronic is not the length of the illness, but whether deterioration occurs in family and social relationships" (Janecek, 1984, p. 2).

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

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

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

The use of such phrases as "mentally ill" should not obscure the basic fact that these are individuals with a whole array of positive contributions and abilities. Although mental health problems are clearly important, it is also important to recognize the strengths of the individual and his/her right to be respected and appreciated. "Indeed, one of the most serious obstacles to more rewarding lives for these people is the stigmatization and devaluation which occurs, both in organized service settings and in society at large" (NIMH 1976, pp. 1-4).

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

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

- A comprehensive evaluation of strengths and weaknesses, and an opportunity to participate in setting goals and developing a plan for appropriate services;
- Appropriate and continuing medical, psychiatric, or psychological treatment as necessary, including periodic review and regulation of medication;
- A place to go or a person to call for help in dealing with acute behavioral, emotional, or physical distress;
- Training in "coping skills" to assist in tasks of daily living, and when appropriate, assistance in performing these tasks;
- Dependable, available resources to provide assistance as needed or when crises arise, who will protect the person from exploitation, represent the person as necessary, and espouse the person's cause in dealing with the system;
- Opportunities for validation of personal worth, for being appreciated and valued as a human being;
- A residential setting [a place to live] which provides emotional support, practical assistance in daily living, and which resembles other community living arrangements as much as possible [in a family or a household composed of people of one's own choosing];
- Assistance to family and significant others in relation to any difficulties they may experience as a result of the person's mental illness;

The people who are of concern to the Governor's Commission on Mental Health are Minnesotans who have a mental/psychiatric disorder which is clinically definable and who experience disruption in their abilities to function in daily life.
Assistance to neighbors or employers in coping appropriately with any unusual, annoying, or disturbing aspects of the person's behavior;

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

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

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

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

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

A History of Studies and Consultations

The history of mental health services in Minnesota has not only been one of a series of policy and service initiatives, but also marked by numerous reports and recommendations. Since 1961, at least 21 separate efforts have focused on issues related to mental health services and people with mental health problems. Each has taken a different perspective on a different set of issues, yet together they constitute an impressive body of recommendations, most of which have not been implemented.

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

Advocacy and Policy
The rights of people with mental health problems should be supported and enforced. Special efforts should be made to reach out to individuals who are members of minority groups. The capacity to oversee the system should be created. (1972, 1977, 1979, 1988)

Coordination and Leadership
To address the needs of people with mental illness, it is necessary to exercise leadership and coordinate the efforts of several state agencies. (1971, 1976, 1978, 1978, 1985)

Services:

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

State Hospitals:

Personnel and Training:
Efforts should be directed at: a) providing a training program for personnel in the field of mental illness, b) stimulating training by providing incentives, c) developing volunteer capabilities, d) providing technical assistance and consulting support to service providers, and e) the development and implementation of a public education program. (1961, 1963, 1969, 1971, 1978, 1979, 1983)

An Information Base:
A data base and information system needs to be developed to assist in the identification of people in need, to gain access to technical and financial assistance, to provide an information clearinghouse, and to document needs and the availability of services. (1971, 1977, 1978, 1979, 1980, 1988)

Funding:
Funding levels should be increased. Disincentives which stand in the way of receiving appropriate care should be removed. (1966, 1968, 1969, 1978, 1979, 1986a, 1986b)

Research:
Funds for research should be provided with an emphasis on effective management and treatment approaches. (1961, 1961, 1977, 1976, 1985)

This summary is, however, far from a complete picture of the more than 10 recommendations put forward in the last three decades related to a range of issues.
THE FINDINGS

Introduction
The Governor's Commission on Mental Health focused its attention on five major issue areas:
1. Policy direction and mission;
2. The needs of people with mental health problems;
3. Planning and delivery of mental health services;
4. Quality assurance and standards; and
5. Funding.

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

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

Issue I: Policy Direction, Mission, and Rights
Two themes were of primary interest to the Commission in this area—the direction of mental health services and the rights of people with mental health problems.

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

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

It is the policy of the state of Minnesota to provide a coordinated approach to the supervision, protection, and habilitation of its mentally retarded citizens. In furtherance of this policy, sections 252A.01 to 252A.21 are enacted to authorize the Commissioner of Human Services...to protect such mentally retarded persons from violation of their human and civil rights by assuring that such individuals receive the full range of needed medical, therapeutic, and educational services to which they are legally entitled.
It is hereby declared to be the public policy of this state that the interests of society are best served by providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services... treatment shall include a continuum of services available for a person leaving a program of treatment.

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

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

The Department of Human Services... is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to help them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

... the purpose [of the mental health division] is to encourage, ensure, or provide opportunities for every person in Minnesota to grow in his/her abilities to get along with others, in ways that are satisfying to him/her, and acceptable to those around him/her.

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

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

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

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

**Rights**

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

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

In a recent review of state statutes to determine the extent to which these rights have been accepted in states (Lyon, Levine, & Zusman, 1982), it was determined that Minnesota had substantially complied in nine areas, partially complied in six areas, and had not complied or contradicted the recommendations in nine areas. According to this review, several states such as Alaska, Arkansas, California, Connecticut, Georgia, Hawaii, Illinois, Kansas, Missouri, Montana, New Jersey, New York, Ohio, and Wisconsin exceed Minnesota in statutory protection of rights.
The following services were identified by 75 percent or more of the counties involved in the study as “essential for mentally ill persons” and were then recommended by the Department to be included in the description of minimal capability:

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

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

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

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

One half of the respondents do not have basic information about the illness, how to cope, nor services available.
The services which allow people to live close to home and family; reduce hospitalization; and are cost effective are seen as inaccessible to many people who require such services.

Outpatient and Community Services:

- Outpatient Services:
  - 60 percent report access (N = 769);

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

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

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

**Issue 3: Planning and Delivery of Services**

**Concerns and Issues**

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

**State Hospitals**

Currently, six of the eight state hospitals, and the Minnesota Security Hospital, serve people with mental illness. Before the deinstitutionalization movement of the 1960s and 1970s, there were over 10,000 beds in the state hospital system for people with mental illness. Today, there are fewer than 2,000 beds. In FY ’93, the average daily census was 1,197 persons (with mental illness), and this is expected to rise to 1,261 in FY ’96 (Naps, 1985, p. 6).

**Nursing Homes**

Many elderly persons with mental illness have been moved into nursing homes, because federal Medicaid funds are available. From 1978, the number of persons (Medicaid-funded) with mental illness in nursing homes has increased from 6,261 to 9,941 in 1993. The Department of Human Services reports 35,000 people with mental illness now living in nursing homes (Department of Human Services, 1996, p. 12). This number (16,250) represents all types of funding in all nursing homes including state-operated.

**Community Residential Programs**

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

Rule 12 is the funding mechanism for grants to counties to help pay for services required by Rule 36. In FY ’93, Rule 12 grants funded 75 facilities with a capacity of 1,076 beds. In total, 29 counties received Rule 12 grants.

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

<table>
<thead>
<tr>
<th>Mental Illness Facilities and Approximate Residents 22,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Rule 36 Facilities</td>
</tr>
<tr>
<td>Rule 36 Community Facilities</td>
</tr>
<tr>
<td>State Hosp. Mt Units</td>
</tr>
<tr>
<td>Pay Hosp. Units</td>
</tr>
</tbody>
</table>


*Includes over 1,000 people under age 65 years.

Additionally, according to the Department of Human Services, approximately 4,000 to 5,000 Minnesotans have mental health needs appropriate for placement in a Rule 36 facility, a semi-independent living arrangement, or a supportive living residence (Department of Human Services, 1996, p. 12). These alternatives are not available to meet the projected need.
Other Outpatient Services

During the previous eligibility for insurance reimbursement for outpatient mental health clinics, The Department of Human Services listed 69 clinics in 1983. Most Rule 29 clinics receive a mix of reimbursement from both public and private sources. There has been no attempt to describe the people served by these clinics and the quality of services received.

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

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

- These sectors and levels of government are not a well-integrated system. To the extent that a system exists, it is not well-understood by those who work in it or those intended to be served by it.

- A change in one part of the system affects the other sector and/or levels of government. There is lack of coordination related to these impacts. Examples of such impacts include new mandates, changes in funding levels, changes in insurance coverage.

- There are inconsistencies among the three sectors and levels of government in terms of regulations, uniformity, and flexibility.

- Responsibility is not well-identified or fixed within either the sectors or the levels of government.

- Leadership is often cited as a problem. As with responsibility, it exists in all sectors and at all levels of government.

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

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

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

There has been a dramatic increase in the availability of community support programs in the state, but their distribution is limited.
Mental health is a field in which there are so many goals and so few agreed upon priorities that progress toward any goal requires sustained effort across years.

— Leighton, 1984 —

There is no unified philosophy, set of goals or policy driving the mental health system. In addition, there appear to be two competing philosophies—a welfare philosophy which implies providing a minimum level of services to all who are eligible, and a health/wellness philosophy which implies providing a level of service that matches the needs of all the people.

An array of services does exist in the state, but not in all parts or in all types of service. Access to services remains a problem. Access is an issue at a number of levels—the existence of a service, its availability, transportation or distance, physical access, adaptation/accommodation for people with sensory impairments, ability to pay, and fear of stigmatization by professionals.

There is no ongoing, integrated method of ensuring accountability in all sectors and levels of government. There is a significant lack of information on the services available to and received by individuals, as well as the outcomes achieved by those services. This puts public officials at a critical disadvantage.

Funding remains a problem in terms of stability and level of funding, and incentives and disincentives for certain programs and services.

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

**Issue 4: Quality Assurance and Standards**

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

**Issues and Concerns**

**Rights**

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

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

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

**Case Management**

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

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

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

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

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

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

Finally, the Commission has identified four top priority recommendations:

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

The Commitment

Goals

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

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

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

Recommendations for the Immediate and Near Future

A Commitment to Excellence

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

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

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

— Rabkin, 1979 —

**Organizing to Meet the Commitment**

**Goals**

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

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

**Recommendations for the Immediate and Near Future**

**A Point of Responsibility**

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

This focal point can be accomplished in several ways:

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

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

**Responsibility for Overseeing Implementation**

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

**Funding for Planning**

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

**A Range of Services**

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

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

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

**Equitable, Adequate, and Accessible Services**

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

**Appropriate Funding and Benefits**

In the immediate future, the objectives of funding allocations should include:

- localized authority and responsibility for placement decisions;
- promotion of quality services; and
- accessibility of a minimum level and range of services statewide without regard for county of responsibility.
In the near future, funding should be provided in such a way as to promote access to an array of mental health services which are capable of achieving quality outcomes, not relying minimally adequate standards.

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

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

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

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

In the near future, funding for mental health services should be based on the person's needs, be directed to the actual provision of services. Existing funding arrangements would be maintained for a transitional period, but thereafter, funding would be tied to the individual and a plan of care.

In the near future, counties should ensure that service providers for services are indeed all available revenue sources.

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

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

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

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

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

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

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

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

Goals

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

Recommendations for the Immediate Future and Near Future

Review and Complete Standards

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

Standards with Quality Content

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

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

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

Monitor Compliance with Standards

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

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

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

— Parents —

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

— Schieppetlik, 1986 —

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

— Schieppetlik, 1986 —

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

— A parent —

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

— Janecak, 1985 —

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

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

— Moore, 1985 —

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

— Board on Aging, 1985 —

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

— Rabkin, 1980 —


Oregon Mental Health System Teams. (1984). An agreement on shared roles and responsibilities in delivery of services for mental or emotional disturbances, alcohol and drug problems, mental retardation or other developmental disabilities. Portland, OR: Author.


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