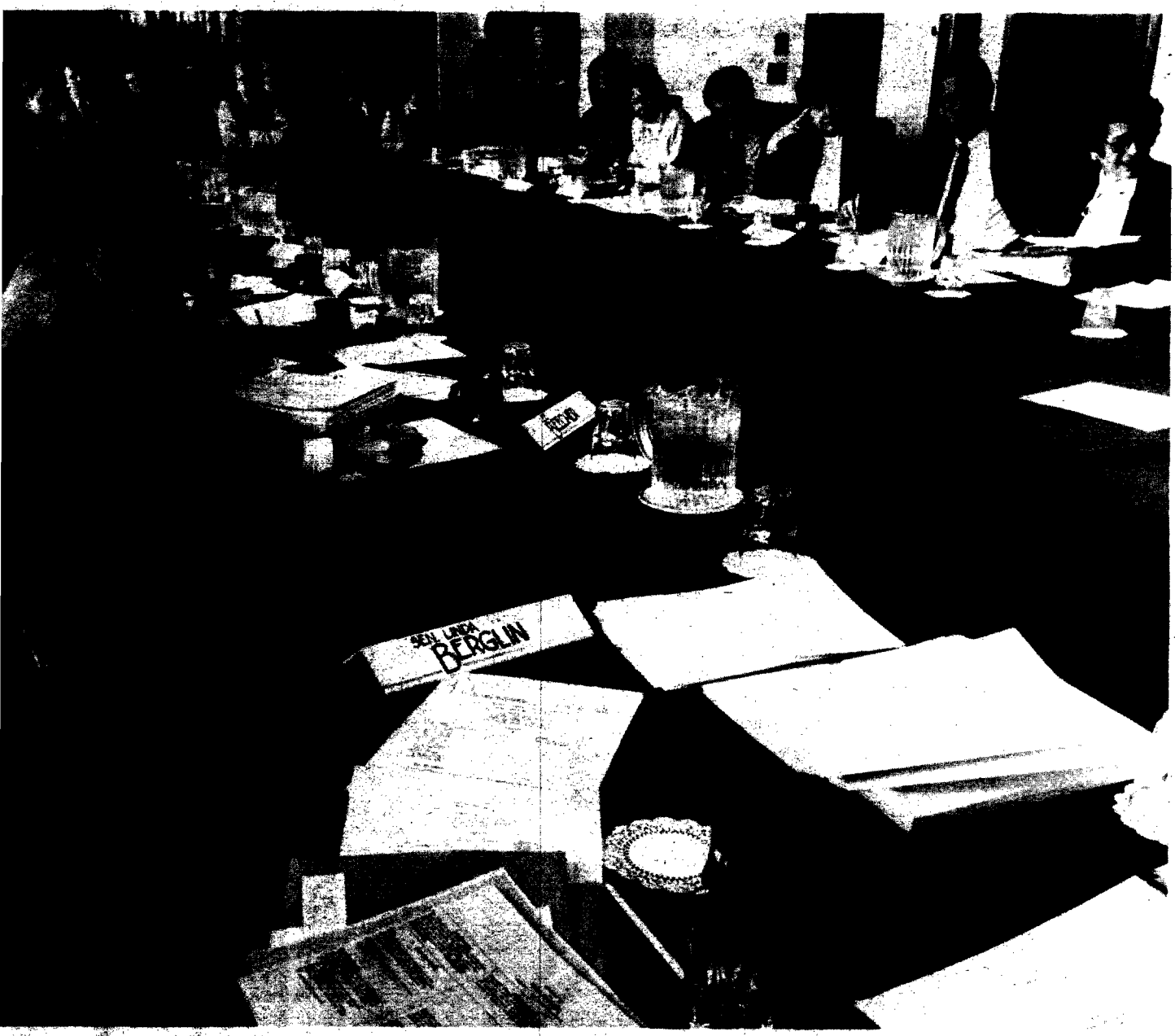
MANDATE FOR ACTION

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

Table of Contents

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



Preparation by:
Bruce Kappel
Colleen Wieck

February 3, 1986

Re-Determination of the Governor's Mental Health Commission

Norma Schleppegrell, Chair	Miller Friesen
Lynn Becklin	Barbara Glick
Lee Beecher	Tish Halloran
Tom Beer	Gail Jackson
Linda Berglin	Rebecca Larsen
Norby Blake	Susan Lentz
Tom Bounds	Jerry Lovrien
Barbara Brooks	Gloria Segal
Elizabeth Buckley	Duane Shimpach
Bill Conley	Zigfrids Stelmachers
Marvin Danner	Lynn Theurer
Rebecca Fink	Dale Wolf

THE CONTEXT

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

— Governor Rudy Perpich

The Governor's Commission on Mental Health

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

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

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

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

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

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

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

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

Definitions and the Needs of People with Mental Health Problems

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

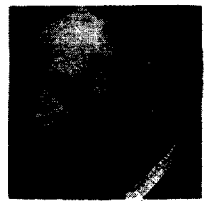
These questions are not easily answered. First, a precise definition of mental illness is illusive. Second, most investigations of "the needs of people with mental illness" focus on the services required or being offered to meet needs, not the fundamental needs of the individuals.

Definitions

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

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

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

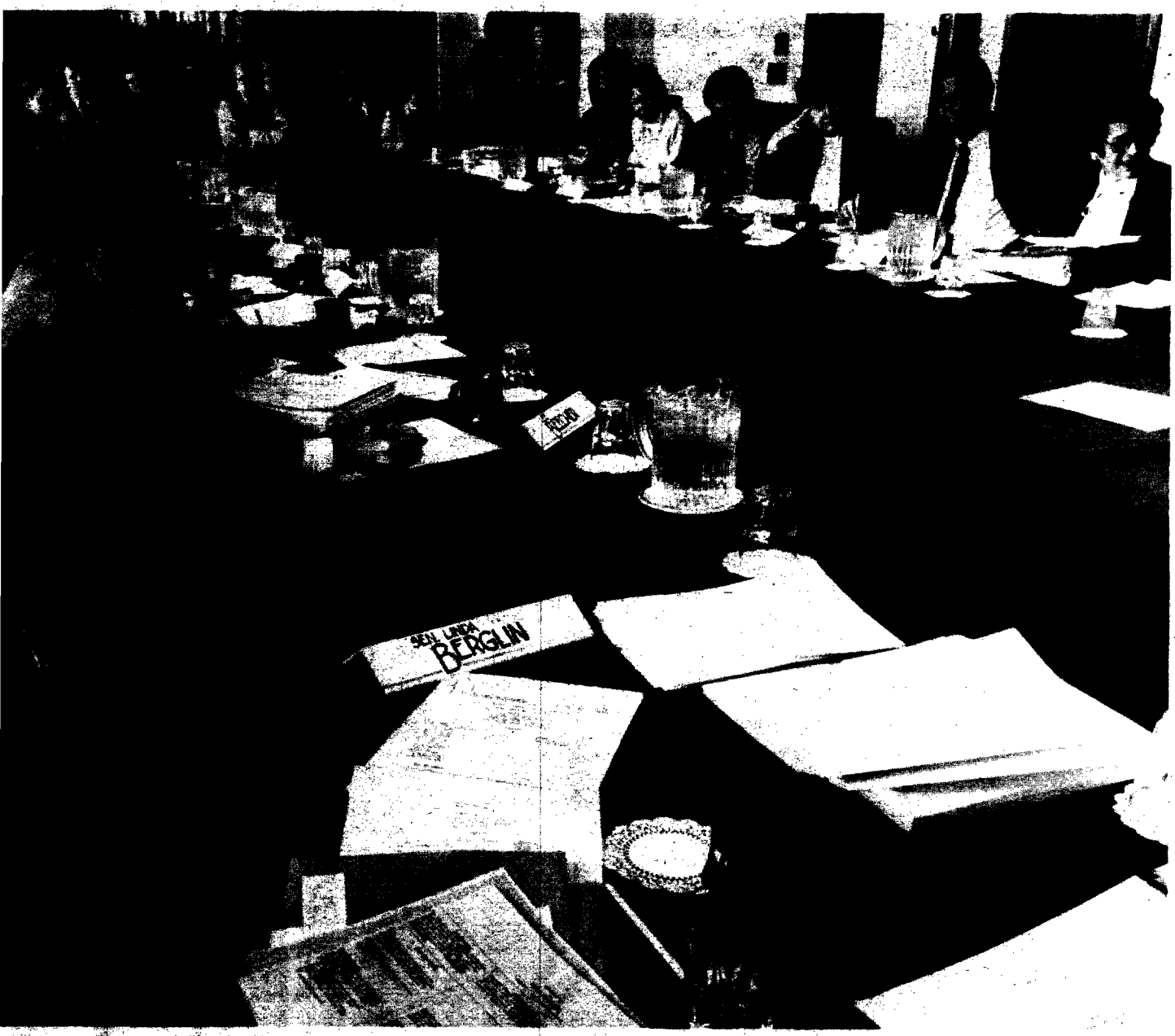


MANDATE FOR ACTION

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

Table of Contents

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



Preparation by:
Bruce Kappel
Colleen Wieck

February 3, 1986

Re-Determination of the Governor's Mental Health Commission

Norma Schleppegrell, Chair	Miller Friesen
Lynn Becklin	Barbara Glick
Lee Beecher	Tish Halloran
Tom Beer	Gail Jackson
Linda Berglin	Rebecca Larsen
Norby Blake	Susan Lentz
Tom Bounds	Jerry Lovrien
Barbara Brooks	Gloria Segal
Elizabeth Buckley	Duane Shimpach
Bill Conley	Zigfrids Stelmachers
Marvin Danner	Lynn Theurer
Rebecca Fink	Dale Wolf

THE CONTEXT

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

— Governor Rudy Perpich

The Governor's Commission on Mental Health

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

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

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

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

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

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

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

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

Definitions and the Needs of People with Mental Health Problems

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

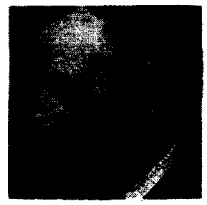
These questions are not easily answered. First, a precise definition of mental illness is illusive. Second, most investigations of "the needs of people with mental illness" focus on the services required or being offered to meet needs, not the fundamental needs of the individuals.

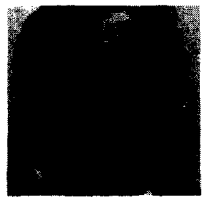
Definitions

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

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

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





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

rder to identify people who are in need of ial mental health services in the popula- , a definition of "person with mental ill- " is necessary. Current definitions of men- lness require, in addition to descriptions of individual's behavior, specifying co-existent lical illnesses, the degree and severity of hosocial stressors, and recognition of the est level of functioning attained by the indi- al in the past. A mental illness may be a ted experience (acute) or of long duration onic), but "the real difference between e and chronic is not the length of the ill- , but whether deterioration occurs in fam- work and social relationships" (Janecek, , p. 2).

ds

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

ike all Minnesotans, people with mental ill- ess need food, clothing, shelter, medical or ealth services, transportation, education, creation, and a secure income. The lack of ne or more of these supports, in fact, may ggravate or stimulate the mental health roblems experienced by the individual. lso, like every other person, chronically isabled adults need a personal support sys- m consisting of other people who care out them as unique individuals" (NIMH, 976, pp. 3-4).

eople who are chronically mentally ill are sually able to learn and develop skills, iendships, and interests which are compati- le with independent living in a community. hese individuals tend to be shy, avoid social ontact with others, and do not show aggres- veness or dangerousness. The cruel para- ox is that they respond to consistent and upportive relationships which are often enied them due to their lack of assertive- ess and the social stigma attributed to men- l illness.

he use of such phrases as "mentally ill" hould not obscure the basic fact that these re individuals with a whole array of positive tributes and abilities. Although mental ealth problems are clearly important, it is so important to recognize the strengths of he individual and his/ her right to be spected and appreciated. **"Indeed, one of he most serious obstacles to more ewarding lives for these people is the tigmatization and devaluation which ccurs, both in organized service set- ngs and in society at large" (NIMH 976, pp. 1-2).**

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

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

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

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

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

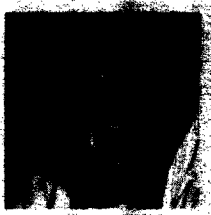
Training in "coping skills" to assist in tasks of daily living, and when appropriate, assistance in performing these tasks;

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

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

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

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



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

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

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

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

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

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

A History of Studies and Commissions

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

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

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

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

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

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

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

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

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

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

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

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

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

THE FINDINGS

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 at Commission and working group meetings.

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

Issue 1: Policy Direction, Mission, and Rights

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

Policy:

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

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

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

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

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

> 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.

ue 2: The Needs of People h Mental Illness

Commission is not aware of any study in nesota which documents the individual ✓ ls of all people with mental illness. There been a number of investigations into some e characteristics of people with needs, as Rule 14 and Rule 36 facilities; the serv- they are receiving; and the services which equired in order to respond to their needs. recent studies illustrate the current state r knowledge in these areas.

y of Services to Mentally Ill People, nesota Department of Human Services

1984 study collected current information e services provided by counties under the munity Social Services Act (CSSA) to peo- vith mental illness, and the views of coun- egarding the accessibility, adequacy and ty of those services. Its recommendations s on the range of services which should be gnated as the "minimum capability" avail- within a county to respond to the needs of le with mental illness.

study indicates that counties are pro- g an array of services to people with tal illness, and that many essential ices are either not available in all ties, or not available to the extent they are needed.

najor areas of services identified as ed are as follows:

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

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

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

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

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

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

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

Access to Mental Health Services (N = 812):

48 percent reported having adequate access;
42 percent reported having no access; and
10 percent reported being unaware of services accessible to them.

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

Inpatient Services (N = 788):

78 percent reported having adequate access;
14 percent reported having no access to a hospital; and
8 percent reported being unaware of the availability of a hospital.

Information:

54 percent reported adequate information about mental illness (N = 710);
47 percent reported adequate information about ways to cope (N = 693); and
51 percent reported adequate information about services available (N = 686).

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

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

Outpatient and Community Services:

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

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

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

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

Issue 3: Planning and Delivery of Services

Concerns and Issues

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

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

State Hospitals

Currently, six of the eight state hospitals, and the Minnesota Security Hospital serve people with mental illness. Before the deinstitutionalization movement of the 1960s and 1970s, there were over 10,000 beds in the state hospital system for people with mental illness. Today, there are fewer than 1,500 beds. In FY '85, the average daily census was 1,197 persons (with mental illness), and this is expected to rise to 1,251 in FY86 (Nagel, 1985, p. 6).

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

Nursing Homes

Many elderly persons with mental illness have been moved into nursing homes, because federal Medicaid funds are available. From 1978, the number of persons (medicaid funded) with mental illness in nursing homes has increased from 6,281 to 9,648 in 1982. The Department of Human Services reports 15,200 people with mental illness now living in nursing homes (Department of Human Services, 1985, p. 12). This number (15,200) represents all types of funding in all nursing homes including state-operated.

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

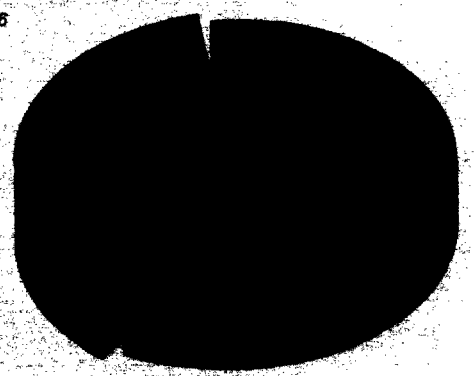
Community Residential Programs

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

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

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

Mental Illness Facilities and Approximate Residents 22,000



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

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

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

[redacted]

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

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

Most of the state seems to have access to the services of a community mental health center. However, the range and nature of services offered by them very 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.

Other Outpatient Services

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

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

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

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

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.

sitive Trends

ile the Commission is concerned about se issues and the fact that they have been standing for a number of years, it is also are that there are a number of positive nds in the state. Members of the Commis- n offered the following statements about h trends:

m very happy with the development of nmunity support projects outside the met- olitan area. Another positive sign is the inning of the development of group homes side the metro area. A good trend is the reasing emphasis on the rights of patients. rther, we are seeing more emphasis on out- ient care."

— Jerry Lovrien

ennepin County is progressive and willing und programs. Others from around the ntry are amazed that a county is funding rofessional crisis center."

— Zigfrids Stelmachers

e most positive thing I can cite is the reased availability of Community Support gram services. Consortiums funded by the Knight Foundation have brought people ether, and as a result, a systems advocacy acity has developed. In Anoka, there is the hly successful Independent Living Pro- m. It is down-to-earth and provides train- in practical, day-to-day living skills. As a ult, hospital stays have been greatly uced, and we have seen a strong retention ormer patients in their homes."

— Rebecca Fink

e concern and motivation [for change] are eady in place. Community Mental Health ters are located throughout the state. As a ult of our counties being part of a Service rd, people have "one stop shopping"; refer- are all internal. The structure is in place. well-distributed. It provides good ess."

— Duane Shimpach

nnesota, at this time, does have a great nber of people committed to quality. There some highly qualified staff who, while trated, are anxious to provide quality ."

— Tom Bounds

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

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

— Miller Friesen

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

— Norby Blake

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

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

— Gail Jackson

THE FUTURE

Introduction

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

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

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

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

Finally, the Commission has identified four top priority recommendations:

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

The Commitment

Goals

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

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

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

Recommendations for the Immediate and Near Future

A Commitment to Excellence

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

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

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

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

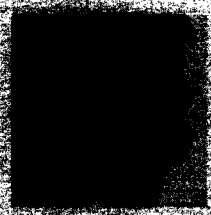
A Commitment to Rights

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

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

A Commitment to Transforming the System

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



he label of mental illness is most universally regarded s a negative attribute.

— Rabkin, 1979 —

Organizing to Meet the Commitment

Goals

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

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

Recommendations for the Immediate and Near Future

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

This focal point can be accomplished in several ways:

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

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

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

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

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

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

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

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

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

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

the immediate future, funding should be vided in such a way as to promote access to array of mental health services which are able of achieving quality outcomes, not rely minimally adequate standards."

the immediate future, legislation should developed which would expand outpatient ntal health group policies and subscriber tracts benefits beyond $600 per year based an individual assessment and treatment n. To remove the current discrimination inst individuals who require outpatient serv- beyond $600 per year, a needs assessment ed on: (1) the severity of stress on the indi- ual, (2) the level of function impairment ex- ienced by the individual, and (3) the like- od of attaining treatment goals shall be vided.

the immediate future, legislation should ntroduced to allow payment for hospital in- ent psychiatric services on a per diem is, rather than on the basis of Diagnosis ated Groupings.

the near future, reimbursement for hospi- based outpatient services should be anded. Standards should be developed for patient treatment to promote continuity of e and individualized treatment.

the near future, community-support pro- ms (Rule 14) should be funded in all nties.

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

the near future, counties should ensure ment to service providers for services ained, and utilize all available revenue rces.

the near future, SSI/SSDI applications by n behalf of Minnesota residents who may lify because of mental disabilities should be le a priority and supported by all levels of e and local government and by private viders.

the near future, services currently funded he McKnight Foundation should be ewed in order to allow inclusion of projects er public funding.

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

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

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

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

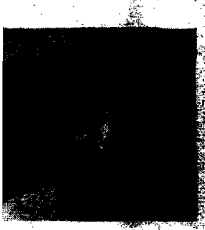
Prevention and Outreach
In the immediate future, prevention services and outreach programs related to mental health should be available to Minnesotans of all ages.

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

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

Basis of client input feedback

cess" has several meanings including availability of ices, transportation or distance, physical accessibility, accommodations for sensory impairments.



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

— Concerned and interested citizen —

Ensuring the Commitment Is Met Goals

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

Recommendations for the Immediate Future and Near Future

Review and Consolidate Standards

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

Standards with Quality Content

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

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

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

Monitor Compliance with Standards

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

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

...d You Know?

...pendence Station, ...ed in 1977, serves an ...age of 40 people at any ...time, serving between 80 ...100 over the course of a ... People who success- ...complete the program, ...t 20% typically, do so in ...12 months. The goal of ...program is independent ..., a by-product of which ...ducing hospitalization. ...ally all patients are on ...c assistance, either ...cal assistance or gen- ...assistance medical care. ...rly half have ...zophrenia, ...her 25% have manic ...ession, and the rest mis- ...neous personality dis- ...s. Most are in their 20s ...30s. For some of the ...nts, treatment serves to ...ilitate them to a level of ...ependence they at one ...had. For a greater ...er, the treatment pro- ... them with [illegible] ... The typical client has ... hospitalized [illegible] ..., has a spotty work his- ...and has not graduated ...high school. ...ment at independence ...assumes that every ...has the potential to ...e it." The emphasis is ...s, not a problem-orien- ... the program empha- ...successes and the pos- ...progress that a patient ... A lot of energy goes ...job development for ... We try to [illegible] model ...y behavior [illegible] work ...ecause the [illegible] ... Center, and others so ...e can have [illegible] people ... either at a paid job or ...ntary service. We ...inate our work with ...providers, many of ... are on the advisory ...

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

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

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

—[illegible], 1988—

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

- Two case managers serve a population of 100 persons suffering with chronic mental illness. The nurse case managers strive to integrate the treatment plan, linking families, the psychiatric and other physicians, social workers, and (often) Rule 36 facilities for a practical and effective treatment plan for the patient. The nurses accept drop-ins, phone calls during the week, and arrange crisis intervention when appropriate.
- Because most patients are on some form of public assistance and receive benefits concerning their housing and basic human needs, county social workers and families are considered an integral part of the support system. Staff at Rule 36 facilities and board and care homes are requested to meet with client, nurse case manager and supervising psychiatrists at intervals.
- Goals are highly individualized to the patient; sometimes they are maintenance-oriented, and at other times striving to establish improvement in basic living skills. Patient responsibility is emphasized and supported. Treatment goals are "concrete and common sense." The program is thus a "no fault" experience for the client. Compliance with the program is high because the patient-client agrees to and participates in the treatment decisions as much as is possible.
- The program is cost-effective. Hospital stays are reduced in length, the frequency of hospitalizations is reduced. Outpatient care is the primary therapy and not viewed as a followup or aftercare to hospitalization. The hospital inpatient service is used as a backup to the outpatient treatment system.

—[illegible], 1988—

Did You Know?

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

— Parents —

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

— Schleppegrell, 1986 —

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

— Schleppegrell, 1986 —

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

— A parent —

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

— Janecek, 1985 —

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

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

— Moore, 1985 —

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

— Board on Aging, 1985 —

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

— Rabkin, 1980 —

erences

rican Psychiatric Association. *(1980). nostic and statistical manual of mental dis- s. Third edition.* Washington, DC: Author.

ungh, J., Leaf, R., Manderscheid, R., and s, W. *(1985).* Estimates of the size and ted characteristics of the adult chronically ally ill population living in U.S. households. *rch in Community and Mental Health, 3,*

ciation of Minnesota Counties. (1985). The ciation of Minnesota Counties 1985 Platform. ul, MN: Author.

y, J. and Kelley, J. (1985). Utilization and age of mental health services in health mainte- organizations. *American Journal of Psychia- 42*(6), 744-746.

rtment of Health and Human Services.). *Health, United States, 1985.* Hyattsville, lational Center for Health Statistics, 166.

rtment of Human Services. (1985). Mental centers and mental health clinics. St. Paul: on of Licensing, Department of Human ces.

rtment of Public Welfare. (1972). *Minne- mental health-mental retardation program spective.* St. Paul, MN: Education and Man- r Development Section, Department of Public re.

rtment of Public Welfare. (1985). *Minne- mental health program in perspective: A rehensive study.* St. Paul, MN: Author.

rtment of Public Welfare. (1982). Statement d and reasonableness of Rule 36. St. Paul, MN: l Health Division.

rty, B. (unpub.). *Rule 14, Mental health pol- d services for chronically mentally ill.* St. MN: Department of Human Services (unpub- manuscript).

an, L., McGuire, T., and Rosenbach, M.). Costs of mandates for outpatient mental care in private health insurance. *Archives of al Psychiatry. 42,* 558-561.

epin County Mental Health Division.). *Five-year directional statement and plan ntal health services for the adult chronically riously mentally ill.* Minneapolis, MN: Men- alth Division, Department of Community Serv- Hennepin County.

ek, J. (1985). *The new role of the family in l health care or we are all therapists now.* presented to the Mental Health Association of sota, Community Education Lecture Series. al: Author, Familystyle Homes.

man, B. (1980). *Minimum standards for l health.* St. Paul, MN: Minnesota Association untary Social Service Agencies (unpublished cript).

Leighton, A. (1984). Barriers to adequate care for mentally ill people. *Social Science and Medicine. 18* (3), 237-241.

Lyon, M., Levine, M., and Zusman, J. (1982). Patients' bill of rights: A survey of state statutes. *Mental Disability Law Review. 6* (3), 178-202.

Mechanic, D. (1985). Mental health and social policy: Initiatives for the 1980s. *Health Affairs. 4,* 75-88.

Medical Services Division, Department of Public Welfare. (1969). *Minnesota's mental health-mental retardation program in perspective: A comprehensive study of education and manpower development.* St. Paul, MN: Author.

Mental Health Advocates Coalition of Minnesota. (1985). *Consumer survey of mental health services in Minnesota.* St. Paul, MN: Author.

Mental Health Advocates Coalition. (1980). *Consensus: Recommendations for Minnesota's mental health system.* St. Paul, MN: Author.

Mental Health Association of Minnesota. (1978). *Face to face with the future: Mental health in Minnesota, where we've been, where we are, where we're going.* Bloomington, MN: Author.

Mental Health Bureau, Department of Public Welfare. (1983). *The quality assurance plan for state facilities.* St. Paul, MN: Author.

Mental Health Medical Policy Committee. (1956). *Mental health survey, state of Minnesota.* St. Paul, MN: Author.

Mental Health Task Force. (1978). *Report to the commissioner of the Department of Public Welfare.* St. Paul, MN: Department of Public Welfare.

Mental Health Division. (1985). *Rule 14: Mental health policy and services for chronically mentally ill.* St. Paul, MN: Department of Human Services (unpublished manuscript).

Mental Health Division. (1983). *Resource directory of services for the mentally ill.* St. Paul, MN: Mental Health Division, Department of Human Services.

Mental Health Division. (1985). *Study of services to mentally ill people.* St. Paul, MN: Mental Health Division, Department of Human Services.

Mental Health Division. (1985). *Report to the legislature on rules 36, 12 and 14 for adult mentally ill persons.* St. Paul, MN: Mental Health Division, Department of Human Services.

Mental Health Division. (1985). *Study of the availability of services to people with mental illness problems.* St. Paul, MN: Mental Health Division, Department of Human Services.

Minnesota Legislative Research Committee. (1961). *Mental health research.* St. Paul, MN: Author.

Minnesota Legislative Research Committee. (1952). *The organization and administration of Minnesota's mental hospitals and division of public institutions.* St. Paul, MN: Author.

Minnesota Regional American Indian Center. (1979). *Mental health service delivery to American Indians in the state of Minnesota: Conference final recommendations.* Minneapolis, MN: Author.

Minnesota State Planning Agency. (1985). *Policy Analysis Series Related to State Hospitals.* St. Paul, MN: Author.

Minnesota State Supreme Court. (1979). *Civil commitment in Minnesota: Final report of the Supreme Court study commission on the mentally disabled and the courts.* St. Paul, MN: Author.

Moore, D. (1985). *The media and the mentally ill.* St. Paul, MN: State Planning Agency (unpublished manuscript).

Nagel, S. (1985). *Funding of mental health services.* St. Paul, MN: State Planning Agency (unpublished manuscript).

National Council of Community Mental Health Centers. (1985). *Comprehensive community mental health care: A services position statement.* Rockville, MD: Author.

National Institute on Mental Health. (1976). *Comprehensive community support systems for adults with chronically disabling mental health problems: Definitions, components, and guiding principles.* Rockville, MD: Mental Health Service Programs, NIMH (unpublished manuscript).

Okin, R. and Dolnick, J. (1985). Beyond state hospital unitization: The development of an integrated mental health management system. *Hospital and Community Psychiatry. 36* (11), 1201-1205.

Olson, P. (1985). Personal communication. St. Paul, MN: Department of Human Services.

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.

Residential Care Study Advisory Council. (1979). *Report of the residential care study.* St. Paul, MN: Minnesota Department of Public Welfare.

Rolvaag, K. (1963). *State of the state message.* St. Paul, MN: Governor's Office.

Rossen, R. (1951). *The Minnesota mental health program 1949-1950: A report to the commissioner of public institutions, Carl J. Jackson.* St. Paul, MN: Author.

S.F. 1555/H.F. 1398. (1985). A bill related to mental health. St. Paul: 1985 Legislature.

Senate Task Force. (1975). *Report of the Senate task force on secure mental health programs in corrections.* St. Paul, MN: Author.

State Planning Agency. (1971). *Behavioral disabilities: A recommended policy for Minnesota.* St. Paul, MN: Task Force on Behavioral Disabilities, Comprehensive Health Planning Program, State Planning Agency.

Talbott, J. (1983). The future of unified mental health services. In J.A. Talbott (Ed.) *Unified Mental Health Systems: Utopia Unrealized.* San Francisco: Jossey-Bass, Inc.

Wray, L. (1985). *Issues in quality assurance paper number 1: Quality assurance — a framework for human service agencies.* St. Paul, MN: Quality Assurance and Protective Services, Department of Human Services (unpublished manuscript).

Wray, L. (1985). *Presentation to the Governor's Mental Health Commission.* St. Paul, MN: Quality Assurance and Protective Services, Department of Human Services.

Acknowledgments

Thank you to all individuals and agencies that provided information for this report.

We thank Michelle Casey, Audrey Clasemann, RoseAnn Faber, Ron Kaliszewski, Miriam Karlins, Karen Kedrowski, Doug Moore, Scott Nagel, and Roger Strand for their contributions.

We also thank those who presented at the Governor's Mental Health Commission meetings: Carol Berde, Larry Burzinski, Susan Carey, Bill Copeland, Bev Driscoll, Luther Granquist, Frank Hansen, Maureen Heaney, Kay Hendrikson, Mary Huggins, Barb Kaufman, Stan Keeley, Tom Kiresuk, Nancy Larsen, Leonard Levine, Vince Mehmel, Janet Moline, Scott Nagel, Pat Siebert, Mike Tripple, Lyle Wray, and John Zakelj.

Funding for the printing of this report was provided by the McKnight Foundation.

For additional free copies of this report, please contact:
Developmental Disabilities Program
Minnesota State Planning Agency
201 Capitol Square Building
550 Cedar Street
St. Paul, Minnesota 55101
(612) 296-4018
(612) 296-9962 TTY

Graphic Design: Destiny 2, Inc., St. Paul.