



League of Women Voters of Minnesota Records

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THE LEAGUE OF WOMEN VOTERS

**MENTAL HEALTH
CONSUMER/FAMILY**

**LEADERSHIP
PROJECT**

FUNDED THROUGH A GRANT FROM
THE NATIONAL INSTITUTE OF MENTAL HEALTH AND
THROUGH THE MINNESOTA DEPARTMENT OF HUMAN SERVICES,
MENTAL HEALTH DIVISION

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LEAGUE OF WOMEN VOTERS MENTAL HEALTH CONSUMER/FAMILY LEADERSHIP PROJECT

MISSION OF THE LWV LEADERSHIP PROJECT

**INCREASE AND MAKE PERMANENT A MEANINGFUL LEVEL
OF CONSUMER AND FAMILY PARTICIPATION IN LOCAL
MENTAL HEALTH ADVISORY COUNCILS (LACs) BY:**

- **INCREASING THE PARTICIPANTS BASE OF
KNOWLEDGE**
- **ESTABLISHING AN INFORMATION NETWORK RUN
BY CONSUMERS AND FAMILY MEMBERS**
- **ENCOURAGING NETWORKING AND AN EXCHANGE
OF INFORMATION AMONG LOCAL ADVISORY
COUNCILS**

Minnesota is moving toward the creation of a complete system of community services for persons with mental illness. Advisory councils can play a major role in implementing this change. Councils can advise county boards and mental health providers, focus attention on mental health services, and help create a climate of community and acceptance for persons with mental illness.

These training sessions are designed to provide information and training that will help consumers and family members to serve more effectively on those councils.

HOW ARE WE SERVING MINNESOTA'S MENTALLY ILL?

*Report of a Citizen Project to Monitor
Mental Health Services in 16 Minnesota Counties*

LEAGUE OF WOMEN VOTERS OF MINNESOTA
EDUCATION FUND

EXECUTIVE SUMMARY

This report is intended to shed light on the question of whether Minnesotans with serious and persistent mental illness are receiving an adequate range of services of high quality. To what extent are community services meeting the needs of persons who would once have spent much of their adult life in state hospitals?

We often hear that "deinstitutionalization has failed." Most persons with serious and persistent mental illness now live in the community, but a variety of reports before 1987 found that community services were seriously lacking. The Governor's Mental Health Commission reported in 1986 that Minnesota's mental health system was a "nonsystem" because of poor coordination and inadequate services. The Program Evaluation Division of the Office of the Legislative Auditor found poor coordination between county case managers and Minnesota's regional treatment centers (RTCs) (formerly state hospitals) serving persons with mental illness. Many persons returned to the RTCs within six months after discharge. A report by the National Public

Interest Research Group ranked Minnesota's community mental health system only 37th among the states.¹

In 1987 the Minnesota Legislature, with the support of Governor Rudy Perpich, passed the Comprehensive Mental Health Act. All 87 Minnesota counties were required to provide a complete array of community services for persons with mental illness "up to available resources." Services were to be provided to people as near to the county as possible. They were to be designed to foster client health and independence and to meet contemporary professional standards.

¹ E. Fuller Torrey, M.D. and Sidney Wolfe, M.D. *Care of the Seriously Mentally Ill: A Rating of State Programs*, Public Interest Citizen Health Research Group, 1986. Office of the Legislative Auditor, *Deinstitutionalization of Mentally Ill People*, 1986. Governor's Mental Health Commission, *Mandate for Action*, 1986.

THE LWVMNEF MONITORING PROJECT

Also in 1987, the League of Women Voters of Minnesota Education Fund adopted a study of community mental health services for persons with serious mental illness. Recognizing that laws are not self-executing it produced, in 1989, checklists to assess county services which were presented in *Monitoring Mental Health Services at the County Level: A Workbook*. Checklist questions asked both about system wide services and about the quality of community mental health programs and regional treatment center services. Thirteen local Leagues of Women Voters and classes in social work at Mankato State University undertook to monitor services in 16 counties in 1990-1991. The counties assessed were: Anoka, Benton-Stearns, Blue Earth, Brown, Cass, Freeborn, Goodhue, Hennepin, Mower, Nicollet, Olmsted, Ramsey, Rice, St. Louis and Washington. More than 167 volunteers made more than 120 visits and interviews, contributing some 2,000 hours to the project.²

LWVMNEF monitoring emphasized services for persons with acute and serious and persistent mental illness, since these were priorities under the 1987 Act. The focus was on services to adults with mental illness, rather than on children who were emotionally disturbed.

Local projects interviewed county officials, RTC administrators, agency providers and staff, and consumers and family members using LWVMNEF checklists.

Implicit in the assumptions underlying the project was the belief stated in the Mental Health Mission statement in the 1987 Act that services should recognize the autonomy and promote the independence of adults with mental illness, as much as possible, and meet high professional standards. The project accepted the premise of the 1987 law that counties should provide an array of mental health services at the county level and that services should be delivered, to the greatest extent possible, near to people's homes.

² Most monitors were members of local Leagues. However, members of the Alliance for the Mentally Ill of Minnesota, the Mental Health Association of Minnesota and interested citizens also took part. Students in social work at Mankato State University and psychology students from Carleton College and St. Olaf College also participated.

³ The inclusion of Ramsey and Hennepin Counties, however, might have been expected to introduce somewhat more negative findings because of the fact that they attract disproportionately more persons with serious mental illness.

Project goals were:

- To assess the completeness and quality of services for persons with mental illness at the county level;
- To train lay people to monitor programs and agencies serving persons with mental illness in their counties;
- To increase the circle of informed citizens by involving them in the monitoring project;
- To create a model for training lay persons in monitoring to be replicated by other groups.
- To report findings about local services to the community.

The LWVMNEF monitoring project was designed to foster cooperation—rather than confrontation—with county officials and service providers. Volunteers were trained to respect client confidentiality and to attempt to be objective and balanced in their reporting.

REPORTING FINDINGS

Because the counties participating in the project were more prosperous and more urban than a representative sample of Minnesota Counties would have been, we believe that their mental health services are also probably more well developed than they might have been in many Minnesota counties.³ For this reason, the report highlights problems which were identified in two or more counties, with the expectation that if they were problems in this group of counties they would probably exist, perhaps in more serious form, in other counties in the state.

We rarely mention specific counties by name and do not attempt to rank counties in terms of adequacy of service. Rather, we are concerned with patterns of service which may be indicative of statewide concerns.

PROJECT FINDINGS

All participating counties were providing the range of services required, at least at a minimal level. This in itself is impressive since almost half of Minnesota's 87 counties were providing few services prior to 1987. All counties were providing community support program (CSP) services, which almost half of the counties did not provide before 1987. Also, all participating counties reported having established an emergency phone line answering mental health calls with a mental health professional on call within 30 minutes.

However, we found evidence of some system problems.

Local Mental Health Advisory Councils (LACs) One mandate for counties under the law was the establishment of local mental health advisory councils. The councils were to include, at a minimum, one consumer of mental health services, one family member of a consumer, one community service provider and one mental health professional. The history of the League in working toward citizen participation and open government caused us to place a high priority on mental health councils being established. We found, in addition to some positive accomplishments for councils, some cause for concern. Two participating counties lacked either a family or a consumer member. Several councils expressed frustration about their role. Others indicated some concern about being controlled by social service directors or providers.

A serious finding, we believe, was evidence that members lacked knowledge of some important county mental health functions. The councils are charged with advising the commissioners on mental health services. Six participating counties indicated they had not been briefed on the county budget process, on state mental health

mandates and on the history of county mental health expenditures. Even fewer councils in participating counties knew the meaning of the phrase "maintenance of effort." (Each county must still spend for mental health services the amount it spent in 1987.) A lack of knowledge of such fundamentals seems a serious obstacle to the council's giving informed advice to the county board. Moreover, a failure to systematically inform council members means that those members not directly involved in designing and providing services—family members, consumers and members of the general public—will be at a disadvantage in reviewing services and listing unmet needs.

Table 1. Knowledge base of members of the Local Advisory Councils

Has the advisory council been briefed on all aspects of county mental health services?

Answer	Number of counties
Yes	12
No	3
Valid answers	15
Missing Data	1

Has the advisory council been briefed on the budget process, on state mandates and on the history of county mental health expenditures?

Answer	Number of counties
Yes	9
No	6
Valid answers	15
Missing Data	1

Do council members understand "maintenance of effort"?

Answer	Number of counties
Yes	7
No	7
Don't Know	1
Valid answers	15
Missing Data	1

The weaknesses cited regarding mental health advisory councils are particularly serious because community mental health services are still evolving. Local mental health councils have an important potential role as mental health services in advising on unmet needs and the kinds of services which will work best in individual counties. They can be important allies to providers and, if they are visible and hard-working, help to educate the public about mental illness and, perhaps, dissipate the stigma surrounding mental illness.⁴

Case Management

One key service to support persons with mental illness in the community is mental health case management. Rule 74 (now Rule 79) case management serves persons with serious and persistent mental illness. It is financed in part by Medical Assistance federal/state funds. Case management can help persons access services and intervene to help persons if their illness flares up. Case managers are responsible, with clients, for formulating community support plans to help assemble appropriate services for each individual. Case management, under law, is available to all persons with serious and persistent mental illness who request it or who are willing to accept it. (Again this mandate is "up to available resources.")

However, our data show that almost as many counties reported not serving all persons with serious and persistent mental illness as reported serving them.

Moreover, our data show that many counties reported very high case management caseloads, clearly a barrier to reaching out to unserved clients. Some persons are underserved because they refuse case management, but some apparently would like it and do not have it.

Table 2. Provision of case management services
Does the county provide case management activities for all persons with serious and persistent mental illness?

Answer	Number of counties
Yes	8
No	7
Valid answers	15
Missing Data	1

Outpatient Services

Outpatient services includes a variety of services: psychotherapy, medication management, group therapy, essential for most persons with serious and persistent mental illness. Many people in this category receive publicly funded medical insurance coverage, Medical Assistance, Medicare or General Assistance Medical Care. They may go to private professionals, to area community mental health centers, or to outpatient programs at public hospitals.

When asked whether the county was providing enough outpatient services a rather discouraging picture emerges. Since outpatient services may deal successfully with symptoms of illness, adjust medications appropriately and, provide a range of services which may prevent a crisis which would require hospitalization and also a worsening of the client's quality of life, this seems to be a serious warning sign.

In parts of Minnesota there are few mental health professionals. However, this problem was just as serious in Ramsey and Hennepin Counties as in several Greater Minnesota counties. Here the difficulty arises, seemingly, from the reluctance of some professionals to take public pay patients, particularly those with major mental illness. (Recently the Medical Assistance rate of reimbursement for outpatient services has been raised, somewhat improving the possibilities for care.)

Table 3. Provision of outpatient services
Is the county providing enough outpatient services within the county to meet the needs of persons with mental illness residing in the county? (Clients may be required to pay a fee based on a sliding scale.)

Answer	Number of counties
Yes	8
No	4
Valid answers	12
Missing Data	4
<i>Are enough mental health professionals available?</i>	
Answer	Number of counties
Yes	7
No	4
Valid answers	11
Missing Data	5

Public Education

A significant weakness shown by our data was the fact that our counties were, for the most part, not undertaking strong public education efforts. They were doing little to publicize either such information as the symptoms of major mental illness or information on available services, as required by the Comprehensive Mental Health Act of 1987. Nor was a major effort being made to inform the public about individual mental health services.

Responses to a question on whether simple, inexpensive means of educating the public were being used highlight this gap.

Table 4. Use of simple methods of education
Are relatively inexpensive, simple methods being tried? (phone stickers or pencils with emergency numbers, for instance)

Answer	Number of counties
Yes	4
No	9
Don't Know	1
Valid answers	14
Missing Data	2

Simple means might include pencils or cards with emergency numbers, a listing of available services, and mental health numbers in county newsletters and, as one county reported, including mention of mental health numbers and services with tax forms or other public billings.

Public education seems crucial since many persons remain ignorant both about symptoms of serious mental illness and about how to seek help. A failure to educate the public contributes to delays in persons seeking help and, in some cases, a failure to find services in a timely manner. In addition, a failure to make known information about mental illness and the mental health system misses the opportunity to chip away at stigma and ignorance surrounding mental illness.

⁴The Mental Health Division of the Minnesota Department of Human Services received a grant from the National Institute of Mental Health to train consumers and family members to serve effectively on their LACs. The LWV/MN NIMH Consumer Family Leadership Project which began in September 1991 has averaged 170 consumers and family members at its quarterly training sessions presented in 12 separate locations in the state. A number of participants are already LAC members. Fifty consumers and family members are now new members of their LACs. The project informs participants on a variety of substantive issues as well as aspects of group process.

Program Visits

Visits to both community mental health programs, largely residential programs, and state regional treatment centers (RTCs) were the basis of some positive feedback and the identification of some problem areas. Our data give some reason to believe that the quality of life for some persons with serious and persistent mental illness is less than optimal.

Visits to community mental health programs found many positives. Monitors were impressed with dedicated staff and satisfied with some building features. However, data pointed to several serious weaknesses which point to real problems of quality of life for persons living in community residential facilities.

Monitors reported that several residential facilities were located in high crime areas or in areas with high concentrations of persons with special needs. This demonstrates that a number of residences are not sited in pleasant or "normal" residential areas.

Administrators from 19 residential facilities (including Rule 36 residential treatment facilities) reported that salaries and working conditions were not "adequate to attract and retain good employees, and prevent high turnover." Inexperienced and underpaid staff are not consistent with quality service.

Table 5. Adequacy of salaries

Are salaries and working conditions adequate to attract and retain good employees, prevent high turnover?

Answer	Number of counties
Yes	8
No	19
Valid answers	27
Missing Data	2

There were also problems with building features. Seven residential facilities reported no air conditioning at all; five others reported air conditioning in only some areas.

Table 6. Presence of air conditioning
Is there air conditioning?

Answer	Number of counties
Yes	15
In some areas	5
No	7
Don't know	1
Valid answers	28
Missing Data	1

A lack of central air conditioning in residential facilities indicates they fail to meet the general standards most of us expect for other residential facilities such as inexpensive motels. More important, air conditioning is important for persons on psychotropic medications because they affect the ability of the body to regulate heat.

A second negative finding was the fact that only five of 28 residential facilities reported they were barrier free. This means that persons in wheelchairs or with severe mobility problems would find it difficult or impossible to access this service.

Nonresidential facilities, on the other hand, all had air conditioning and most were barrier free.

Table 7. Accessibility to handicapped

Is the service site barrier free? Could a person with a wheelchair use this service?

Answer	Number of counties
Yes	5
No	23
Valid answers	28
Missing Data	1

Regional Treatment Centers

Visits to state regional treatment centers brought mixed results. Some of the sites were scored low on interior features. (This is understandable since there is widespread recognition that three of the RTCs are antiquated, difficult to maintain and poorly designed for modern treatment.) The RTCs also offer little central air conditioning; understandable, perhaps, in terms of the age of the buildings but still unfortunate both in terms of a comparison with ordinary hospital facilities, especially because of the problems in body temperature control presented by psychotropic medications. Many RTC clients share rooms with more than one other person, a situation no longer true in most community hospitals and regrettable for stays of several months or years.

However, it was heartening to find that RTC staff pride themselves on practicing negotiation with patients, and on lowering the number of incidents of seclusion and restraint, rather than resorting automatically to seclusion or restraint measures.

Another issue was the absence of case managers from some counties at patient planning sessions. Partly due to the significant distance of RTCs from some counties, case managers do not or cannot attend all discharge planning sessions. This would seem to make it more difficult to arrange for a smooth transition to the community.

In both community residences, Rule 36s and regional treatment centers, there was evidence that clients' participation in some decision making that might concern them was not always being fostered. Perhaps the requirements for hospital accreditation and the emphasis on a medical treatment model interfere with this at RTCs. Resident councils in Rule 36 facilities, however reported little client involvement in facility decision-making or rule-making. (In both cases, however, clients were reported as participating in the formulation of individual treatment plans and quarterly reviews, as required by regulation.) In neither kind of facility were clients, or their family members, involved in hiring of staff.

Involvement of families—or rather a lack of priority on their involvement—was another possible cause for concern. The geographical distance of RTCs from people's home communities makes it more difficult for families to be involved, but it is not clear that a strong effort is always being made.

Barriers

"Limited finances" or "inadequate budget" was the major barrier listed to providing a variety of mental health services. Funding had increased since before 1987 but the impression of administrators and providers was that it was not yet sufficient to provide services of high quality to all potential clients. The stigma surrounding mental illness was cited as a barrier both to creating new programs, moving programs, or building acceptance for existing programs.

CONCLUSION

The 1987 Mental Health Act was a large step forward. It is on the way to being implemented. Minnesota had moved up from 37th place to a ten-way tie for 16th place in community services by the publication of the 1990 edition of *Care of the Seriously Mentally Ill: A Rating of State Programs*.

Our project found, however, a number of indications that a full array of community services were not yet available to all clients in their home communities. Problems were noted in providing sufficient outpatient services, strong case management services, in accessing residential treatment facilities. Efforts to educate the public both about signs of mental illness and specific services offered were weak. There were concerns regarding the effectiveness of local mental health advisory councils (LACs).

A number of concerns were systems problems; overall capability of the system was limited in meeting all client needs. But there were also problems with the quality of some services which were provided. The low salaries reported by residential facilities and their structure and equipment impact directly on the quality of life of clients with serious mental illness in the community. The antiquated structures housing some of the state regional treatment centers directly impact the quality of care.

There is also some suggestion that client independence and autonomy is not always being fostered in decision making in facilities where they live, although legal mandates of client participation in individual treatment and community planning are apparently being observed.

Since our data were gathered in 1990-91 there have been certain positive upward trends in mental health services. The number of case managers has increased and the average caseload size had declined to 42 clients to one full time case manager in 1992. Plans for funding to follow clients to the community when Moose Lake RTC closes is a major step forward. New efforts to build transition services from RTCs to the community are encouraging. Community Support Program (CSP) services are better funded.

However, there is still room for substantial improvement. Salaries of staff in community residences and non-residential programs are no better than they were then in terms of cost of living. (They are still approximately 30 percent less than comparable salaries in RTCs.) Some facilities, both in the community and at RTCs are out of date for modern treatment.

Many services are inadequate to meet the needs of all potential clients.

* * * * *

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The League of Women Voters of Minnesota Education Fund gratefully acknowledges the help of the hundreds of individuals whose cooperation made this project possible.

The responsibility for the report, however, rests with the League of Women Voters of Minnesota Education Fund alone.

* * * * *

To obtain a copy of the complete report call or write:

LWV of Minnesota Education Fund
550 Rice Street • St. Paul, Minnesota 55103 • (612) 224-5445

The cost of \$15 includes tax. Add \$2.00 for postage and handling.
Bulk discounts are available upon request.

LWV CONSUMER/FAMILY TRAINING SESSION

MARCH 1992

SCHEDULE FOR THE DAY

10:00 a.m	Sign in. Coffee and donuts
10:30-11:00	Welcome. Introductions
11:00-12:15	First Activity: Understanding The Mission Statement of the Comprehensive Mental Health Act (pages 2, 3)
12:15-1:00	LUNCH. FREE TIME
1:00-2:30	Second Activity: Combining Personal Experience With Hard Facts. How To Tell Your Story (pages 4-9)
2:30-3:00	Third Activity: Goal Setting and Evaluation (pages 10-14)
	Additional Thoughts, Notes and Preparation For May Training Session (pages 15-24)

WHAT IS AN ADVISORY COUNCIL?

One way of finding what an advisory council is all about is to look at how it is organized and its purpose and responsibilities. **The legislature required specific representation on local mental health advisory councils.** Important to us is the requirement that consumers and family members serve on the council.

Why does the statute establishing local advisory councils require that there be a consumer and a family member on each council?

Why are you as consumers and family members present at these training sessions?

**AS A FAMILY MEMBER OR A CONSUMER, YOU ARE UNIQUELY
QUALIFIED TO WORK TOWARD A BETTER MENTAL HEALTH SYSTEM
AT THE COUNTY LEVEL BECAUSE:**

- you know the system from the **inside** out;
- you know what mental illness feels like, and what services are of primary importance to persons with mental illness;
- you can speak with some authority because you know first hand the weaknesses and strengths of your county system.

The role of any kind of advisory council varies greatly. Some councils are strong and are able to initiate change. Others are less effective and struggle with their role. What makes some councils more effective than others? The answer probably lies in the people who serve on them and in the person who leads them.

The training sessions for the LWV Mental Health Consumer/Family Leadership Project will provide skills and knowledge that can help each of you become more effective members of your advisory councils. It is important that both the chair of the council and the council members know how to hold effective meetings, how to solve problems, how to set priorities, and how to compromise.

**EACH OF US CAN FIND THE POWER TO MAKE CHANGE
AND...TOGETHER WE CAN MAKE A DIFFERENCE!**

TRAINING SESSION I MARCH 1992 MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY:

UNDERSTANDING THE COMPREHENSIVE MENTAL HEALTH ACT

In 1987, the Minnesota Legislature passed the Minnesota Comprehensive Mental Health Act. The purpose of this act was to create a mental health system in Minnesota that was unified as well as accountable and comprehensive.

Task 1: Following is a summary of the mission statement of the Comprehensive Mental Health Act. Read it aloud with the group.

The Mental Health Act recognizes the rights of people with mental illness to control their lives as fully as possible. In furthering this aim it seeks:

1. to promote the independence and safety of people with mental illness;
2. to reduce the chronicity of mental illness;
3. to provide quality services designed to stabilize, support, and improve the functioning of people with mental illness;
4. to prevent the deepening of mental illness.;
5. to give a quality of service that is effective, efficient, and appropriate.

Task 2: Take some time to think about the statements just read.
List two aims from the mission statement on the previous page that in your experience you think are being carried out.

1. _____

2. _____

List two parts of the mission statement that you think are not being carried out in your county:

1. _____

2. _____

Task 3: With a partner, talk about the parts of the mission statement that you think are being carried out and those that are not.

List two points that you agree upon:

1. _____

2. _____

Task 4: Come back into the large group. Leader will list on the board the points that partners agreed upon.

(You might note here the points mentioned more than once)

QUESTION FOR DISCUSSION:

If mental health services are mandated, is it ever possible to cut back on those services?

SECOND ACTIVITY:

COMBINING PERSONAL EXPERIENCE WITH HARD FACTS.

How To Tell Your Story and Move On.

Sometimes consumers and family members feel over-whelmed when talking to providers and mental health professionals. But real world experiences are very valuable in educating county commissioners, legislators, and the general public. Personal accounts are often the most remembered part of a testimony or presentation.

Most effective is combining a personal experience with a specific request or a reminder that adequate services in a specific area are not being provided. To do this, the person needs to have the facts well in mind and to be able to tell his or her story effectively. The second activity is designed to help you do this.

Task 1: Take a few minutes to think about a need that has come up in the past month for you or your family member that could have been met if services had been available. Or think of a need you might have in the future.

Examples: help in completing medical assistance forms; help in providing transportation needed for yourself or family member to doctor, drop-in center, movie, etc.

Write down your need, or one you might have in the future:

1. _____

Task 2: With a partner talk about the need you listed above. Relate that need to your personal life. Share with your partner how mental illness in yourself or a family member has affected how you live and how you feel.

Task 3: Gather in the large group. If you feel comfortable, share with the group for two or three minutes a little bit of your own story. List one important experience or fact about yourself that you would like to focus on:

1. _____

**IF YOU DO NOT FEEL READY TO DO THIS,
JUST PASS WHEN YOUR TURN COMES,
AND LISTEN TO OTHERS.**

QUESTION FOR DISCUSSION:

When is a person ready to tell a very personal story in a public setting?

**Example of testimony combining personal experience and facts.
Given before the State Advisory Council on Mental Health
November 7, 1991, State Office Building, Room 5 State Capitol**

My name is _____. I have been a member of the _____ County Mental Health Advisory Council since it was established four years ago. I also serve on the Board of the Alliance for the Mentally Ill. Today I speak as a private citizen who is very concerned about the quality of mental health care in Minnesota, and as a consumer.

I was glad to see this forum called "Designing Community Services with Limited State Resources". That is real. It is honest. It focuses on where we really are. Local advisory councils struggle with county social services to find ways to provide quality services, and indeed, to fulfill state mandates on smaller and smaller budgets.

The State Advisory Council objectives pose the question of when hospitalization is appropriate and necessary and if the consumer can choose the treatment setting. In the time I have, I would like to address that question.

Over the past thirty years, I've received care in private hospitals and at one time when my insurance and private means of financing ran out in an RTC. In preparing for testimony today, I've thought a lot about the time I've spent in hospitals. I've tried to make some sense out of a whole patchwork of care that I have received. Each time I entered a hospital, I felt an overwhelming sense of failure. My surroundings didn't help this negative thinking. Actually hospitals are very depressing places to be because:

1. Hospitals are institutional. There is no way to disguise that.
2. The medical model on which a hospital runs encourages passivity.
People do things **for you** or **to you**. You are rewarded for being a "good" patient, which is sometimes confused with getting well.

Minnesota continues to use hospitals as the cornerstone of treatment for persons with serious and persistent mental illness. Some states manage their care for mentally ill people with a minimal use of hospitals. Those states have in place a strong community support system.. This is nothing new. E. Fuller Torrey in his report rating of the delivery of mental health services by states says that models for such programs were developed 25 years ago.

Paul Carling who was outside examiner for the Minnesota Mental Health System in 1989 says in his letter to then Commissioner of Mental Health, Ann Wynia:

"The most effective systems are those which have a positive future vision of a completely community-based system.

- (1) they [hospitals] are clinically inappropriate as a service for the vast majority of severely disabled patients;**
- (2) they are extremely costly to maintain and extremely difficult to change..."**

Dr. Carling goes on to say that the use of hospitals can only be reduced through an intensive effort to put in place a strong community support system at the county level. He says that any planning for state hospitals "must be based on their future use, not their present one."

In my own case, hospitalization was expensive and of no lasting help to me. It was used because there was no alternative. As a state we are locked into this mode of treatment.

I am angry for the years of my life that have been lost. I am sad for the time I could not function as a mother, a wife, a responsible contributing citizen. I am convinced if appropriate community resources had been available to me as an alternative to hospitalization, I could have been stabilized in my community.

I do think that we will always need hospitals to serve persons who need acute care. There are situations in which hospitalization is appropriate. But for large numbers of persons who suffer serious and persistent mental illness, a strong community support system which includes crisis care could make possible functioning at the highest level in the most unrestrictive setting.

The 1988 Torrey report noted that Minnesota was "improving most impressively." In 1990 we were characterized as "going nowhere." The price we have paid to maintain jobs at regional treatment centers has been paid by consumers of mental health services or family members who don't have a strong lobby, or even a voice. For persons with mental illness, sometimes it takes every bit of energy just to make it through a day.

YOU DON'T HAVE TO BE AN EXPERT TO MAKE A DIFFERENCE

There is a mystique surrounding advocacy—that you have to be an expert. Not so. Advocacy is like anything else: beginners are not expected to know as much as professionals, and the more you do the easier it gets. Advocacy is simply a matter of seeing a need and finding a way to address it. It means literally “to plead the cause of another.” It is a practical way to translate basic values into policies and laws. Staying out of the process doesn’t mean that laws or policies won’t get passed. It just means that they will get passed without reflecting your priorities and views.

Providing testimony is a particularly useful way to take part in the process.

Testimony provides a written record of the various views on an issue.

Testimony forces groups and individuals to clarify their views and present a unified position of support or opposition.

Testimony can be an effective way to influence legislators and county commissioners.

An effective testimony includes:

- basic facts, including who you are and who you represent;
- clear statement of your point(s) of agreement or disagreement with what is being discussed;
- specific recommendation about changes you would like to make;
- real examples of people who will be affected by the matter being discussed and how these changes will be brought about.

When testifying:

1. Thank the board or committee for hearing your testimony.
2. Make your point in a non-blaming manner.
3. Have copies of your statement available for the board or committee members or anyone else who might be interested including the media.
4. Consider beforehand possible questions, and your response to these questions.
5. Do not be afraid to say "I do not know, but I will find out and get back to you." Then DO IT.

✓ CHECKLIST

- ___ Get on agenda
- ___ Find out if there is a time limit
- ___ Decide what needs to be said
- ___ Prepare statement
- ___ Practice: alone and before others until comfortable
- ___ Consider possible questions and your responses

KEEP REMINDING YOURSELF:

**LAWS WILL BE PASSED WITH OR WITHOUT ME.
THE CHOICE IS MINE.**

THIRD ACTIVITY:

GOAL SETTING FOR TRAINING SESSIONS

Task 1: By setting small goals for yourself, you can work toward the final goal of improving the mental health system in your county. The goals that you choose should reflect your present participation on or interest in serving on your local advisory council.

Goals can be very complicated or quite simple. Look at the suggestions on page 12. Take some time to think about one goal that you would like to accomplish before our next meeting in May.

Task 2: Choose from the list or make up your own long term goal that you will try to accomplish in six months.

Task 3: After writing these goals down on the form below, check them with Marilyn or Erica. One copy should be left with them, and one should be left in this workbook.

NAME: _____

I WANT TO ACCOMPLISH THE FOLLOWING DURING THE NEXT 2 MONTHS:

GOAL #1

Date written: _____

Reviewed and approved by _____

Outcome of Goal #1

Reviewed by _____

Date _____

GOAL #2, LONG TERM

Date written: _____

Reviewed and approved by _____

Outcome of Goal #2

Reviewed by _____

Date _____

PROJECT PARTICIPANT GOALS

(Below are some ideas. You are free to think up your own goals.)

1. Meet individually with the chair of your Local Advisory Council and the social services director to discuss an orientation session for new members of the council.
2. Read entire Comprehensive Adult Mental Health Act. (See appendices.)
3. Apply to your county to represent your LAC at the annual CSP Conference in June.
4. Identify and speak to minority representatives of your community to discuss mental health needs and issues of these minority groups. Report this back to your LAC with your recommendations.
5. Participate in a public presentation in your county about mental health services.
6. Read current county adult mental health plan. (Ask for CSSA plan from your social services or human services director.)
7. Acquaint yourself with specific county services by talking with:
 - a provider of Rule 74 case management.
 - a director of community support services
 - a provider of mental health emergency services
 - person responsible for social services budget
 - director of Rule 36 facility
8. Organize and meet with a group of consumers or a group of family members to talk about their needs, goals, and impressions of services.
9. Request time on LAC meeting agenda to discuss a topic of your interest or concern, and recommend action on it.
10. Meet with person who directs education and prevention services for your county. Determine the activities of this program satisfy the requirements outlined in the Mental Health Act.
11. Read the county Rule 14 application.
12. Read the parliamentary procedure form on page __ in the appendices. Visit your advisory council and report what rules are used to run the meeting.

THIRD ACTIVITY:

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Reviewed by _____

Date _____

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Date written: _____

Reviewed and approved by _____

Outcome of Goal #2

Reviewed by _____

Date _____

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This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

WHO ME? SERVE ON AN ADVISORY COUNCIL?

WHAT WILL I DO?

WHAT WILL I SAY?

Serving on an advisory council is challenging. Most people feel inadequate for a period of time. Experienced people have said that serving on an advisory board or council is very difficult at first. New people often are terrified.

The following pages are take-home material. Read them at your leisure. Take time to answer the questions after you have had time to think about the workshop today. If you give the material some thought, you should learn something about your style of operating in a group discussion. This will better prepare you for the training session in May. That session will focus on how the unique style of an individual affects the function of the group as a whole.

As a member of a local advisory council, you will learn about the county system and the needs of persons with mental illness who are within that system. You can also serve as a liaison between the community and the council. As a council member you will be exposed to many different kinds of people, many whose views may be quite different from your own. A strong council is one in which its members share individual knowledge and viewpoints and try to understand each other's views.

**THIS SELF INVENTORY CAN HELP YOU UNDERSTAND HOW YOU
APPROACH TASKS TAKEN ON BY A GROUP**

- ___ Am I open to different viewpoints?
- ___ Am I willing to share my information with the general community and/or become a spokesperson for persons with mental illness?
- ___ Am I willing to contribute my experiences to emphasize an issue or deepen the committee's insights?
- ___ Can I balance my desire to see results with the patience to wait for them?
- ___ Do I willingly ask for information and answers not readily given?
- ___ Do I have a commitment to learn about rules and laws that affect services and the quality of life for persons with mental illness?
- ___ Can I listen carefully and respectfully and learn from the comments of others?
- ___ Can I apply knowledge gained from my experiences to system-wide issues which may not affect me directly?
- ___ Am I willing to try to work with others to arrive at decisions agreed upon by the whole council?

[illegible]

PARTICIPATION AND FOLLOW-THROUGH

DURING EACH ADVISORY COUNCIL MEETING, YOU HAVE A RESPONSIBILITY TO THINK ABOUT, ANALYZE, AND QUESTION WHAT IS BEING DISCUSSED. MEMBERS SHOULD ASK THEMSELVES:

- ☐ Do I understand what is being said?
- ☐ Do I understand the language used? How about acronyms and rule numbers?
- ☐ Do I agree? Can I state my reasons for agreeing or disagreeing?
- ☐ Do I need more information? Is the person who has the information present?
- ☐ Are there topics I would like to hear discussed? Am I being provided with enough background information to have a clear view of the problems or issues at hand?
- ☐ Do I have some personal experience that would relate to what is being discussed? Can I tell it in a relevant and effective manner?
- ☐ Has the discussion adequately touched on (1) the quality of service being provided, (2) mandated services, (3) and the availability of funds if funds are required?
- ☐ Is the council looking for creative ways to solve problems.

Don't be afraid to ask questions. Remember that your unasked question may also be the unasked question of other committee members. If you are silent, an ineffective decision may be made. It is your responsibility as an advisory council member to make sure that you and the other members have all the information needed to make an informed decision.

[illegible]

When accepting an advisory board position, you take on the responsibilities of that position. You will be expected to attend meetings, contribute your knowledge, and aid in researching information. You will need to ask questions, seek information, and find evidence that may not be readily available.

TO MEET YOUR RESPONSIBILITY AS AN EFFECTIVE ADVISORY COMMITTEE MEMBER, YOU MAY NEED TO DO MANY OF THE FOLLOWING:

- Find out the process for putting items on the agenda.
- Keep to the agenda by not speaking off the subject, not repeating what has already been said, not monopolizing the discussion, and encouraging each member to contribute opinions.
- Prepare for meetings, read materials, come with information that has been requested.
- Review documents regarding purpose, philosophy, budget, staff, programs, and services.
- Realize that the council's goal is not a fault-finding mission.
- Focus on possible solutions instead of past failures.

As you become an active contributor to the council, make sure that other members have the appropriate opportunities to contribute. Be aware that there are many way to contribute. You may:

- give your opinion**
- ask questions**
- resolve conflicts**
- keep the meeting on the topic**
- keep the agenda moving along**
- seek out information that has not
been provided**
- make sure that all sides of the issue are presented**

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page, typical of notebook paper. There are no margins, text, or other markings on the page.

LWV
CONSUMER/FAMILY TRAINING SESSION
MAY, 1992

SCHEDULE FOR THE DAY

- | | |
|---------------------------|--|
| 9:45-10:00 a.m. | Sign in. Coffee and Donuts |
| 10:00 a.m. (sharp) | Overview of Training Session I.
New Materials Distributed. Summary of
Response From Participants of Session I. |
| 10:30-11:00 | General Discussion. Goals Accomplished.
Change in LAC Participation, Understanding? |
| 11:00-12:15 | First Activity: (Choose which session you want.
The second choice is more appropriate for members of
LACs and chairs.)

Session 1. Write, Call, Visit: First Steps
Toward Being Heard (pages 25-31)

Session 2. Group Process: Groundwork For
Effective Meetings.
- Review Homework (pages 18-23)
- Group Process (pages 32-36) |
| 12:15-1:00 | LUNCH. FREE TIME |
| 1:00-2:30 | Second Activity: Why Some Groups Crash,
Others Fly (pages 36-46) |
| 2:30-3:00 | Third Activity: Goal Setting and Evaluation |

**“NEVER DOUBT THAT
A SMALL GROUP OF
THOUGHTFUL,
COMMITTED CITIZENS
CAN CHANGE THE WORLD.
INDEED, IT’S
THE ONLY THING THAT
EVER HAS.”**



Margaret Mead

TRAINING SESSION II

MAY 1992

MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

WRITE, CALL, VISIT: FIRST STEPS TOWARD BEING HEARD

THERE ARE THREE WAYS TO COMMUNICATE
YOUR VIEWS TO POLICY MAKERS.
YOU CAN **WRITE**, YOU CAN **CALL**, OR YOU CAN **VISIT**.

WRITING A LEGISLATOR OR POLICY MAKER

Politicians and other decision makers pay attention to their mail. They know that responding to concerned citizens is good politics and crucial to their survival. Every letter counts, but a personal letter is more effective than a form letter or petition.

Most state legislators and some national legislators say that fifteen letters on a single issue will receive their attention. To county commissioners, social services directors or other agency officials, and mayors, a much smaller number of letters can be impressive. **Even one letter can make a difference**, and that letter may be yours. Every letter counts, and every letter is read, unless the public official is not doing his or her job which is listening to the public.

Letters to policy makers should:

- Have the policy maker's name spelled correctly, and use correct title.
- Be concise, informed, and polite.
- Be short (one page is best) and legible.
- State your purpose in the first paragraph.

VISITING A LEGISLATOR OR POLICY MAKER

Elected officials can be visited on the job (at the state capital, the city council chambers, or the county commissioner's chambers), in their local offices, or wherever they are engaged in public business. For a person who is inexperienced at meeting a policy maker, the best approach might be to make an appointment beforehand. But at times appointments are difficult or impossible to arrange. Experienced and inexperienced lobbyists should be ready to seize an opportunity when it arises and speak to a policy maker at a rally, a parade, a fund raiser, or in the state house corridors.

Often you will have only a few minutes to make your point, so it helps to have ready a short 90 second version of what you want to say. It is always smart to use the 90 second version, followed by more details, or a more elaborate version if there is time.

When you visit a policy maker (all kinds), you should be clear about:

- Who you are and what group you represent.
- What issue concerns you.
- What you want from them (support for a bill, a budget request).
- How you mean to share the results of this meeting with others (through a mailing or newsletter, in person).

Also:

- Leave a fact sheet with an outline of your basic message, plus your name and telephone number for more information.
- Always thank the policy maker for his or her time or any recent action of which you approve.

REMEMBER:

- Policy makers won't think you are rude for stating what you want. They may think it odd if you don't. **PART OF THEIR JOB IS TO BE ASKED AND PART OF YOUR JOB IS TO ASK.**
- You can't be persuasive if you are not understood. Avoid jargon, technical terms, initials or abbreviations. Be prepared to go over the basics if necessary.

If your letter is about a bill or specific policy:

- Cite the bill or policy by name and/or number.
- Know if your legislator is one of the authors, if so acknowledge it.
- State whether you support or oppose it and why.
- Be factual and speak from your own experience or knowledge.
- Be constructive. Explain an alternative or better solution to the problem.
- Be moderate, not angry. You will want to have future contact with the legislator.
- Do not make demands. Never threaten defeat at the next election.
- Ask for the policy maker's views on the issue or bill.
- Send a note of appreciation when your elected official supports your issue.

Your letter doesn't need to be on fancy stationery or written in technical or legal language. Even a rough letter is better than no letter at all.

YOUR LETTER MIGHT HAVE MORE IMPACT IF IT IS ONE OF MANY. WHENEVER POSSIBLE, AFFILIATE YOURSELF WITH A GROUP WHICH SUPPORTS YOUR VIEWS.

CALLING A LEGISLATOR OR POLICY MAKER

Politicians and policy makers also pay attention when citizens take the trouble to call and express their views. The same general rule given for writing applies to calling. Let the person know concisely who you are, what you are calling about, and what you want. For example, do you want him or her to support a bill, to oppose a budget cut, or act on a proposal. If there is a message machine, state who you are, and what you want the policy maker to support or oppose.

Calling is an especially good way for the politically shy person to get started. Whether talking directly to a receptionist or a machine, callers only need to leave their message, name and address or phone number. Usually no questions are asked, no positions challenged.

DON'T FORGET: AT EVERY STEP IN THE PROCESS OF POLICY ADVOCACY THERE IS A ROLE FOR EVERYONE: TO WRITE LETTERS, MAKE PHONE CALLS, GATHER FACTS, WORK WITH THE MEDIA, TO LOBBY, DISCUSS, THINK, SHOW UP, AND CARE.

Task 1: Write a letter to one of the persons listed below:

- Your County Commissioner
- A State Legislator
- Chair of Your Local Advisory Council
- Your Director of Social Services
- Your City Council Member
- Your Congressional Representative or Senator

In the letter, write about a mental health issue of importance to you. For example:

1. need for a drop-in center.
2. better job opportunities for persons with mental illness.
3. a good or bad aspect of the county community support program.
4. the need in your county for good, affordable housing for persons with mental illness.

REMEMBER:

- Focus on one issue or concern.
- Relate that concern to a personal experience.

(example of letter on page 30)

FIRST ACTIVITY
WRITE, CALL, VISIT

TASK 1 WORK PAGE FOR LETTER TO POLICY MAKER

Your name
Your address
City, State, Zip

Date

Correct Title of Policy Maker and Name
Address
City, State, Zip

Dear:

Sincerely,

Your name

SAMPLE LETTER

Mary Johnson
684 Plymouth
Happy Valley, MN 56789

John Olson
Paradise County Board of County Commissioners
Paradise, MN 51234

January 10, 1992

Dear Commissioner Olson:

I am a consumer of mental health services in Paradise County. I want you to know that I like and depend on most county services, especially the new CSP Drop In Center. I think these services have been very important in reducing my hospitalizations. For the first time since I began living with mental illness 15 years ago I feel as if I belong in my community now and have made many new friends.

I hope you will vote to increase CSP staff by two people in the next budget. Now, the CSP center is only open three days a week and sometimes the staff is not free to talk to clients on a one-to-one basis. It would certainly help my recovery if there was a staff person that I could talk to when I have a problem.

I know that you want to have excellent services in Paradise County and hope you will support this increase.

Thank you for your attention.

Sincerely,

Mary Johnson

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

TRAINING SESSION II

MAY 1992

MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

GROUP PROCESS: GROUNDWORK FOR EFFECTIVE LAC MEETINGS

Local advisory councils can be only as effective as their members. Communication with each other and with county officials is primary to bringing about change in the mental health system. Knowing how the group process works is important to members of any body that sets out to make change. Understanding **how you function in a group** helps to strengthen your participation in that group. The assignments in the workbook for Session I were designed to help you better understand how an advisory council works, and how you work on an advisory council.

TASK 1: Look at the "self assessment" assignment on page 18 under the "Past Workshops" tab. List three strengths that you see in yourself as a member of your LAC.

1. _____
2. _____
3. _____

In what ways do you think you could strengthen your own participation on your council?

1. _____
2. _____

Task 2: With the other people at your table, talk about your strengths and areas you need to work on. How do you think your strengths affect your council?

Task 3: With the same group, turn to page 20 of your homework. Discuss with the group the following:

- Which of the responsibilities that are listed did you find important to you when you read the assignment?
- In your assessment of yourself as a LAC member what responsibilities that are listed have you not taken on? What will you do about it?

Task 4: What best describes your participation on your council?
Check all that apply.

- ☐ quiet, don't make waves
- ☐ impatient
- ☐ confused, not sure what's going on
- ☐ well prepared
- ☐ know parliamentary procedure
- ☐ ask often for clarification of issues
- ☐ try to stick to the agenda
- ☐ bored
- ☐ have much to learn
- ☐ know my own goals, but not how to accomplish them
- ☐ active between meetings
- ☐ interrupt often
- ☐ have contact with members between meetings
- ☐ know names of all persons on the committee
- ☐ often frustrated
- ☐ discouraged—nothing changes because of me able to compromise

Task 5: What best describes your LAC?

- ☐ meetings are well attended
- ☐ meetings are well organized
- ☐ members are educated about mental health system
- ☐ in meetings many points of view are accepted
- ☐ chair delegates tasks
- ☐ conflicts are resolved satisfactorily
- ☐ council reports regularly to commissioners
- ☐ meetings are exciting, challenging
- ☐ members are active, informed
- ☐ professionals do most of the talking
- ☐ members use mental health jargon
- ☐ members feel free to ask questions
- ☐ consumers and family members express views
- ☐ council is task oriented (do, not talk)
- ☐ members listen
- ☐ the meeting keeps to an agenda
- ☐ meeting has closure (no loose ends)
- ☐ members help set agenda
- ☐ meetings are boring
- ☐ council has no impact on system
- ☐ meetings don't give opportunity for me to raise issues

NOTES

AIDS TO COMMUNICATION

LISTENER

1. Listen. Show interest. Give the speaker your full attention. Look at person who is speaking.
2. Don't interrupt.
3. Give feedback on what you hear.
4. Question what you don't understand.
5. Avoid anger over differences of opinion or preference. Allow others to be different from yourself.
6. Attempt to determine what led the speaker to the position being taken.
7. Give your feeling response to what was said.
9. Confirm that everyone is clear on agreements made.

SPEAKER

1. Stick to the subject. Be specific. Don't generalize or be vague.
2. Attack problems, not people.
3. Don't monopolize. Hear others. Be brief.
4. Don't assume you are understood. Check it out.
5. Respect individual differences.
6. Be as open as the situation will allow.
7. Remember your point of view is information, not law.
8. Focus on positive possibilities, not just negatives.

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SECOND ACTIVITY

WHY SOME GROUPS CRASH, OTHERS FLY

Groups are made up of many different kinds of people. Each member of a group brings to it his or her experience, personality, and individual communication skills. If one member dominates the discussion this affects the whole group. A member who says little also affects the working of that group in a different way. But if these differences are respected within a group, those very differences can make the group strong and encourage creative problem solving.

TASK 1: Read aloud this summary of qualities found in groups.

IN PRODUCTIVE GROUPS

1. People listen and pay attention to each other.
2. People discuss the subject at hand.
3. Everyone's ideas and suggestions are welcomed.
4. Everyone has a chance to state his or her views.
5. The group uses its agenda as a guide for discussions.
6. One or two members are appointed to summarize the discussion and see that everyone has had a chance to speak.
7. Members know and use problem-solving steps.
8. Members are clear about what group decisions have been made and are committed to them.

IN LESS PRODUCTIVE GROUPS

1. People do not listen and everyone tends to talk at the same time.
2. The discussion jumps from one idea to another.
3. Some member's ideas don't seem to count, so they feel they don't belong.
4. One or two people do all the talking.
5. The agenda is not clear and there is no written guide for discussions.
6. No one summarizes or checks to see if everyone who wants to speak has actually spoken. Discussions go on and on until people get tired.
7. No order is followed for identifying and solving problems.
8. The decision making process is not clear and people are not committed to the plans made.
9. One or two people do all the talking.

**AS GROUPS LEARN TO SOLVE PROBLEMS
TOGETHER AND TO COMMUNICATE MORE
EFFECTIVELY WITH EACH OTHER, THEY REACH
A KIND OF "GROUP MATURITY."**

•

**LOOK AT THE "GROUP MATURITY STAGES"
SHOWN ON THE OPPOSITE PAGE.**

•

**WHAT STAGE OF GROUP DEVELOPMENT DO YOU
SEE YOUR LAC IN AT THIS TIME?**

•

**PUT AN X UNDER THE DESCRIPTION THAT
BEST FITS YOUR COUNCIL**

THEN

TAKE A LOOK AT WHERE YOU ARE.

•

WHERE YOU HAVE BEEN.

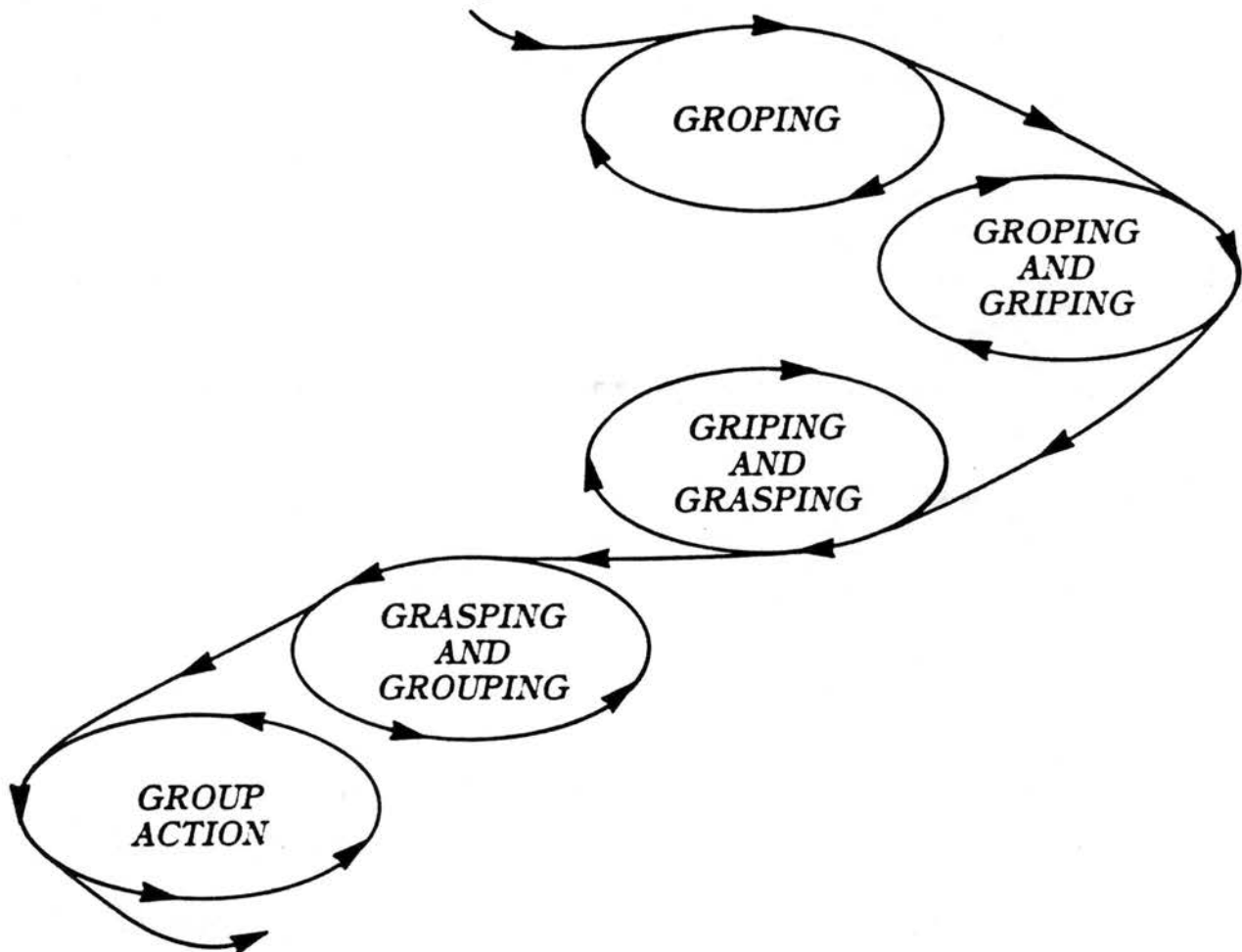
•

AND WHERE YOU MIGHT GO.

GROUPS

Groups may go through several stages in working together. Each step can be introduced with "G":

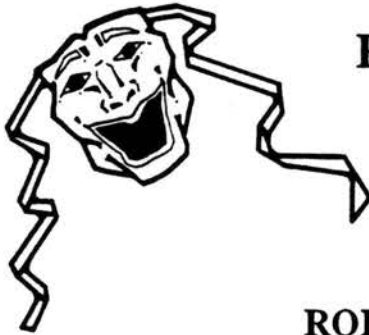
Stages of Group Maturity



ADAPTED FOR FCL USE BY JAMES LONG, STAFF DEVELOPMENT SPECIALIST, COOPERATIVE EXTENSION, WSU

PRINTED IN:
GROUP PROCESS, GROUP BEHAVIOR, FAMILY COMMUNITY LEADERSHIP, WASHINGTON STATE UNIVERSITY

Group Process: ROLE PLAYING



ROLE PLAYING AS A WAY TO UNDERSTAND HOW A GROUP WORKS

There are many kinds of roles that might be represented on an LAC. In role playing, individual characteristics are greatly exaggerated. By role playing a LAC meeting, we might be able to see in microcosm how the **behavior of an individual affects the whole group**. Understanding the different ways that people approach tasks is very important to understanding how a particular group functions.

Look at the different roles on the opposite page. Do the names “eager beaver,” “clarifier,” “brilliant one,” “the expert,” “debunker,” and “creative optimist” sound familiar? If they do it is **probably** because every group is made up of people with some of these characteristics!

Task 2: The group will role play an LAC meeting. You can choose to be an observer or you can take one of the roles described on the opposite page.

The leader will briefly describe the roles. If you want to play a role, try to take one that is very different from yourself. If you're shy, take an aggressive role. If you tend to speak out strongly, take a role that is more quiet.

ROLE PLAY

TYPES THAT MAKE UP A GROUP

- **MODEL MEMBER**
- **EAGER BEAVER**
- *Clarifier*
- **BRILLIANT ONE**
- *Emotional One*
- **SILENT ONE**
- **PARLIAMENTARIAN**
- *RECOGNITION SEEKER*
- **Debunker**
- **THE EXPERT**
- *Creative Optimist*

REFERENCE: ADAPTED FROM SATHRE, OLSON & WHITNEY, LET'S TALK, FORESMAN & COMPANY, 1977

ADAPTED FROM GROUP PROCESS
GROUP BEHAVIOR

Supplement C
EFFECTIVE GROUPS

Family Community
Leadership

ROLE PLAY CHARACTERS

Model Member:

As a model member of a discussion group, you consider the needs of the group and its goal; you make every effort to help the group reach the goal. Your contributions are candid and brief; you make sure others understand your ideas, and you try to understand theirs. You provide leadership services when you can, and you do so appropriately. You are aware of other members, and you try to help them make their greatest contribution to the group.

Eager Beaver:

You are interested in reaching a solution quickly. You value efficiency and speed. Sometimes you are impatient with those who wish to take time to discuss a point. You want to keep on task and get things done.

Clarifier:

You are well prepared and articulate. You see issues clearly in your own mind, and you want others to understand them. You will often ask "are you trying to say....?" Or, "I'm sorry I don't understand the issues here—could we go over them again?" You help the council arrive at a decision together, and to make that decision clearly understood by all.

Brilliant One:

You are intelligent; you know it, and so does the rest of the group. You do not try to dominate; you are patient, explaining points carefully and answering all questions. As the discussion progresses, your patience may grow short; you talk more often and in more positive terms. If the other members don't accept your ideas, you may feel that they don't understand you.

The Expert:

You have learned professional jargon from reading reports and summaries, "Rule 36," "Rule 14," "CSP," "DRS," and "SPMI" are so familiar to you that you don't notice that others on the council don't understand them. You do your homework well and know what position the county or state holds on any mental health issue at any given time. You sometimes become caught up in details and may miss what other members of the council are saying. You have little patience with others as they struggle to understand issues and unfamiliar terms; nevertheless, you are a very valued council member because you know issues.

Emotional One:

You react strongly to the contributions of others. You are passionate about your commitment to the work of the council. Mental health rules and legislation are not as important to you as the people that they affect. You approach decision making from what you feel inside, and often make statements such as, "That just doesn't seem right somehow" or "That attitude really makes me angry." You have built-in guides to your opinions that sometimes make your views seem illogical. You express your opinions quite freely and quite early.

Silent One:

For many reasons, you will not talk in a group. You may believe that you have nothing to say, that others have more important contributions, or you may simply be shy. Although you may answer a question briefly, you will not initiate a discussion; you just don't want to talk.

You agree with everything that is said. You make contributions and you think everyone else's remarks are very good. Because you wish to please everyone, you try to avoid disagreements; therefore, you are not at all critical of what other council members have to say. If you are asked what you think of the council, your answer is "it's just great."

You have served on your council for a long time and have been embroiled in mental health issues long enough to know that hard work is not always rewarded. You sometimes intersperse your comments with, “Well it won’t work anyway,” or “What’s the point?”. Your fellow council members admire you for your past dedication, and have come to accept your position as part of “advocate burnout,” with the result that your remarks are ignored.

You read voraciously on every subject imaginable and belong to a number of "grass roots" organizations, all of which you believe in passionately. You enjoy people and often involve them in your unusual problem solving. Your ideas are usually unique and sometimes appear to be somewhat bizarre. Your ideas come in a flash and sometimes overwhelm others. Your creative energy is endless, and you come up with a solution for even the most sticky problem. You challenge fellow council members to think beyond what has been done in the past. You are convincing and engaging and often initiate cooperative efforts in making your ideas work. Hence, you are respected even though your ideas sometimes seem a little "on the fringe."

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Group Process: PURPOSE OF MEETING

PURPOSE OF MEETING: THE COUNTY HAS JUST RECEIVED A FOUR BEDROOM HOUSE AS A GIFT FROM AN ORGANIZATION IN TOWN. IS IT A VIABLE OPTION TO TURN THE HOUSE INTO A DROP-IN CENTER FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS?

FACTS AS YOU HAVE THEM:

For:

1. The owner presents the house to the county with no strings attached.
2. The county has no other meeting place for consumers of mental health services.
3. CSP workers are enthusiastic and have offered to supervise some of the repair.

Against:

1. The house is in a poor neighborhood, not close to public transportation.
2. The house is not in good repair and would require repairs before it could be used as a center.
3. There may be a "NOT IN MY BACK YARD" problem with neighbors.
4. The area that the house is in is zoned residential and the city has indicated that it will restrict the time the drop-in center could be used, and limit the number of people who can be in it at one time.

Group Process: OBSERVING ROLE PLAYING

If you choose the observer role, wait until the roles have been assigned to those who will play them. Then choose one role that you want to observe. Notice how the actor that you are observing takes part in the meeting. Look for the behavioral traits listed below and mark them "Often" or "Never".

	OFTEN	NEVER
<u>Ask yourself, did the role player:</u>		
1. Listen carefully.		
2. Ask for clarification.		
3. Speak clearly and used simple words.		
4. Help group get back on track.		
5. Help group arrive at a decision.		
6. Speak out at the right time.		
7. Take only as much time as was necessary		
8. Differ in a respectful manner.		
9. Interrupt other members.		

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper appears slightly aged or off-white. There is no handwriting or other markings on the page.

GROUP PROBLEM SOLVING

To solve problems, groups go through several steps:

1. Searching for the problem.
2. Focusing on the problem
3. Exploring alternative ways to solve the problem and choosing one.
4. Planning.
5. Acting on the plan.
6. Evaluating how well the problem was solved.

The steps above are arranged in sequence. A group may skip around a lot. Eventually, however, successful groups accomplish all steps.

Adapted from: Davis, Paterson, Mackeracher and Cawley, Shared Process Evaluation System (SHAPES), 1975

**LWV
CONSUMER/FAMILY TRAINING SESSION
SEPTEMBER, 1992**

SCHEDULE FOR THE DAY

9:45-10:00 a.m.	Sign in. Coffee and Donuts.
10:00 a.m. (sharp)	Overview of Training Session I, II New Materials Distributed.
10:30-11:00	General Discussion. Goals Accomplished. Check Local Resource Material.
11:00-11:30	First Activity: Funding Mental Health Services Within the County.
1:30-12:15	Second Activity: Stigma: Myth and Reality.
12:15-1:00	LUNCH. FREE TIME
1:00-3:00	Third Activity: Stigma: Watching the Media.
3:00-3:30	Goal Setting and Evaluation. Catch-up Time for New Participants.

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Committee for
Leadership
Education
Advocacy and
Results

NAME:	COUNTY:	REPRESENTING:
Adams, Chris	Minneapolis	MN Depressive & Manic-Depress. Ass.
Alexander, Beverly	International Falls	Region 3
Bird, Floida	Elk River	Region 7
Baustian, Leora	Luverne	Region 8
Carver, Marilyn		Alliance for the Mentally Ill
Christlieb, Jo	Bemidji	Region 2
Davison, Linda	Minneapolis	Mental Health Association
Dungay, Robert	Fergus Falls	Region 4
Eide, Sharon	Milan	Region 6
Ferris, Kevin	Babbitt	Region 3
Grobe, John	Duluth	Region 3
Latham, Mary	Richfield	Schizophrenia Assoc. of Minnesota
Mundell, Michelle L.	North Mankato	Region 9
Schimelpfenig, Doug	Minneapolis	Region 11A
Tennant, Patricia	St. Paul	Region 11B
Thompson, Rebecca	Faribault	Region 10
Vertina, Teresa	Roseau	Region 1

League of Women Voters Management Team: Kay Erickson, President LWVMN; Barbara Flanigan, 3rd Vice President (Mental Health Director); Sally Sawyer, Executive Director.

Department of Human Services, Mental Health Division Advisors to Project: Bruce Weinstock, Director, State Mental Health Advisory Council; Jerome Storck, Senior Analysis Specialist

TRAINING SESSION III SEPTEMBER, 1992 MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

FUNDING MENTAL HEALTH SERVICES WITHIN THE COUNTY

Funding mental health services at the county level is an intricate process. If we are to have an influence on how mental health dollars are spent within our county, it is important to understand the county's funding sources as well as the process by which these funds are distributed. Each county responds in its own way to the requirements of the Mental Health Act. Counties are expected to provide a "full array of services" up to "available resources." In some counties, this means that some mental health services mandated in the act will not be provided because the county does not have "available resources." The *Mandates Reform Act (1991)* may further limit the county's obligation.

Each county is different in its approach to budgeting, but in all counties the board of commissioners have the task of balancing a variety of interests. To be fair in setting mill rates, commissioners must consider the voices of all tax payers. The county needs to allocate tax dollars among competing interests. It is important that the county board considers suggestions from individual citizens as it makes budgetary decisions.

LAC members are asked to provide the county board with a report of unmet mental health needs in their county and to participate in developing the mental health component of the social services plan. The budget is an important part of the mental health plan. To better advise the county board, an LAC member should:

1. Find out the major decision makers in your county.
2. Find out the county's time line for the budget process.
3. If possible obtain projected expenditures for mental health early in the budgeting process. Wise advocates won't wait until the budget has been completed.
4. Be relevant and specific when talking with board members, agency heads, or in making a presentation before the county board. "Write, Call, Visit" in this workbook provides tips on how to approach your policy makers.

In Minnesota counties operate on a fiscal year from January 1 to December 31. The first rumblings about appropriations and the budget can start as early as eight months **before the fiscal year actually begins**. Below is a typical budget time line. It varies from county to county, so ask your county administrator, county auditor, or social services director to provide a time line for your county.

TYPICAL TIME LINE

April-May. Some county boards develop an overall budget for county departments and contracting agencies for the coming year. This is based on revenue projections. The county commissioners may develop specific instructions about **their** program priorities for certain departments or agencies.

June-Mid-July. The county board or administrator may request detailed requests and justifications from all departments and contracting agencies.

Mid-July-August. Departmental requests are reviewed and modified. The county staff often proposes a budget to the county board at this time.

September-November. Some county boards hold public hearings. If hearings are not held in your county, ask your social services director how you can have input on budgetary decisions. By law the board must act on a proposed levy before September 15.

November-December. The county board holds "Truth in Taxation" hearings which are mandated by state law and are open to the public. The meeting must be held on the 2nd Tuesday of December. It is intended to give property holders a chance to express their views on proposed mill rates. It is probably too late to impact the budget, but the "Truth in Taxation" hearing is an appropriate place for people with an interest in specific services to speak up.

A final vote on the budget is taken after the hearings are completed.

January 1 Fiscal year begins. Budget goes into effect.

NOTE: THE COUNTY BOARD MAY MAKE ADJUSTMENTS TO THE ADOPTED MENTAL HEALTH BUDGET DURING THE YEAR.

For additional information see "Funding Mental Health Services" under "Local Resources" tab.

SECOND ACTIVITY

STIGMA

The archaic meaning of stigma is “a mark burned into the skin; a scar left by a hot iron.” A modern dictionary defines it as “a mark of shame or discredit.” Whether old or current, these definitions point out the way in which mental illness is often perceived. Today myths about mental illness still abound.

Public attitudes concerning such things as alcoholism and epilepsy have changed greatly over time. There is a better understanding of mental retardation than there was ten years ago. People with physical handicaps have made good progress in gaining equal access to transportation and public buildings and on the job. People with mental illness have been somewhat slower in gaining equal consideration for themselves in such areas as the workplace and housing. They lag behind other groups with disabilities in achieving a general understanding and acceptance of their illness by the public. The stigma—that “brand,” that “mark of shame”—still surrounds mental illness and causes it to be shrouded in secrecy and misperception.

The *Americans With Disabilities Act (1990)* will usher in a whole new concept in the workplace. After years of demanding that employees adjust to the workplace, employers now are required to have a more flexible workplace to adjust to individual differences. This act covers people with mental illness as well as other disabilities. Through the enactment of the *Americans With Disabilities Act* there is reason for new hope that **all disabilities** will be better understood and accepted by the general public.

An important task for consumers and family members is to help the general public understand mental illness. To teach others, we must be well informed ourselves. A good place for us to start is to look at some of the myths that still surround mental illness.

TASK 1: Read aloud with the group the myths and realities about mental illness listed on the following page.

MENTAL ILLNESS

MYTHS AND REALITY

MYTH: Mental Illness does not affect the average person.

REALITY: Mental Illness can strike anywhere. The National Institute of Mental Health's statistics show 35 million American have some form of mental illness in any given six months. One in four families will be affected by mental illness over a lifetime.

MYTH: Most people who struggle with mental illness live on the streets or in mental hospitals.

REALITY: About two thirds of Americans who have a mental illness live in the community, either with their family or in various types of community-living settings.

MYTH: Children do not get mental illness.

REALITY: Twelve million children and adolescents do suffer diagnosable emotional disorders, including depression, attention deficit disorder, autism, and manic-depressive illness.

MYTH: A person can recover from a mental illness by thinking positively or with prayer.

REALITY: Mental illness is a brain disease. Recovery is possible when the person receives the necessary treatment and supportive services. As with any other physical disease, positive attitude helps in recovery.

MYTH: People who have a mental illness are dangerous.

REALITY: Violence among mentally ill people is not common. They are more frequently the victims of crime than its perpetrators.

MYTH: If you have a mental illness, you are "crazy" all the time.

REALITY: A person suffering from even the most severe mental illness is in touch with reality as often as he/she is out of touch with it. Some people with mental illness deal with it quietly and there are no outward signs of the illness.

MYTH: If people with other handicaps can cope on their own, people who have a mental illness should be able to do so as well.

REALITY: Most people who have been through a disabling illness need medical care and often physical therapy to return to normal functioning. Similarly, following mental illness a person may need medication, talk therapy, and social rehabilitation.

MYTH: You can't talk to someone who has a mental illness.

REALITY: Persons suffering some kinds of mental illness may experience delusions or act disturbed at times, but in their calmer moments they will probably be able to discuss most things reasonably and rationally. People in a severe depressive episode may be almost mute, but they still very much need to receive reassurance and encouragement.

MYTH: A person who has a mental illness will make a second-rate employee.

REALITY: Many persons recovering from mental illness make excellent employees. In fact employers frequently report that they out-perform other workers in attendance and punctuality and are about equal in motivation, quality of work, and job tenure.

MYTH: Persons with mental illness can work successfully at low-level jobs, but they aren't suited for really important or responsible positions.

REALITY: Recovering mental patients are individuals. As such their career potential depends on their particular talents, abilities, experience, and motivation, as well as their current state of physical and mental health.

A number of political leaders, artists, and others have achieved greatness despite the handicap of mental illness. Few of us can hope to match the accomplishments of *Abraham Lincoln*, *Ernest Hemingway*, *Sylvia Plath*, *Virginia Woolf*, and *Robert Schumann*. But ordinary people recovering from mental illness can reasonably expect to work at a responsible job, if society does not arbitrarily bar their way.

**DON'T LET FALSE STATEMENTS
ABOUT MENTAL ILLNESS OR PERSONS WHO HAVE A
MENTAL ILLNESS GO UNCHALLENGED.**

The best way to fight stigma is to provide correct information about what mental illness is and how mentally ill people can be helped.

The following four pages provide some basic information about mental illness. The pages are easily copied, and can be used in your place of work, your church, the public schools or civic organizations to which you belong to better inform the general public about mental illness.

**IF YOU DON'T HELP TO EDUCATE
THE GENERAL PUBLIC ABOUT MENTAL
ILLNESS — WHO WILL?**

THE REALITY OF MENTAL ILLNESS

*"The future?
I can't look too far ahead.
I won't look too far ahead.
I like to be in control of my life.
With this illness
you can't be in control.
What I do, instead, is
take control over what I do
when I get sick.
I can't control
when it's going to happen
or how intense it's going to be.
I can control how I handle it
and what I do." Vicki*

*"Mental illness is biochemical.
It comes in many different ways.
You can hear voices,
be totally paranoid,
be afraid to talk to somebody.
You can be so scared
to walk outside your door
that you want to die." Carrie*

*"When you talk about
falls from grace,
maybe for us who are
psychiatrically ill,
the word is 'breaks.'
We go through 'breaks.'
They are horrible.
I have been through four.
I went through three in
successive years.
One right after the other.
I didn't even know what hit me."
Bill*

*"It is not demon possession.
It is just a chemical imbalance
you can't control without
getting the right help for it." Gail*

What is mental illness? Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and/or relating. The result is a substantially diminished capacity for coping with the ordinary demands of life. In America, today, 35 million people suffer from some form of mental illness. One in four American families is affected by mental illness. No segment of society is immune. Mental illness can affect persons at any age and can occur in any family.

How prevalent is mental illness? Mental illness is twice as prevalent as Alzheimer's disease, six times as prevalent as diabetes, and five times as prevalent as multiple sclerosis. In fact more hospital beds in America are occupied by people who have a mental illness than those who have cancer, heart, and lung disease *combined*.

Is it possible to recover? People can and do recover from mental illness. There are some famous examples, including President Abraham Lincoln, philosopher William James, U.S. Senator Thomas Eagleton, popular singer Rosemary Clooney, actress Patti Duke, and professional golfer Bert Yancy. With proper treatment, two out of three people who have a mental illness can expect to get better and lead productive lives. In the United States, at least two million people who have been hospitalized with a mental illness are currently a part of the community.

Does mental illness have different forms? Mental illness has various forms. In America over 9 million people suffer from depression, 2.8 million from schizophrenia and more than 13 million from anxiety disorder.

Is there a difference between mental illness and mental retardation? Yes. People with mental retardation have diminished intellectual capacities, but people who have a mental illness have normal intellectual capacities. However, some may have difficulty performing at a normal level due to their illness, their medication or lack of a supportive environment.

Is mental illness due to "poor parenting?" Mental illness is NOT caused by dysfunctional families nor is it evidence of weakness of character.

What causes mental illness? Its causes are not fully understood. It is thought the brain's neurotransmitters do not function properly due to a biochemical imbalance in the brain. This sort of imbalance is comparable to imbalances in other areas of the body that cause illnesses such as diabetes and cancer. And, just as with diabetes, many symptoms of mental illness can be controlled with medication.

Other factors may contribute. Heredity may be a factor in mental illness, as it is in diabetes and cancer. Stress may contribute to the onset of mental illness in vulnerable persons. "Recreational" drugs may also contribute to onset but are unlikely to be the primary cause. Family interaction and early childhood training were once dominant as theories of causation, but research no longer supports these theories.

"Patients have told me they are frightened of doing the wrong thing or eliciting some response from someone in public that will hurt them. I think they have very low self esteem and are very vulnerable to being overwhelmed by people in authority. Overwhelmed by routine interactions that would not bother you or me." Roy Wilson, M.D.

"My grandfather committed suicide when my mother was seven. It was not until my first breakdown when I asked for a family history that I found out about it. He had been in the state hospital for a year before he committed suicide. I realized then that this is the living experience that has no name. The 'untalked' about shadow that can follow any person." Ruth

What treatments are available? An expanding range of medications is currently available. While they do not cure these illnesses, they reduce symptoms markedly for most people. In addition, most persons can profit from supportive therapy and from a community program to help them rebuild self-confidence and learn independent living skills. With quality comprehensive treatment, symptoms may substantially subside and many people experience periods of remission. Others may require on-going support programs designed specifically for people who have these illnesses. The goal is to enable them to achieve the highest degree of independence, productivity, and satisfaction in their lives.

Can mental illness be prevented or cured? Since the causes of mental illnesses are not fully known, there is little effective prevention. However, research to determine causes and to plan strategies for prevention and rehabilitation is progressing. Similarly, there are no identified cures for mental illnesses, but proper treatment may substantially improve the functioning of persons with these illnesses, and in some cases they may completely recover.

Does research offer hope? The key to finding cures for people who have mental illnesses is in scientific research on the brain and in genetics. Recent developments in research technology point to the decade of the 1990's as the pivotal decade in the understanding of all diseases of the brain.

Can a person who has had a mental illness ever be normal? Mental illness is often temporary. A previously well-adjusted individual may have an episode of illness lasting weeks or months, and then may go for years, or even a lifetime, without another. To label such a recovered person as "abnormal" is both unfair and unrealistic. Others may become ill periodically. Between episodes, they may be perfectly well. At these times they understandably resent being treated as other than normal. Like any of us, people who have had a mental illness deserve to be judged on their own merits. Too often, they are thought of only in terms that unfairly label them.

(Statistics used throughout this publication are taken from research made available by the National Institute of Mental Health.)



REACHING OUT TO SOMEONE WHO HAS A MENTAL ILLNESS

As you do with other friends, treat someone who has a mental illness as you would want to be treated, with understanding and respect.

When a person with a mental illness:

is withdrawn,
is overstimulated,
becomes insecure,
is fearful,

You need to:

initiate relevant conversation.
limit input, do not force discussion.
be accepting.
stay calm.

When symptoms or medications cause behaviors such as:

disorientation or preoccupation,
difficulty with concentration,
stress in ordinary situations,
trouble remembering,
unsound judgement,

You need to:

keep to a known, structured routine.
slow down, and perhaps repeat; use simple, short sentences.
create an uncomplicated, predictable environment.
help the person record information.
remain rational and reinforce common sense.

Some symptoms of mental illness are unlike anything you will encounter elsewhere. *YOU* can't change that, but you can refrain from further destroying the person's integrity.

When a person with a mental illness:

is not grounded in reality,
believes delusions,
displays little empathy,
has difficulty making contact,
seems totally lacking self-esteem and motivation,

You need to:

listen for kernels of truth, or wait for a better time.
avoid arguing.
recognize this as a symptom; try not to respond in kind.
make direct contact and keep the initiative.
affirm the person's value; treat accomplishments positively.

POSSIBLE SIGNS AND SYMPTOMS OF MENTAL ILLNESS

Not all symptoms occur in every person with a mental illness. Each of them indicates excessive and/or EXAGGERATED patterns of perceptions, behaviors and feelings. Although, individuals and societies vary as to what is "normal," a person with a mental illness should be evaluated if there is a change to extremely unusual behavior. Never hesitate to call a physician to share these concerns, just as you would for any illness.

SEEK MEDICAL EVALUATION IF SOME OF THESE EXAGGERATED BEHAVIORS BEGIN TO APPEAR.

"He would get on a pace and he would pace up and down the hall. He would laugh sometimes and cry sometimes. I would go to the door many nights and ask him what was wrong. He would say nothing and be crying." Ida Mae

"She doesn't come down to dinner with the family anymore. Sometimes she takes a tray in her room. Sometimes she doesn't eat anything at all. Her table manners, when she does eat with us, are atrocious. She never combs her hair or washes her hands before coming to the table. Her clothes are all over her room in piles. Six equal piles of dirty clothes. She doesn't like me to touch that." Marian

"If you go in the kitchen, as soon as you leave, he rushes in to see what you may have done. If something is left on the counter, a plate, a bowl, whatever, he washes it and dries it two or three times. He also has to have the kitchen floor and the hall floor mopped twice a day in a certain way. Always left to right, left to right." Sue

SYMPTOMS

withdrawal or distrust of friends and family.
decline in academic, athletic, or job performance.
slovenliness or decline in personal hygiene.
inappropriate dressing for weather or occasion.
self destructive actions.
glazed or faraway stare and/or bizarre posturing.
excessive changes in sleeping or wakefulness.
excessive changes in appetite - too little or too much.
excessive seeking of approval.
excessive writing of nonsensical or disconnected thoughts and words.
abuse of alcohol or other drugs.

PERCEPTIONS

extreme or unusual sensitivity to LIGHT/COLORS/NOISE.
fear of touching or being touched by others or things.
changed sense of self (body parts diseased, detached, hanging, etc.).
hallucinations: either auditory (hearing voices) and/or visual (seeing something that is non-existent).
certain clothing having unusual meaning.

EMOTIONS/FEELINGS/THOUGHTS

extreme anxiety over the smallest things.
extreme guilt over "past sins" or bad conduct.
extreme pessimism and/or unceasing depression.
extremely low self esteem.
suicidal thoughts.
paranoia towards everyone and everything.
delusions of power/wealth/knowledge.
exaggerated, blunted, or inappropriate emotional response (laugh/cry).
inability to express or feel any emotion.

Reprinted from:

A Community of Care and Healing

Presbyterian Church U.S.A., 100 Witherspoon Street, Louisville, Kentucky 40202

CAN WE CHALLENGE THE MYTHS ABOUT MENTAL ILLNESS AND MAKE THEM INTO REALITIES? WE CAN START BY TAKING A LOOK AT OURSELVES.

Stigma is perpetuated by our own shame as well as by the misunderstanding of others. Before we ask others to look realistically at mental illness, perhaps we should ask:

“Am I free from perpetuating the stigma that exists around mental illness?”

Can you look back and see yourself in the same place that you now see others? Did you believe and perhaps pass along the **very same myths** that you find so offensive today? In the following exercise, you are asked to look back to a time when you did not know much about mental illness. This is probably the place most people are at this time. Perhaps you can better understand people who don't know much about mental illness by “walking in their moccasins.”

TASK II: Try to remember a time when you saw what you thought was a misperception about mental illness shown by another person or something around you. It made you uncomfortable, but you did not speak out.

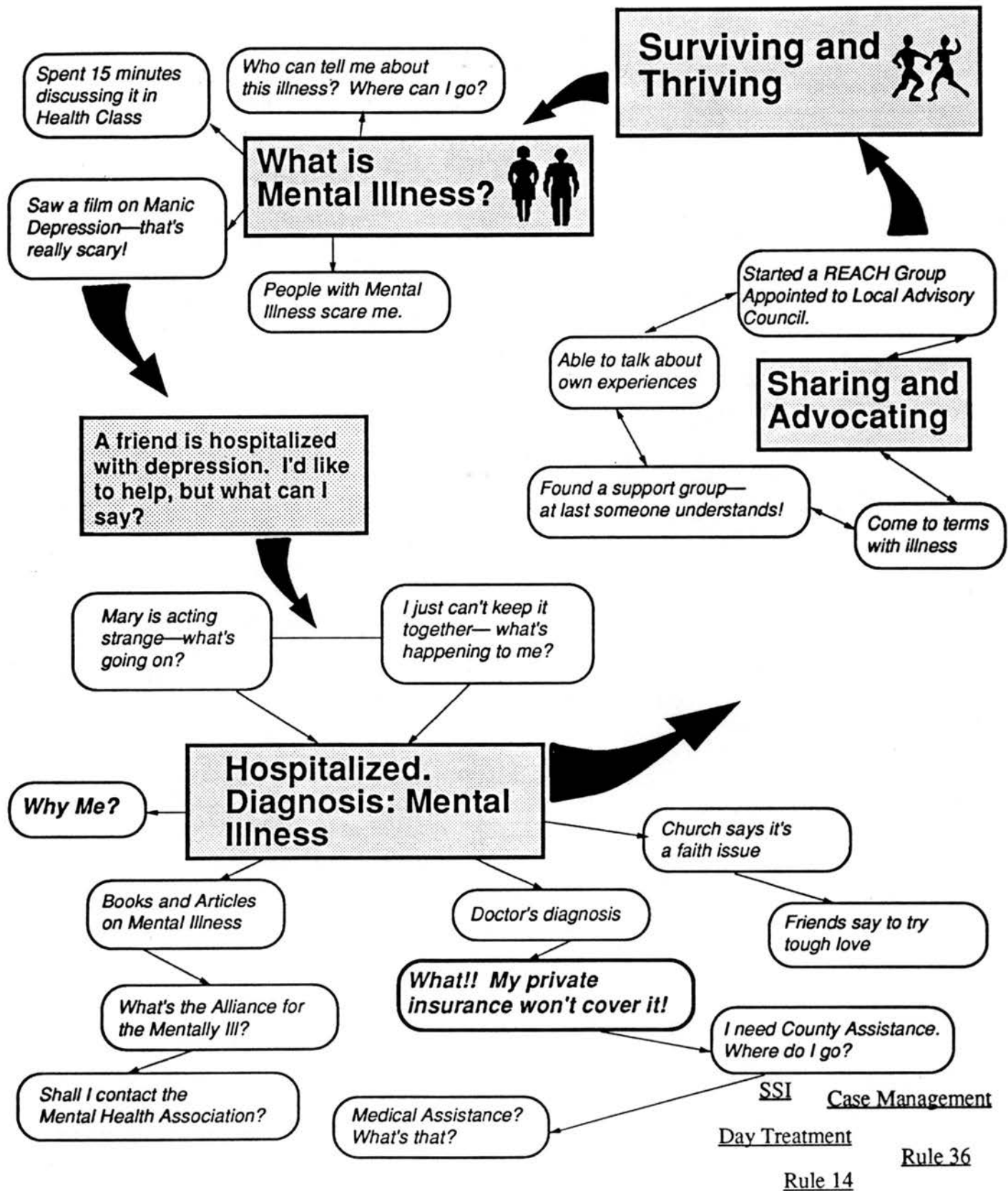
With the people at your table, discuss the example above. Why were you unable to express your feelings about it? Would you be more likely to say something now?

As with all learning, we are at different stages at different times. Look at the diagram on the opposite page. What stage of growth do you think you are in at this time? Ask yourself:

-
- This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

58

IT'S A HARD WAY TO LEARN



THIRD ACTIVITY

WATCHING THE MEDIA

TURNING MYTHS ABOUT MENTAL ILLNESS INTO REALITY AND UNDERSTANDING.

On the following pages are examples of words such as “nut” “unstable” “looney” “throwing a tantrum” and “funny farm” used in a way that is demeaning to people who are actually struggling with the symptoms of mental illness.

There is a letter written to a newspaper that points out what the writer sees as discrimination by an insurance company. A good project for an advisory council would be to respond to the use of language that reenforces the stigma of mental illness. A good example of this is the letter written by the Hennepin County Mental Health Advisory Council Media Committee.

LOOK THROUGH THE EXAMPLES THAT APPEAR ON THE FOLLOWING PAGES...SOME OF THEM YOU WILL FIND DISTURBING. BE PREPARED TO FEEL SOME ANGER.

Lest you become too judgmental about the perpetuation of stigma, ask yourself if, as family members or consumers, you have been reluctant to speak out because of the **stigma within yourself**. If you keep quiet because of that stigma, you miss the opportunity to show others by example that people with mental illness and their family members are credible and thoughtful people.

insty-prints® ORIGINAL
TANTRUM MAT

DIRECTIONS:

When
the need for
throwing a
tantrum is
felt, place
both feet
on the
space
provided
and jump
rapidly up
and down.

**3918 West Old Shakopee Road
Bloomington, Minnesota 55437**
Located at France Avenue & Old Shakopee Road
in the Penn Cycle building, next to McDonald's
881-0660

Incoherent screaming is also permissible. If
symptoms persist see your nearest psychiatrist
-You may be a nut.



Alliance for the Mentally Ill of Minnesota



State affiliate of
the National Alliance
for the Mentally Ill
(NAMI)

1595 Selby Avenue #103

St. Paul, Minnesota 55104

(612) 645-2948

Mr. Mike Meirovitz
Insty-Prints Inc.
World Headquarters
1010 So. 7th St.
Mpls. MN 55415

May 22, 1989

Dear Mr. Meirovitz:

Thank you for considering the concerns of our organization regarding the last two sentences on the Insty-Prints advertising piece "Tantrum Mat." I feel as if you fully understand our objections to the ad, and am pleased that you plan to relate those concerns to others in your organization so that an appropriate response can be taken. To reiterate what I mentioned over the phone about a possible response: A letter attached to the ad asking your local units around the country not to use the ad would be an excellent response.

From our point of view we continue to work to help change public attitudes about mental illness and the effort and treatment it takes to overcome these illnesses. One of our local groups is distributing buttons around Dakota County this month, for example, that say "May is Mental Health Month: Take Time For It." In all, we have 26 county affiliate groups working at the local level, doing what we do at the state level, which is to try to educate the public and encourage improved services for those affected. This effort is difficult to accomplish when the media, advertisers, etc. treat the idea of mental illness as if it didn't exist except in caricature. It is in fact real, painful, and disrupts the lives of millions.

I have enclosed some information on our organization and on the National Alliance for the Mentally Ill which has over 900 affiliate groups in the United States. I would also encourage Insty-Prints to consider printing pro-Mental Health slogans on their advertisements -- you'll make a lot of friends (nearly all of the affiliates use copying services to try to educate the public about mental illness).

Sincerely



Chuck Krueger
Public Information Coordinator

insty-prints®, inc.

FRANCHISOR OF COMMERCIAL QUICK PRINT & COPY CENTERS

1010 South Seventh Street • Suite 450 • Minneapolis, MN 55415

FAX (800) 369-1234 • FAX (612) 338-8074

(800) 779-1000 • (612) 337-9800

May 25, 1989

MAY 26 1989

Chuck Krueger
Alliance for the Mentally Ill of Minnesota
1595 Selby Ave.
St. Paul, MN 55104

Dear Mr. Krueger:

Thank you for bringing to my attention your concerns regarding the Insty-Prints advertising piece, "Tantrum Mat". On behalf of the entire Insty-Prints organization, I apologize for the distribution of a piece that has some offensive connotations. It has never been the position of Insty-Prints to distribute an advertising piece that has a negative or dual meaning, and we are truly sorry that the piece was distributed. The "Tantrum Mat" was included as part of the Insty-Prints direct mail program provided by Insty-Prints, Inc. to our many franchisees. As I mentioned during our telephone conversation, this piece was used in the May mailing package, and has a one time use only. The artwork will not be provided by Insty-Prints, Inc. to its franchisees for any future use, and in fact, Insty-Prints, Inc. will discourage its future use and inform all Insty-Prints franchise locations of the offensive connotations of this mailer and to discontinue use of the piece.

Mr. Krueger, once again I want to thank you for bringing this matter to my attention. Insty-Prints continues to work very hard at being a good member of the community and we do greatly appreciate your support.

Sincerely,

INSTY-PRINTS, INC.


Michael Meirovitz
Advertising Manager

MM/jlg

Anti-Stigma in Action

Insty-Prints Pulls Offensive Ad

A stigmatizing ad produced for and widely circulated by Insty-Prints has been pulled out of circulation after AMI of Minnesota brought it to the attention of Insty-Prints ad manager Mike Meirovitz at the company's world headquarters in Minneapolis.

The ad, called "Tantrum Mat" shows two shoe-sized footprints and states that if jumping up and down on the "mat" fails and "if incoherent screaming persists, see your nearest psychiatrist—You may be a nut."

According to Meirovitz, the ad was developed several years ago and until recently had been used mostly in the western United States. Since the company has over 300 outlets, the potential of the stigma perpetuated was very large.

Meirovitz responded quickly to the matter when it was brought to his attention. He then wrote back to AMI: "I apologize for the distribution of a piece that has some offensive connotations. The artwork will not be provided by Insty-Prints to its franchises for any

future use, and in fact, Insty-Prints will discourage its future use and inform all Insty-Prints franchise locations of the offensive connotations of this mailer and to discontinue use of the piece."

The Alliance's main complaint with the ad, of course, was that the ad infers that if you have problems you are probably "inchoerent and screaming" and that you must be a "nut" to seek help from a psychiatrist. To have this circulated by a printing business whose customers might find it "cute" and further photocopy it off for distribution is most alarming.

In summary, the Alliance takes exception to the media's growing tendency to represent mental illness as if it didn't exist except in caricature. It is in fact real, painful, and disrupts the lives of millions.

AMI is equally suprised and thankful that Insty-Prints listened with concern and a willingness to learn from our complaint, and then acted immediately to do something to correct it.

Mental Health Advocate — June/July '89 issue

Alliance for the Mentally Ill of Minnesota

1595 Selby Ave. #103
St. Paul, Minnesota 55104
(612) 645-2948



Box 215

Northfield, MN 55057

Ph. (507) 645-8175

January 8, 1992

Marketing Director
Post-It Notes
3M Creative Expression Products
P.O. Box 33594
St. Paul, MN 55133

Dear Sir or Madam,

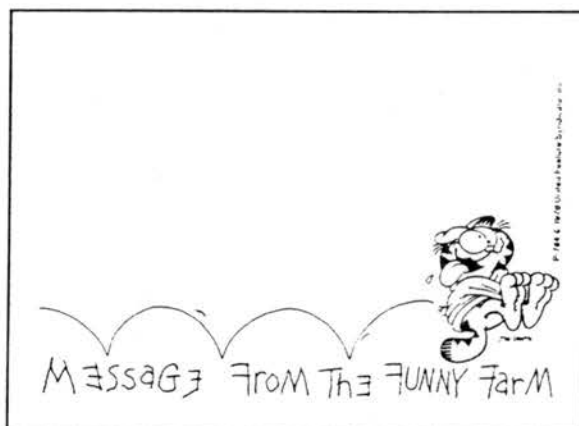
I find the message and image that this message brings to mind, very offensive. Society is quite sensitive to making fun of persons with physical handicaps, the developmentally disabled, or someone with a chronic illness like diabetes. We try not to make racist remarks or to show disrespect toward women. We would consider it very unacceptable to make fun of someone who is battling cancer, heart disease or diabetes.

So why are people who struggle to recover from mental illness fair game for a stupid cartoon and a message that is all scrambled and backward? As a person recovering from a mental illness, I find your **post-its** in very poor taste. Most informed people now realize that mental illness is a biological disease which can be treated. Like any other serious illness, it is a long and painful way to recovery. You make that recovery infinitely harder by promoting stereotypical misinformation about this illness.

Sincerely,

Marilyn Carver

Marilyn Carver
Board Member
Alliance for the Mentally Ill/Minnesota



IT'S A LOONEY BIN SALE!



Hundreds Of Bin-Stock Wallcoverings
Reduced 60% Off Normal Retail.

You'll love it! It's crazy! It's hundreds of bins of **in-stock wallcoverings** reduced **60% off list price**. All current-season patterns. All popular colors. All priced so ridiculously low—it's loonacy! Hurry to the Budget Paint & Wallpaper store nearest you and look for specially-marked looney bins. Book order discounts from **50-80%**. Window treatments reduced **half-off** or more! Hurry! Sale ends 4/25.

MINNESOTA'S
GREATEST
COVER-UP!

**Budget Paint &
Wallpaper**

STAR-TROBANK

P. 25

4-17-92

BLOOMINGTON 881-7858
(6 Blocks E. of Lyndale on 98th St.)

NORTHTOWN 785-1110
(Across from K-Mart on Hwy. 10)

PLYMOUTH 841-1483
(1 Mile W. of Hwy. 169 on Hwy. 55)

Store hours: M-F 9-9, Sat. 9-5, Sun. Noon-5 - Phone orders always welcome

HENNEPIN COUNTY MENTAL HEALTH ADVISORY COUNCIL
Barbara Flanigan CHAIRPERSON
2405 Sheridan Avenue South
Minneapolis, Minnesota 55405
(612) 374-2892

April 28, 1992

Budget Paint and Wallpaper
108 West 98th Street
Bloomington, Minnesota 55420

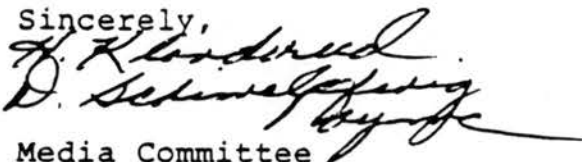
To Whom it May Concern:

The Media Committee of the Mental Health Advisory Council of Hennepin County is trying to eradicate words of stigma which unfairly target those persons who have a mental illness.

Your recent advertisement in the Star and Tribune (page 2B, April 17, 1992) is an example of using words of stigma. For years people have connected "looney bin" with a hospital for the mentally ill. It is time those words were put to rest. Your use of the words for an advertisement, with the picture of a loon, is inappropriate and thoughtless.

We hope that in the future you will find some more creative way to advertise your sales than to picture a loon which has nothing to do with a bin.

Sincerely,



Media Committee
HCMHAC
Helen Klanderud
Douglas Schimelpfenig
Co-Chairs

ADVERTISING WITH REAL BITE.

4 May 1992

Hennepin County Mental Health Advisory Council
Media Committee
2405 Sheridan Avenue South
Minneapolis, MN 55405

Dear Members of the HCMHAC Media Committee:

Thank you for your letter of 4/28/92 regarding Budget Paint & Wallpaper's spring "Looney Bin Promotion." I apologize for any perceived insensitivity on my part in using words of stigma which you would like put to rest. I understand your position and your concern.

In advertising, the use of familiar words, images and illustrations are devices used to invite people into a sales message, project a product/store image, and increase sales. Our '92 marketing plan was, and is, to establish Budget Paint & Wallpaper in the marketplace as a Minnesota-based company by use of a positioning statement: "Minnesota's Greatest Cover-Up." Maroon and gold store colors support this Minnesota theme. And the state bird, the loon, supports the Minnesota theme—while providing a platform to promote our main product—bin-stock wallcovering (stored in 750 bin receptacles per store) as an alternative to the notorious retail "Crazy Days Sales".

There was no intention to unfairly target persons with a mental illness through the "Looney Bin Promotion." However, your desire to eradicate words of stigma is a point well-taken. I will take a look at all future media advertising with this point in mind. Thank you for taking time to write and express your feelings on this matter.

Sincerely,



Susan Eckstrom, President
Abramson/Eckstrom & Associates

cc: Mr. Jeff Lien, Budget Paint & Wallpaper

A report from a survivor of the system

For most of my life, I've had a chronic and rather common medical problem. Four years ago, I decided it was time to face up to it. My condition wasn't improving any. It was getting harder and harder for me to function.

The specialist started me on an extended course of treatment, while warning that I shouldn't expect improvement overnight. How right that was. I was lucky in one important respect, though: I have relatively generous health insurance benefits through my husband's employer, so I could afford the treatment.

About a year and a half later, I was despondent. My pain was increasing. The doctor still held out hope, but was there really anything left to hope for?

Then came the letter from the insurance company terminating treatment. The letter said I wasn't getting anywhere, that I was as "well" as I would ever be.

I believed the insurance company. Those people surely knew what they were talking about. I would never be able to work again. I'd be in pain and agony the rest of my life.

After I got that letter, I nearly killed myself. I'll spare you the gory details, but I assure you that I was completely serious. Life wasn't worth living.

Cruel and unusual treatment by the insurance company? Not unusual, and not even deliberately cruel. Just an everyday use of a common double standard.

I don't have cancer, or heart disease, or lung problems. If I had any of those, my insurance company wouldn't have cut me off. My medical problem is more common than all of those combined, but it isn't considered worthy of the same level of support.

You see, my problem is depression. That

In my opinion

Gloria Stier



makes all the difference. Even when I was clearly suicidal, when I had been taken to a hospital in the Twin Cities by a friend, it took over three hours — three hours of argument by my therapist in Northfield and the admissions staff at the hospital — before the insurance company could be convinced that I should be admitted. Yet, I was probably as close to dying that day as a person who is suffering a heart attack.

Most insurance policies do not cover mental illness to the same extent as physical illness. Many people with health insurance have no financial protection at all against mental illness.

Even though one in five Americans — *one in five* — will suffer from mental illness at some point in their lives, only 20 percent of them will get professional care. Imagine if only 20 percent of cancer patients got professional care.

I am relatively lucky. I do have limited coverage, and eventually I was able to get the insurance company to reconsider.

But how many people have the energy, while suffering from a debilitating illness, to appeal a routine policy decision? How many people whose therapists are not as supportive and understanding, whose mental outlook is equally bleak. How many give up in the end? When suffering from depression, it is very easy to think that it isn't worth it, that things will never get

better.

Eventually, my body took revenge on the system. Last year, I developed a stomach ulcer, which ended up costing the insurance company more than \$2,300. That's the equivalent of 50 therapy sessions. It is only since I've been able to remember, and face, some of my past that my general stress level has gone down and my ulcer healed.

I'm feeling much better now. It took a good therapist, a lot of hard work, and help from friends, my husband, and God. Hopefully, I'll never go through severe depression again.

Now that I am in better shape than I can ever remember being, why am I writing this column? To ask you for your help in changing the system, and to provide you with more facts to help you decide.

- Only 2 percent of Americans with private health care coverage have policies that adequately and fairly cover severe mental illness.

- Only 37 percent of all health insurance policies provide inpatient coverage for severe mental illnesses comparable to coverage for other illnesses, and only 8 percent have comparable outpatient coverage.

Those terrifying statistics, and many others, are part of the findings in a Senate bill called the Equitable Health Insurance Coverage of Severe Mental Illness Act of 1992. This landmark piece of legislation was introduced in May by Sen. Pete Domenici of New Mexico. This federal bill calls for full parity in covering treatment of severe mental and physical illnesses.

How about the various state health care reform plans? Most of them incorporate the discriminatory policies which now exist in

most private plans. However, there is one approved state plan that provides equitable coverage for mental and physical illnesses.

The state of Oregon, when deciding to provide basic health care for all residents, ranked more than 700 medical conditions and treatments, considering the cost and effectiveness of treatment and the cost to society and individuals for not treating a condition. Coverage of treatment for most mental illnesses was found to be cost-effective, just as for most physical illnesses.

Oregon's decision to include mental health care in its master list of medical conditions was based on research which was summarized in a 1991 report from Oregon Health Services Commission. The report stated that:

1. The mind and body are inseparable...Many medical/surgical conditions have psychological symptoms...Many mental illnesses are at least partially caused by genetic or other biological factors.

2. Mental health...services are usually effective...These services improving functioning...and extend life...

3. Effective...care contributes to decreased utilization of other health services. Lack of...treatment...may create or exacerbate other health problems and may interfere with the treatment of those problems.

4. The costs of timely and effective treatment...are less than the health care costs of delayed treatment and are much less than the combined social and health care costs when treatment does not occur.

5. Attitudes such as stigma and denial...can cause providers and consumers

to avoid or delay appropriate treatment.

In Rice County there are about 650 children who are severely emotionally disturbed and 370 adults whose mental illness is severe and persistent. In any six-month period, another 5,000 adults would benefit from professional treatment for milder forms of mental illness.

Now, here's how you can help:

- Ask our legislators to support the Senate bill. This proposed federal law will help millions of people and will cut the overall cost of medical insurance and social programs.

National Alliance of the Mentally Ill is circulating a petition in support of the bill and hopes to collect a million signatures. In Northfield, copies of the petition are available at the reference desk at the public library. Sign the petition. Better yet, take a copy and ask others to sign.

- When someone you know is having emotional problems, act the same way as you would when a friend is physically ill. Show your concern, keep in touch, offer support. Be a good friend.

For more information, call me at 645-7674 or the Mental Health Coalition of Rice County at 663-8993.

Gloria Stier is treasurer of Mental Health Coalition of Rice County, a local affiliate of National Alliance of the Mentally Ill (NAMI) which is a grass-roots organization dedicated to changing public attitudes about mental illness, promoting self-help, affecting positive change in the mental health system and supporting research.

How to Do a Media Watch and How to Respond to a Offensive News Story, Ad, or Program

The following information on media watch was developed by the National Alliance for the Mentally Ill.

Organizing a Media Watch

Elect or appoint a "media watch" committee in your organization or community. Assign different people to monitor different media, including radio, TV, newspaper, magazines, etc. The committee should also develop procedures for reporting on both positive and negative coverage.

Involve the entire group or organization in the media watch process. Inform them how to document the story and the media watch representative to call.

Constructive Responses to an Offensive News Story, Ad, or Program

Responding by letter

Send a letter on the group's letterhead, signed by the group leader, whether the Advisory Council Chair or the advocacy group president or other representative.

Also send individual letters to illustrate that a number of people are concerned. If handwritten, make sure they are legible.

Make reference to the story or item about which you are writing. Give author, date, etc.

Be concise. Stay focused and current. Check your accuracy. Include supplemental brochures, fact sheets, etc. if it will help make your point.

Be positive and constructive. Avoid being rude, threatening, or self-righteous. Remember, if your letter should be published or read, you are really representing your organization and cause to the whole community. Thus, it is important to make a positive impression.

Use your own words and personalize your letter. Don't apologize for writing, which tends to undermine your argument. Instead, focus specifically on the issue.

Time your letter so that it arrives promptly while the issue is still current.

Responding with a meeting

Schedule a meeting between you and other members of your group, and the reporter or manager. Meetings can be either informal lunches or formal meetings at the reporter's office.

Understand mental illness
EVERY MIND MATTERS

Prepare for the meeting by determining the desired outcomes, the key people to influence, the strengths and weaknesses of the situation, the anticipated responses by the media, and some strategies for dealing with some of those likely responses. Rehearse key points and practice ways to effectively respond when they avoid or are defensive of your feedback.

Attend meeting, keeping your desired outcomes focuses and your key points prepared.

Remember to keep things in perspective. Approach the media with a level of action consistent with the significance of the issue. In other words, don't overreact.

Respect lines of authority. Contact the reporter directly and use this opportunity to build a relationship with the reporter. Then if the reporter is not responsive, contact his/her supervisor or editor.

Responding with increased public awareness

Distribute literature in public places, like church bulletins, shopping malls, local newsletters, etc.

Host a seminar with a reputable speaker. Develop publicity materials and encourage media coverage, via press releases and follow-up calls to editors and reporters.

Develop press releases or feature stories that take a more positive or accurate view of the issue.

Building Media Relationships

Gather information about all media in your area and the specific reporters that cover issues specific to your cause. Update the information annually.

Maintain information about reporters in a card file. Collect any vital information, as well as specifics of their type of coverage.

Send out press releases regarding your events and follow-up with reporters and editors to encourage coverage.

Remember to reward reporters or media that tell a positive story. Cultivate relationships by inviting them to speak at a meeting of your organization and present them with an award or certificate of appreciation. Or ask media representatives to serve on your advisory board.

TASK III: Still in your group look at the ads below.

As a group, write a letter to either of these merchants stating your objections to stigmatizing words. Focus on two main points to be made in the letter.

Appoint a scribe to write the letter on the form on page 70.

When the letter is finished, designate a member of your group to copy the letter, address the envelope and put it in the mail.

A NOTE OF CAUTION: IF YOU SPEND TIME BEING ANGRY AND TALKING ABOUT HOW INSENSITIVE AND STEREOTYPING THESE TWO EXAMPLES ARE—YOU WON'T FINISH YOUR LETTER!!!

DON'T GET MAD, GET TO WORK.



WE PROVIDE SUPPORT FOR UNSTABLE WOMEN.

With all our years of professional experience, it's no wonder we can handle almost any problem. Provided it's not emotional. **SHOE-A-NEW**

BRING THIS AD IN FOR \$2.00 OFF WIMMIN'S HEELS
(MEN'S AS WELL) EXP. JUNE 30TH

Chuck Ruehl Agency
6211 N.E. 5th Street
Fridley, MN 55432



Lunatik
612 West Lake Street
Minneapolis, MN 55408

MEDIA WATCH LETTER

Your name
Your address
City, State, Zip

Correct Title of Marketing Director, Pres.
Company, Radio Station, Newspaper, etc.
Address
City, State, Zip

Date

Dear:

Sincerely,

ASSIGNMENT #1 FOR NOVEMBER

RECORD STIGMA PRODUCING ADS, NEWS ARTICLES, RADIO OR T.V. SHOWS OR STATEMENTS
MADE BY OTHER PEOPLE

YOUR NAME: _____

Stigmatizer's Name: _____

Street Address: _____

City, State, Zip: _____

Copy and date of ad, news article, name of t.v. or radio show, description of statement made:

Your response: _____

(Did you write, call, try to explain the misperception — or do nothing.)

If you responded by letter, telephone, or verbal explanation, give the date
of response: _____

Please send to:

NIMH CONSUMER/FAMILY TRAINING PROJECT

MEDIA WATCH

League of Women Voters

550 Rice Street

St. Paul, MN 55113

ASSIGNMENT #2 FOR NOVEMBER

FIND OUT THE POSITION OF YOUR PUBLIC REPRESENTATIVE REGARDING MENTAL HEALTH SERVICES

Review pages 25-28 in "Past Workshop" section before you begin this assignment

Attend a candidates forum if possible. Listen carefully during the question period, you may want to ask your candidate about a mental health issue that is important to you.

For example:

STATE CANDIDATE:

Health insurance is a state and national issue at this time. Many insurance plans limit the amount that can be spent for mental illness. Do you think this is discriminatory?

COUNTY COMMISSIONER:

Do you think our county has adequate services available in the community for persons with serious and persistent mental illness? Will you support community services for persons with mental illness if there are cuts in funding?

I attended a candidates forum and asked the following question about mental illness:

_____ I attended a candidates forum in my area, but did not ask a question.

_____ There were no candidate forums in my area.

_____ I sent the candidates a letter asking my question.

_____ I sent the candidates the public education sheets included in Training Session III of this workbook. (Be sure to include a personal note about why you are sending the information.)

Was there a response? _____

Your signature: _____ Date: _____

Send to:

NIMH CONSUMER/FAMILY TRAINING PROJECT
CANDIDATE WATCH
League of Women Voters
550 Rice Street
St. Paul, MN 55113

**LWV NIMH CONSUMER/FAMILY
LEADERSHIP TRAINING
NOVEMBER, 1992**

SCHEDULE FOR THE DAY

9:45-10:00 a.m.	Sign In. Coffee and Donuts.
10:00 a.m. (sharp)	Introductions and Report from Participants on "Watching the Media" or "Attending a Candidate Forum"
10:30-11:30	First Activity: Notebook Review (pages 77-79)
11:30-12:15	Second Activity: Group Process: Effective Governance (pages 80-83)
12:15-1:00	LUNCH. FREE TIME.
1:00-2:00 p.m.	Third Activity: The Art of Listening (pages 84-87)
2:00-3:00 p.m.	Do's and Don'ts of Advocacy (page 88)

STIGMA

and

MYTHS

Myths create stigma, and stigma keeps myths alive.

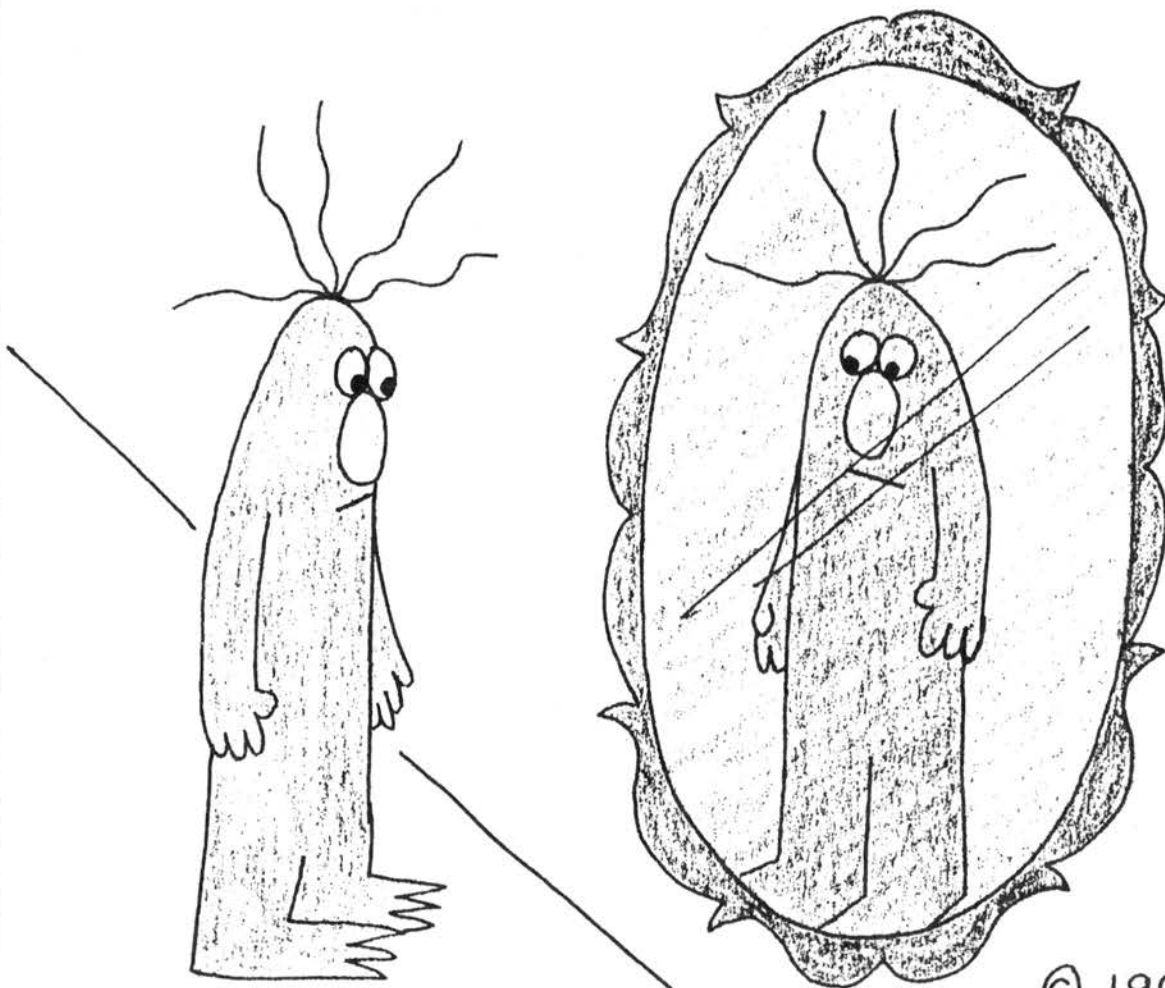
"Bently", in these pictures depicts some of the stigma and myths connected with mental illness. The term **MI** is not used as a means to offend anyone. It is used to further depict the stigma of mental illness.

Sherry (Bently) Shappell

Sherry Shappell is a participant in the Brainerd NIMH Training Sessions.

She says it for us all!!

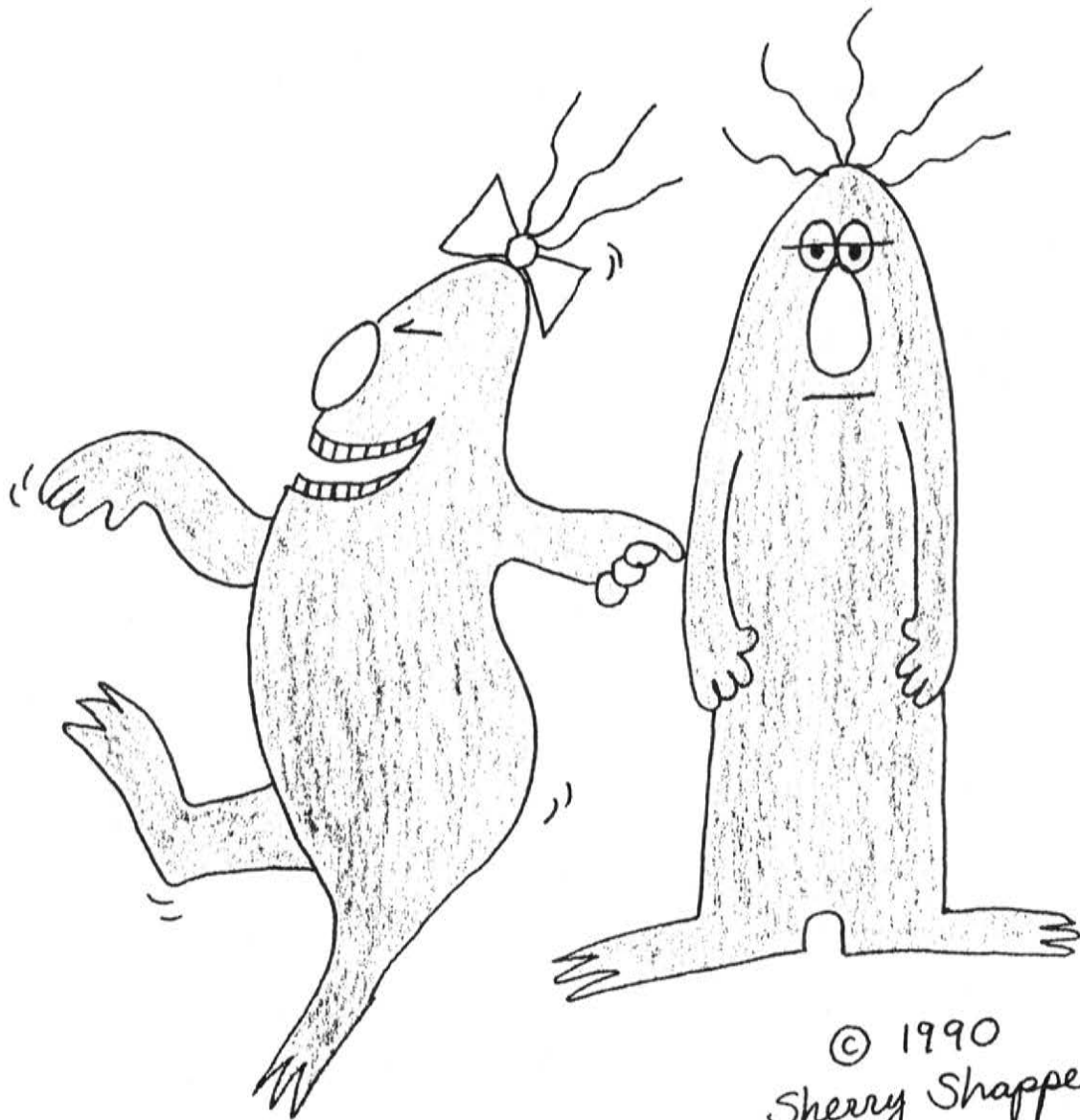
For copyright information, call Sherry at (218) 828-9338



© 1991
Sherry Shappell

Ever wonder what
an **MI** looks like?

Don't touch an **MI**, you
might catch something.



© 1990
Sherry Shappell

TRAINING SESSION IV

NOVEMBER 1992

MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

NOTEBOOK REVIEW

IT'S ALMOST HALFWAY TIME!!!
TIME TO REVIEW, REFLECT, AND ASSESS.
Lets do it together.

Task 1: We have covered a great deal of material. Some project participants have attended all training sessions for this project. Other participants joined after the sessions were underway. This is a good time to bring everyone up to date. Today, we are going to review all the material in your notebook.

As the material is reviewed, please note what specific material has helped you in the following way:

1. to have a better understanding of your own mental illness or the illness of a family member.
2. to have a better understanding of the local or state mental health system.
3. to gain confidence and increase your motivation to educate other people about mental illness.
4. to better understand the group process and how it effects your participation on your local advisory council.
5. to increase your sense of personal empowerment.
 - in your ability to speak up in groups.
 - in your awareness of the importance of listening in groups.
 - in an enhanced confidence in your relationship with peers, leaders, or supervisors.
 - in your better understanding of the stigma about mental illness, especially the stigma that you carry within yourself
6. to have a better understanding of the role of LACs.
7. to see the power that can come through networking with other mental health organizations.

understanding of MI _____

understanding of mental health system _____

educate others _____

group process _____

personal empowerment _____

role of LAC _____

networking _____

What aspect of the training has been most helpful to you?

List below issues or skills that you feel are important that have not been covered so far in the NIMH Training and have not been listed in the "future topic" questions.

Task 2. In a small group, talk about what you have written above. Before beginning.

1. each group should assign a scribe to summarize the group discussion; and
2. each group will **decide how much time will be given for each person to talk and how much time the group wants for general discussion.**

Group discussion will last 20 minutes, then each group will give a summary of their discussion.

SECOND ACTIVITY

GROUP PROCESS: EFFECTIVE GOVERNANCE

**WHAT HAPPENS TO INDIVIDUALS IN A GROUP
WHEN THEY COME TOGETHER WITH A COMMON GOAL,
SHARE PERSONAL EXPERIENCES, FRUSTRATIONS, AND DREAMS?**

SOMETIMES THEY BOND!

INDIVIDUALS IN THE GROUP MAY EXPERIENCE PERSONAL GROWTH.

AND THEY JUST MAY GO OUT AND ACCOMPLISH AMAZING GOALS.

So, let's take a look at ourselves! From looking at this group, we can learn how groups function. This can help LAC members as they "grope," "gripe," and "grasp," in an attempt to identify the purpose of their council and to discover how to achieve their stated purpose. As council members wrestle with problems and begin to understand their individual differences, they will eventually "group." In the "grouping" process comes the tapping of the energy and resources of the people who make up the council.

**We can evaluate our NIMH Training Group in the same
way that we might later evaluate our LACs.**

Task 1. Rate this NIMH training group by using the "Evaluation Form – Group Process" on pages 81 and 82.

Using the ten variables on the evaluation form, list the three areas that you gave lowest marks:

1. _____
2. _____
3. _____

GROUP PROCESS
GROUP SELF-EVALUATIONS

EVALUATION FORM - GROUP PROCESS

Should your group wish to analyze its progress, have each member rate each variable independently on a scale from 1 to 5.

1 = Missing Completely

5 = Operating Ideally

1. LISTENING

Members don't really
listen to one another--
they interrupt and don't
try to understand others.

1 2 3 4 5

All members really
listen and try hard
to understand.

2. OPEN COMMUNICATION

Members are guarded or
cautious in discussions.

1 2 3 4 5

Members express both
thoughts and feelings
openly.

3. MUTUAL TRUST AND CONFIDENCE

Members evidence suspicion
of one another's motives.

1 2 3 4 5

Members trust one another
and do not fear ridicule
or reprisal.

4. ATTITUDES TOWARD DIFFERENCES
WITHIN GROUP

Members avoid arguments,
smooth over differences,
suppress or avoid
conflicts.

1 2 3 4 5

Members search for,
respect, and accept dif-
ferences and work through
them openly--they are not
pressured to conform.

5. MUTUAL SUPPORT

Members are defensive
about themselves and
their functions.

1 2 3 4 5

Members are able to give
and receive help.

GROUP PROCESS
GROUP SELF-EVALUATIONS

6. INVOLVEMENT-PARTICIPATION

Discussion is dominated
by a few members.

1 2 3 4 5

All members are involved,
free to participate in
any way they choose.

7. CONTROL METHODS

Subject matter and deci-
sions are controlled by
the chairperson.

1 2 3 4 5

All members accept
responsibility for pro-
ductive discussion and
for decisions.

8. FLEXIBILITY

The group is locked in
on established rules and
members find it hard to
change procedures.

1 2 3 4 5

Members readily change
procedures in response
to new situations.

9. USE OF MEMBERS RESOURCES

Individuals' knowledge,
abilities, and experience
not utilized.

1 2 3 4 5

Each member's knowledge,
abilities, and experience
are fully utilized.

10. OBJECTIVES OR PURPOSES

Objectives are not clear
or not understood and
there is no commitment
to them.

1 2 3 4 5

Objectives are clear,
are understood, and
there is full commitment
to them.

Reference:

Field Associate Guide to Rural Development, Northwest Regional Educational Laboratory, 1978.

GROUP PROCESS
GROUP BEHAVIOR

Supplement E
EFFECTIVE GROUPS

 **Family
Community
Leadership**

Task 2. Having as individuals, identified some problem areas in this group in Task 1, can we, as a group, establish some rules that might lead toward better communication and more effectiveness within our group? Do we have any unspoken rules?

GROUP RULES

1. (Established at first training session.) Complete confidentiality. Any personal story shared in this group remains here.

2. _____

3. _____

4. _____

5. _____

THIRD ACTIVITY

THE ART OF LISTENING

Our training has emphasized the importance of speaking out in groups and responding orally to issues that are important to you. Just as important as **being heard** in a group is being able to **listen**. The inability to actively listen can create a huge barrier in communication. How often do we **think we heard**, but find we misunderstood what was said? And how often do we ask if **what we heard is actually what was said?**

POSITIVE ATTITUDES THAT AID LISTENING:

1. **EMPATHY.** This shows a desire to understand the thoughts, feelings and positions of the other person. This does not mean that the listener should have the same feelings and positions as the speaker, just that the listener understands the speaker.

2. **ACCEPTANCE.** Acceptance is toward the individual and not necessarily toward what the speaker represents. It does not mean that the listener agrees with the actions, ideas, and values of the speaker. Acceptance shows a willingness to let the other person feel the way she/he does. People feel the way they do because of the experiences they have had. Trying to understand the reason for the feelings rather than being judgmental about them is respectful and leaves the way open for compromise.

3. **FEEDBACK OR REFLECTION.** This is the process in which the listener relates back to the speaker the content or feelings conveyed. This process helps the listener understand. The listener might check his/her understanding by using such phrases as...

The way I understand you is...

Are you saying...

You sound as though..

I get the feeling that...

The main purpose is to understand the speaker—not to belittle, mimic, or antagonize.

4. **USE OF CREATIVE SILENCE.** Many times the listener short-circuits communication by becoming overly anxious about silence. The speaker may be thinking. Allow her/him time to collect thoughts and feelings. Don't jump in too fast. Silence can be equally productive for the speaker and the listener.

Review "Aids to Communication" on Page 35 of "Past Workshops."

Task 1. Most of us think of ourselves as good, attentive listeners. Look over the following list. Do any of these descriptions apply to you?

IN LISTENING TO A SPEAKER, DO I...

- **DECIDE EARLY THAT THE INFORMATION IS USELESS?**
- **MENTALLY PRACTICE MY REPLY?**
- **LOOK FOR FLAWS SO I CAN “CLOBBER THE SPEAKER”?**
- **CONCENTRATE ON MINUTE DETAILS?**
- **GET NERVOUS IF IT’S QUIET?**
- **BECOME BORED, MAKE OUT SHOPPING LISTS, DOODLE?**
- **TURN OFF DURING THE TECHNICAL PARTS?**
- **GET PULLED IN BY EMOTIONAL WORDS?**
- **AUTOMATICALLY TURN OFF WHEN EMOTIONAL WORDS ARE USED?**
- **ASK QUESTIONS JUST TO MAKE MY POINT?**
- **BECOME PREOCCUPIED BY A SPEAKER’S MANNER, DRESS?**
- **NOT LISTEN IF I DON’T AGREE?**

In the September training session, we talked about stigma and stigma-perpetuating language. Participants in that session expressed a variety of ways that they deal with stigma. Some people said that stigmatizing language made them angry and they wanted to speak out about it. They chose to educate people who didn't understand mental illness by pointing out what highly loaded words like "crazy," "lunatic," and "looney bin," could mean to a person with mental illness and their family. Others said they dealt with such language by actually adopting it to describe themselves (which is an appropriate use of the language). The effect of such use is that it makes the words less personal and less powerful if the individual described by them can laugh at those words. As with many emotional issues, in talking about stigma, people responded in many ways.

Some participants said that the discussion encouraged them to think about the stigma that can be conveyed by language. A number of participants shared stories about how words used by people who do not understand what mental illness is were belittling and painful to them. The next task asks you to recreate an incident in which stigmatizing language effected what you thought of yourself as a person.

Task 2. Write a one or two minute account of an experience in which you felt stigmatized. Try to write your thoughts in as few words as possible. FOCUS in on a single experience and a single feeling.

Task 3. Once again, in a small group, share what you have written, if you feel comfortable doing so.

Listeners, pay particular attention to the person who is speaking by:

1. Giving the speaker (or teller) your complete attention.
2. Letting the person tell his/her story without interruption.
3. Waiting it out if there is silence.
4. Waiting until the person is finished, if clarification is needed.

Try consciously to be aware of:

1. Your **empathy level.**
2. Your own **acceptance of what is being said.**
3. Your acceptance of silence

Did complete concentration on listening make a difference in hearing the person, relating to the person, and accepting of what the person said?

Do you think you are a good listener? _____

How could you become a better listener?

Do's and Don'ts of Advocacy:

How to Make Your Voice Count

By Laurie Flynn

NAMI Executive Director

How to advocate:

1. Personalize the horror of mental illness. It is better to say, "John slept on a park bench last night because not enough housing exists" than to say, "More housing should be built for the mentally ill." Personalize the effects government neglect is having on your relative.

2. Look for political power. If you are not getting political power at a meeting, don't go to it, because then you are giving power away. The providers and officials need us to support their programs. Unless they genuinely listen to what we are telling them, we must not let them use us as window-dressing for their programs. Meetings take up too much time for us to attend those that are not useful to us.

3. Claim your power as representatives of consumers and patients. We are the voice of those who use services, not run them. Maintaining our identity as families and consumers gives us credibility.

4. Confront failure. If the system messes up, we cannot be afraid to tell them so. No one else will do it if we don't.

5. Be an absolutist in principle, but a pragmatist in practice.

6. Don't give up the fight—ever! Persistence is power for changing the system.

Several types of members may get in the way of improving care:

1. The Nice Person. These folks value being liked by the providers and officials more than improving care for the mentally ill people.

2. The Whiner. This person would rather whine and complain than generate plans for improving the problem.

3. The Clinging Vine. This person expects others to do the work; he or she is just along to receive support rather than to offer much in return.

4. The Victim. This person is the silent, long-suffering victim who would rather maintain this role than do something about it.

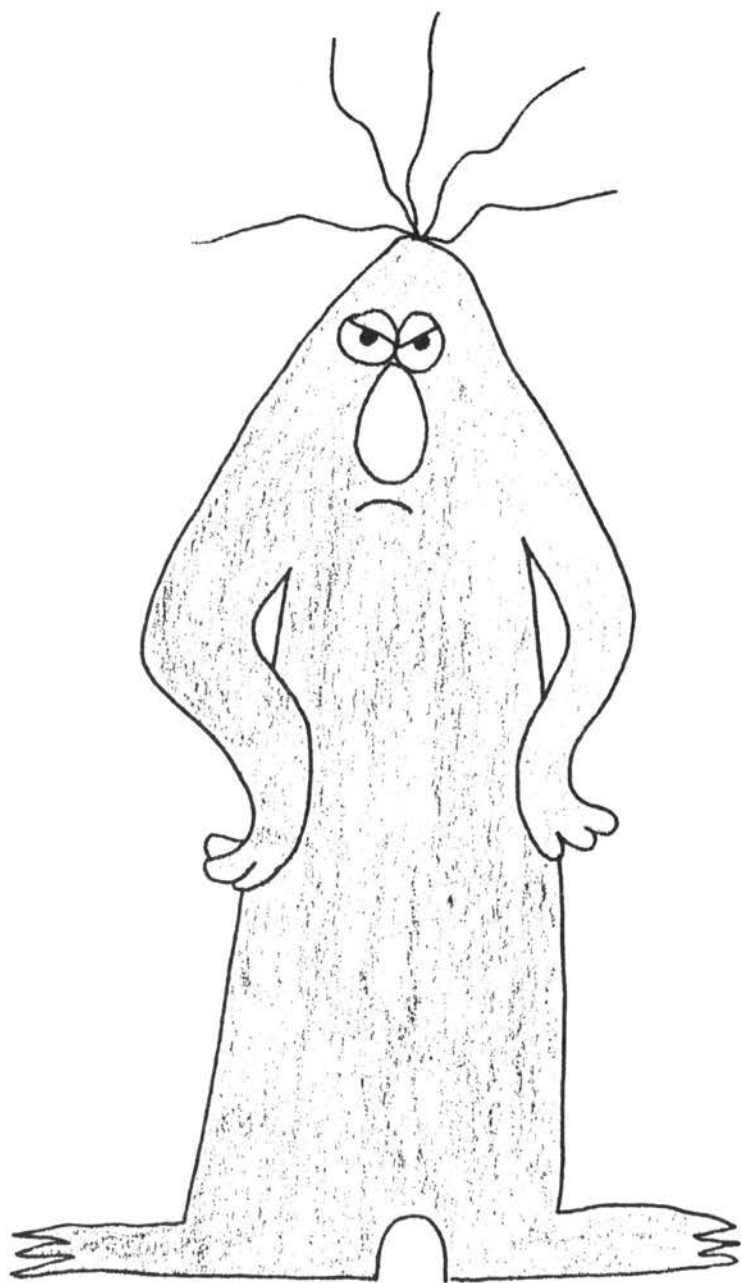
5. Visiting Royalty. This person wants everything to change instantly but doesn't want to get involved in making it happen.

6. The Waiter. This person sits and waits for change, waits for promises to be kept that politicians and officials have no intention of keeping.

7. The Bomb Thrower. This person writes frequent angry letters, but never suggests a plan for alleviating the problem. He never follows up on the letters.

8. The Scaredy Cat. This person doesn't advocate because he is afraid the officials will take it out on them or their relative.

9. The Appeaser. This advocate settles for far too little, and expresses great thanks for only minor improvement. ☺



If you
can't be
with me in
my lows,
don't mess
around
with my
highs.

© 1989
Sherry Shappell

**LWV
CONSUMER/FAMILY TRAINING SESSION
FEBRUARY, 1993**

SCHEDULE FOR THE DAY

9:45-10:00 a.m.	Sign in. Coffee and Donuts.
10:00-10:30	New Materials Distributed. Check-In from Advisory Councils.
10:30-11:15	First Activity: Community Support Program.
11:15-12:15	Guest Speaker, Questions, Discussion.
12:15-1:00	LUNCH. FREE TIME
1:00-2:00	Second Activity: State Mandated Mental Health Services
2:00-2:30	All-State Conference for LWV NIMH Project, Spring, 1994
2:30-3:30	Third Activity: Goal Setting and Evaluation. Catch-up Time for New Participants.

TRAINING SESSION V

FEBRUARY 1993

MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

COMMUNITY SUPPORT PROGRAMS

*Services That Help People With Mental Illness
Live In Their Home Community*

The Community Support Program (CSP) of the National Institute of Mental Health (NIMH) was established in 1978 as a new federal program to address unmet needs of persons with serious and persistent mental illness. The NIMH model differed from the traditional medical model followed at the time. The CSP program required eight specific services aimed at keeping persons with long-term mental illness in the community. The strong social support included in the CSP model is thought now to lessen the need for hospital stays for some patients and help reduce the number of hospitalizations for clients who need intensive care when their illness cycles.

Before the Comprehensive Mental Health Act was passed in Minnesota in 1987, only 40 of 87 counties had any kind of CSP program in place. Presently county boards must see that CSP services are provided to meet the special needs of adults with serious and persistent mental illness. Though all mandated services are required up to "available resources," the 1992 Report to the Legislature from the Department of Human Services states that "all 87 counties in Minnesota now make most of the eight CSP services available to their residents." The eight mandated CSP services are listed on page 92.

CSP services, particularly psychosocial rehabilitation, tend to focus on clients' wellness, rather than their illness. CSP programs are funded by Rule 14 state funds (90 percent) with a ten percent county match and may be supplemented by additional county levies.

DRS

(Division of Rehabilitation Services of MN Jobs and Training)

DRS and CSP programs overlap to some extent. The Mental Health Division of the Minnesota Department of Human Services and DRS are currently attempting to encourage systematic coordination of vocational services for persons with serious mental illness. DRS, funded with federal and state monies, is charged with aiding persons with disabilities, including psychiatric disabilities, in training and finding employment. Services are time-limited and outcome oriented.

While CSP Services and DRS vocational services sustain persons with serious mental illness in the community, they are administered by separate agencies which are structured and funded quite differently. CSP services are funded by state and county dollars (Rule 14 and CSSA money and county levies). DRS vocational services are funded by federal and state dollars and DRS requirements and practices are determined in considerable part by federal requirements and guidelines.

The "development of employability and work-related opportunities" is a mandated service for CSP programs, but more formal vocational services are provided by DRS. Successful employment for persons with mental illness provides structure and heightens self-esteem as well as increasing income.

Eligibility for CSP programs and vocational programs in many counties is limited to persons with serious and persistent mental illness. SPMI is specifically defined in the Comprehensive Mental Health Act. To understand the eligibility for services in the county system, it is important for members of local advisory councils to know the legal definition of "serious and persistent" mental illness. The statute defining serious and persistent mental illness appears on page 91.

Much of the material on these pages is taken from the
League of Women Voters of Minnesota Education Fund CSP Vocational
Mental Health Monitoring Program, 1993

Task I: The statute printed below is in your workbook, Mental Health Act, page 5. With the leaders, read below the definition of:

- (a) mental illness, and**
- (c) serious and persistent mental illness**

245.462 DEFINITIONS.

Subd. 20. Mental illness.

(a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the (ICD-9-CM), current edition....or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition....and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness: means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

- (1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;
- (2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;
- (3) the adult:
 - (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or border line personality disorder;
 - (ii) indicates a significant impairment in functioning; **and**
 - (iii) has a written opinion from a mental health professional stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless an ongoing community support services program is provided; or
- (4) the adult has been committed by a court as a mentally ill person under chapter 253B, or the adult's commitment has been stayed or continued.

Task II: With other people at your table, use the working sheet on the opposite page to identify the “basic needs” and the “comfort needs” of a person with serious and persistent mental illness. Match these needs with the CSP services listed above.

**CSP SERVICES MANDATED
BY THE MINNESOTA
COMPREHENSIVE MENTAL HEALTH ACT***

- client outreach: locate clients and inform them of available services
- medication monitoring
- assistance in independent living skills
- development of employability and work-related opportunities
- crisis assistance
- psychosocial rehabilitation
- help in applying for government benefits
- housing support services
- day treatment

* services required up to “available resources.”

“Basic Needs”

“Basic needs” are the very basic requirements for a person with a serious mental illness to survive. They include food, shelter, etc.

- 1.
- 2.
- 3.
- 4.

Community Support Services that address “basic needs”:

“Comfort Needs”

“Comfort needs” are those that are important for quality of life. They may include comfortable housing or a place to socialize. The need for psychotropic medication and the monitoring of that medication may be a “basic need” or a “comfort need.” Where does client empowerment belong?

- 1.
- 2.
- 3.
- 4.

Community Support Services that address “comfort” needs:

Task III: Presentation by CSP worker. The speaker will discuss the philosophy of the CSP program and the day-to-day challenge of providing required services with limited resources.

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Although consumer-run programs are becoming more and more common in other states, very few exist in Minnesota. There is, however, a growing effort to include consumers in decision making and to employ consumers when possible in programs that provide mental health services. Some residences such as Vail Place are run on a "clubhouse model" that builds on the strengths and wellness of its members and is operated as much as possible by its members.

The following outline of a consumer-run CSP program is taken from Models of Community Support Services by Beth A Stroul, National Institute of Mental Health Community Support Program: 1986, p. 49.

CONSUMER-RUN CSP PROGRAMS

In some states selected CSP programs follow the consumer-run alternative model in which services are planned, administered, delivered and evaluated by consumers. Such services are based on the belief that no one knows what their needs are better than consumers themselves. Consumer run alternatives strive to create non-bureaucratic, non-hierarchical structures.

Principles for consumer run alternatives:

- The service must provide help with needs as defined by the clients.
- Participation in the service must be completely voluntary.
- Clients must be able to choose to participate in some aspects of the service without being required to participate in others.
- Help is provided by the clients of the service to one another and may also be provided by others selected by the clients. The ability to give help is seen as a human attribute and not as something acquired by education or professional degrees.
- Overall direction of the service, including responsibility for financial and policy decisions, is in the hands of service recipients.
- Clients of the service must determine whether participation is limited to ex-patients or is open to all. If an open policy is decided upon, special care must be taken that the non-patients do not act oppressively toward the ex-patients.
- The responsibility of the service is to the client and not to relatives, treatment institutions or the government. Information about the client must not be transmitted to any other party without the consent of the client, and such information must be available to the client.

SECOND ACTIVITY

STATE MANDATED MENTAL HEALTH SERVICES AT THE COUNTY LEVEL

The 1987 Minnesota Comprehensive Mental Health Act describes a local delivery system that uses all available resources to develop a coordinated system of affordable adult mental health services. County boards are responsible for providing a "full array of services" to people with serious and persistent mental illness who reside in their county up to "available resources." (Workbook, Mental Health Act, section 245.466, "Local Service Delivery System," page 9.)

Mandated services (including CSP programs) may be provided by a contracting agency or directly by the county. In some counties services are provided by a variety of agencies. Funding, as we have discovered in earlier training sessions, comes from many sources. As a result of the many elements involved, people with serious and persistent mental illness sometimes are not matched-up with appropriate services. It is not uncommon to hear the expression that eligible people were not provided the services they needed because they "just fell through the cracks." In many instances inadequate resources make it impossible to provide services to all persons with serious and persistent mental illness who need them.

A vigilant LAC should be aware of mandated services that are not available in their county or services that are not as effective as they could be. Because county boards oversee many departments and services, it is almost impossible for each commissioner to be well informed about mental health issues. The local advisory council, which is responsible for reporting to the county board about mental health needs, is the logical body to keep a county board informed regarding mental health programs. The board needs to know the mental health programs that are run effectively and make good use of county dollars. To properly advise the county board on mental health matters, LAC members must know **which mental health services must be provided by the county.**

MANDATED SERVICES APPEAR ON THE OPPOSITE PAGE.

SERVICES THAT EACH COUNTY MUST PROVIDE:

- ☐ emergency services
- ☐ education and prevention services
- ☐ outpatient services
- ☐ community support program services
- ☐ residential treatment services (Rule 36)
- ☐ acute care hospital inpatient treatment services
- ☐ regional treatment center inpatient services
- ☐ screening for inpatient and residential treatment
- ☐ case management

**These services are defined in the workbook, Mental Health Act, section 245.462, page 1.
All services are mandated up to "available resources."**

A county may show cause not to provide a mandated service. The Mandate Reform Act, passed in 1991, allows counties to receive a waiver from providing a mandated service if compliance is financially impossible. (Workbook, Mental Health Act, page 55)

The Mandate Reform Act also allows counties to provide services in a manner that encourages creative use of that county's resources. The county may choose to combine services or design them in a way that suits their particular purpose. These provisions in the Mandate Reform Act allow demonstration projects to test models that are less complex and costly to administer.

Task I: Discuss with participants from your county the mandated services listed on page 97. Decide as a group the availability of mandated services in your county as follows:

- ☒ This service is available in my county
☐ This service is not available in my county.
☐ We (I) are not sure if this service is available in my county.

Our county has received a waiver for the following services. (In some counties day treatment has received a waiver.)

1. _____
2. _____

Task II: The 1992 Mental Health Report to the Legislature states that "the provision of locally available mental health emergency services is the highest priority of the Adult Mental Health Act." With the help of the leader, list the specific services that are included under emergency services. (Workbook, Mental Health Act, page 12.)

Do you agree that emergency services should be the highest priority in your county?
Yes ___ No ___

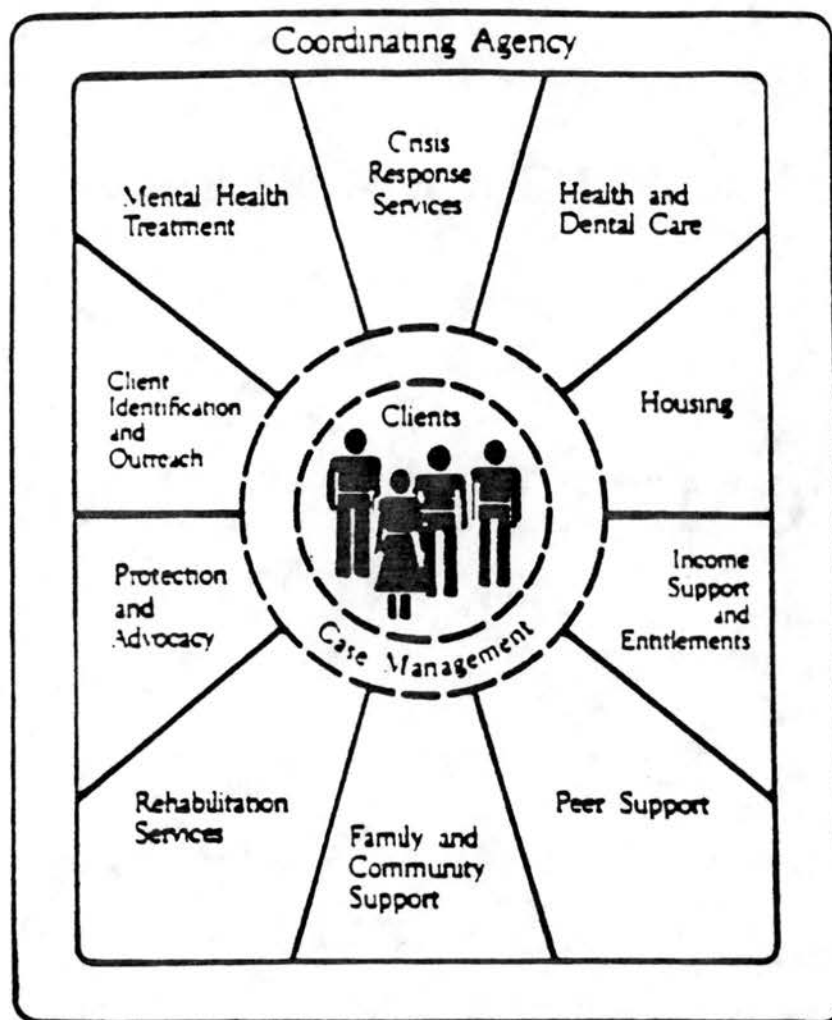
How do "emergency services" differ from "crisis assistance" which is a component of CSP?

REFERENCE MATERIALS

**COMMUNITY SUPPORT
SERVICES**

The community support system model below includes some services that Minnesota community support programs do not require. Notice that this model includes case management as an integral part of a suggested system of support. Are there other services in this model that are not included in Minnesota CSP programs?

COMMUNITY SUPPORT SYSTEM



The National Institute of Mental Health defines a Community Support System as "an organized network of caring and responsible people committed to assisting persons with long-term mental illness to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community. The CSS concept includes the entire array of treatment, life support, and rehabilitation services needed to assist persons with severe, disabling mental illness to function at optimal levels within the community. Accordingly, the CSS concept delineates an array of essential components."*

*Models of Community Support Services, Beth A. Stroul, National Institute of Mental Health Community Support Program. 1986.

CSP: Program of Firsts

Reprinted from *Innovations & Research*

Volume 1, Number 1. December 1991, page 8.

National Alliance for the Mentally Ill

....CSP [The Community Support Program] was established at the National Institute of Mental Health (NIMH) in 1978 as a new federal program concept which used modest funding support to states to stimulate pivotal systems changes and a new service delivery concept based on rehabilitation principles. The early founders recognized the need for individuals with psychiatric disabilities to have access to a comprehensive array of services and supports linked through something called "case management." Through its guiding principals and values, the Program introduced new words into mental health such as "respect," "choice," "positive attitudes," "dignity," and "empowerment," while rejecting other words such as "chronic," "limited" and "patient." Although new and strange and resisted by many, these concepts gradually gained acceptance and are now familiar to the mental health field.

To further rehabilitation in mental health, CSP forged the first formal linkage with the Rehabilitation Services administration, which resulted in co-funding the first rehabilitation research and training center in psychiatric disability at Boston University. The federal interagency agreement inspired new agreements at state and local levels, which increased the availability of vocational rehabilitation services for individuals with psychiatric disabilities.

In 1984, as vocational and social rehabilitation were gaining recognition and acceptance in the field, CSP again pushed forward and supported the early efforts...to incorporate rehabilitation principles into approaches to meet the housing and support needs of people with psychiatric disabilities. This evolved into the now familiar "supported housing" approach....The mission statement [from the supported housing studies] stimulated the first serious state and local planning efforts to increase decent, affordable, integrated housing for mental health clients.

....beginning in the early 1980s, the Program focused attention on the emerging consumer/ex-patient movement. Together with consumer/ex-patient leaders throughout the nation, CSP championed active roles for people diagnosed with a mental

illness, promoted self-help/mutual support approaches, and insisted on empowerment as a basic principle in all aspects of services....self-help and mutual support approaches, and opportunities for employment within the mental health system are burgeoning throughout the nation.

....In 1985 and 1986, staff recognized that certain population groups had unique problems and needs and supported the first service demonstration projects for individuals with psychiatric disabilities who were homeless, elderly, and who had substance abuse problems. One of the most innovative and successful projects supported by CSP was the first demonstration of a supported learning approach in a normalized college setting for young adults with severe psychiatric disabilities. Conducted at Boston University by the Center for Psychiatric Rehabilitation, this approach is now being replicated in other sites around the nation.

Understanding the need for collaboration to address the problems of fragmented and non-existent services, CSP from its inception used the unusual approach for a federal program of convening participatory planning meetings. These brought together all the key players including, for the first time, family members and primary consumers who understand the needs and problems firsthand. They were able to interact with and educate the researchers who produce new knowledge to solve the problems, the decision-makers who translate new knowledge into policies and programs, and the practitioners who implement new approaches. These participatory planning meetings evolved into the unique national event of the Learning Community Conference.

....The field [of mental health] is changing rapidly. Research is expanding our knowledge base. Innovative programs are moving beyond the CSP model. The process of planning is changing as families and consumers assume prominent roles and want answers to questions that are relevant to their interests and concerns....

**Table 2: Community Support Programs
(Adults Only)**

Number of Clients Served:	Number of adult clients ¹ receiving CSP services ² during the year.
Number of Clients per 10,000:	Number of adults receiving this service per 10,000 adults living in the county.
Percent of Clients With SPMI:	Percentage of adults receiving this service reported as having SPMI. ³

¹ Only clients reported on a *client-specific* basis are included.

² Day treatment is not included. See Table 4 for data on day treatment.

³ Serious and persistent mental illness.

	Number of Clients Served	Number of Clients per 10,000	Percent of Clients with SPMI
Aitkin	38	40	87%
Anoka	137	8	99%
Becker	43	22	88%
Beltrami	113	47	92%
Benton	70	33	• 60%
Big Stone	32	69	84%
Blue Earth	321	77	• 79%
Brown	117	60	• 76%
Carlton	30	14	97%
Carver	50	15	92%
Cass	6	4	83%
Chippewa	29	30	86%
Chisago	36	17	• 78%
Clay	121	32	80%
Clearwater	21	36	95%
Cook	16	55	88%
Cottonwood	5	5	100%
Crow Wing	91	28	92%
Dakota	208	11	98%
Dodge	12	11	92%
Douglas	54	26	89%
Faribault	28	23	93%
Fillmore	46	31	100%
Freeborn	29	12	100%
Goodhue	96	33	98%
Grant	9	19	89%
Hennepin	2,333	29	99%
Houston	30	23	97%
Hubbard	30	28	97%
Isanti	37	21	84%
Itasca	83	28	95%
Jackson	42	49	81%
Kanabec	36	40	92%
Kandiyohi	149	54	96%
Kittson	19	45	89%
Koochiching	30	25	100%
Lac qui Parle	47	72	100%
Lake	26	33	85%
Lake of the Woods	9	31	• 78%
Le Sueur	27	16	93%
Lincoln	14	28	100%
Lyon	86	48	92%
McLeod	51	22	• 67%
Mahnomen	14	40	93%
Marshall	24	31	83%
Martin	63	38	97%
Meeker	50	34	96%
Mille Lacs	41	31	88%
Morrison	73	36	• 78%
Mower	117	42	97%

As Reported by the Counties to CMHRS

CSP – Adults

Calendar Year 1991

	Number of Clients Served	Number of Clients per 10,000	Percent of Clients with SPMI
Murray	24	34	100%
Nicollet	55	27	* 49%
Nobles	8	5	100%
Norman	10	17	90%
Olmsted	85	11	91%
Otter Tail	96	26	82%
Pennington	35	36	97%
Pine	35	23	91%
Pipestone	2	3	* 0%
Polk	97	42	98%
Pope	16	21	94%
Ramsey	991	27	100%
Red Lake	13	41	85%
Redwood	33	27	100%
Renville	45	35	91%
Rice	63	17	95%
Rock	2	3	100%
Roseau	20	19	100%
St Louis	429	29	95%
Scott	61	15	100%
Sherburne	54	19	100%
Sibley	35	34	89%
Stearns	219	26	94%
Steele	51	23	94%
Stevens	1	1	100%
Swift	25	32	100%
Todd	28	17	100%
Traverse	11	33	82%
Wabasha	39	28	100%
Wadena	50	53	100%
Waseca	30	23	97%
Washington	189	19	92%
Watsonwan	25	30	* 60%
Wilkin	17	32	100%
Winona	104	29	99%
Wright	11	2	91%
Yellow Medicine	20	23	100%
State Totals	8,218	26	94%

* CSP is only for persons with serious and persistent mental illness (SPMI). If there are questions or technical assistance is desired, please phone CMHRS Technical Assistance at (612) 297-2734.

**Table 4: Day Treatment
(Adults Only)**

Number of Clients Served:	Number of adult clients receiving day treatment ¹ during the year.
Number of Clients per 10,000:	Number of adults receiving this service per 10,000 adults living in the county.
Hours of Service Provided:	Total hours ² of day treatment service adult clients received during the year.
Hours of Service per 10,000:	Hours of services provided per 10,000 adults living in the county.
Hours of Service per Client:	Mean number of day treatment hours provided adult clients. ³
Percent of Clients with SPMI:	Percentage of adults receiving this service reported as having SPMI.

¹ See Table 2 for other community support services.

² Day treatment services reported in days were converted to 4 hours for each day reported.

³ Total hours provided divided by the number of persons receiving this service.

Day Treatment – Adults

Calendar Year 1991

	Number of Clients Served	Number of Clients per 10,000	Hours of Service Provided	Hours of Service per 10,000	Hours of Service per Client	Percent of Clients with SPMI
Aitkin	3	3	163	172	54	67%
Anoka	60	4	4,297	254	72	97%
Becker	3	2	92	47	31	67%
Beltrami	23	10	2,852	1181	124	100%
Benton	17	8	880	416	52	82%
Big Stone						
Blue Earth	58	14	4,126	991	71	90%
Brown	3	2	187	95	62	100%
Carlton	3	1	122	58	41	100%
Carver						
Cass	2	1	54	34	27	100%
Chippewa	41	43	7,052	7310	172	80%
Chisago	5	2	695	329	139	100%
Clay	44	12	5,780	1529	131	100%
Clearwater	7	12	564	958	81	86%
Cook	8	27	360	1228	45	100%
Cottonwood	17	18	645	687	38	71%
Crow Wing	32	10	3,139	971	98	97%
Dakota	170	9	22,630	1172	133	96%
Dodge	14	13	714	662	51	93%
Douglas						
Faribault	10	8	882	709	88	100%
Ilmore	2	1	267	178	134	100%
Freeborn	75	31	8,858	3611	118	100%
Goodhue	35	12	1,052	360	30	100%
Grant	1	2	3	6	3	
Hennepin	191	2	20,693	261	108	73%
Houston	31	24	1,737	1317	56	94%
Hubbard	1	1	136	125	136	100%
Isanti	9	5	891	500	99	89%
Itasca	62	21	4,403	1502	71	89%
Jackson						
Kanabec	1	1	120	135	120	
Kandiyohi	290	105	47,656	17189	164	70%
Kittson	6	14	302	709	50	100%
Koochiching	13	11	669	551	51	92%
Lac qui Parle	12	18	1,283	1954	107	100%
Lake	26	33	2,132	2706	82	85%
Lake of the Woods						
Le Sueur	4	2	596	364	149	100%
Lincoln						
Lyon	65	36	9,853	5459	152	100%
McLeod	33	15	2,180	958	66	61%
Mahnomen	3	9	34	98	11	100%
Marshall	11	14	649	829	59	82%
Martin	43	26	4,247	2532	99	98%
Meeker	54	37	7,340	4987	136	80%
Mille Lacs	13	10	1,086	821	84	92%
Morrison						
Mower	59	21	9,380	3370	159	98%

As Reported by the Counties to CMHPS

Day Treatment – Adults

Calendar Year 1991

	Number of Clients Served	Number of Clients per 10,000	Hours of Service Provided	Hours of Service per 10,000	Hours of Service per Client	Percent of Clients with SPMI
Murray	8	11	235	334	29	100%
Nicollet	5	2	473	228	95	100%
Nobles	36	24	1,114	754	31	58%
Norman	5	9	323	555	65	80%
Olmsted	47	6	62,964	8183	1340	96%
Otter Tail	16	4	956	256	60	100%
Pennington	28	29	912	936	33	96%
Pine	13	9	1,109	729	85	92%
Pipestone	11	15	623	826	57	45%
Polk	55	24	3,251	1392	59	100%
Pope						
Ramsey	361	10	34,227	936	95	64%
Red Lake	6	19	310	978	52	100%
Redwood	12	10	1,247	1005	104	100%
Renville	55	43	6,005	4709	109	69%
Rice	3	1	323	89	108	100%
Rock	19	27	1,302	1855	69	58%
Roseau	16	15	844	816	53	100%
St Louis	439	29	71,834	4792	164	92%
Scott	22	6	1,270	319	58	100%
Sherburne	11	4	730	255	66	73%
Sibley	2	2	176	171	88	100%
Stearns	103	12	7,033	820	68	73%
Steele	51	23	2,962	1350	58	90%
Stevens	1	1	219	269	219	100%
Swift	64	82	2,937	3745	46	77%
Todd	4	2	248	153	62	100%
Traverse						
Wabasha	24	17	1,519	1083	63	96%
Wadena	12	13	449	476	37	100%
Waseca	14	11	1,128	875	81	100%
Washington	58	6	8,452	832	146	78%
Watsonwan	16	19	881	1049	55	63%
Wilkin						
Winona	62	17	4,537	1257	73	97%
Wright	5	1	557	120	111	100%
Yellow Medicine	3	4	422	495	141	100%
State Totals	3,147	10	402,373	1,254	128	84%

As Reported by the Counties to CMHRS

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: OTHER CSP SERVICES (0434)
 PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		CL	HR
	CL	HR	CL	HR	CL	HR		
01 AITKIN	33	4053	3	64	2	135	38	4251
02 ANOKA	132	46753	0	0	2	365	134	47117
03 BECKER	38	1829	4	79	1	83	43	1991
04 BELTRAMI	102	13003	0	0	7	10	109	13013
05 BENTON	42	2869	0	0	28	1390	70	4258
06 BIG STONE	25	3158	0	0	0	0	25	3158
07 BLUE EARTH	181	53158	7	27	32	227	220	53412
08 BROWN	109	25548	1	1	2	19	112	25567
09 CARLTON	29	571	1	24	0	0	30	595
10 CARVER	46	5364	2	6	1	0	49	5370
11 CASS	3	1677	0	0	0	0	3	1677
12 CHIPPEWA	23	3470	0	0	1	1	24	3470
13 CHISAGO	27	757	2	7	4	9	33	773
14 CLAY	97	2666	15	46	9	53	121	2765
15 CLEARWATER	20	1335	0	0	1	36	21	1370
16 COOK	12	750	0	0	1	5	13	755
17 COTTONWOOD	5	4743	0	0	0	0	5	4743
18 CROW WING	74	1217	0	0	3	27	77	1244
19 DAKOTA	202	16161	0	0	6	576	208	16737
20 DODGE	11	861	1	1	0	0	12	862
21 DOUGLAS	41	3806	0	0	5	26	46	3832
22 FARIBAULT	26	9847	0	0	1	11	27	9857
23 FILLMORE	46	1633	0	0	0	0	46	1633
24 FREEBORN	25	1621	0	0	0	0	25	1621
25 GOODHUE	93	9751	0	0	2	270	95	10021
26 GRANT	7	541	1	7	0	0	8	547
27 HENNEPIN	2263	354956	6	449	7	276	2276	355681
28 HOUSTON	28	840	0	0	1	2	29	842
29 HUBBARD	30	1768	0	0	0	0	30	1768
30 ISANTI	30	1471	1	3	4	69	35	1544
31 ITASCA	78	4938	1	60	3	74	82	5071
32 JACKSON	33	387	1	1	5	14	39	401
33 KANABEC	33	1421	3	138	0	0	36	1559
34 KANDIYOH	131	8085	0	0	1	1	132	8086
35 KITTSON	15	963	1	133	0	0	16	1096
36 KOOSKICHINGO	30	1006	0	0	0	0	30	1006
37 LAC QUI PARLE	46	2163	0	0	0	0	46	2163
38 LAKE	21	210	1	4	3	10	25	223
39 LAKE OF THE WOODS	4	15	0	0	2	7	6	22
40 LESUEUR	22	12069	0	0	2	34	24	12103
41 LINCOLN	13	513	0	0	0	0	13	513
42 LYON	70	3155	1	2	6	82	77	3239
43 MCLEOD	34	3272	6	217	11	37	51	3525
44 MARSHEN	9	498	1	3	0	0	10	501

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: OTHER CSP SERVICES (0434)
PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		# CL	# HR
	# CL	# HR	# CL	# HR	# CL	# HR		
45 MARSHALL	18	1371	1	97	1	68	20	1535
46 MARTIN	58	16752	0	6	2	6	60	16764
47 MEEKER	38	3955	0	0	1	3	39	3958
48 MILLE LACS	36	2373	1	3	4	95	41	2470
49 MORRISON	51	1161	2	3	9	60	62	1223
50 MOWER	113	18406	0	0	3	671	116	19077
51 MURRAY	16	2065	0	0	0	0	16	2065
52 NICOLLET	26	11399	2	20	23	510	51	11929
53 NOBLES	7	5203	0	0	0	0	7	5203
54 NORMAN	9	298	1	19	0	0	10	317
55 OLMSTED	77	13327	1	106	2	429	80	13862
56 OTTER TAIL	77	1738	8	213	7	64	92	2015
57 PENNINGTON	34	897	0	22	0	0	34	919
58 PINE	32	887	1	10	2	13	35	910
59 PIPESTONE	0	0	0	0	1	3	1	3
60 POLK	84	3508	1	5	0	0	85	3513
61 POPE	15	740	0	0	1	2	16	741
62 RAMSEY	984	153981	1	26	5	347	990	154353
63 RED LAKE	11	509	0	0	2	7	13	516
64 REDWOOD	25	1031	0	0	0	0	25	1031
65 RENVILLE	40	3665	0	0	3	95	43	3760
66 RICE	59	7867	0	0	2	2	61	7869
67 ROCK	2	1757	0	0	0	0	2	1757
68 ROSEAU	18	483	0	0	0	0	18	483
69 ST. LOUIS	365	15621	12	266	1	3	378	15889
70 SCOTT	60	10506	0	0	0	0	60	10506
71 SHERBURNE	51	2330	0	0	0	0	51	2330
72 SIBLEY	29	2735	0	0	4	19	33	2755
73 STEARNS	203	16803	1	7	13	279	217	17089
74 STEELE	44	4194	0	0	2	1	46	4195
75 STEVENS	1	154	0	0	0	0	1	154
76 SHIFT	21	818	0	0	0	0	21	818
77 TODD	28	1462	0	0	0	0	28	1462
78 TRAVERSE	9	562	0	0	2	41	11	603
79 WABASHA	39	898	0	0	0	0	39	898
80 WADENA	45	7809	0	0	0	0	45	7809
81 WASECA	28	2142	0	0	0	0	28	2142
82 WASHINGTON	161	8512	6	50	3	14	170	8576
83 WATONWAN	15	3280	1	1	9	58	25	3339
84 WILKIN	17	654	0	0	0	0	17	654
85 WINONA	103	2290	0	0	1	3	104	2293
86 WRIGHT	8	3672	0	0	0	0	8	3672
87 YELLOW MEDICINE	16	1822	0	0	0	0	16	1822
99 UNKNOWN	9	94	0	0	1	8	10	102

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MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: OTHER CSP SERVICES (0434)
PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		CL	HR
	CL	HR	CL	HR	CL	HR		
STATE TOTALS -->	7421	954601	98	2120	257	6642	7776	963362

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: CLIENT OUTREACH (0403)
 PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		CL	HR
	CL	HR	CL	HR	CL	HR		
01 AITKIN	1	2	1	2	0	0	2	3
02 ANOKA	3	10	0	0	0	0	3	10
03 BECKER	1	0	0	0	0	0	1	0
04 BELTRAMI	19	8	0	0	1	2	20	9
05 BENTON	25	29	0	0	10	7	35	35
06 BIG STONE	15	80	1	0	4	2	20	82
07 BLUE EARTH	57	290	7	15	17	47	81	352
08 BROWN	19	48	1	4	1	2	21	54
09 CARLTON	3	7	0	0	0	0	3	7
11 CASS	1	0	0	0	1	1	2	1
12 CHIPPEWA	4	17	0	0	3	7	7	24
13 CHISAGO	1	10	0	0	2	4	3	14
15 CLEARWATER	4	8	0	0	1	0	5	9
16 COOK	3	2	0	0	0	0	3	2
18 CROW WING	32	197	1	2	4	5	37	204
20 DODGE	9	55	1	1	0	0	10	56
21 DOUGLAS	8	24	0	0	2	2	10	26
26 GRANT	1	2	0	0	0	0	1	2
27 HENNEPIN	510	2359	0	0	2	1	512	2360
31 ITASCA	4	16	0	0	0	0	4	16
32 JACKSON	5	11	0	0	3	10	8	21
33 KANABEC	10	12	1	2	0	0	11	13
34 KANDIYOH	28	133	0	0	2	1	30	134
35 KITTSO	8	30	0	0	1	8	9	38
37 LAC QUI PARLE	6	25	0	0	0	0	6	25
38 LAKE	10	10	0	0	2	6	12	15
39 LAKE OF THE WOODS	4	10	0	0	0	0	4	10
41 LINCOLN	7	16	0	0	0	0	7	16
42 LYON	33	94	0	0	0	0	33	94
44 MAHOMEN	12	54	1	8	0	0	13	63
45 MARSHALL	14	130	1	92	3	28	18	250
46 MARTIN	2	2	0	0	0	0	2	2
47 MEEKER	5	6	1	1	0	0	6	7
48 MILLE LACS	1	2	0	0	0	0	1	2
49 MORRISON	50	573	2	18	12	121	64	712
51 MURRAY	14	31	0	0	0	0	14	31
52 NICOLLET	1	1	0	0	0	0	1	1
55 OLMSTED	11	13	0	0	0	0	11	13
56 OTTER TAIL	1	1	0	0	1	3	2	4
57 PENNINGTON	22	112	0	0	0	0	22	112
60 POLK	57	221	1	3	0	0	58	224
61 POPE	9	19	0	0	0	0	9	19
63 RED LAKE	5	15	0	0	1	1	6	16
64 REDWOOD	22	113	0	0	0	0	22	113

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: CLIENT OUTREACH (0403)
PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		CL	HR
	CL	HR	CL	HR	CL	HR		
65 RENVILLE	6	44	0	0	0	0	6	44
66 RICE	11	10	0	0	0	0	11	10
68 ROSEAU	3	4	0	0	0	0	3	4
69 ST. LOUIS	198	2592	9	188	2	2	209	2782
70 SCOTT	25	52	0	0	0	0	25	52
72 SIDLEY	16	34	0	0	0	0	16	34
73 STEARNS	69	65	0	0	7	13	76	77
74 STEELE	30	89	0	0	0	0	30	89
76 SWIFT	11	29	0	0	0	0	11	29
77 TODD	17	44	0	0	0	0	17	44
78 TRAVERSE	2	6	0	0	0	0	2	6
80 WADENA	13	17	0	0	0	0	13	17
81 WASECA	11	13	0	0	0	0	11	13
82 WASHINGTON	21	49	1	1	1	2	23	51
83 WATONWAN	5	6	1	6	6	14	12	25
84 WILKIN	2	3	0	0	0	0	2	3
87 YELLOW MEDICINE	9	18	0	0	0	0	9	18
99 UNKNOWN	2	3	0	0	0	0	2	3
STATE TOTALS -->	1508	7870	30	340	89	287	1627	8497

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: EMPLOYABILITY (0437)
 PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		CL	HR
	CL	HR	CL	HR	CL	HR		
02 ANOKA	2	4	0	0	0	0	2	4
29 HUBBARD	1	0	0	0	0	0	1	0
48 MILLE LACS	1	1	0	0	0	0	1	1
49 MORRISON	1	0	0	0	0	0	1	0
56 OTTER TAIL	1	168	0	0	0	0	1	168
62 RAMSEY	1	0	0	0	0	0	1	0
82 WASHINGTON	36	219	5	48	1	16	42	282
86 WRIGHT	1	1	0	0	0	0	1	1
STATE TOTALS -->	44	393	5	48	1	16	50	457

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: DAY TREATMENT UTILIZATION (D453)
PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		CL	HR
	CL	HR	CL	HR	CL	HR		
01 AITKIN	2	148	1	15	0	0	3	163
02 ANOKA	58	4264	0	0	2	33	60	4297
03 BECKER	2	86	1	6	0	0	3	92
04 BELTRAMI	23	2852	0	0	0	0	23	2852
05 BENTON	14	774	2	28	1	78	17	880
07 BLUE EARTH	52	3916	0	0	6	210	58	4126
08 BROWN	3	187	0	0	0	0	3	187
09 CARLTON	3	122	0	0	0	0	3	122
11 CASS	2	54	0	0	0	0	2	54
12 CHIPPEWA	33	6127	0	0	8	925	41	7052
13 CHISAGO	5	695	0	0	0	0	5	695
14 CLAY	44	5780	0	0	0	0	44	5780
15 CLEARWATER	6	513	0	0	1	51	7	564
16 COOK	8	360	0	0	0	0	8	360
17 COTTONWOOD	12	600	0	0	5	45	17	645
18 CROW WING	31	3118	0	0	1	21	32	3139
19 DAKOTA	163	21442	0	0	7	1188	170	22630
20 DODGE	13	672	0	0	1	42	14	715
22 FARIBAULT	10	882	0	0	0	0	10	882
23 FILLMORE	2	267	0	0	0	0	2	267
24 FREEBORN	75	8858	0	0	0	0	75	8858
25 GOODHUE	35	1052	0	0	0	0	35	1052
26 GRANT	0	0	1	3	0	0	1	3
27 HENNEPIN	140	14668	41	4901	10	1124	191	20692
28 HOUSTON	29	1734	0	0	2	3	31	1736
29 HUBBARD	1	136	0	0	0	0	1	136
30 ISANTI	8	870	1	21	0	0	9	891
31 ITASCA	55	4033	5	305	2	65	62	4403
33 KANABEC	0	0	1	120	0	0	1	120
34 KANDIYOH	202	42892	1	26	87	4738	290	47656
35 KITTSON	6	302	0	0	0	0	6	302
36 KOOCHICHINGO	12	666	1	3	0	0	13	669
37 LAC QUI PARLE	12	1283	0	0	0	0	12	1283
38 LAKE	22	1829	2	182	2	121	26	2132
40 LESUEUR	4	596	0	0	0	0	4	596
42 LYON	65	9853	0	0	0	0	65	9853
43 MCLEOD	20	2125	4	35	9	20	33	2180
44 MAHONEN	3	34	0	0	0	0	3	34
45 MARSHALL	9	530	1	118	1	1	11	649
46 MARTIN	42	4144	0	0	1	103	43	4247
47 MEEKER	43	6877	1	46	10	417	54	7340
48 MILLE LACS	12	930	0	0	1	156	13	1086
50 MOHR	58	9368	0	0	1	12	59	9380
51 MURRAY	8	233	0	0	0	0	8	233

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MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: DAY TREATMENT UTILIZATION (D453)
 PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		# CL	# HR
	# CL	# HR	# CL	# HR	# CL	# HR		
52 NICOLLET	5	473	0	0	0	0	5	473
53 NOBLES	21	727	1	14	14	373	36	1113
54 NORMAN	4	194	1	129	0	0	5	323
55 OLMSTED	45	59640	1	3300	1	24	47	62964
56 OTTER TAIL	16	956	0	0	0	0	16	956
57 PENNINGTON	27	898	1	14	0	0	28	911
58 PINE	12	1106	1	3	0	0	13	1109
59 PIPESTONE	5	441	3	161	3	21	11	622
60 POLK	55	3251	0	0	0	0	55	3251
62 RAMSEY	231	24338	42	4843	88	5046	361	34227
63 RED LAKE	6	310	0	0	0	0	6	310
64 REDWOOD	12	1247	0	0	0	0	12	1247
65 RENVILLE	38	4946	0	0	17	1059	55	6005
66 RICE	3	323	0	0	0	0	3	323
67 ROCK	11	949	0	0	8	353	19	1302
68 ROSEAU	16	785	0	0	0	59	16	844
69 ST. LOUIS	402	66009	34	5255	3	570	439	71834
70 SCOTT	22	1270	0	0	0	0	22	1270
71 SHERBURNE	8	485	3	245	0	0	11	730
72 SIBLEY	2	176	0	0	0	0	2	176
73 STEARNS	75	6160	16	501	12	372	103	7033
74 STEELE	46	2842	2	10	3	110	51	2962
75 STEVENS	1	219	0	0	0	0	1	219
76 SWIFT	49	2256	0	0	15	681	64	2937
77 TODD	4	248	0	0	0	0	4	248
79 WABASHA	23	1518	0	0	1	1	24	1519
80 WADENA	12	449	0	0	0	0	12	449
81 WASECA	14	1128	0	0	0	0	14	1128
82 WASHINGTON	45	6659	11	1791	2	2	58	8451
83 WATONWAN	10	663	1	42	5	176	16	881
85 WINONA	60	4424	0	0	2	113	62	4537
86 WRIGHT	5	557	0	0	0	0	5	557
87 YELLOW MEDICINE	3	422	0	0	0	0	3	422
89 OUT-OF-STATE	2	36	0	0	0	0	2	36
99 UNKNOWN	9	1348	0	0	0	0	9	1348
STATE TOTALS -->	2646	363322	180	22115	332	18310	3158	403747

SAS

14:34 FRIDAY, DECEMBER 4, 1992 1

CMHRS

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: CRISIS ASSISTANCE (0432)
PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP	ADULTS						TOTAL	
	S&P		ACUTE		OTHER		CL	HR
	CL	HR	CL	HR	CL	HR		
01 AITKIN	15	96	1	19	0	0	16	115
02 ANOKA	3	6	0	0	0	0	3	6
04 BELTRAMI	77	366	0	0	2	5	79	372
05 BENTON	16	22	0	0	14	15	30	37
06 BIG STONE	6	23	0	0	0	0	6	23
07 BLUE EARTH	10	25	1	2	0	0	11	27
08 BROWN	25	139	0	0	0	0	25	139
09 CARLTON	5	3	1	0	0	0	6	4
10 CARVER	0	0	1	1	0	0	1	1
12 CHIPPEWA	7	23	0	0	0	0	7	23
15 CLEARWATER	17	137	0	0	1	6	18	143
16 COOK	6	33	1	1	0	0	7	34
18 CROW WING	20	39	0	0	1	0	21	39
20 DODGE	5	9	0	0	0	0	5	9
21 DOUGLAS	25	49	0	0	0	0	25	49
22 FARIBAULT	1	2	0	0	0	0	1	2
24 FREEBORN	7	23	0	0	0	0	7	23
26 GRANT	5	10	0	0	0	0	5	10
27 HENNEPIN	44	47	0	0	0	0	44	47
28 HOUSTON	3	4	0	0	0	0	3	4
29 HUBBARD	9	37	0	0	0	0	9	37
30 ISANTI	1	1	0	0	1	1	2	2
31 ITASCA	21	98	1	1	0	0	22	99
32 JACKSON	1	2	0	0	0	0	1	2
33 KANABEC	11	61	1	4	0	0	12	65
34 KANDIYOH	17	33	0	0	1	0	18	33
35 KITTSO	6	20	1	4	0	0	7	24
37 LAC QUI PARLE	8	32	0	0	0	0	8	32
38 LAKE	5	5	0	0	0	0	5	5
39 LAKE OF THE WOODS	4	21	0	0	0	0	4	21
41 LINCOLN	6	9	0	0	0	0	6	9
42 LYON	25	88	0	0	0	0	25	88
44 MAHOMEN	6	68	0	0	0	0	6	68
45 MARSHALL	9	63	1	4	0	0	10	67
46 MARTIN	8	30	0	0	0	0	8	30
47 MEEKER	8	19	0	0	0	0	8	19
49 MORRISON	14	47	1	3	4	10	19	60
51 MURRAY	4	5	0	0	0	0	4	5
54 NORMAN	1	2	0	0	0	0	1	2
55 OLMSTED	3	7	0	0	1	2	4	9
56 OTTER TAIL	2	5	0	0	1	3	3	8
57 PENNINGTON	17	97	0	0	0	0	17	97
59 PIPESTONE	0	0	1	4	0	0	1	4
60 POLK	28	127	0	0	0	0	28	127

MINNESOTA DEPARTMENT OF HUMAN SERVICES / MENTAL HEALTH DIVISION

SUMMARY REPORT: CRISIS ASSISTANCE (0432)
 PERIOD: JAN91-DEC91

(ALL UNITS CONVERTED TO HOURS)

COUNTY OF FIN RESP		ADULTS						TOTAL	
		S&P		ACUTE		OTHER			
		# CL	# HR	# CL	# HR	# CL	# HR		
61	POPE	7	14	0	0	0	0	7	14
62	RAMSEY	16	24	0	0	0	0	16	24
63	RED LAKE	3	17	0	0	0	0	3	17
64	REDWOOD	12	34	0	0	0	0	12	34
65	RENVILLE	7	50	0	0	1	2	8	52
66	RICE	10	20	0	0	0	0	10	20
68	ROSEAU	10	50	0	0	0	0	10	50
69	ST. LOUIS	91	1309	6	163	0	0	97	1472
70	SCOTT	3	8	0	0	0	0	3	8
71	SHERBURNE	3	6	0	0	0	0	3	6
72	SIBLEY	17	106	0	0	1	4	18	110
73	STEARNS	68	114	0	0	5	16	73	131
74	STEELE	20	52	0	0	0	0	20	52
76	SWIFT	6	5	0	0	0	0	6	5
77	TODD	10	29	0	0	0	0	10	29
78	TRAVERSE	2	9	0	0	0	0	2	9
79	WABASHA	2	12	0	0	0	0	2	12
80	WADENA	8	55	0	0	0	0	8	55
81	WASECA	8	29	0	0	0	0	8	29
82	WASHINGTON	36	67	1	1	0	0	37	68
83	WATONWAN	3	6	0	0	3	4	6	9
84	WILKIN	5	10	0	0	0	0	5	10
85	WINONA	7	14	0	0	0	0	7	14
86	WRIGHT	3	8	1	3	0	0	4	11
87	YELLOW MEDICINE	5	21	0	0	0	0	5	21
STATE TOTALS -->		873	4001	19	208	36	69	928	4277

**LWV
CONSUMER/FAMILY TRAINING SESSION
APRIL, 1993**

SCHEDULE FOR THE DAY

9:45-10:00 a.m.	Sign in. Coffee and Donuts.
10:00-10:45	New Materials Distributed. Check-In from Participants and Local Advisory Councils.
10:45-12:15	First Activity: Case Management (pages 118-126)
12:15-1:00	LUNCH. FREE TIME.
1:00-2:30	Second Activity: Role Play, "The Best Local Advisory Council Ever." (pages 127-130)
2:30-3:00	Wrap-up. Discussion of Future Training Sessions and the State Convention of Consumer/Family Training Project.

TRAINING SESSION VI

APRIL 1993

MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

CASE MANAGEMENT SERVICES

The Comprehensive Adult Mental Health Act requires that case management services be made available by county boards to all adults with serious and persistent mental illness who reside in the county. The service is required in all cases where the adult requests or consents to receive the service. As with other services, case management must be provided "up to available resources."

Case management provides the coordinating link between the many services that counties are required by mandate to make available to persons with serious and persistent mental illness. The case manager is directly responsible for finding services that are appropriate and available to individuals requiring them and in assisting those individuals in accessing those services. Because case loads are heavy and many case management responsibilities are somewhat undefined, the quality of services given depends greatly upon the expertise and commitment of the individual case manager.

To understand case management services, members of local advisory councils should know how eligibility for case management is determined and the process that takes place once a determination is made. A step by step description of entry into the mental health system through case management is given on pages 119 and 120 following the definition of case management. The purpose of presenting case management as a step by step process is for clarity only. In actuality the steps may vary according to individual needs.

The definition of case management and the training required for case management is taken directly from the Comprehensive Adult Mental Health Act; the language of the steps is adapted from the Act.

League of Women Voters NIMH Consumer/Family
Mental Health Leadership Project, Minnesota Department
of Human Services, Mental Health Division

Session VI
Case Management
"Best LAC Ever" Role Play

ADULT COMPREHENSIVE MENTAL HEALTH ACT

245.462 DEFINITIONS

Subd. 3. Case management services.

“Case management services” means activities that are coordinated with the community support services program as defined in subdivision 6 and are designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client’s mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Required Training of Case Manager

Subd. 4 Case manager.

...A case manager must have a bachelor’s degree in one of the behavioral sciences or related fields from an accredited college or university and have at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client. The case manager shall meet in person with a mental health professional at least once each month to obtain clinical supervision of the case manager’s activities....Clinical supervision must be documented in the client record.

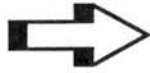


CASE MANAGEMENT SERVICES STEP BY STEP



*A DIAGNOSTIC ASSESSMENT DETERMINES THE
SEVERITY OF THE ILLNESS AND WHAT TREATMENT
AND SUPPORT IS NEEDED.*

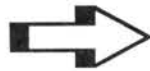
Diagnostic assessment means a written summary of the history, diagnosis, strengths, vulnerabilities, and general service needs of an adult with a mental illness using diagnostic, interview, and other relevant mental health techniques provided by a mental health professional used in developing an individual treatment plan or individual community support plan.



WHEN ELIGIBILITY FOR CASE MANAGEMENT IS DETERMINED, A FUNCTIONAL ASSESSMENT MUST BE MADE.

Functional assessment is an assessment by the case manager of the adult's:

- (1) **mental health symptoms** as presented in the adult's diagnostic assessment;
- (2) **mental health needs** as presented in the adult's diagnostic assessment;
- (3) use of drugs and alcohol;
- (4) vocational and educational functioning;
- (5) social functioning, including the use of leisure time;
- (6) interpersonal functioning, including relationships with the adult's family;
- (7) self-care and independent living capacity;
- (8) medical and dental health;
- (9) financial assistance needs;
- (10) housing and transportation needs; and
- (11) other needs and problems.



AN INDIVIDUAL TREATMENT PLAN IS DEVELOPED FOR A PERSON RECEIVING CASE MANAGEMENT.

An individual treatment plan is a written plan of intervention, treatment and services for an adult with mental illness....The plan identifies goals and objectives, treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives.

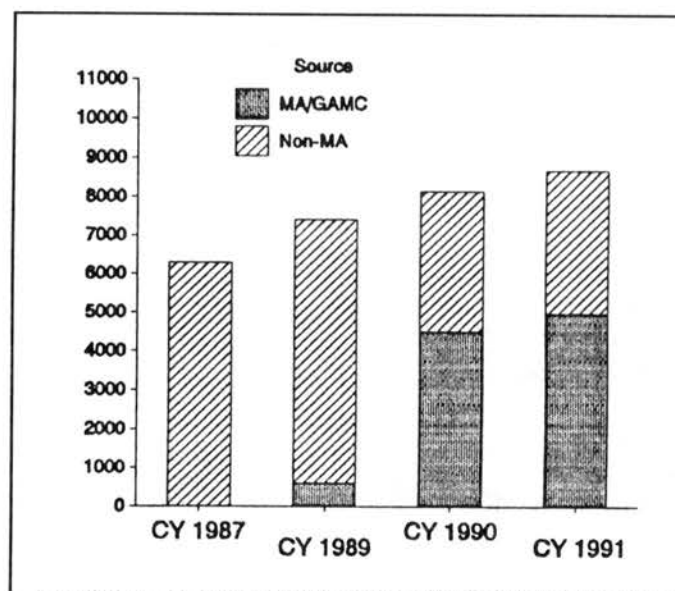
ON THE BASIS OF THE DIAGNOSTIC ASSESSMENT AND THE FUNCTIONAL ASSESSMENT, AN INDIVIDUAL COMMUNITY SUPPORT PLAN IS WRITTEN.



An individual community support plan is a written plan developed by a case manager on the basis of a diagnostic assessment and functional assessment. It identifies specific services needed by an adult with serious and persistent mental illness to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships, financial management, housing, transportation and employment.

All persons with serious and persistent mental illness (SPMI) do not receive case management and all persons receiving case management are not determined SPMI.

The percentage of adults with SPMI receiving case management rose sharply from 1987 to 1990. Medical Assistance funding has become the most important component of case management funding.



This graph shows the proportion of case management that is billed to MA. The proportion of clients served through MA in relation to all case management clients is increasing. The statewide percentage of Rule 74 (now replaced with Rule 79) case management hours billed to MA was 56% for the calendar year of 1990.

RULE 74 WHICH GOVERNED CASE MANAGEMENT HAS BEEN REPLACED BY RULE 79.

Some changes incorporated in the new Rule 79 are:

- a limit on case load size. Effective December 27, 1992, case managers must have average caseloads of 40 clients to 1 full-time case manager. By January 1, 1994 the average caseload must be 30 clients to one case manager. (Counties may exceed this ratio "only to the extent that the increased revenue is insufficient to hire additional case managers.")

- a provision for a case management team to be a part of case management. This can include CSP providers and other agencies providing services to the adult.

(Although the inclusion of a team approach to case management was generally welcomed by those testifying about the new Rule 79, some concern has been expressed that this team approach may remove independence and hence mutual monitoring that took place under the old rule.)

- case managers may provide "other mental health services" if qualified. The cost of these services would not be reimbursed by Medical Assistance.

Rule 74 had been amended before Rule 79 was in place to include in-county travel time which was not originally permitted.

Members of local advisory councils would do well to monitor both case management and community support services in their county. The way in which these services are delivered can make a tremendous difference in the daily lives of persons with mental illness. Good case management and good community support services can also determine the degree of self sufficiency that an individual receiving services can achieve.

Often people with mental illness who qualify for case management and community support services choose not to have them for various reasons. Many people participating in these training sessions have had first hand experience with case management either as a consumer or a family member.

Did case management, as you experienced it, fit the description from the Comprehensive Mental Health Act? Were you surprised at the precise definition of the service and how it is to be administered? Consumers and family representatives on local mental health advisory boards often have to span the huge gap that exists between legalistic definitions used by the system and the consumer or family's experiential understanding. For this reason alone, it is important to have family members and consumers on LACs. The fact that services are for people is sometimes forgotten.

Let us look at case management from a people perspective.

CASE MANAGEMENT

DOES THIS CORRECTLY DESCRIBE THE SERVICE OR THE PERSON RECEIVING IT?

IS THE INDIVIDUAL A CASE?

IS THE "CASE" MANAGED?

Are there better words to describe this service? For instance, are there more descriptive words that embrace empowerment and self sufficiency? Is the term case management paternalistic? Does it send a message to the professional who provides it and to the individual who receives it?

Task 1: In a small group discuss the components of ideal case management from a consumer/family point of view. List below some essential components of good case management decided upon by the group.

1. _____
2. _____

Could there be a better term for what is now called "case management" that suggests an equal relationship between professional and consumer? A relationship in which the consumer makes the important decisions with suggestions from a "peer helper."

**Table 1: Rule 74 Case Management
(Adults Only)**

Number of Clients Served:	Number of adult clients receiving Rule 74 case management ¹ during the year.
Number of Clients per 10,000:	Number of adults receiving this service per 10,000 adults living in the county.
Hours of Service Provided:	Total hours of Rule 74 case management service adult clients received during the year.
Hours of Service per 10,000:	Hours of service provided per 10,000 adults living in the county.
Hours of Service per Client:	Mean number of Rule 74 case management hours provided ² adult clients.
Percent of Clients With SPMI:	Percentage of adults receiving this service reported as having SPMI. ³

¹ General case management (code 0493x) is not included in this table.

² Total hours provided divided by the number of persons receiving this service.

³ Serious and persistent mental illness.

Case Management – Adults

Calendar Year 1991

	Number of Clients Served	Number of Clients per 10,000	Hours of Service Provided	Hours of Service per 10,000	Hours of Service per Client	Percent of Clients with SPMI
Aitkin	14	15	56	59	4	* 43%
Anoka	382	23	5,468	323	14	80%
Becker	29	15	317	160	11	* 76%
Beltrami	65	27	568	235	9	88%
Benton						
Big Stone	25	54	54	116	2	92%
Blue Earth	116	28	2,441	586	21	90%
Brown	69	35	673	344	10	94%
Carlton	8	4	22	10	3	100%
Carver	34	10	415	124	12	94%
Cass	1	1	9	6	9	100%
Chippewa	16	17	232	240	15	* 50%
Chisago	58	27	534	253	9	* 50%
Clay						
Clearwater	24	41	375	637	16	88%
Cook	12	41	347	1183	29	92%
Cottonwood	31	33	289	308	9	* 74%
Crow Wing	163	50	3,161	978	19	* 74%
Dakota	493	26	8,141	422	17	90%
Dodge	17	16	296	275	17	94%
Douglas	55	26	754	361	14	* 76%
Faribault	30	24	455	366	15	93%
Fillmore	24	16	673	449	28	100%
Freeborn	1	0	4	2	4	100%
Goodhue	131	45	1,097	375	8	84%
Grant						
Hennepin	2,465	31	28,912	364	12	99%
Houston	44	33	1,563	1185	36	93%
Hubbard	21	19	322	297	15	95%
Isanti	36	20	581	326	16	* 64%
Itasca	99	34	1,442	492	15	97%
Jackson	55	64	198	232	4	* 71%
Kanabec	3	3	9	10	3	* 67%
Kandiyohi	93	34	632	228	7	82%
Kittson	1	2	15	35	15	100%
Koochiching	22	18	287	236	13	* 59%
Lac qui Parle	12	18	377	574	31	100%
Lake	18	23	507	643	28	83%
Lake of the Woods	6	20	121	410	20	100%
Le Sueur	27	16	191	117	7	* 74%
Lincoln	17	33	255	501	15	* 53%
Lyon	82	45	1,368	758	17	* 35%
McLeod	79	35	733	322	9	85%
Mahnomen	10	29	102	294	10	100%
Marshall	18	23	251	321	14	* 39%
Martin	69	41	1,051	627	15	96%
Meeker	31	21	277	188	9	* 74%
Mille Lacs	45	34	1,125	850	25	* 64%
Morrison	46	23	1,196	588	26	91%
Mower	1	0	7	3	7	100%

Case Management – Adults

Calendar Year 1991

	Number of Clients Served	Number of Clients per 10,000	Hours of Service Provided	Hours of Service per 10,000	Hours of Service per Client	Percent of Clients with SPMI
Murray	9	13	34	48	4	* 67%
Nicollet	64	31	578	279	9	* 25%
Nobles	11	7	139	94	13	* 18%
Norman	5	9	23	40	5	100%
Olmsted	254	33	3,729	485	15	91%
Otter Tail	9	2	20	5	2	100%
Pennington	41	42	570	585	14	93%
Pine	32	21	409	269	13	* 53%
Pipestone	16	21	55	73	3	* 50%
Polk	55	24	429	184	8	98%
Pope	17	22	52	67	3	* 53%
Ramsey	2,161	59	25,751	704	12	96%
Red Lake	7	22	86	271	12	86%
Redwood	28	23	206	166	7	* 68%
Renville						
Rice	91	25	1,129	311	12	* 70%
Rock	6	9	178	254	30	* 67%
Roseau	5	5	121	117	24	100%
St Louis	861	57	10,169	678	12	* 53%
Scott	118	30	1,996	501	17	92%
Sherburne	83	29	1,579	552	19	83%
Sibley	39	38	557	542	14	95%
Stearns	251	29	3,921	457	16	* 74%
Steele	62	28	1,055	481	17	98%
Stevens	7	9	105	129	15	* 71%
Swift	21	27	253	323	12	95%
Todd	29	18	256	158	9	97%
Traverse	10	30	86	261	9	* 50%
Wabasha	40	29	970	691	24	100%
Wadena	13	14	124	131	10	100%
Waseca	43	33	872	676	20	100%
Washington	297	29	4,994	492	17	* 44%
Watsonwan	38	45	653	777	17	* 63%
Wilkin	21	39	250	464	12	100%
Winona	128	35	1,566	434	12	98%
Wright	96	21	1,340	289	14	97%
Yellow Medicine	28	33	445	522	16	86%
State Totals	10,094	31	132,603	413	13	86%

* Rule 74 Case management is only for persons with serious and persistent mental illness (SPMI). If there are questions or technical assistance is desired, please phone CMHRS Technical Assistance at (612) 297-2734.

As Reported by the Counties to CMHRS

SECOND ACTIVITY



ROLE PLAY



THE BEST LOCAL ADVISORY COUNCIL EVER

Task 1: The leader will briefly describe the role play characters. If you would like to take part in the role play, ask for the role you would like to do. Detailed descriptions of the characters are on pages 129 and 130.

Tips for role-play participants.

- try to play your role as convincingly as possible.
- choose a role somewhat different from your own personality. One of the purposes of role play is to experience how another-and very different-person feels.

Once roles are assigned, in addition to the role you play (debunker, emotional one, conformist, brilliant one, etc.), participants will decide who will assume the following LAC positions for their roles:

LAC chair
social services staff person (also secretary)
csp representative
consumer representative(s)
family representative(s)
mental health professional representative

Make sure that the primary role (debunker, emotional one, conformist, brilliant one, etc.) and lac position are compatible. For example, the role of a community support person probably reflects a person who is somewhat idealistic, helpful, caring, etc. This person would probably would not be a debunker.

ROLE PLAY

TYPES THAT MAKE UP A GROUP

- **MODEL MEMBER**
- **EAGER BEAVER**
- *Clarifier*
- **BRILLIANT ONE**
- *Emotional One*
- **SILENT ONE**
- **PARLIAMENTARIAN**
- **Debunker**
- **THE EXPERT**
- *Creative Optimist*

REFERENCE: ADAPTED FROM SATHRE, OLSON & WHITNEY, LET'S TALK, FORESMAN & COMPANY, 1977

ADAPTED FROM GROUP PROCESS
GROUP BEHAVIOR

Supplement C
EFFECTIVE GROUPS

Family Community
Leadership

ROLE PLAY CHARACTERS

Model Member:

As a model member of a discussion group, you consider the needs of the group and its goal; you make every effort to help the group reach the goal. Your contributions are candid and brief; you make sure others understand your ideas, and you try to understand theirs. You provide leadership services when you can, and you do so appropriately. You are aware of other members, and you try to help them make their greatest contribution to the group.

Eager Beaver:

You are interested in reaching a solution quickly. You value efficiency and speed. Sometimes you are impatient with those who wish to take time to discuss a point. You want to keep on task and get things done.

Clarifier:

You are well prepared and articulate. You see issues clearly in your own mind, and you want others to understand them. You will often ask "are you trying to say....?" Or, "I'm sorry I don't understand the issues here—could we go over them again?" You help the council arrive at a decision together, and to make that decision clearly understood by all.

Brilliant One:

You are intelligent; you know it, and so does the rest of the group. You do not try to dominate; you are patient, explaining points carefully and answering all questions. As the discussion progresses, your patience may grow short; you talk more often and in more positive terms. If the other members don't accept your ideas, you may feel that they don't understand you.

The Expert:

You have learned professional jargon from reading reports and summaries, "Rule 36," "Rule 14," "CSP," "DRS," and "SPMI" are so familiar to you that you don't notice that others on the council don't understand them. You do your homework well and know what position the county or state holds on any mental health issue at any given time. You sometimes become caught up in details and may miss what other members of the council are saying. You have little patience with others as they struggle to understand issues and unfamiliar terms; nevertheless, you are a very valued council member because you know issues.

Emotional One:

You react strongly to the contributions of others. You are passionate about your commitment to the work of the council. Mental health rules and legislation are not as important to you as the **people** that they affect. You approach decision making from what you feel inside, and often make statements such as, "That just doesn't seem right somehow" or "That attitude really makes me angry." You have built-in guides to your opinions that sometimes make your views seem illogical. You express your opinions quite freely and quite early.

Silent One:

For many reasons, you will not talk in a group. You may believe that you have nothing to say, that others have more important contributions, or you may simply be shy. Although you may answer a question briefly, you will not initiate a discussion; you just don't want to talk.

Conformist:

You agree with everything that is said. You make contributions and you think everyone else's remarks are very good. Because you wish to please everyone, you try to avoid disagreements; therefore, you are not at all critical of what other council members have to say. If you are asked what you think of the council, your answer is "it's just great."

Debunker:

You have served on your council for a long time and have been embroiled in mental health issues long enough to know that hard work is not always rewarded. You sometimes intersperse your comments with, "Well it won't work anyway," or "What's the point?". Your fellow council members admire you for your past dedication, and have come to accept your position as part of "advocate burnout," with the result that your remarks are ignored.

Creative Optimist:

You read voraciously on every subject imaginable and belong to a number of "grass roots" organizations, all of which you believe in passionately. You enjoy people and often involve them in your unusual problem solving. Your ideas are usually unique and sometimes appear to be somewhat bizarre. Your ideas come in a flash and sometimes overwhelm others. Your creative energy is endless, and you come up with a solution for even the most sticky problem. You challenge fellow council members to think beyond what has been done in the past. You are convincing and engaging and often initiate cooperative efforts in making your ideas work. Hence, you are respected even though your ideas sometimes seem a little "on the fringe."



Situation: The LAC is holding its usual monthly meeting. The new rule 79 is being discussed. The chair has read aloud a section contained in the new ruling which reads:

"...the average caseload of a case manager providing case management services to adults with serious and persistent mental illness must not exceed the ratio of 40 clients to one full-time equivalent case manager." —Rule 79, 9520.0903, Subpart 2A.

This county, which we will call Lakehood, is a sparsely populated county which has one case manager and one CSP worker. Prior to the meeting the LAC chair has obtained from the social services director, the number of persons who are currently receiving case management services. The number is 50. How can Lakehood County conform to the new rule? Possible solutions:

- Reach the 40 figure by cutting out the person who needs case management least.
- Ignore the state rule governing case management.
- Ask for a waiver.
- Find the funds to hire another half-time case manager.

LWV
CONSUMER/FAMILY TRAINING SESSION
SEPTEMBER, 1993

SCHEDULE FOR THE DAY

9:45-10:00 a.m.	Sign In. Coffee and donuts.
10:00-10:45	Participant Check In. Report by County on CSSA Plan, Unmet Needs Identified by LAC.
10:45-11:15	Quicky Exam: Ten Questions. Discussion.
11:15-12:15	First Activity: The Voice of the People.
12:15-1:00	LUNCH. FREE TIME.
1:15-2:15 p.m.	Second Activity: Care and Feeding of State Legislators.
2:15-3:00	Discussion of State Conference. • Purpose of Conference • Ideas for Workshops • Speakers • Eligibility, scholarships • Transportation, carpooling • Volunteer Area Coordinators

Materials distributed:	Summary of Grant Writing Workshop Revised Definition of Serious and Persistent Mental Illness Scholarship Applications
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TRAINING SESSION VII SEPTEMBER 1993 MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

THE VOICE OF THE PEOPLE

Can you really make a difference?

Can you? Can you really make a difference? Have you asked yourself that question as your workbooks have grown bigger and bigger? As we studied the statutory requirements of local advisory councils? As we discussed the mission of the Mental Health Act, and the rules that govern the statutes in that act? After many discussions about what constitutes a quality mental health system? You may now ask, "Have we done it all, and if we have where do we go from here?"

As participants we may think that after six full days of study, we have learned all there is to know about the mental health system. Yes, we have covered a great deal of material together, but we really cannot understand the mental health system in Minnesota until we understand the legislative process by which that system was created and through which it is presently governed. Our seventh training session will give us an overview of the way the Minnesota legislative system operates.

It almost seems that a kind of mystique surrounds the legislative process. Mental health advocates who fight like tigers at the local level shrink like well fed pussy cats in the sun when the state legislature is mentioned, mumbling, "Oh no, I don't know anything about bills, sessions, and amendments. I'm not sure I want to know! I leave all that up to other people who understand it." Actually, taken slowly, learning about the legislative system is not at all frightening. We need to take it one small step at a time.

*The legislative process should reflect the desires of
the ordinary citizen who smarts and struggles under the status quo.*

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

The legislative process represents a means for change to the person who has seen or experienced defects in a governmental system that may not be serving people in the best way possible. A democratic system of government should serve the outraged, the angry, and the dissatisfied just as much as it serves the contented and the indifferent. The legislative process is slow. Advocacy may not seem to work at first, and it is easy to become impatient. It may take years to bring about an important change.

We all see laws and policies that have outlived their usefulness. It is the duty of our legislators to enact new laws where needed, change laws that need change, and provide money to fund unmet needs. Legislators serve at our pleasure, and if the laws are to serve all citizens, people with special interests and needs must become involved.

***Remember, laws are going to be passed —
with or without you.***

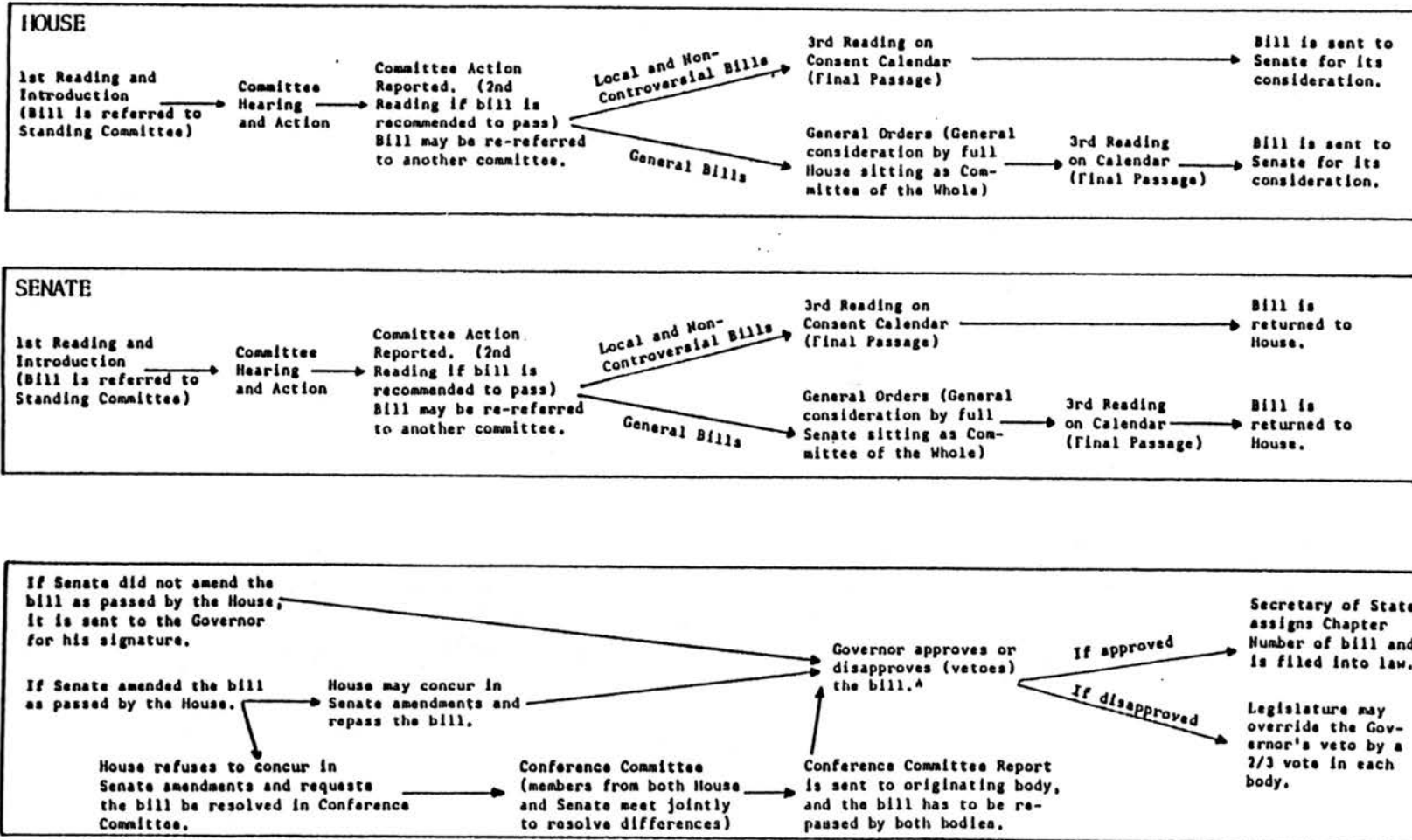
Just being an informed citizen is not enough in a democracy. Citizens in a democracy need to decide what they want from their government, what they are willing to pay for what they want, and how they can see their goals accomplished. The first step toward accomplishing specific goals is to know how the legislative process works.

Basic Facts About the Minnesota Legislature

- The State of Minnesota is divided into 67 senate districts.
- Each senate district is divided into two of the 134 house districts.
- Senators have four year terms, representatives two year terms - The Minnesota Legislature convenes in regular session each odd-numbered year on the first Tuesday after the first Monday in January
- The Legislature meets in regular session both years of the biennium for a total of 120 legislative days. The first year of the biennium is a long session which includes funding, the second year of the biennium is a short session.

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

HOW A BILL (HOUSE FILE NO. 1) BECOMES A LAW



Bills introduced in Senate follow same procedure beginning with Senate action first.

How to Track a Bill

*If the Governor does not return a bill within three days, it becomes a law unless the Legislature has adjourned. Bills passed during the last three days of a session may be presented to the Governor during the three days following adjournment. They become law only if the Governor signs them within 14 days after adjournment.

How to Track a Bill Through the Legislature

Consult the chart (on the previous page) mapping the process by which a bill becomes a law. At each step of the process you can become involved in some way. It is important to understand the process and the possibilities for exerting influence at the appropriate stages. Ideally, a lobbyist would help initiate the legislation, help write the bill, help find the authors (a most important step - the choice can determine the outcome), help make the necessary changes, and guide the bill to its final passage. When such complete participation is impossible, the lobbyist may seek to influence legislation at any stage of the process. A good lobbyist may become indispensable to the chief author of a bill.

In developing legislation and/or lobbying, lobbyists will have contact with committee chairs, committee secretaries, research assistants, and the research staff. It is probable that at some point lobbyists will be working with various state departments and state agencies that will be affected by the legislation. These contacts will vary with the issue and personalities involved. Lobbyists will also want to contact the Governor and Administration staff.

BILL DRAFTED AND INTRODUCED

Anyone can propose an idea for a bill. The Revisor of Statutes will put the bill in the proper form. However, each bill must have at least one legislator in each house as its sponsor or chief author. Up to four additional authors in each house may be selected with the chief author's approval. Confer with your legislative sponsors as you are researching and drafting your proposed bill. The thoroughness of your research and amount of support you can prove for your idea will be influential in your ability to obtain legislative sponsors. Seek a cross section of sponsors for your bill, i.e., IR and DFL, metro and non-metro, male and female. You should select authors who are members of the committees which will hear the bill.

COMMITTEE ACTION

Here is great opportunity for citizen involvement. All bills are assigned to committees for action. All committee meetings or hearings are open to the public.

Before the Hearing

1. Write letters, make phone calls, send a fax, or (best of all) make personal visits to all members of the committee. It is helpful to provide each member with a fact sheet and other resource materials. Lots of information is helpful, but be sure to include a one page condensation for immediate perusal. Legislators do not have time to thoroughly research every bill.

How to Track a Bill Through the Legislature (continued)

2. Contact any other legislators or public officials, including the Governor, who might influence the committee. Keep in touch with any state agencies involved in the issue.
3. Organize a coalition of other organizations.
4. Try to have each legislator contacted by a resident of her/his district.

At the Hearing

1. Attend. Be quietly conspicuous in the audience by wearing a button indicating your support or affiliation.
2. Testify.

GENERAL ORDERS

Contact all legislators now that the full House or Senate will be debating the bill.

1. Provide fact sheets and resource materials.
2. Give your opinions on whatever amendments were attached by committee or are contemplated on the floor.
3. Ask all members of your coalition to make similar contacts with legislators.

CALENDAR

Contact the legislators again. Perhaps just a short letter or phone call. They should all have the facts from you by now.

SECOND HOUSE

Action is the same as in the first house. However, if you are a chief lobbyist (if you have been instrumental in drafting and/or supporting the bill), you will serve as the eyes and ears of each chief author by advising her/him of the action taken in the other house and its committees. There is very little communication between authors in the two houses. You can be that vital communication link.

How to Track a Bill Through the Legislature (continued)

CONFERENCE COMMITTEE

If the House and Senate versions of a bill are not in total agreement, a conference committee of three to five Senators and an equal number of Representatives must meet to reconcile the differences. It is still possible to be influential at this stage. Messages may be conveyed to members of the conference committee and key legislative leaders in the form of phone calls, letters and brief visits. Use your judgment here. Don't overpower them. Generally, by the time these committees are formed it is late in the session and everyone is extremely busy. Your presence at conference committee meetings may be the most effective lobbying technique at this stage. You may be called upon to provide information on the bill.

GOVERNOR

After a bill has passed both houses your messages should be directed to the Governor and his staff. Be sure all members of your coalition make this contact. The Governor should hear from all parts of the state. NOTE: This is probably not your first contact with the Governor's office on this issue. He/she has heard from you and/or your supporters since the bill was first introduced.

MONITOR THE IMPLEMENTATION

As a concerned citizen lobbyist your job is not over once the Governor signs a bill. That bill will not be effective unless it is enforced. Various state administrative agencies are responsible for such enforcement through rule making and supervision. The legislative lobbyist now becomes a monitor. Determine which agency will be responsible for enforcement of your bill. Attend any rule making sessions. You have opportunities for input here. Keep the public informed on how well the law is being implemented.

*"How to Track a Bill Through the Legislature" reprinted with permission from
How To Make A Difference, A Citizen's Guide To State Government, compiled and researched
for the League of Women Voters of Minnesota by Betty Bayless, Erica Buffington and
Jean Tews; revised 1993 by Susan Simmonds.*

Members of the legislature perform many functions in order to represent people with widely varying interests.

Writing and enacting legislation is the function we primarily associate with a legislative body. But legislators perform other functions, such as resolving policy conflicts and overseeing the administration of public policy. The exchange of information is the center around which all legislative functions revolve.

In Minnesota current legislative information is available for lobbyists and citizens interested in following any part of the legislative process. The numbers listed in the box below will help you make better use of the information system.

LEGISLATIVE INFORMATION

All numbers are area code 612 unless noted.

To identify your legislative district and your legislators

SENATE INFORMATION OFFICE: 296-0504

HOUSE INFORMATION OFFICE: 296-2146

Toll Free number for house information: 1-800-657-3550

To track progress of specific bills

SENATE INFORMATION OFFICE: 296-0504

HOUSE INDEX: 296-6646

To obtain a copy of a bill at no charge

SECRETARY OF THE SENATE: 296-2344

CHIEF CLERK OF HOUSE: 296-2314

For up to date committee schedules and agendas

SENATE HOTLINE: 296-8088

HOUSE CALLS: 296-9283

Free weekly publications on legislative action:

Briefly, publication of MN Senate: 296-0259

Session Weekly, House publication: 296-2146

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

SO WHAT CAN I DO TO INFLUENCE LEGISLATIVE POLICY?

Many legislators have full-time jobs in addition to their legislative position. They probably have limited resources for office expenses and paid staff. Legislators depend on constituents to keep them informed. A legislator who truly represents his/her constituency appreciates receiving information and opinions from them. "Write, Call, Visit" (Workbook, pp. 25-28) noted that citizens' interests and concerns are not only good politics but crucial to the survival of a politician.

The legislative process is complicated, but it is not impossible to understand. As you work toward a better understanding of that process, it is best to **go slowly at first**. Your first exposure might be accompanying an experienced person to a hearing or committee meeting on a mental health issue. Seeing a committee in action may encourage you to become more involved.

To prepare yourself for further involvement:

- Call Legislative Information (pg. 137) and ask to have "Briefly" and "Session Weekly" sent to you. These publications will keep you informed on what is currently going on in the legislature.
- Review the section titled "Write, Call, Visit" in this workbook (Training Session II, pp. 25-58). A good way to become involved in the political process is to write or call your legislator regarding an issue that is important to you. Writing or calling becomes crucial when specific legislation is being considered that will directly affect services for persons who have a mental illness. It is important to let lawmakers know exactly what you want included in a bill, because if it is passed, it will affect citizens for a long long time.
- Attend as many public meetings on mental health issues as you can.
- Join groups or organizations that work for better government, such as the League of Women Voters, as well as advocacy groups for people with mental illnesses, such as the Alliance for the Mentally Ill, the Mental Health Association, or the State Consumer Network. (For addresses, see Workbook, **RESOURCE** tab).
- Read the "Mental Health Advocate," the newsletter for the Minnesota Alliance for the Mentally Ill. It contains up to date information about what is taking place in the legislature in language that a beginner can understand.

- Place your name on "legislative alert" lists for mental health issues through the Alliance for the Mentally Ill and The Mental Health Association. This will provide you with current information about bills in the legislature and how to contact key legislators.
- Join with other people working for better mental health services. Belonging to a group of people whose members are bound together by a common interest provides an immediate means of support.
- Become very familiar with the Minnesota Comprehensive Mental Health Act so you will know present mental health legislation.

***Materials that will help you understand
the legislative process:***

For a comprehensive guide to the legislature, participants may want to obtain a copy of the League of Women Voters guide to the state government, **How to Make a Difference**. This guide is updated every two years and includes maps, a current listing of state senators and representatives, detailed steps of how to lobby, and how to track a bill. Available from the League of Women Voters, 550 Rice St., St. Paul, MN 55113. The 1993 price is \$10.00 plus \$2.00 mailing.

To subscribe to the "Mental Health Advocate" call the Minnesota Alliance for the Mentally Ill and ask if there is an affiliate near you. The newsletter comes with a paid membership to a local alliance. A one year subscription to the Newsletter without membership costs \$15.00; for persons on a fixed income without membership a subscription costs \$5.00. For a subscription without a membership to AMI, send a check to Alliance for the Mentally Ill, 1595 Selby Ave, Suite 103, St. Paul, MN 55104. The "Advocate" is sent free to drop-in centers, group homes, and city libraries.

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

RULE-MAKING

The legislative process does not really end with the passage of a law. For much legislation administrative "rules" are written to fill in the details which guide state and local governments in the implementation of a law. Once adopted, rules have the force of law. They are often in force for many years. Rules are developed by state agencies working with advisory groups. The Department of Human Services is involved in most rules affecting the mental health system.

Rules are very important in setting policy since the language in the law may leave many gaps in establishing policies. There may be honest differences of opinion about what the legislature had in mind when writing the legislation and how certain terms should be defined. (e.g., the new case management rule, Rule 79, includes important changes from the old Rule 74, including setting the goal of 30 clients to one case manager. A summary of Rule 79 is on the pages following 121, Training Session VI in this workbook.)

Since a rule will define policy for many years it is important for advocates to be involved in the rule-making process. Ordinarily, the rule is drafted by the appropriate division of the government department, usually DHS, working with an advisory committee. The rule may go through a number of different drafts. When the final draft is published, it is distributed to affected groups and citizens who request it. If the rule is controversial a public hearing is held at which all interested persons can speak. The hearing is conducted by hearing examiners from the independent Office of Hearing Examiners. Written testimony is also taken during a specific time period. At the end of the period, after the hearing, the division prepares and publishes the final rule.

Citizens can express their views during the rule-making process in several ways:

1. Make sure that advocates of strong mental health services, including consumers and family members, serve on the advisory committee participating in drafting the rule.
2. Sit in on sessions of the advisory group, even if not an official member.
3. Be included on the list for distribution of drafts of the new rule.
4. Respond to the rule either by written testimony or by a public statement or both. (The Hennepin County Mental Health Advisory Council, for instance, has prepared statements and testified at several rule-making hearings.)

SECOND ACTIVITY

CARE AND FEEDING OF STATE LEGISLATORS

Task 1: There are many ways to skin a cat! Reaching legislators can sometimes tax even the most creative minds. Share with others at your table ways that your advisory council has helped your legislators to become aware of the needs of persons with mental illness in your county or what your LAC might do in the future.

As ideas generate, make a check list of the ways in which an LAC can work with legislators. This list might include educating legislators about mental illnesses, bringing to their attention the needs of people who have serious and persistent mental illness, gaps in services, and discrimination issues.

What do you consider the most pressing concerns, and how can you convey them to legislators?

THREE WAYS TO SKIN A CAT

Concern:

How to present it to your legislator:

Concern:

How to present it to your legislator:

Concern:

How to present it to your legislator:

TERMS USED IN THE LEGISLATIVE PROCESS

ADJOURNMENT	The time called to end a session.
AMENDMENT	Any alteration made or proposed to be made in a bill or motion by adding, changing, substituting, or omitting.
BICAMERAL	Two bodies within a Legislature - in Minnesota, 134 Representatives elected to two-year terms in the House; 67 Senators elected to four-year terms in the Senate.
BILL	A proposal to change or abolish an existing law or create a new one.
CALENDAR House	Bills on the Calendar are up for final passage and must be on the members' desks for at least 24 hours before the House acts. One or more committees have approved the bills and the Committee of the Whole has approved the bills when they are on General Orders. These bills have had two readings on the House floor. To amend a bill on the Calendar, a member must have unanimous consent of the full House.
Senate	All the bills, resolutions, and other matters coming before the Senate for final action are placed on the Calendar in the order in which they have been acted upon in Committee of the Whole. The Calendar is printed and on members' desks one calendar day before the items are considered.
CHIEF AUTHOR	Legislator who sponsors a bill and whose name appears after the file number on the bill.
COMMITTEE	Members delegated by a legislative body to consider and make recommendations concerning the disposition of business referred to it. Committees may: recommend passage of a bill in its original form; recommend passage after amending the bill; may recommend not to pass or may propose a substitute; or make no recommendation, in which case a bill dies when the session ends.
Ad Hoc	Appointed for some special purpose; automatically dissolves upon completion of this specific task.

TERMS USED IN THE LEGISLATIVE PROCESS (continued)

Committee of the Whole	The entire membership of the House or Senate acting as a single committee with the presiding officer as chair.
Conference	A committee composed of members of each house appointed to recommend a compromise between different versions of a bill approved by both houses.
Interim	A committee delegated to study or investigate certain matters, primarily after the Legislature creating the committee has adjourned and to report to the next regular session.
Joint	A committee composed of members of each house.
Select	A special committee of legislators or of Senators or of House members.
Standing	The regular, ongoing committees of the Legislature set up to perform certain legislative functions. Each Legislature establishes its own standing committees, deciding how many there will be, what they will be called, and what their function will be.
COMPANION BILLS	Identical bills introduced in both houses.
COMPROMISE	A conference committee agreement on different or conflicting versions of the same legislation which both houses have passed.
CONCURRENCE AND REPASSAGE	When the House passes a House File (bill), it sends the bill to the Senate for approval. If the Senate votes to amend the House File, that new version of the bill must come back for a House vote to "concur" (agree) with the Senate amendments and "repass" the bill. This same process is repeated if the Senate passes the original bill and sends it to the House.
CONSENT CALENDAR	List of non-controversial bills which usually passes without debate; bypasses usual General Orders and Calendar procedures.

TERMS USED IN THE LEGISLATIVE PROCESS (continued)

GENERAL ORDERS	A list of bills awaiting preliminary action in the House and Senate each day during the session.
HEARING	Committee meeting for the purpose of listening to arguments for and against an issue by concerned groups and individuals.
HOUSE FILE (H.F.)	A bill introduced in the House of Representatives.
INTERIM	The interim is the period of temporary adjournment between the session of the first year and the session of the second year of the biennium. Legislators continue their work and, consequently, lobbyists must be prepared to observe and testify. Legislative committees study specific problems during the interim to report findings to the next legislative sessions. They also may hear bills and make recommendations on their passage. To learn about interim activity, contact committee chair or secretary.
JOURNAL, HOUSE AND SENATE	The official chronological record of the action taken and the proceedings of the respective houses. Journals are kept on a daily basis in each house, and the printed copy of the day's proceedings is usually available by mid-morning the following day.
LEGISLATIVE COMMISSIONS	See page 7.
LINE VETO	The Governor vetoes a portion or portions of an appropriation bill, thus allowing other provisions of the bill to become law. This veto applies to appropriation bills only.
LOBBYIST	A person engaged in influencing legislation. May be paid or volunteer, full-time or part-time.
MEMORIALIZE	To address or petition the federal Congress on a specific matter by memorial resolution.

TERMS USED IN THE LEGISLATIVE PROCESS

(continued)

OMNIBUS BILL	A bill that combines several or many legislative measures related to the same subject. Most often the phrase "omnibus bill" means one of the several omnibus appropriations bills that are passed each year. In odd-numbered years, these bills appropriate money. Each bill provides funding for a broad array of services.
RECONSIDERATION	Any member may ask the respective house to reconsider a vote as long as that member voted on the prevailing side (the side that cast the majority of votes on that issue). A member must make the motion to reconsider within two meeting days of the original vote.
REVISOR OF STATUTES	A legal authority office which puts bills into proper legal form, properly places approved amendments into the language of the bill (a procedure known as engrossing), and updates the Minnesota Statutes to include new laws.
RULE 1.10	Chair of the House Ways and Means Committee can bring up for immediate consideration tax or appropriation bills that are on General Orders. Those bills bypass the usual General Orders and Calendar procedures. Customarily, the chair informs the House of the bills they want the House to consider under Rule 1.10 one day prior to actual consideration.
RULES	Regulating principles or methods of procedure adopted by the Legislature:
Joint	Rules governing the relationship between and affecting matters between the two houses.
Standing	Permanent rules adopted by each house for the duration of the session.
Temporary	Practices which may be adopted at the beginning of a session until standing rules are adopted.
SENATE FILE (S.F.)	A bill introduced in the Senate.
SINE DIE	Adjournment without a day being set for reconvening. Final adjournment.

TERMS USED IN THE LEGISLATIVE PROCESS

(continued)

SPECIAL ORDERS

Rules of the House allow the chair of the Committee on Rules and Legislative Administration to bring up on Special Orders any bill that had its second reading. This means the bill skips General Orders and the Calendar and the House can consider, amend, and pass the bill in one day.

SUSPENSION OF THE RULES

Under House Rules, every bill must get three readings on the House floor on three different days. If two-thirds of the House agrees, a bill can get its first, second, and third readings on the same day. This is a Suspension of the Rules to Advance a Bill and occurs when it is urgent that a bill pass within a limited amount of time. In the Senate a motion to suspend the rules for the purpose of advancing a bill shall be made only under the order of business, "Motions and Resolutions," and a 2/3 vote is needed.

LWV
CONSUMER/FAMILY TRAINING SESSION
November 1993

SCHEDULE FOR THE DAY

- 9:45-10:00 a.m.** **Sign In. Coffee and donuts.**
- 10:00-10:30** **Announcements.**
Quick Workbook Check, Distribution of Missing Material.
- 10:30-11:30** **First Activity: Monitoring Mental Health Delivery Systems.**
 1. Overview: LWV Monitoring Report:
 How Are We Serving Minnesota's Mentally Ill?
 2. Local Task Force.
- 11:30-12:15** **Group Discussion: Is My LAC Still Wandering?**
Will Formation of a County Task Force Give My LAC a
Needed Direction? Does My LAC Need a Road Map?
- 12:15-1:00** **LUNCH. FREE TIME.**
- 1:15-3:00 p.m.** **Second Activity: Creative Networking.**
Planning a Meeting — On Your Own.

Materials distributed:

"Closure or Downsizing of Regional Treatment Centers"
News article on LWV monitoring study
Leader's packet.
Check list
"The Art of Delegating"

TRAINING SESSION VIII

NOVEMBER 1993

MENTAL HEALTH LEADERSHIP PROJECT

FIRST ACTIVITY

MONITORING MENTAL HEALTH DELIVERY SYSTEMS

In our last Training Session, we learned something about the intricate structure of the legislative process. The workbook material described the process by which laws are passed, funded, and subsequently enforced. The training stressed the fact that once a law is passed, its enforcement is not a "done deal." In Minnesota counties bear a major responsibility for providing mental health services that are mandated by law. As funding for local services becomes increasingly scarce, it is important that Local Mental Health Advisory Councils make sure that mandated services are, indeed, delivered and are of high quality. Monitoring of mental health services is one way of doing this. Monitoring can be done in a variety of ways.

The following material is taken from a recent publication, *Monitoring Mental Health Services at the County Level: A Workbook*, and describes some monitoring techniques that are currently being used in Minnesota.

- 1** Some services are monitored by outside accrediting agencies or by state licensing bodies. Psychiatric in community hospitals and regional treatment centers are accredited by the Joint Committee in Hospital Accreditation (JCAH) and/or by the federal Health Care Financing Administration (HCFA).
- 2** Community residential treatment programs (Rule 36s) are licensed by the Department of Human Services.
- 3** Vocational rehabilitation programs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)...
- 4** and community mental health centers are voluntarily certified by the Department of Human Services.
- 5** County contracts with private agencies ordinarily include reporting requirements designed to ensure at least minimal compliance with county program objectives.

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

6 Professionals providing care and therapy to persons with mental illness must meet licensing requirements established by the state.

7 Official procedures also exist for reporting abuse of persons with mental illness....under the Vulnerable Adults Act and [for] reporting to the Office of the Ombudsman for the Mentally Retarded and Mentally Ill.

8 A particular omission in many official monitoring procedures is the absence of attention to "quality of life" factors beyond minimal compliance to health and safety. Most regulatory mechanisms for programs for persons with serious mental illness do not attempt to assess such intangibles as staff morale, respect for the dignity of the clients or the overall attitude of acceptance or nonacceptance of persons with mental illness in the community.* (emphasis editor's)

MONITORING BY CONSUMERS AND FAMILIES

In some states, county and state offices have independent boards or teams that monitor mental health services. A team of consumers and family members called the Consumer Satisfaction Team monitors services in Philadelphia. The program is funded by the County and State Offices of Mental Health. An independent board made up of consumers, family members, and mental health professionals supervises all activities of the team. Fifty-one percent of this board must be consumers and family.

In Oklahoma and Oregon monitoring is currently being done by consumers and family members from the Alliance for the Mentally Ill. This monitoring appears to be more informal and somewhat less comprehensive than the Pennsylvania system.

ARC (Association of Retarded Citizens) of Minnesota says that it is essential that organizations be involved in monitoring "to improve the quality and availability of services." ARC believes that monitoring requires service providers to be accountable for the success or failure of their programs. ARC recommends that advisory committees be used as an effective and legitimate means for monitoring the quality of residential services.

*League of Women Voters of Minnesota Education Fund *Monitoring Mental Health Services at the County Level: A Workbook*, St. Paul, 1989.

In Minnesota the League of Women Voters has been monitoring mental health services since 1990. This monitoring is different from that previously described, since most monitors were members of local chapters of League of Women Voters, and had no previous contact with the mental health system.

The first phase of the League of Women Voters Mental Health Monitoring Project took place in sixteen counties. Monitors, using check-lists prepared by the League of Women Voters, assessed county mental health services, as well as Rule 36 facilities and Regional Treatment Centers. In the second phase of the project affordable housing for persons with serious and persistent mental illness was monitored. The final monitoring project focused on CSP/vocational services at the county level. Checklists used by monitors as well as the final report of the first phase of the project, *How are We Serving Minnesota's Mentally Ill?*, are available from the League of Women Voters of Minnesota Education Fund.

Of particular importance to members of Local Advisory Councils in this report are the results of monitoring LACs. That section is reprinted here. It is hoped that these specific findings create a base of knowledge on the effectiveness of Local Mental Health Advisory Councils that will be helpful to LAC members.

Material beginning on page 150 and continuing through page 157 is reprinted from *How Are We Serving Minnesota's Mentally Ill?* with permission from The League of Women Voters of Minnesota Educational Fund, 1993.

The checklist used by monitors to interview LAC chairs and members follows that report.

LOCAL MENTAL HEALTH ADVISORY COUNCILS (LACs)

Background

The Community Social Services Act of 1979 transferred authority for allocating federal Title XX funds and state funds for a variety of social needs from the state to the county. It also mandated that each county establish a mechanism for citizen participation to advise the county board about human service needs. The mandate in the 1987 Comprehensive Mental Health Act for local mental health advisory councils was intended to provide advice focused more specifically on mental health needs and services. The Act required all counties to establish a local mental health advisory council (LAC) or to designate the mental health subcommittee of an existing advisory council to serve this function. The 1987 Legislature judged that providing for a systematic mechanism for incorporating the views of a diverse group of knowledgeable citizens justified the creation of LACs and outweighed county concerns about the burden of an additional state mandate.¹

County boards of commissioners were to appoint mental health advisory council members to reflect "a broad range of community interests". Each council was to include "at least one consumer of mental health services, one family member of a person with mental illness, one mental health professional, and one community support services program representative." There was nothing to prevent counties from also including representatives of community groups, clergymen, representatives of the chamber of commerce, etc. and a number of them did.

All local mental health advisory councils were required to include representatives from four different groups making a minimum membership of four. The Mental Health Division of

the Minnesota Department of Human Services recommended that multi-county councils include at least six members.

Each local mental health advisory council was required to meet at least quarterly to "review, evaluate, and make recommendations regarding the local mental health system." LACs were to arrange for annual input from their regional treatment center regarding coordination of care between the regional treatment center and community-based services.

Each county board was required to report to the state Mental Health Division "the methods used to ensure the local advisory council's active participation in the county board's ongoing authorities and responsibilities for mental health services."

The local mental health advisory council was also charged to identify the three highest unmet needs for mental health services in the county for the CSSA plan. (Initially the Mental Health Division required the signature of the chair of the local advisory council as having participated in the formulation of the plan on all mental health plans and proposals for mental health grants to the state. However, this requirement has been omitted from the CSSA plan since 1991 when the plan format was shortened considerably.) The streamlining of the format for the CSSA Plan, which now incorporates the county mental health plan, has also reduced the number of questions to counties relating to LAC composition and functioning.

During the 1991 legislative session (after the LWV monitoring project), new language described the role of local advisory councils. The county board must "develop and coordinate a system of affordable and locally available adult mental health services..."

¹ Interview with Bill Conley, director of public affairs, Mental Health Association of Minnesota.

"...with the involvement of the local adult mental health advisory council or the adult mental health subcommittee of an existing advisory council, develop a biennial adult mental health component of the community social services plan required in section 256E.09 which considers the assessment of unmet needs in the county as reported by the local adult mental health advisory council... The county shall provide, upon request of the local adult mental health advisory council, readily available data to assist in the determination of unmet needs."

Additional new language states that the local advisory council must:

"...provide to the county board a report of unmet mental health needs of adults residing in the county to be included in the county's biennial mental health component of the community social services plan..., and participate in developing the mental health component of the plan..."

The LAC Role

The LWV Monitoring Project placed a high priority on gathering information concerning LACs because of the LWVMN's historical commitment to an open, responsive governmental process and to citizen participation in the governmental process. As stated above, county human service advisory boards were explicitly mandated in the 1979 CSSA Act in Minnesota. Citizen or lay advisory groups have characterized a number of federal programs at least since the New Deal. A number of programs dating from the War on Poverty in the 1960s mandate citizen advisory groups, often including persons living in poverty. Government at a number of levels has entrusted the tasks of evaluating some social service programs to lay groups.

It is important to note that local mental health advisory councils were not intended to be the decision-making authorities for mental health policies in counties. They are, after all, advisory to the board of county commissioners; they have no taxing authority and are not charged with final responsibility for policy making. As advisory groups, they bear none of the responsibility for liability or state sanctions which county administrators and staff may face. In addition, members of LACs are named by county commissioners; they do not, necessarily, perfectly include or represent a cross-section of all consumers, family members or service providers, or advo-

cates in the county. The method of appointment of LACs may tend to exclude "radical" advocates.² Nevertheless, LACs may serve as effective mechanisms for the infusion of new ideas including the perspectives of consumers and family members, be able to analyze policies from a broader perspective and, perhaps, suggest new solutions to system problems. LACs can never be panaceas for all systems problems but they have the potential to increase awareness of mental health needs in the community and to improve the way policy is shaped and delivered. This role is particularly important for a service system which is still being developed.

The establishment of representative and active mental health advisory councils might be expected to affect the overall priority assigned to mental health services and funding devoted to mental health services by the county board. They might be expected to recommend changes in the priority assigned to specific services and to the overall delivery of mental health services. Since LACs do not operate under constraints against advocacy like county or agency employees, active mental health councils may broaden public support for mental health services and help counties and service providers reach their goals; they can serve as allies and collaborators of mental health providers and professionals. Reports of LAC activity assembled by Bruce Weinstock, Mental Health Division, Minnesota Department of Human Services, in the quarterly LAC Newsletter show that a number of LACs serve as catalysts for change.³ Effective LACs have interpreted their role broadly; they have initiated educational efforts in their communities, advocated for change at other governmental levels, and have organized hearings to determine county mental health needs.

There is an inherent tension, however, between the responsibility of county staff and county boards and advisory councils. Active and assertive councils may be viewed as threatening to the status quo by counties and providers. Rather than being welcomed as collaborators they may be feared as adversarial. County boards, particularly those which do not want to improve mental health services or believe they lack the resources to do so, may not want to support strong advocates for change. Even dedicated county social service administrators and service providers may believe that they alone are best equipped to set and implement policies for their clients with mental illness. They may be reluctant to widen the number of policy-makers, or policy reviewers, especially by admitting clients and family members to this circle. This attitude may be particularly true of mental health professionals, since they are accustomed to working within a hierarchical medical model.

² However, most LAC members are at least mildly interested in mental health issues; they have the potential to be "moderate" advocates. Persons who oppose government involvement in mental health, those who champion an increase in services to other groups at the expense of persons with mental illness and those who are largely unaware of mental health issues are not likely to join LACs.

³ *Local Advisory (LAC) News*, Newsletter of Local Mental Health Advisory Councils, Minnesota Dept. of Human Services, Mental Health Division.

In addition, if county officials, who will be expected to staff the council and explain county policies and programs, are already overworked, dealing with an advisory council may be viewed simply as an additional burden.

Project Findings

Monitoring projects in 15 counties responded to questions concerning LACs.⁴ In some cases the checklists were completed on the basis of answers from county administrators; in others responses were from chairs of local advisory councils. Questions were answered quite fully with a number of additional comments.

In nine counties responses came primarily from one person. That person was the council chair in seven of these reports; the other two responses came from mental health administrators. In the remaining six counties, information was obtained from various combinations of people: two received information from sets of administrators, one from staff members involved in direct client relations, one from multiple members of the council and two from combinations of council members, administrators and direct service staff.

LAC Composition

Two of the 15 counties responding reported difficulty in meeting the LAC membership requirements. (Table 3-1) The categories not being filled, consumers and family members, are precisely the categories necessary to ensure that non-provider perspectives are brought to bear in evaluating needs and programs. One county, which reported no family involvement in the LAC and only one consumer member, noted that their LAC was "always heavy on the side of professionals."

Although our data neither support or refute this view it may be that, particularly in small counties, the continuing stigma against mental illness and the small potential pool of consumers and family members make it difficult to find persons interested in filling these slots. (Two counties indicated concern among consumer and family members at having their names and status made public, attesting to their perception of ongoing stigma.) Not all smaller counties, however, reported difficulties however. Brown County, a relatively small county, reported that their LAC had two consumer and two family members.

Table 3-1. Composition of Local Advisory Councils

Is there at least one consumer, one family member of a person with mental illness, one mental health professional and one community support services program representative?

<u>Answer</u>	<u>Number of counties</u>
Yes	13
Missing a consumer	1
Missing a family member	1
Valid answers	15
Missing Data	1

(As stated earlier, although two out of 15 is not close to a majority of participating counties, we believe that if two counties report they are not able to comply with statutory requirements, this is a significant finding. To have two counties out of 15 acknowledge that the LAC fails to meet the membership requirement may well imply that more than these two counties were actually out of compliance.)

There are often problems, of course, in recruiting volunteers for any community service. The failure to recruit consumers and family members, particularly at the early stages of establishing LACs, may not mean that counties have not made some effort. However, successful recruitment may require more than a simple ad in the local paper or one phone call. Interesting prospective consumer and family council members may depend on several contacts, clear explanations, briefing of possible volunteers, arranging transportation, etc. Meeting times and places may need to be adapted to meet the schedules and preferences of consumers and family members. It may be helpful to ensure that there is more than one consumer and family member on the council to create an acceptable comfort level. Our data do not show whether or not counties which report difficulty in attracting consumers and family members are expending this effort.

If sufficient consumer and family members are recruited, county staff and the chair of the advisory council may need to make special efforts to insure that they become active participants. Systematic briefings for non-professional members, for example, and making a conscious effort to establish a comfortable atmosphere for meetings may be needed to retain consumer and family members and to help make them effective members.

⁴ Certain tables will be presented in the text. All other tables referred to in this section may be found in Appendix A under "Local Advisory Councils."

Projects in all 15 reporting counties stated that their LACs had at least the minimum number of required members: four members for a single county council and six for the one multi-county council. (Table A-1) (A comment from the Ramsey County checklist pointed out that if the LAC included all the categories of membership required by statute it would be necessary to have quite a large advisory council to also include representatives of the public.)

LAC Attendance

Fourteen responding counties reported that attendance was "good" at LAC meetings. (Table A-2) Cass and Stearns both reported that attendance was "excellent." Mower reported 100 percent attendance. However, one county reported that membership was waning and attendance was inconsistent. (Since respondents were not asked for a specific percentages they might differ on what "active" participation and "good" attendance were.) Findings on the participation of LAC members were quite positive. Fourteen out of 15 counties said most members actively participate. (Table A-3) (This means participation without consumer and family members, of course, in at least one case.)⁵

Frequency of Meetings

The 1987 Act mandates that LACs must meet "at least quarterly." All of our responding counties indicated that their LAC met at least quarterly; most met at least nine times a year. (Table 3-2) Several counties—Anoka, Mower, Benton/Stearns and Washington—volunteered that they had subcommittees which met in addition to regular committee meetings. (It should be noted that quarterly meetings would probably not be sufficient to explain and thoroughly discuss all county mental health services, particularly if a number of lay members were relatively unacquainted with different programs and relevant legislation. Quarterly meetings might be enough, however, if several active subcommittees met more frequently.)

Liaison with RTCs

Project data indicate that regular input from the state regional treatment centers (RTCs), formerly state hospitals, is not being provided to all LACs. (Table 3-3) Three of the 15 counties stated they were not receiving such input from their

RTC. Several LACs reported visiting their RTC or occasionally meeting with them. In at least one county a social worker from the RTC served on the LAC. Our data do not show why this communication is not taking place; it may be due to a lack of initiative on the part of either the RTCs or the LACs. In any case, a lack of regular communication with the RTC will almost certainly impair the ability of the LAC to advise the county on coordination of RTC and community services. One checklist reported that they had communicated with their RTC but that there were still complaints of clients being "dumped" back to the county without aftercare or medications. (Note: Efforts by RTCs since 1990-91 to help "bridge" the transition of persons back to the community may have affected this pattern.)

Table 3-2. Meeting frequency for Local Advisory Councils
How often does the council meet?

<u>Answer</u>	<u>Number of counties</u>
Monthly (9-14 times a year)	10
Bi-monthly (5-8 times a year)	3
Quarterly (4 times a year)	2
Valid answers	15
Missing Data	1

Table 3-3. Coordination between Local Advisory Councils and the Regional Treatment Centers

Is the advisory council arranging annually for input from the regional treatment center review board regarding coordination of care between the regional treatment center and community-based services?

<u>Answer</u>	<u>Number of counties</u>
Yes	12
No	3
Valid answers	15
Missing Data	1

⁵ The Mental Health Division of DHS applied for and received a three-year grant from NIMH to train consumers and family members to be effective LAC members. The grant was awarded to the League of Women Voters of Minnesota to establish the NIMH LWVMN Leadership Training Project. Starting in September 1991 the project provides quarterly training sessions in 11 regions of the state. Attendance averages 170 statewide. In addition to training consumers and family members who are already LAC members to be more effective, the project has enabled 50 consumers and family members to become members of their LACs. Despite this success, there are reports of relatively inactive LACs in the southwest, southeast and northwest corners of the state, according to Erica Buffington, project director.

The Knowledge Base of LAC Members

One set of three questions concerned the knowledge base of LAC members—an important factor if LACs are to provide timely and appropriate advice to the county board. Knowledge is an important base of power and systematically informing lay members of LACs is almost certainly necessary to enable them to participate fully in policy discussions with service providers and to evaluate their local mental health system. Answers to these questions indicate that not all LAC members were being well informed about basic aspects of mental health policy and services. (Table 3-4) Twelve counties reported their council had been thoroughly briefed on county mental health services, but three counties answered “no.” Comments indicated varying degrees of formal orientation for new members. Some stated it was difficult to understand the complexities of the system, and that orientation was an ongoing process. One county reported their LAC had too much printed material to absorb—they received “volumes” at meetings with almost no time to study, and then were asked to approve plans or grants. They believed one meeting a month was not sufficient to learn about the system and take action. Another county reported it was really up to new members to take the initiative in learning about county services. Several counties indicated, though, that they hoped LAC members would become more expert through experience; the LAC process was still very new.

Six county respondents answered “no” when asked if their LAC had been briefed on the budget process, on state mandates and on the history of county mental health expenditures; only nine councils answered “yes”. Several counties reported that their LAC had been briefed—in one case given innumerable charts—but that their understanding of the budget was unclear. A respondent from one county expressed the view that the county did not want their LAC to know about the budget! One county reported that their LAC did not “work actively with finances” and an in-depth understanding of the budget did not exist. Another reported that while the budget had been explained in a broad way members did not understand the “flexibility” of the actual budget.

The record was worse when counties were asked if LACs understood the phrase “maintenance of effort” (the clause in the 1987 Act intended to guarantee that counties did not reduce mental health spending below a certain figure.) Seven counties answered “yes”, seven answered “no”, and one answered “don’t know.”

Table 3-4 Knowledge base of members of the Local Advisory Councils

Has the advisory council been briefed on all aspects of county mental health services?

<u>Answer</u>	<u>Number of counties</u>
Yes	12
No	3
Valid answers	15
Missing Data	1

Has the advisory council been briefed on the budget process, on state mandates and on the history of county mental health expenditures?

<u>Answer</u>	<u>Number of counties</u>
Yes	9
No	6
Valid answers	15
Missing Data	1

Do council members understand “maintenance of effort”?

<u>Answer</u>	<u>Number of counties</u>
Yes	7
No	7
Don't Know	1
Valid answers	15
Missing Data	1

Relationship with the County Board

One important measure of LAC success is regular communication with the board of county commissioners. (Communication with the director of mental health services and/or the social services director is also important, though not required by statute.) The structure of this communication may take different forms in different counties.

Two questions concerned the relationship between the advisory council and the county board. The first question asked whether the council has access to the commissioners. Eleven counties reported some regular access to the commissioners. (Table A-4) (In one case, however, it appeared that the county social services director acted for the whole LAC.)

The second question asked whether the council “regularly participate[d] in the county board’s ongoing activities and

responsibilities for mental health services." Six counties reported that their LAC participated through a variety of means. One communicated "only through the director of social services" and two communicated "through the county plan." Three counties gave no answer or a very vague answer. (Table A-5) Comments from Anoka County indicated the LAC attended whenever a relevant mental health issue was on the commissioner's agenda.

Several counties commented they communicated regularly with their county boards; others indicated informal communication and suggested that since the LAC was new, formal communication would develop. Benton County reported that the county board might not always agree but it always listened to their suggestions.

A third question concerned LAC participation in providing feedback on long-range county priorities for the county mental health system. LACs in at least two counties stated they are not reporting feedback on long-range priorities. (Table A-6) This is unfortunate since this would seem to be an important LAC function. Although our data do not show this, this failure may partly be due to an absence of focus on long-range priorities throughout county decision-making. A comment from Rice County indicated that the LAC needed to look at goals and objectives on a long range basis but that this was not getting done because they were too busy with immediate needs. A response on a checklist from Nicollet County reinforced this problem. They were also frustrated because the format of the CSSA Plan was only for two years—instead of ten years.

The Independence of LACs

An additional concern arising from answers to our questionnaires has to do with the independence of LACs. If LACs are to advise the county board and also the county social service director, one would hope that they would arrive at their recommendations independently and then offer advice. Timely briefings on mental health service issues from the director and regular attendance by the director or county commissioners as ex officio, non-voting, members are desirable and important. Our data suggest, however, that in several counties social service directors or county commissioners chaired the LAC and also represent the views of the council to the county board. Other counties reported that county commissioners and social service directors are voting members of the LAC.⁶ If the individuals involved do not dominate meetings, this arrange-

ment may work. However, it could inhibit other council members from voicing their opinions. If the LAC is to offer an independent point of view it seems inappropriate to have major county decision-makers pre-empt this function. Comments from a mental health professional in one county expressed concern that the county social services director, who convened the LAC, set the agenda and determined the frequency of the meetings, was making it difficult for LAC members to raise criticisms or act as advocates.

In another county, concern was expressed that the chair of the LAC was a director of the local mental health center which received most county referrals (90 percent) under contract with the county.

Comments from some projects indicate that some "citizen" members, including consumers and family members, feel overwhelmed by professionals and county people. Since professionals and county employees are, by definition, better informed on specific issues, they are in a position to dominate, particularly if they do not place a high priority on creating a group of well-informed laypersons.

Suggestions that county administrators were manipulating LACs were made by respondents from two counties. One reported that the county director wanted to limit meetings to only the required four each year to save expenses—apparently stipends and mileage. Another county reported that clerical support was stopped because of a director's annoyance at LAC composition.

LAC Effectiveness

Several questions attempted to assess the effectiveness of LACs in advising their county boards. One question asked whether county boards considered the advice of the local mental health advisory council in carrying out their authorities and responsibilities, as required by the 1987 Act. All 15 counties responding reported that their county boards did consider the advice of the councils. (Table A-7) If this is accurate, project counties are complying with the act. Our questions could not determine the extent that county boards seriously weighed advice from local councils. One county reported "There is really no indication that the county commissioners seriously consider the recommendations of the LAC."

⁶ Although the practice of having social service directors and county commissioners serve as voting members of LACs was allowed, the Mental Health Division of the MN Department of Human Services 1989-1991 recommended that county commissioners and heads of county social service departments ex-officio, not be voting, members of mental health advisory councils.)

A number of reporters stated that the advice of the LAC is not always followed. However, a comment from Ramsey pointed out that the advice of even an effective advisory council might not always be followed and that members need to be empowered to "know that's OK." Cass reported that the "funds were not available to carry out all requests." Stearns reported that the county commissioners were open to the LAC but that they were too "strapped by financial concerns" to respond to LAC requests. Ramsey and Rice, however, both noted specific instances where the county board had implemented their recommendations, concerning the need for a drop-in center and for case management and a special contingency fund, respectively.

One county expressed frustration at that the LAC was not given enough time to respond to the draft of the county plan that was to be submitted to the state; they only received it the day before it was to be signed. Although time lines for reporting back to the state are often tight, this would seem to indicate that at least in that county, county decision making had not been readjusted to allow for meaningful LAC participation.

Relating to Citizens and Advocates

Two questions explored the interaction between the advisory council and citizens and advocacy groups. In answer to the first question; five counties reported they had no process for communicating with interested citizens; ten did report such a process. (In smaller counties, this lack of a formal process may not be a problem; frequent informal communication may exist.) Six counties mentioned that their meetings were open and that the public was invited to attend. (A-8)

In answer to a related question, all but one of the counties reported that the council responded to requests from advocacy groups, consumers and interested citizens. Several counties mentioned close cooperation with local chapters of the Alliance for the Mentally Ill and the Mental Health Association. (A-9)

Metro/Greater Minnesota Differences

Some differences between compliance with LAC requirements emerged in reports from the four metropolitan counties and the 11 Greater Minnesota counties in our reporting group. Our data indicate that counties outside the metro area have a

more difficult time having effective LACs. While understandable in terms of the lower population density, absence of anonymity and absence of organizations of consumers and family members, this finding is unfortunate since it is precisely in Greater Minnesota where community mental health services are least well developed and where the 1987 Act mandates might be expected to have the greatest effect.

Greater Minnesota counties were more likely to have LACs that met less than 12 times a year (most commonly, this meant nine monthly meetings in the fall, winter and spring.) (A-10) They were also more likely to indicate dissatisfaction with the amount of time available for meetings and with the amount of information provided to council members. (A-11) Members of non-metro LACs were less likely to have been briefed on the services provided by the county or on the budget process. (A-12) Finally, only Greater Minnesota counties reported problems in keeping the full slate of members required by law. One county reported difficulty in filling the "family member" position; another reported difficulty in filling the "consumer" position. (A-13)

However, the metro area counties were not in complete compliance with LAC requirements either. Two of the four metro counties reporting were not in regular contact with their RTC (Anoka Metro). (A-14) Only one greater Minnesota county reported no such contact. And, while metro county advisory council members were more likely to have been briefed on various aspects of the local system, they were reported as less likely than Greater Minnesota counties to understand the "maintenance of effort" requirement in the 1987 Act.

Barriers to Effective LACs

The barriers to fully effective LACs reported by counties reinforced the findings mentioned earlier.⁷

Two barriers reported concerned confusion over the intended LAC role. One county said they needed a clearer statement of goals from the state; another cited "unclear mission" as a problem.

Four counties expressed comments like "LAC does not know the issues or cannot stay abreast of the issues" as a barrier to effective LACs.

These comments are similar to the results of a survey from 130 LAC members conducted by Bruce Weinstock, state liaison

⁷ See Appendix B: Barriers, Table 1.

to LACs, in 1991. The survey found that 62 percent of the respondents felt that their LAC had a good sense of its role and purpose and 66 percent of the members felt a sense of accomplishment. Twenty-five percent of respondents, however, were unsure of the role of their LAC and 15 percent said their LAC gave reactive advice.⁸

Several other counties cited difficulties with the support, independence and knowledge of the council. One barrier to LAC effectiveness mentioned was "without strong leadership, the county agenda prevails." Another project stated that the county board did not give the LAC a strong voice so it had no power. Two projects declared "County does not share information with the council." "Insufficient time to get through agenda," was also mentioned as a problem.

Three counties reported "Council needs its own budget." In one county the fact that "the county and provider were at odds" impeded council effectiveness.

Two counties mentioned the lack of clerical support and an independent budget as limiting their effectiveness.

Conclusion

It seems clear that the mandate to create LACs was being carried out at least a minimal level by participating counties; however, the potential foreseen for the LACs by the framers and supporters of the 1987 Act is not always being realized. In part this may reflect the difficulty of finding effective leadership among providers, consumers and family members and/or the difficulties involved in assembling a sufficient number of interested and informed persons in a sparsely populated county. Continuing stigma against mental illness and competing demands on the time and energies of family

members and consumers may make it difficult for them to participate actively.

The failure on the part of counties to implement the mandate wholeheartedly may arise in part from a reluctance to "share power" or to create a body which may urge the county to allocate more revenue for mental health services. (However, interestingly, one county reported that the fact that the LAC was not active or able to act as an advocate was a barrier to a complete system of mental health services.) A lack of strong county support may also reflect a lack of experience in dealing with a citizen advisory body and with recruiting from groups which have, in the past, not been characterized by a high sense of self esteem. Mental health advisory councils at the county level are relatively new and a complete understanding of their role and the necessary underpinnings for them to fulfill that role may not yet exist. County staff have not been trained to work effectively with advisory councils. They may not see them as helpful allies but rather as an additional requirement piled on counties by the state.

Unlike other mandated services, barriers to the establishment of effective LACs are not primarily a matter of insufficient funding; LACs are not very costly. Some staff time, per diem payments or mileage allowances may be necessary. It may also require creativity to find hours that are convenient for non professionals.

LACs need certain tools to function effectively: copies of the act, of the county plan, briefings on county services and on the county budget and minimal clerical support. A lack of these tools may frustrate councils and create an adversarial or confrontational relationship between council members and the county. Or, it may lead to a passive council which is perceived as "rubberstamping" county policies. This may in turn create frustration and cause members tend to drop out.

⁸ Quoted in "LAC News", Newsletter of Local Mental Health Advisory Councils, Minnesota Dept. of Human Services, Mental Health Division, Winter 1991.

LWV MONITORING CHECK LIST
(from Monitoring Mental Health Services at the County Level,
League of Women Voters.)

MANDATED

1. Do the council members reflect "a broad range of community interests"?
YES NO
2. Is there at least one consumer, one family member of a person with mental illness, one mental health professional and one community support services program representative?
YES NO
3. Does the council meet at least quarterly to "review, evaluate and make recommendations regarding the local mental health system?"
YES NO
4. Does the county board consider the advice of the local mental health advisory council in carrying out its authorities and responsibilities?
YES NO
5. Is the advisory council arranging annually for input from the regional treatment center review board regarding coordination of care between the regional treatment center and community-based services?
YES NO

COMMENTS:

6. Are there barriers to effective advisory council operation?
YES NO

If so, what are they?

IMPORTANT BUT NOT MANDATED

1. Does the council have more than four members (one county) and at least six members (for multi-county)?

YES NO

2. Does the council have access to the commissioners?

YES NO

If so, how and how often?

3. Does the council actively participate in the county board's ongoing activities and responsibilities for mental health services?

YES NO

If yes, how?

4. Does the council communicate regularly with the director of mental health services or the social services director?

YES NO

If not, comment:

5. Does the council review the long-range priorities for county mental health programs?

YES NO

If so, does it provide feedback?

6. How often does the council meet?

Is this sufficient to participate actively in the planning process?

7. Is attendance good at advisory council meetings?

YES NO

Do most of the members actively participate?

8. Has the advisory council been briefed on all aspects of county mental health services?

YES NO

9. Does the advisory council have a process for communicating with interested citizens?

YES NO

10. Does the advisory council respond to requests from advocacy groups, consumers, interested citizens?

YES NO

11. Has the advisory council been briefed on the budget process, on state mandates, and on the history of county mental health expenditures?

YES NO

Task I: In small groups, preferably with people from the same county, discuss the LWV monitoring report as it relates to your LAC. Possible questions for discussion:

- Does your LAC serve as an ally of mental health providers and professionals?
Have you initiated educational efforts in your community?
Have you advocated for change?
Have you organized hearings on mental health issues?
- Do you think county administrators see your LAC as a helpful influence or a threat?
- Do you think your LAC has a clear idea of its mission?
- Is there more than one consumer and one family member serving on your council? Has the ratio of professionals to consumer/family/interested citizen changed since the LWV NIMH Consumer/Family training began?
- Are LAC meetings well attended? Do all council members participate?
- Are meetings open, and is the public invited to attend?
- Do you receive yearly input from the state regional treatment center that serves your county? If so, does your LAC or the RTC initiate contact?
- Has your LAC been briefed on the budget process? If so, are you actively involved in budgetary decision making?
- Does your LAC have regular communication with your board of county commissioners?
- Do county administrators tend to dominate meetings? Is the LAC chair employed by the county? Do you feel the LAC can make recommendations and advise county commissioners in a way that is independent of official county bodies?
- Do you think your LAC fills the statutory requirements outlined in the Comprehensive Mental Health Act? Did you, for instance, identify unmet mental health needs in your county for inclusion in the 1994-95 CSSA plan?
- Can you identify some barriers to the effectiveness of your LAC at this time?

(from Laws, 1993, special session chapter 1, article 7, section 48, subd. 2)
The entire law is reprinted in this workbook on page 163.

- By June 1, 1994, the LAC may make recommendations to the statewide task force on the feasibility and desirability of various methods of service delivery and funding, in regard to ensuring that services meet the specific needs of each client and that counties have greater flexibility in paying for services. (emphasis editor's)
- By June 1, 1994, the LAC may make recommendations to the commissioner for establishing protocols and procedures that ensure coordination of services, or for legislative and rule changes that will improve local coordination.

Task II: In light of the Task I discussion, how do you think your LAC can facilitate the appointment of task force members and give direction to such a task force?

(The page contains faint horizontal lines, suggesting it was part of a lined notebook or document.)

to facilitate the development of local protocols and procedures under subdivision 2. The task force shall submit a final report to the legislature by January 1, 1995, with its findings and recommendations. Once this report has been submitted, the task force will expire.

Subd. 2. [DEVELOPMENT OF LOCAL PROTOCOLS AND PROCEDURES.] (a) By January 1, 1994, each local adult mental health advisory council established under Minnesota Statutes, section 245.466, subdivision 5, may establish a task force to develop recommended protocols and procedures that will ensure that the planning, case management, and delivery of services for adults with severe mental illness are coordinated and make the most efficient and effective use of available funding. The task force must include, at a minimum, representatives of county medical assistance and mental health staff and representatives of state and county public employee bargaining units. The protocols and procedures must be designed to:

(1) ensure that services to adults are adequately funded to meet the adult's needs;

(2) ensure that planning for services, case management, service delivery, and payment for services involves coordination of all affected agencies, providers, and funding sources; and

(3) maximize available funding by making full use of all available funding, including medical assistance.

(b) By June 1, 1994, each council may make recommendations to the statewide task force established under subdivision 1 regarding the feasibility and desirability of existing or proposed methods of service delivery and funding sources to ensure that services are tailored to the specific needs of each adult and to allow where feasible greater flexibility in paying for services.

(c) By June 1, 1994, each local advisory council may report to the commissioner of human services the council's findings and the recommended protocols and procedures. The council may also recommend legislative changes or rule changes that will improve local coordination and further maximize available funding.

Subd. 3. [FINAL REPORT.] By February 15, 1995, the commissioner of human services shall provide a report to the legislature that describes the reports and recommendations of the statewide task force under subdivision 1 and of the local advisory councils under subdivision 2, and provides the commissioner's recommendations for legislation or other needed changes.

SECOND ACTIVITY

CREATIVE NETWORKING

Networks serve as communication facilitators. Sharing information within networks is informal, and members of agencies or groups within a network retain their individual identity. Such networks are quite easy to implement, and can provide valuable linkage in the coordination of an activity. Such loose collaboration brings people of like interests together to do a job that is bigger than one person or one group can do.

Individuals in groups that make up a network act as conduits, and can provide the essential energy needed to bring people together in a working group.

A good network is made up of people with the following characteristics:

- a strong sense of personal mission (usually altruistic);
- a low threshold for appropriate outrage;
- a willingness to take calculated risks;
- a strong sense of integrity;
- the endurance of a long-distance runner;
- an incredible sense of humor;
- a capacity for looking past the dreary and envision the shining;
- spontaneity, flexibility and adaptability;
- inner directedness driven by strong energy;
- the capacity to incite energy in others.

Networks operate at a high level of trust and reciprocity. They rely on the faith that they are going to work, that the money somehow will come, and that people will be drawn together to work toward a common goal.

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

Networks excel at introducing new ideas and developing them. They work best when made up of people with an intense purpose that requires individual initiative and dedication.

WOULD IT BE WORTHWHILE TO FORM A LAC CONSUMER/FAMILY NETWORK?

The formation of an LAC Consumer/Family Network would be a way to continue the spirit and dedication of individuals who have learned together, complained together, and provided a spark that has ignited many an LAC, or in some cases, an entire community.

This Network could continue to operate through local advisory councils. Such a network could further some of the goals of this project, such as:

- creating better understanding of mental illnesses, and
- obtaining quality services for people who have a mental illness.

If a strong mental health organization already exists in your area, you might want to join it. See if your goals are consistent with the goals of that existing organization. Forming another separate group might just add another organization to an already fragmented advocacy effort. However,

***Planning a meeting of project participants from your area
could be a first step toward deciding how to
continue a strong consumer/family voice on your LAC.***

NETWORKING WITH OTHER ORGANIZATIONS OR PEOPLE

What groups in your area might want to join your efforts?
Provide meeting space? Make cash or in-kind contributions?

FRIENDLY PROVIDERS

DROP IN CENTER

REACH

Minnesota Consumers
Network

Other Consumers and
Family Members

OTHER MEMBERS OF
LACs

CHURCHES

LOCAL SERVICE CLUBS

Mental Health Association

Mental Health Center

ALLIANCE FOR THE MENTALLY ILL

CSP Workers

_____	_____
_____	_____
_____	_____
_____	_____

**LAC CONSUMER/FAMILY
NETWORK**

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

Task I: Plan a meeting to take place sometime before the all-state convention in May. Decide in your group what the purpose of the meeting will be. (It could be to establish the identity of your group; to explore ways to strengthen your LAC; to become involved in educating your community about mental illness; or to continue to work toward the goals of LWV NIMH Leadership project.)

Purpose of meeting; _____

Task II: How will your group be brought together? Do you need a convener or co-leaders to work out the details of this meeting?

Name of chair(s) _____

Address: _____

City: _____ Zip: _____ Tel: _____

Name of chair(s) _____

Address: _____

City: _____ Zip: _____ Tel: _____

Reminder: good leaders know how to delegate responsibility.
Reading through "The Art of Delegating" and going over the check list
might be helpful before setting up a meeting.

If you plan a meeting, after choosing a leader or leaders, you may want to decide:

1. How will members of group be notified?
2. How will expenses be covered? (Consider long distance calls, postage, copying, refreshments.)
3. What other groups should be invited?
4. What are possible meeting times.
5. What are possible meeting places.

League of Women Voters NIMH Consumer/Family Mental Health Leadership Training Project.

Closure or Downsizing of Regional Treatment Centers

The legislature recognizes that there are persons with mental illness who need the level of care provided by the state's regional treatment centers (RTCs), and that there are some patients living in these facilities whose needs can be met equally well or better in the community, with adequate support services. The conditions for closure of a state regional treatment center were expanded in this session, and the Department was given responsibility to develop alternative services for patients with mental illness now living in the Moose Lake RTC catchment area, prior to the closure of that facility. The approved budget spends more for the array of Moose Lake alternatives than was being spent for the Moose Lake RTC.

[Minnesota Statutes (1992), section 246.0135, as amended by Laws 1993]

- Closure of a state regional treatment center continues to be prohibited without specific legislative authorization.
- Prior to closing or downsizing an RTC, the commissioner shall develop enough community-based alternative services to meet the needs of patients of the facility and other persons whose needs can be met in the community.
- Counties in the catchment area of a closed or downsized RTC will not be required to pay a greater cost for care for alternative services than the amount set by the commissioner for cost of care at the RTCs.
- Funds diverted from RTCs as a result of closure or downsizing cannot be used for purposes unrelated to care and treatment of persons who reside in an RTC, or who, in the absence of community alternatives, might reside in an RTC.

[Minnesota Statutes (1992), section 253.015, subd. 3, as amended by Laws 1993]

- Prior to the closure of the Moose Lake Regional Treatment Center in 1995, the commissioner will develop alternative community-based services in the Moose Lake catchment area. Funding is provided for services in community nursing facilities; state-operated crisis community services; community support services; state-operated acute care psychiatric inpatient treatment; and psychiatric inpatient beds in community hospitals. New funding for community mental health alternatives in the 1994-95 biennium includes \$2.2 million in grants to counties, \$1.9 million for state-operated community mental health services, and \$2.5 million for the state share of Medical Assistance for expanded community services.
- The commissioner will establish 75 beds at the Brainerd RTC to serve persons with mental illness being relocated from the Moose Lake RTC, including 15 beds for persons with traumatic brain injury.

LWV FAMILY CONSUMER LEADERSHIP TRAINING

Region 1

Best Western Hotel
Thief River Falls

Region 7A, 7B

Holiday Inn
St. Cloud

Region 2

Holiday Inn
Bemidji

Region 9

Holiday Inn
Mankato

Region 3A

Radisson Downtown
Duluth

Region 10

Zumbro Lutheran Church
Rochester

Region 3B

Holiday Inn
Eveleth

Region 11A

Best Western Regency
Minneapolis

Region 4

Park Hotel
Alexandria

Region 11B

Kelly Inn
St. Paul

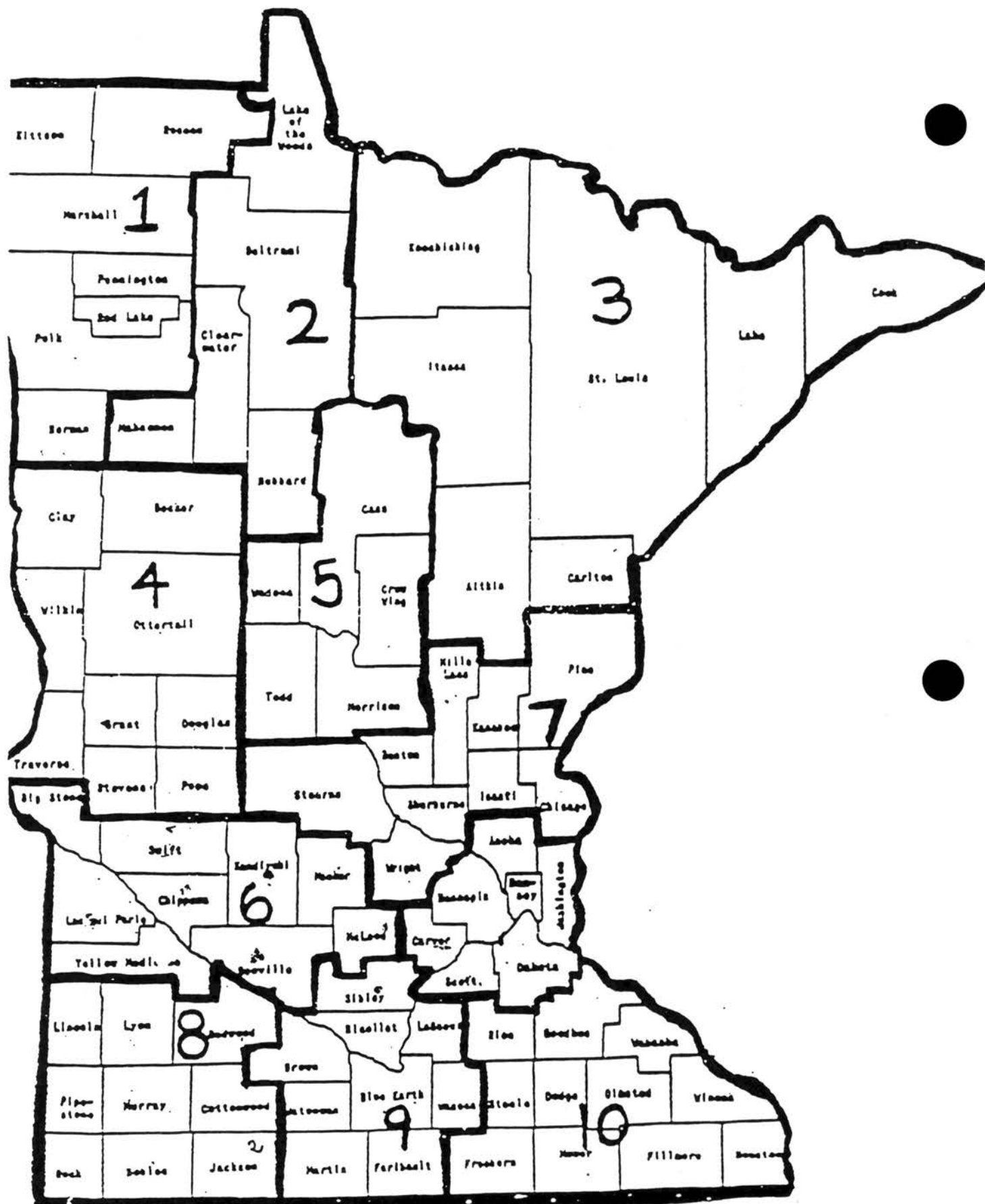
Region 5

Sept.: Quarterdeck on
Gull Lake
Nov.: Holiday Inn
Brainerd

Region 6

Holiday Inn
Willmar

If you are signed up and cannot attend, please call at the League office and leave a message. This would help us immensely in being able to give a correct number count for lunch. **THANK YOU!!**



REGIONS

REGION 1 (7 counties)

Kittson
Marshall
Norman
Pennington
Polk
Red Lake
Roseau

REGION 4 (9 counties)

Becker
Clay
Douglas
Grant
Otter Tail
Pope
Stevens
Traverse
Wilkin

REGION 7 (9 counties)

Benton
Chisago
Isanti
Kanabec
Mille Lacs
Pine
Sherburne
Stearns
Wright

REGION 10 (11 counties)

Dodge
Fillmore
Freeborn
Goodhue
Houston
Mower
Olmsted
Rice
Steele
Wabasha
Winona

REGION 2 (5 counties)

Beltrami
Clearwater
Hubbard
Lake of the Woods
Mahanomen

REGION 5 (5 counties)

Cass
Crow Wing
Morrison
Todd
Wadena

REGION 8 (9 counties)

Cottonwood
Jackson
Lincoln
Lyon
Murray
Nobles
Pipestone
Redwood
Rock

REGION 11 (7 counties)

Anoka
Carver
Dakota
Hennepin
Ramsey
Scott
Washington

REGION 3 (7 counties)

Aitkin
Carlton
Cook
Itasca
Koochiching
Lake
St. Louis

REGION 6 (9 counties)

Big Stone
Chippewa
Kandiyohi
Lac Qui Parle
McLeod
Meeker
Renville
Swift
Yellow Medicine

REGION 9 (9 counties)

Blue Earth
Brown
Faribault
LeSeur
Martin
Nicollet
Sibley
Waseca
Watsonwan

LWV MONITORING CHECK LIST
(from Monitoring Mental Health Services at the County Level,
League of Women Voters.)

MANDATED

1. Do the council members reflect "a broad range of community interests"?
YES NO
2. Is there at least one consumer, one family member of a person with mental illness, one mental health professional and one community support services program representative?
YES NO
3. Does the council meet at least quarterly to "review, evaluate and make recommendations regarding the local mental health system?"
YES NO
4. Does the county board consider the advice of the local mental health advisory council in carrying out its authorities and responsibilities?
YES NO
5. Is the advisory council arranging annually for input from the regional treatment center review board regarding coordination of care between the regional treatment center and community-based services?
YES NO

COMMENTS:

6. Are there barriers to effective advisory council operation?
YES NO

If so, what are they?

IMPORTANT BUT NOT MANDATED

1. Does the council have more than four members (one county) and at least six members (for multi-county)?

YES NO

2. Does the council have access to the commissioners?

YES NO

If so, how and how often?

3. Does the council actively participate in the county board's ongoing activities and responsibilities for mental health services?

YES NO

If yes, how?

4. Does the council communicate regularly with the director of mental health services or the social services director?

YES NO

If not, comment:

5. Does the council review the long-range priorities for county mental health programs?

YES NO

If so, does it provide feedback?

6. How often does the council meet?

Is this sufficient to participate actively in the planning process?

7. Is attendance good at advisory council meetings?

YES NO

Do most of the members actively participate?

8. Has the advisory council been briefed on all aspects of county mental health services?

YES NO

9. Does the advisory council have a process for communicating with interested citizens?

YES NO

10. Does the advisory council respond to requests from advocacy groups, consumers, interested citizens?

YES NO

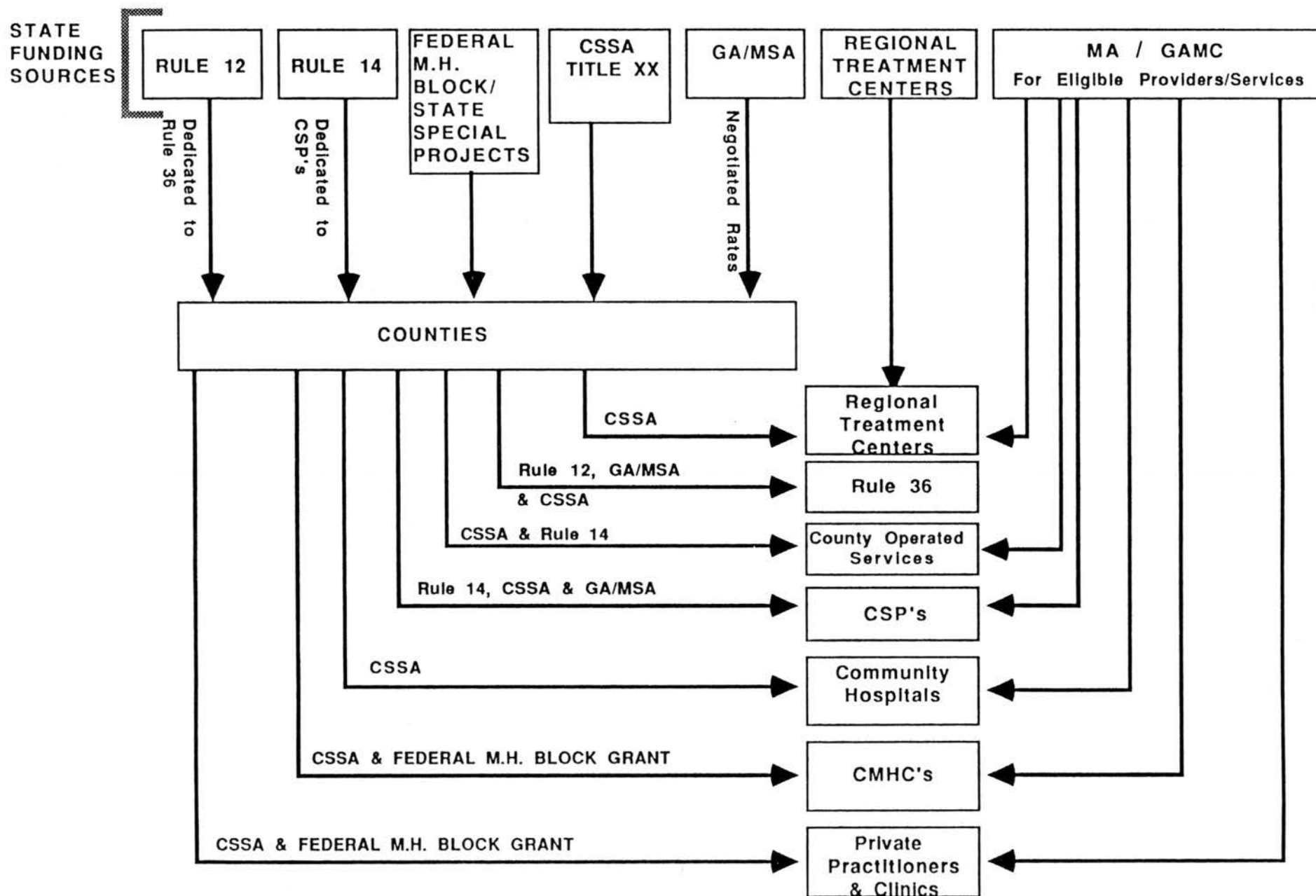
11. Has the advisory council been briefed on the budget process, on state mandates, and on the history of county mental health expenditures?

YES NO

ADULT MENTAL HEALTH SERVICES

CURRENT DHS FUNDING FLOW

2/91



5A

Table 5

CHILDREN'S MENTAL HEALTH SERVICES

2/91

CURRENT STATE FUNDING FLOW

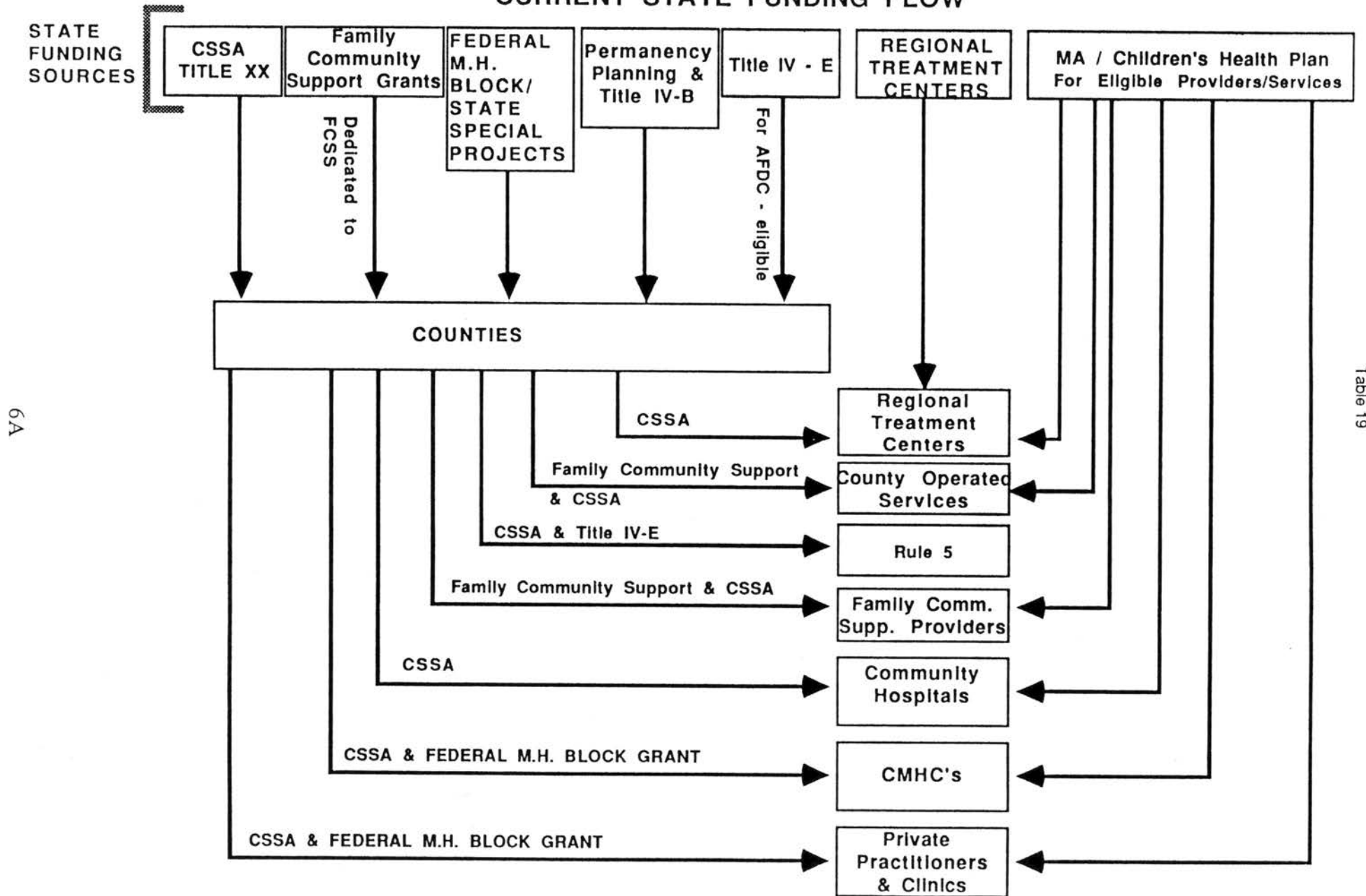
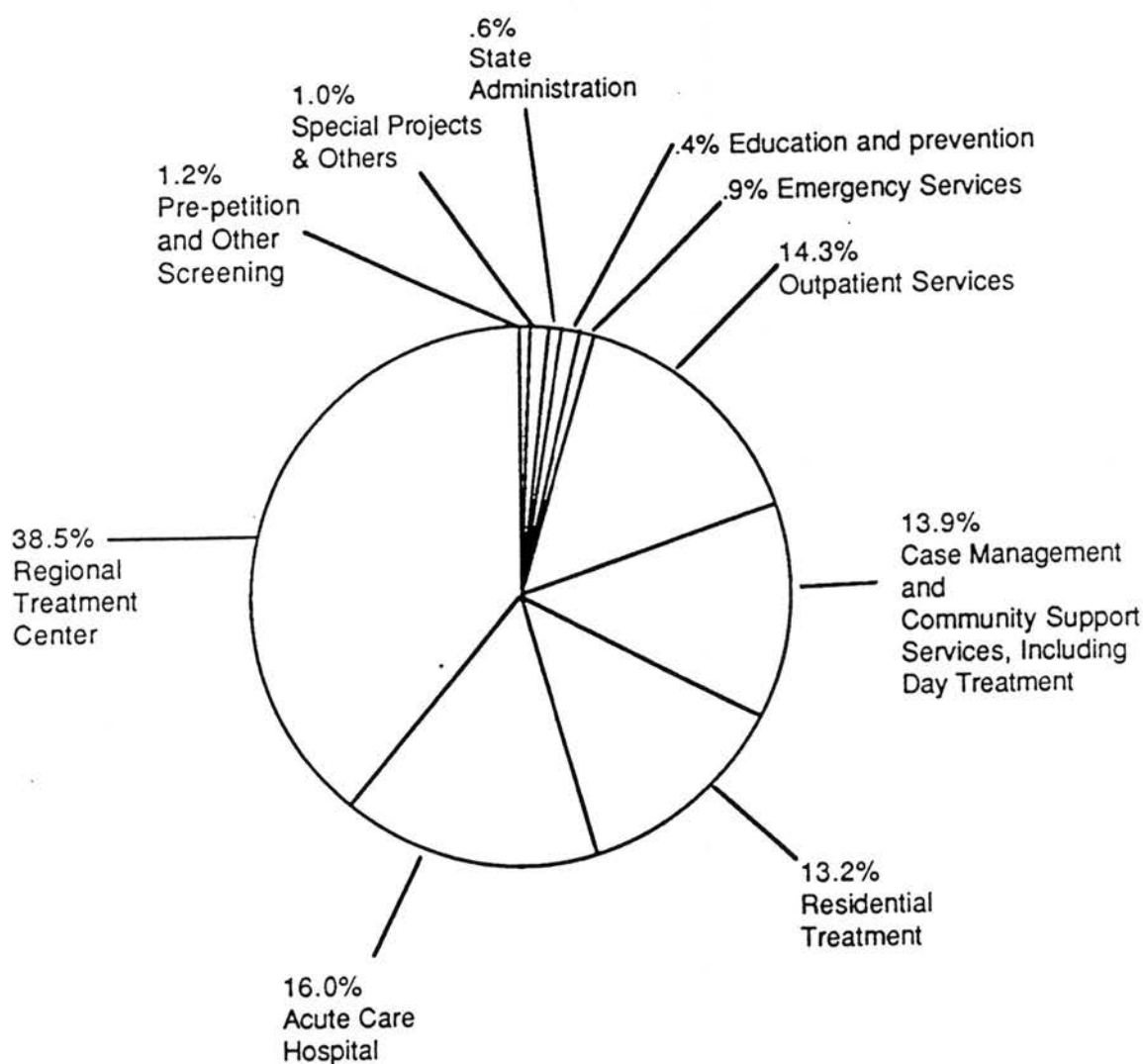


Table 19

FISCAL 1991 Estimated DHS Expenditures Adult Mental Health Services



TOTAL: \$227,500,000

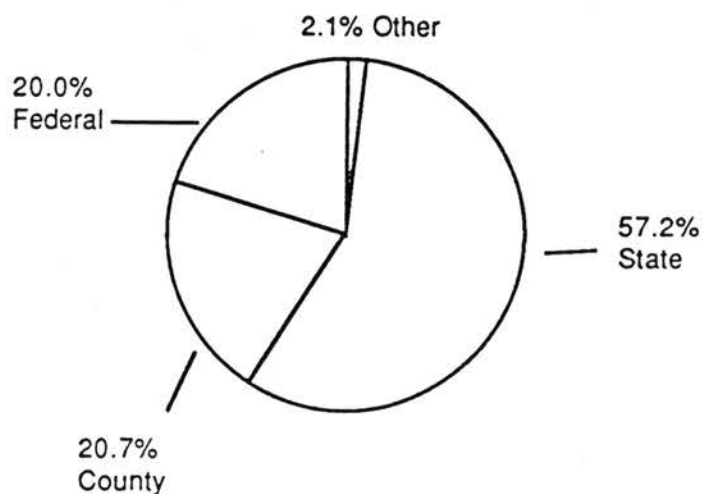
In addition to the above, MH services are also funded by the Departments of Education, Corrections, Jobs and Training, plus direct federal funding to providers through Medicare and Veterans Administration, plus private insurance and private pay.

This table does not include Income Maintenance payments for nursing homes or living expenses of persons with mental illness who are not residents of Rule 36 facilities.

Feb 1991

Table 7

**FISCAL 1991
DHS Funding Sources
Adult Mental Health Services**



Federal, State and County Funding

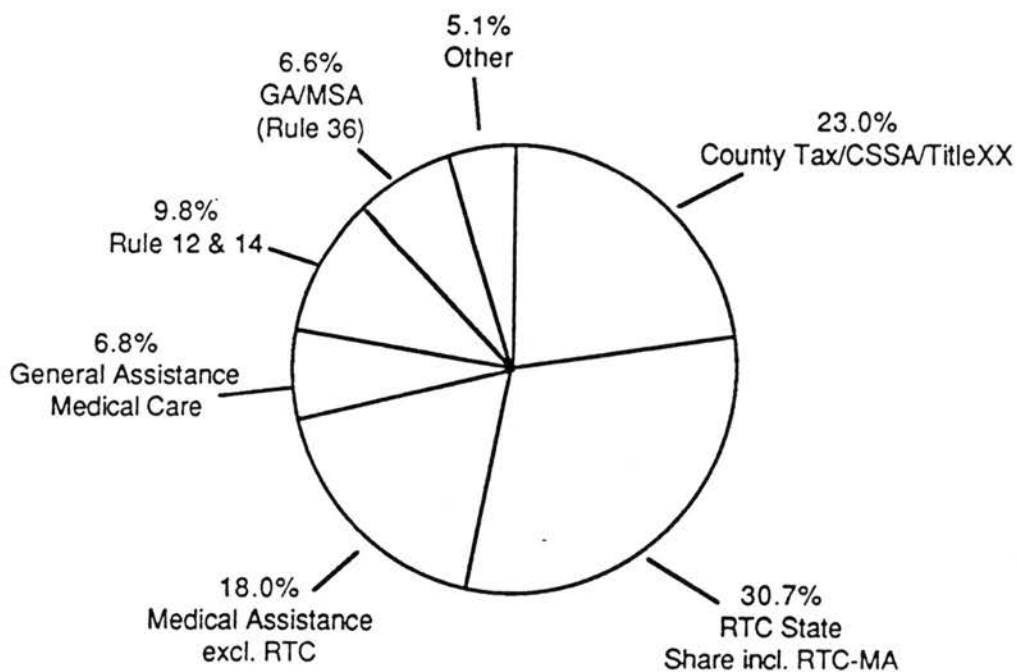
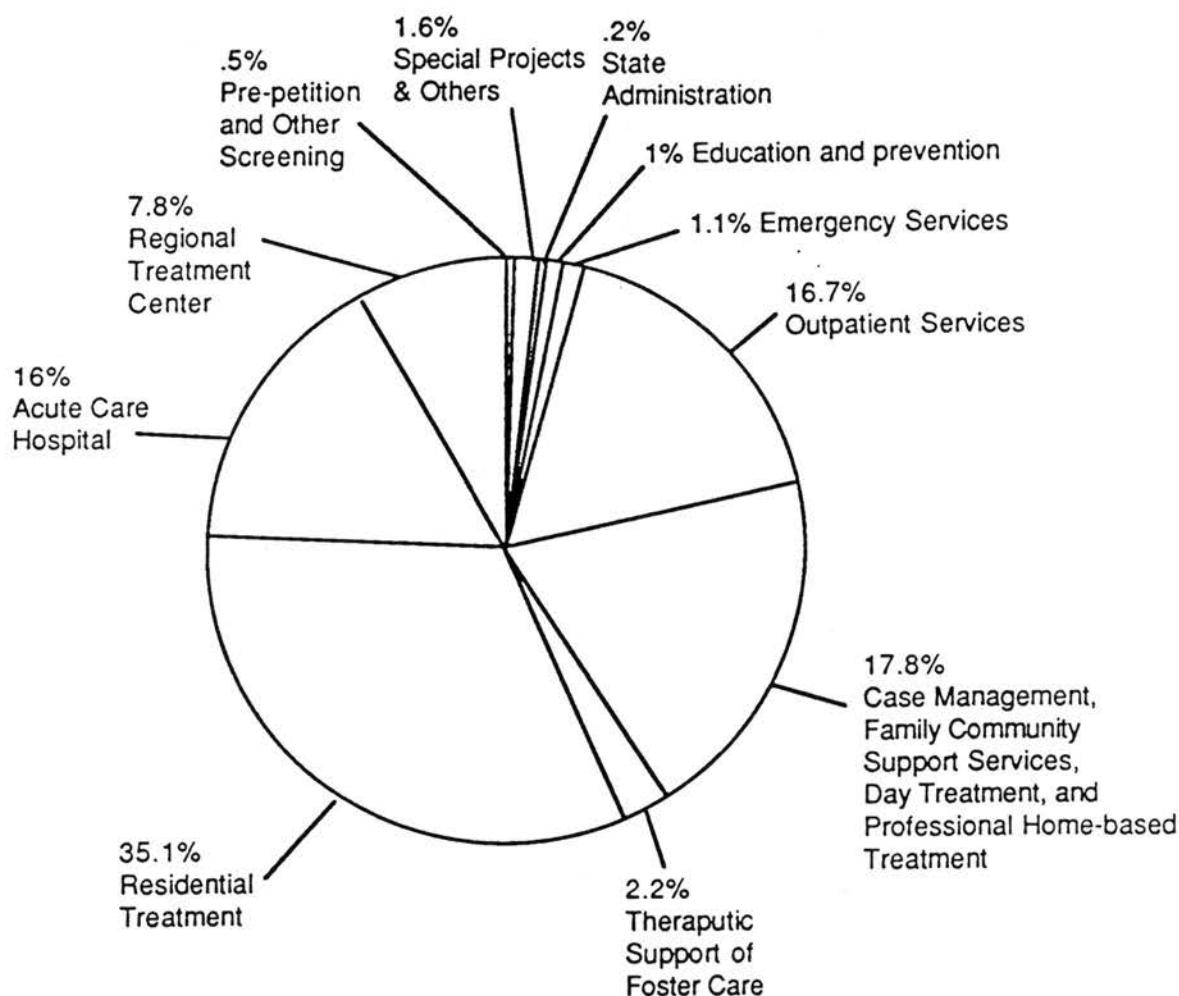


Table 8

Funding by Program Category

Feb 1991

FISCAL 1991 Estimated DHS Expenditures Children's Mental Health Services



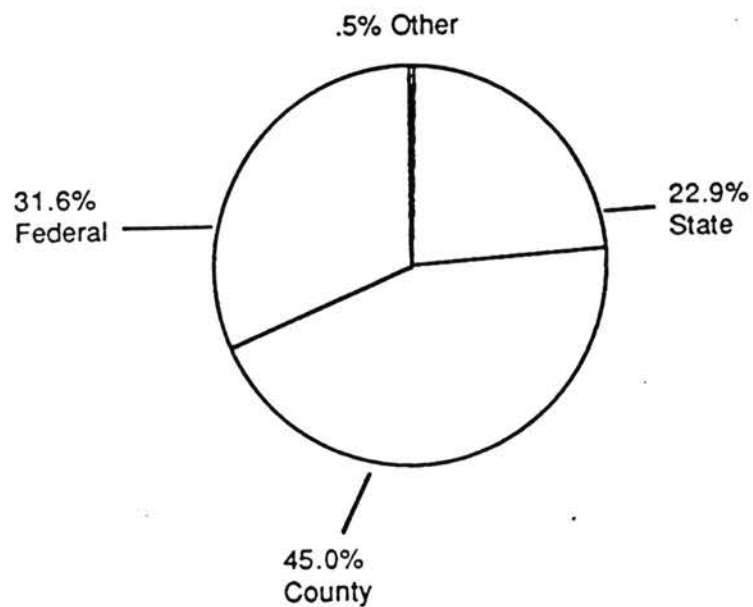
TOTAL: \$63,100,000

In addition to the above, MH services are also funded by the Departments of Education, Corrections, Jobs and Training, plus private insurance and private pay.

This table does not include Income Maintenance payments for living expenses.

Feb 1991

**FISCAL 1991
DHS Funding Sources
Children's Mental Health Services**



Federal, State and County Funding

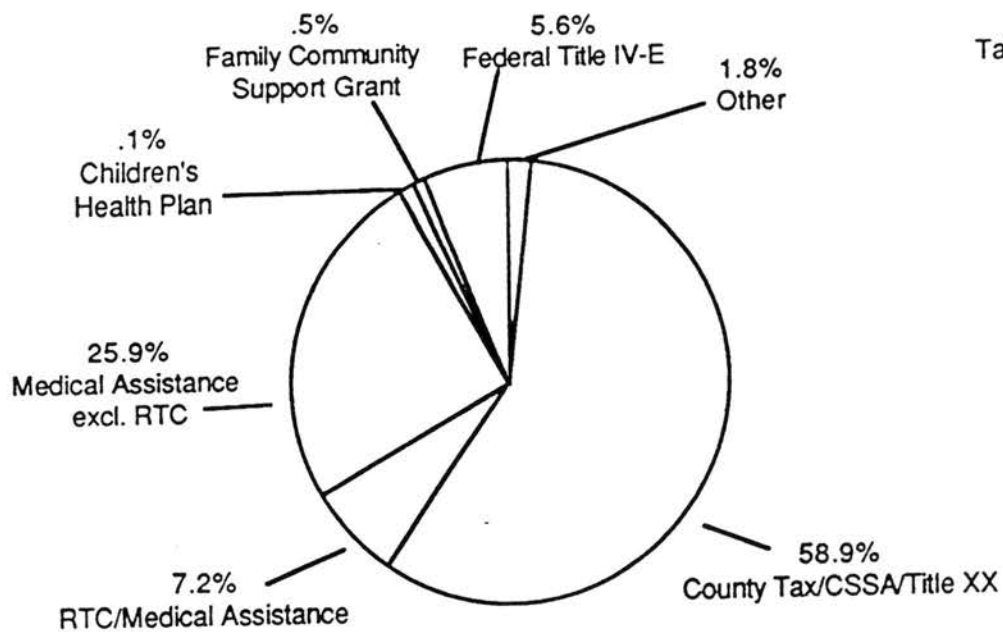
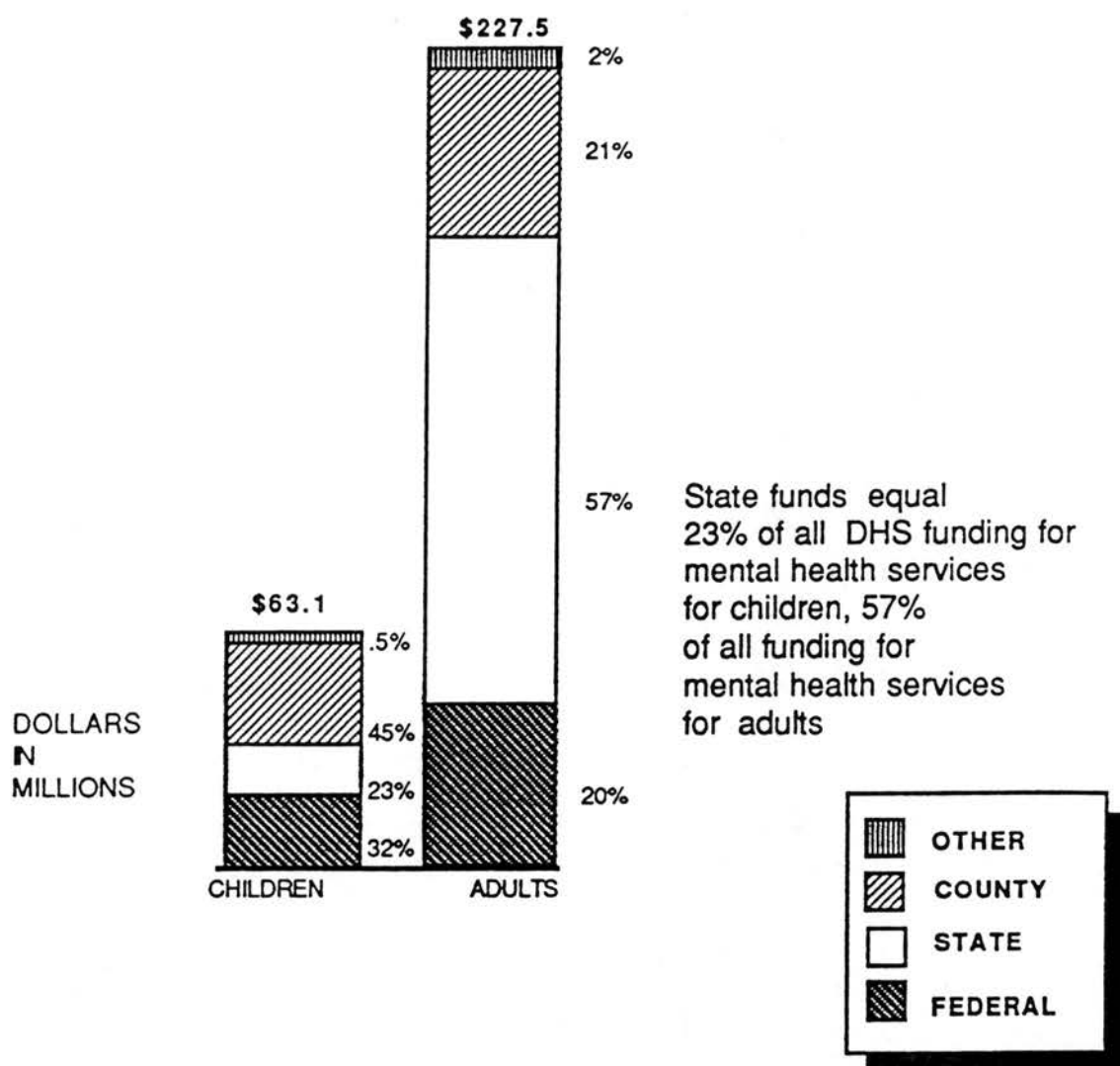


Table 22

Funding by Program Category

Feb 1991

**FEDERAL, STATE AND COUNTY
FUNDING SOURCES:
MENTAL HEALTH SERVICES
FOR
CHILDREN AND ADULTS
(ESTIMATED; FISCAL 1991)**



Feb 1991

ESTIMATES OF COUNTY EMOTIONAL DISTURBANCE/MENTAL ILLNESS PREVALENCE BASED ON 1990 CENSUS

COUNTIES	TOTAL COUNTY 1990 POPULATION	UNDER 18 CHILDREN 1990 POPULATION	CHILDREN % OF CTY POPULATION	SEVERE EMOTIONAL DISTURBANCE 5 %	EMOTIONAL DISTURBANCE 11.8 %	ADULT 18 & OVER 1990 POPULATION	SERIOUS & PERSISTENT MENTAL ILLNESS 1.0 %	ADULT MENTAL ILLNESS (NOW S&P) 14.8% - 1.0%
MARTIN	22,914	6,143	26.81%	307	706	16,771	168	2,314
MEeker	20,846	6,127	29.39%	306	705	14,719	147	2,031
MILLE LACS	18,670	5,437	29.12%	272	625	13,233	132	1,826
MORRISON	29,604	9,258	31.27%	463	1,065	20,346	203	2,808
MOWER	37,385	9,555	25.56%	478	1,099	27,830	278	3,841
MURRAY	9,660	2,620	27.12%	131	301	7,040	70	972
NICOLLET	28,076	7,347	26.17%	367	845	20,729	207	2,861
NOBLES	20,098	5,331	26.53%	267	613	14,767	148	2,038
NORMAN	7,975	2,153	27.00%	108	248	5,822	58	803
OLMSTED	106,470	29,528	27.73%	1,476	3,396	76,942	769	10,618
OTTER TAIL	50,714	13,443	26.51%	672	1,546	37,271	373	5,143
PENNINGTON	13,306	3,562	26.77%	178	410	9,744	97	1,345
PINE	21,264	6,043	28.42%	302	695	15,221	152	2,100
PIPESTONE	10,491	2,949	28.11%	147	339	7,542	75	1,041
POLK	32,498	9,143	28.13%	457	1,051	23,355	234	3,223
POPE	10,745	2,960	27.55%	148	340	7,785	78	1,074
RAMSEY	485,765	120,104	24.72%	6,005	13,812	365,661	3,657	50,461
RED LAKE	4,525	1,354	29.92%	68	156	3,171	32	438
REDWOOD	17,254	4,846	28.09%	242	557	12,408	124	1,712
RENVILLE	17,673	4,922	27.85%	246	566	12,751	128	1,760
RICE	49,183	12,908	26.24%	645	1,484	36,275	363	5,006
ROCK	9,806	2,786	28.41%	139	320	7,020	70	969
ROSEAU	15,026	4,683	31.17%	234	539	10,343	103	1,427
ST LOUIS	198,213	48,321	24.38%	2,416	5,557	149,892	1,499	20,685
SCOTT	57,846	18,001	31.12%	900	2,070	39,845	398	5,499
SHERBURNE	41,945	13,318	31.75%	666	1,532	28,627	286	3,951
SIBLEY	14,366	4,082	28.41%	204	469	10,284	103	1,419
STEARNS	118,791	33,009	27.79%	1,650	3,796	85,782	858	11,838
STEELE	30,729	8,792	28.61%	440	1,011	21,937	219	3,027
STEVENS	10,634	2,500	23.51%	125	288	8,134	81	1,122
SWIFT	10,724	2,882	26.87%	144	331	7,842	78	1,082
TODD	23,363	7,131	30.52%	357	820	16,232	162	2,240
TRAVERSE	4,463	1,171	26.24%	59	135	3,292	33	454
WABASHA	19,744	5,712	28.93%	286	657	14,032	140	1,936
WADENA	13,154	3,712	28.22%	186	427	9,442	94	1,303
WASECA	18,079	5,184	28.67%	259	596	12,895	129	1,780
WASHINGTON	145,896	44,315	30.37%	2,216	5,096	101,581	1,016	14,018
WATONWAN	11,682	3,281	28.09%	164	377	8,401	84	1,159
WILKIN	7,516	2,126	28.29%	106	244	5,390	54	744
WINONA	47,828	11,730	24.53%	587	1,349	36,098	361	4,982
WRIGHT	68,710	22,385	32.58%	1,119	2,574	46,325	463	6,393
YELLOW MEDICINE	11,684	3,155	27.00%	158	363	8,529	85	1,177
TOTAL	4,375,099	1,166,783	26.67%	58,339	134,180	3,208,316	32,083	442,748

Note: Total, child and adult population figures are from summary reports based on the 1990 census. The prevalence estimates for severe emotional disturbance and emotional disturbance are those currently used by the National Institute of Mental Health. The prevalence estimates for serious and persistent mental illness (1%) and all mental illness (14.8% for 6 month period) are based on national estimates. Although these are currently our best estimates, when applying these estimates to a smaller population base such as a smaller county, the rate could vary higher or lower.

ESTIMATES OF COUNTY EMOTIONAL DISTURBANCE/MENTAL ILLNESS PREVALENCE BASED ON 1990 CENSUS

COUNTIES	TOTAL COUNTY 1990 POPULATION	UNDER 18 CHILDREN 1990 POPULATION	CHILDREN % OF CTY POPULATION	SEVERE EMOTIONAL DISTURBANCE 5 %	EMOTIONAL DISTURBANCE 11.8 %	ADULT 18 & OVER 1990 POPULATION	SERIOUS & PERSISTENT MENTAL ILLNESS 1.0 %	ADULT MENTAL ILLNESS (NOW S&P) 14.8% - 1.0%
AITKIN	12,425	2,959	23.81%	148	340	9,466	95	1,306
ANOKA	243,641	74,369	30.52%	3,718	8,552	169,272	1,693	23,360
BECKER	27,881	8,108	29.08%	405	932	19,773	198	2,729
BELTRAMI	34,384	10,228	29.75%	511	1,176	24,156	242	3,334
BENTON	30,185	9,044	29.96%	452	1,040	21,141	211	2,917
BIG STONE	6,285	1,641	26.11%	82	189	4,644	46	641
BLUE EARTH	54,044	12,391	22.93%	620	1,425	41,653	417	5,748
BROWN	26,984	7,397	27.41%	370	851	19,587	196	2,703
CARLTON	29,259	8,211	28.06%	411	944	21,048	210	2,905
CARVER	47,915	14,507	30.28%	725	1,668	33,408	334	4,610
CASS	21,791	5,929	27.21%	296	682	15,862	159	2,189
CHIPPEWA	13,228	3,581	27.07%	179	412	9,647	96	1,331
CHISAGO	30,521	9,404	30.81%	470	1,081	21,117	211	2,914
CLAY	50,422	12,625	25.04%	631	1,452	37,797	378	5,216
CLEARWATER	8,309	2,419	29.11%	121	278	5,890	59	813
COOK	3,868	936	24.20%	47	108	2,932	29	405
COTTONWOOD	12,694	3,305	26.04%	165	380	9,389	94	1,296
CROW WING	44,249	11,928	26.96%	596	1,372	32,321	323	4,460
DAKOTA	275,227	82,146	29.85%	4,107	9,447	193,081	1,931	26,645
DOOGUE	15,731	4,949	31.46%	247	569	10,782	108	1,488
DOULGAS	28,674	7,780	27.13%	389	895	20,894	209	2,883
FARIBAULT	16,937	4,494	26.53%	225	517	12,443	124	1,717
FREEBORN	20,777	5,781	27.82%	289	665	14,996	150	2,069
FILLMORE	33,060	8,530	25.80%	427	981	24,530	245	3,385
GOODHUE	40,690	11,450	28.14%	573	1,317	29,240	292	4,035
GRANT	6,246	1,617	25.89%	81	186	4,629	46	639
HENNEPIN	1,032,431	238,809	23.13%	11,940	27,463	793,622	7,936	109,520
HOUSTON	18,497	5,312	28.72%	266	611	13,185	132	1,820
HUBBARD	14,939	4,089	27.37%	204	470	10,850	109	1,497
ISANTI	25,921	8,112	31.30%	406	933	17,809	178	2,458
ITASCA	40,863	11,558	28.28%	578	1,329	29,305	293	4,044
JACKSON	11,677	3,136	26.86%	157	361	8,541	85	1,179
KANABEC	12,802	3,885	30.35%	194	447	8,917	89	1,231
KANDIYOH	38,761	11,037	28.47%	552	1,269	27,724	277	3,826
KITTSOM	5,767	1,506	26.11%	75	173	4,261	43	588
KOOCHICING	16,299	4,149	25.46%	207	477	12,150	122	1,677
LAC QUI PARLE	8,924	2,359	26.43%	118	271	6,565	66	906
LAKE	10,415	2,535	24.34%	127	292	7,880	79	1,087
LAKE OF WOODS	4,076	1,128	27.67%	56	130	2,948	29	407
LE SUEUR	23,239	6,865	29.54%	343	789	16,374	164	2,260
LINCOLN	6,890	1,801	26.14%	90	207	5,089	51	702
LYON	24,789	6,739	27.19%	337	775	18,050	181	2,491
MCLEOD	32,030	9,282	28.98%	464	1,067	22,748	227	3,139
MAHONEN	5,044	1,574	31.21%	79	181	3,470	35	479
MARSHALL	10,993	3,169	28.83%	158	364	7,824	78	1,080

Note: Total, child and adult population figures are from summary reports based on the 1990 census. The prevalence estimates for severe emotional disturbance and emotional disturbance are those currently used by the National Institute of Mental Health. The prevalence estimates for serious and persistent mental illness (1%) and all mental illness (14.8% for 6 month period) are based on national estimates. Although these are currently our best estimates, when applying these estimates to a smaller population base such as a smaller county, the rate could vary higher or lower.

ADULT MENTAL HEALTH PROJECTED COUNTY EXPENDITURES FOR 1990

COUNTY	EDUCATION/PREVENTION		EMERGENCY SERVICES		OUTPATIENT TX		CASE MANAGEMENT		COMMUNITY SUPPORT		DAY TREATMENT	
	EXPENDIT.	PER CAP*	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP
NICOLLET	\$17,000	\$0.82	\$20,000	\$0.96	\$161,102	\$7.77	\$33,000	\$1.59	\$36,000	\$1.74	\$35,000	\$1.69
NOBLES	\$2,432	\$0.16	\$6,485	\$0.44	\$122,902	\$8.32	\$40,000	\$2.71	\$31,635	\$2.14	\$13,896	\$0.94
NORMAN	\$500	\$0.09	\$2,000	\$0.34	\$22,500	\$3.86	\$13,000	\$2.23	\$27,211	\$4.67	\$9,500	\$1.63
OLMSTED	\$8,500	\$0.11	\$240,521	\$3.13	\$229,446	\$2.98	\$96,408	\$1.25	\$167,459	\$2.18	\$99,320	\$1.29
OTTER TAIL	\$15,600	\$0.42	\$33,280	\$0.89	\$260,818	\$7.00	\$80,000	\$2.15	\$89,300	\$2.40	\$45,000	\$1.21
PENNINGTON	\$5,000	\$0.51	\$7,500	\$0.77	\$22,000	\$2.26	\$30,000	\$3.08	\$36,122	\$3.71	\$10,000	\$1.03
PINE	\$2,800	\$0.18	\$1,000	\$0.07	\$90,500	\$5.95	\$91,397	\$6.00	\$30,095	\$1.98	\$9,000	\$0.59
PIPESTONE	\$1,364	\$0.18	\$3,636	\$0.48	\$74,748	\$9.91	\$15,000	\$1.99	\$27,414	\$3.63	\$9,200	\$1.22
POLK	\$2,100	\$0.09	\$8,000	\$0.34	\$128,700	\$5.51	\$32,000	\$1.37	\$100,153	\$4.29	\$30,000	\$1.28
POPE	\$3,000	\$0.39	\$2,000	\$0.26	\$48,480	\$6.23	\$17,500	\$2.25	\$10,000	\$1.28	\$6,000	\$0.77
RAMSEY	\$36,734	\$0.10	\$381,821	\$1.04	\$2,537,266	\$6.94	\$2,337,576	\$6.39	\$2,096,464	\$5.73	\$835,159	\$2.28
RED LAKE	\$300	\$0.09	\$1,200	\$0.38	\$10,200	\$3.22	\$4,900	\$1.55	\$30,003	\$9.46	\$8,943	\$2.82
REDWOOD	\$6,000	\$0.48	\$7,000	\$0.56	\$72,072	\$5.81	\$20,000	\$1.61	\$33,773	\$2.72	\$25,000	\$2.01
REGION VIII	\$11,537	\$0.38	\$13,028	\$0.43	\$170,572	\$5.65	\$145,000	\$4.80	\$151,067	\$5.01	\$89,505	\$2.97
RENVILLE	\$14,000	\$1.10	\$14,000	\$1.10	\$80,000	\$6.27	\$70,000	\$5.49	\$25,000	\$1.96	\$60,000	\$4.71
RICE	\$2,500	\$0.07	\$10,000	\$0.28	\$80,500	\$2.22	\$25,000	\$0.69	\$83,500	\$2.30	\$10,000	\$0.28
ROCK	\$1,326	\$0.19	\$3,537	\$0.50	\$57,397	\$8.18	\$14,250	\$2.03	\$14,527	\$2.07	\$7,580	\$1.08
ROSEAU	\$900	\$0.09	\$750	\$0.07	\$8,500	\$0.82	\$18,055	\$1.75	\$51,590	\$4.99	\$1,000	\$0.10
SAINT LOUIS	\$48,000	\$0.32	\$66,000	\$0.44	\$604,000	\$4.03	\$725,000	\$4.84	\$536,000	\$3.58	\$131,000	\$0.87
SCOTT	\$4,000	\$0.10	\$6,543	\$0.16	\$105,716	\$2.65	\$75,000	\$1.88	\$58,000	\$1.46	\$14,352	\$0.36
SHERBURNE	\$2,000	\$0.07	\$10,400	\$0.36	\$89,440	\$3.12	\$90,000	\$3.14	\$46,800	\$1.63	\$15,600	\$0.54
SIBLEY	\$16,250	\$1.58	\$4,000	\$0.39	\$36,000	\$3.50	\$17,000	\$1.65	\$40,000	\$3.89	\$4,000	\$0.39
STEARNS	\$2,014	\$0.02	\$12,209	\$0.14	\$275,070	\$3.21	\$148,325	\$1.73	\$144,830	\$1.69	\$141,410	\$1.65
STEELE	\$6,508	\$0.30	\$3,617	\$0.16	\$131,986	\$6.02	\$79,962	\$3.65	\$36,335	\$1.66	\$20,751	\$0.95
STEVENS	\$5,000	\$0.61	\$6,200	\$0.76	\$15,170	\$1.87	\$25,000	\$3.07	\$33,023	\$4.06	\$0	\$0.00
SWIFT	\$7,500	\$0.96	\$11,000	\$1.40	\$75,500	\$9.63	\$35,000	\$4.46	\$10,000	\$1.28	\$58,000	\$7.40
TODD	\$4,500	\$0.28	\$1,020	\$0.06	\$87,083	\$5.36	\$29,160	\$1.80	\$42,000	\$2.59	\$17,000	\$1.05
TRAVERSE	\$3,000	\$0.91	\$1,000	\$0.30	\$15,500	\$4.71	\$13,000	\$3.95	\$32,644	\$9.92	\$0	\$0.00
WABASHA	\$2,200	\$0.16	\$3,850	\$0.27	\$37,831	\$2.70	\$36,144	\$2.58	\$22,489	\$1.60	\$38,592	\$2.75
WADENA	\$4,000	\$0.42	\$2,000	\$0.21	\$39,891	\$4.22	\$8,000	\$0.85	\$53,102	\$5.62	\$0	\$0.00
WASECA	\$1,005	\$0.08	\$1,117	\$0.09	\$49,759	\$3.86	\$21,214	\$1.65	\$31,426	\$2.44	\$4,696	\$0.36
WASHINGTON	\$6,869	\$0.07	\$69,197	\$0.68	\$668,728	\$6.58	\$263,736	\$2.60	\$501,194	\$4.93	\$222,704	\$2.19
WILKIN	\$1,000	\$0.19	\$1,000	\$0.19	\$58,680	\$10.89	\$13,121	\$2.43	\$46,318	\$8.59	\$0	\$0.00
WINONA	\$12,750	\$0.35	\$30,072	\$0.83	\$156,793	\$4.34	\$126,189	\$3.50	\$93,539	\$2.59	\$162,467	\$4.50
WRIGHT	\$12,000	\$0.26	\$70,200	\$1.52	\$224,820	\$4.85	\$59,892	\$1.29	\$89,853	\$1.94	\$6,400	\$0.14
YELLOW MEDICINE	\$3,585	\$0.42	\$3,108	\$0.36	\$47,550	\$5.58	\$13,888	\$1.63	\$39,049	\$4.58	\$20,000	\$2.34
TOTAL	\$850,173	\$0.26	\$2,009,376	\$0.63	\$17,413,341	\$5.43	\$10,220,427	\$3.19	\$12,523,400	\$3.90	\$3,461,884	\$1.08

NOTE: 1) THE TOTALS LISTED IN THIS TABLE ARE FROM THE STATE-APPROVED COUNTY MENTAL HEALTH PLANS
 2) THE PER CAPITA COLUMN IS CALCULATED BY DIVIDING THE EXPENDITURES BY THE NUMBER OF COUNTY RESIDENTS 18 YEARS OR OLDER AS COUNTED IN THE 1990 CENSUS.

ADULT MENTAL HEALTH PROJECTED COUNTY EXPENDITURES FOR 1990

COUNTY	EDUCATION/PREVENTION		EMERGENCY SERVICES		OUTPATIENT TX		CASE MANAGEMENT		COMMUNITY SUPPORT		DAY TREATMENT	
	EXPENDIT.	PER CAP*	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP
AITKIN	\$1,500	\$0.16	\$11,000	\$1.16	\$62,290	\$6.58	\$20,254	\$2.14	\$39,132	\$4.13	\$9,000	\$0.95
ANOKA	\$39,300	\$0.23	\$74,508	\$0.44	\$291,200	\$1.72	\$489,400	\$2.89	\$632,800	\$3.74	\$6,500	\$0.04
BECKER	\$1,500	\$0.08	\$4,000	\$0.20	\$130,000	\$6.57	\$30,000	\$1.52	\$39,600	\$2.00	\$11,500	\$0.58
BELTRAMI	\$2,000	\$0.08	\$58,569	\$2.42	\$84,275	\$3.49	\$54,863	\$2.27	\$137,033	\$5.67	\$44,464	\$1.84
BENTON	\$2,000	\$0.09	\$5,000	\$0.24	\$61,046	\$2.89	\$67,222	\$3.18	\$42,872	\$2.03	\$23,625	\$1.12
BIG STONE	\$600	\$0.13	\$400	\$0.09	\$10,000	\$2.15	\$13,000	\$2.80	\$32,939	\$7.09	\$0	\$0.00
BLUE EARTH	\$8,319	\$0.20	\$7,174	\$0.17	\$229,548	\$5.51	\$76,808	\$1.84	\$221,526	\$5.32	\$103,803	\$2.49
BROWN	\$4,000	\$0.20	\$4,000	\$0.20	\$130,000	\$6.64	\$72,000	\$3.68	\$45,235	\$2.31	\$4,860	\$0.25
CARLTON	\$37,750	\$1.79	\$6,800	\$0.32	\$115,000	\$5.46	\$45,000	\$2.14	\$63,408	\$3.01	\$0	\$0.00
CARVER	\$11,562	\$0.35	\$16,794	\$0.50	\$175,960	\$5.27	\$68,456	\$2.05	\$98,597	\$2.95	\$0	\$0.00
CASS	\$900	\$0.06	\$4,421	\$0.28	\$144,652	\$9.12	\$18,389	\$1.16	\$79,172	\$4.99	\$5,773	\$0.36
CHIPPEWA	\$2,500	\$0.26	\$9,000	\$0.93	\$106,667	\$11.06	\$61,388	\$6.36	\$22,000	\$2.28	\$24,500	\$2.54
CHISAGO	\$6,000	\$0.28	\$6,000	\$0.28	\$78,000	\$3.69	\$30,000	\$1.42	\$49,150	\$2.33	\$20,793	\$0.98
CLAY	\$17,016	\$0.45	\$6,035	\$0.16	\$179,037	\$4.74	\$24,323	\$0.64	\$87,807	\$2.32	\$16,505	\$0.44
CLEARWATER	\$300	\$0.05	\$7,630	\$1.30	\$26,250	\$4.46	\$13,119	\$2.23	\$40,000	\$6.79	\$6,556	\$1.11
COOK	\$4,800	\$1.64	\$4,200	\$1.43	\$39,940	\$13.62	\$24,126	\$8.23	\$20,591	\$7.02	\$0	\$0.00
COTTONWOOD	\$2,733	\$0.29	\$7,433	\$0.79	\$48,583	\$5.17	\$25,026	\$2.67	\$24,617	\$2.62	\$12,843	\$1.37
CROW WING	\$4,000	\$0.12	\$10,000	\$0.31	\$145,000	\$4.49	\$175,000	\$5.41	\$109,738	\$3.40	\$27,500	\$0.85
DAKOTA	\$15,430	\$0.08	\$273,675	\$1.42	\$742,125	\$3.84	\$395,258	\$2.05	\$318,419	\$1.65	\$156,750	\$0.81
DODGE	\$920	\$0.09	\$1,000	\$0.09	\$23,000	\$2.13	\$33,271	\$3.09	\$39,046	\$3.62	\$4,550	\$0.42
DOUGLAS	\$1,000	\$0.05	\$10,000	\$0.48	\$45,000	\$2.15	\$30,000	\$1.44	\$55,000	\$2.63	\$0	\$0.00
FILLMORE	\$1,500	\$0.10	\$6,800	\$0.45	\$45,000	\$3.00	\$16,364	\$1.09	\$39,178	\$2.61	\$0	\$0.00
FMW	\$2,379	\$0.06	\$4,218	\$0.11	\$129,334	\$3.44	\$51,852	\$1.38	\$314,593	\$8.36	\$97,772	\$2.60
FREEBORN	\$4,200	\$0.17	\$11,900	\$0.49	\$330,000	\$13.45	\$60,000	\$2.45	\$54,800	\$2.23	\$11,000	\$0.45
GOODHUE	\$33,720	\$1.15	\$41,433	\$1.42	\$123,410	\$4.22	\$52,329	\$1.79	\$153,835	\$5.26	\$14,175	\$0.48
GRANT	\$850	\$0.18	\$750	\$0.16	\$16,750	\$3.62	\$10,207	\$2.21	\$35,500	\$7.67	\$5,100	\$1.10
HENNEPIN	\$230,716	\$0.29	\$209,967	\$0.26	\$5,545,057	\$6.99	\$2,656,833	\$3.35	\$3,732,821	\$4.70	\$350,115	\$0.44
HOUSTON	\$7,127	\$0.54	\$3,439	\$0.26	\$28,980	\$2.20	\$31,000	\$2.35	\$26,706	\$2.03	\$10,000	\$0.76
HUBBARD	\$500	\$0.05	\$1,300	\$0.12	\$42,000	\$3.87	\$37,600	\$3.47	\$66,500	\$6.13	\$0	\$0.00
ISANTI	\$2,000	\$0.11	\$5,407	\$0.30	\$131,989	\$7.41	\$57,130	\$3.21	\$36,979	\$2.08	\$1,034	\$0.06
ITASCA	\$12,207	\$0.42	\$52,261	\$1.78	\$156,002	\$5.32	\$50,000	\$1.71	\$127,114	\$4.34	\$12,738	\$0.43
JACKSON	\$1,605	\$0.19	\$11,240	\$1.32	\$15,816	\$1.85	\$13,680	\$1.60	\$33,249	\$3.89	\$0	\$0.00
KANABEC	\$2,500	\$0.28	\$850	\$0.10	\$31,412	\$3.52	\$14,400	\$1.61	\$55,747	\$6.25	\$0	\$0.00
KANDIYOHI	\$34,900	\$1.26	\$13,850	\$0.50	\$223,728	\$8.07	\$78,300	\$2.82	\$149,225	\$5.38	\$126,590	\$4.57
KITSON	\$475	\$0.11	\$325	\$0.08	\$5,200	\$1.22	\$9,200	\$2.16	\$46,288	\$10.86	\$0	\$0.00
KOOCHICHING	\$3,000	\$0.25	\$8,000	\$0.66	\$77,854	\$6.41	\$89,866	\$7.40	\$39,686	\$3.27	\$26,900	\$2.21
LAC QUI PARLE	\$13,877	\$2.11	\$6,791	\$1.03	\$34,830	\$5.31	\$17,593	\$2.68	\$38,993	\$5.94	\$0	\$0.00
LAKE	\$3,740	\$0.47	\$2,200	\$0.28	\$43,515	\$5.52	\$5,720	\$0.73	\$22,395	\$2.84	\$9,900	\$1.26
LAKE OF WOODS	\$1,182	\$0.40	\$963	\$0.33	\$3,782	\$1.28	\$2,123	\$0.72	\$212	\$0.07	\$963	\$0.33
LE SUEUR	\$5,050	\$0.31	\$6,600	\$0.40	\$131,095	\$8.01	\$25,000	\$1.53	\$30,000	\$1.83	\$3,000	\$0.18
MCLEOD	\$2,560	\$0.11	\$1,000	\$0.04	\$70,000	\$3.08	\$35,000	\$1.54	\$45,000	\$1.98	\$25,000	\$1.10
MAHOMEN	\$500	\$0.14	\$2,500	\$0.72	\$30,000	\$8.65	\$8,000	\$2.31	\$30,663	\$8.84	\$6,000	\$1.73
MARSHALL	\$7,600	\$0.97	\$1,400	\$0.18	\$7,800	\$1.00	\$31,800	\$4.06	\$34,000	\$4.35	\$3,000	\$0.38
MEEKER	\$14,600	\$0.99	\$8,100	\$0.55	\$58,000	\$3.94	\$36,720	\$2.49	\$33,716	\$2.29	\$46,000	\$3.13
MILLE LACS	\$3,000	\$0.23	\$10,000	\$0.76	\$60,000	\$4.53	\$60,000	\$4.53	\$39,200	\$2.96	\$24,000	\$1.81
MORRISON	\$17,981	\$0.88	\$4,402	\$0.22	\$66,690	\$3.28	\$16,080	\$0.79	\$101,903	\$5.01	\$1,000	\$0.05
MOWER	\$4,500	\$0.16	\$7,750	\$0.28	\$240,304	\$8.63	\$124,010	\$4.46	\$138,500	\$4.98	\$47,000	\$1.69

ADULT MENTAL HEALTH

ADULT MENTAL HEALTH PROJECTED COUNTY EXPENDITURES FOR 1990

COUNTY	RULE 36 (EXCL. RULE 12)		ACUTE CARE HOSPITAL		REG. TX. CENTER		ALL SCREENING*		ALL OTHER*		TOTAL (EXCL. RULE 12)	
	EXPENDIT.	PER CAP*	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP
NICOLLET	\$8,000	\$0.39	\$12,000	\$0.58	\$39,568	\$1.91	\$14,000	\$0.68	\$0	\$0.00	\$375,670	\$18.12
NOBLES	\$5,000	\$0.34	\$32,000	\$2.17	\$30,000	\$2.03	\$3,175	\$0.22	\$31,632	\$2.14	\$319,157	\$21.61
NORMAN	\$11,607	\$1.99	\$4,000	\$0.69	\$31,537	\$5.42	\$2,750	\$0.47	\$0	\$0.00	\$124,605	\$21.40
OLMSTED	\$153,722	\$2.00	\$2,300	\$0.03	\$194,996	\$2.53	\$44,434	\$0.58	\$0	\$0.00	\$1,237,106	\$16.08
OTTER TAIL	\$40,096	\$1.08	\$12,500	\$0.34	\$268,719	\$7.21	\$20,000	\$0.54	\$0	\$0.00	\$865,313	\$23.22
PENNINGTON	\$0	\$0.00	\$37,720	\$3.87	\$26,623	\$2.73	\$5,560	\$0.57	\$0	\$0.00	\$180,525	\$18.53
PINE	\$9,000	\$0.59	\$4,000	\$0.26	\$33,022	\$2.17	\$6,000	\$0.39	\$0	\$0.00	\$276,814	\$18.19
PIPESTONE	\$0	\$0.00	\$7,500	\$0.99	\$11,000	\$1.46	\$2,239	\$0.30	\$0	\$0.00	\$152,101	\$20.17
POLK	\$87,450	\$3.74	\$22,000	\$0.94	\$128,155	\$5.49	\$7,000	\$0.30	\$89,033	\$3.81	\$634,591	\$27.17
POPE	\$42,000	\$5.39	\$4,000	\$0.51	\$2,520	\$0.32	\$2,000	\$0.26	\$0	\$0.00	\$137,500	\$17.66
RAMSEY	\$654,804	\$1.79	\$853,342	\$2.33	\$899,217	\$2.46	\$336,053	\$0.92	\$0	\$0.00	\$10,968,436	\$30.00
RED LAKE	\$0	\$0.00	\$900	\$0.28	\$4,961	\$1.56	\$2,200	\$0.69	\$0	\$0.00	\$63,607	\$20.06
REDWOOD	\$0	\$0.00	\$2,500	\$0.20	\$45,994	\$3.71	\$6,000	\$0.48	\$0	\$0.00	\$218,339	\$17.60
REGION VIII	\$23,292	\$0.77	\$20,000	\$0.66	\$116,115	\$3.85	\$20,000	\$0.66	\$0	\$0.00	\$760,116	\$25.19
RENVILLE	\$18,000	\$1.41	\$2,000	\$0.16	\$36,000	\$2.82	\$7,000	\$0.55	\$10,000	\$0.78	\$336,000	\$26.35
RICE	\$24,000	\$0.66	\$8,000	\$0.22	\$97,200	\$2.68	\$10,500	\$0.29	\$0	\$0.00	\$351,200	\$9.68
ROCK	\$3,413	\$0.49	\$9,000	\$1.28	\$9,142	\$1.30	\$5,310	\$0.76	\$0	\$0.00	\$125,482	\$17.87
ROSEAU	\$6,000	\$0.58	\$18,000	\$1.74	\$4,000	\$0.39	\$1,900	\$0.18	\$2,300	\$0.22	\$112,995	\$10.92
SAINT LOUIS	\$5,988	\$0.04	\$264,000	\$1.76	\$369,600	\$2.47	\$105,000	\$0.70	\$180,000	\$1.20	\$3,034,588	\$20.25
SCOTT	\$63,600	\$1.60	\$10,000	\$0.25	\$40,000	\$1.00	\$3,444	\$0.09	\$0	\$0.00	\$380,655	\$9.55
SHERBURNE	\$14,560	\$0.51	\$12,000	\$0.42	\$49,501	\$1.73	\$10,640	\$0.37	\$16,401	\$0.57	\$357,342	\$12.48
SIBLEY	\$9,000	\$0.88	\$13,000	\$1.26	\$21,300	\$2.07	\$4,500	\$0.44	\$0	\$0.00	\$165,050	\$16.05
STEARNS	\$2,982	\$0.03	\$17,315	\$0.20	\$350,928	\$4.09	\$36,400	\$0.42	\$41,979	\$0.49	\$1,173,462	\$13.68
STEELE	\$60	\$0.00	\$0	\$0.00	\$18,766	\$0.86	\$5,415	\$0.25	\$0	\$0.00	\$303,400	\$13.83
STEVENS	\$0	\$0.00	\$5,000	\$0.61	\$10,350	\$1.27	\$8,000	\$0.98	\$0	\$0.00	\$107,743	\$13.25
SWIFT	\$13,280	\$1.69	\$1,500	\$0.19	\$28,080	\$3.58	\$3,750	\$0.48	\$0	\$0.00	\$243,610	\$31.06
TODD	\$7,000	\$0.43	\$18,000	\$1.11	\$29,600	\$1.82	\$7,000	\$0.43	\$0	\$0.00	\$242,363	\$14.93
TRAVERSE	\$4,500	\$1.37	\$0	\$0.00	\$5,000	\$1.52	\$2,500	\$0.76	\$0	\$0.00	\$77,144	\$23.43
WABASHA	\$8,674	\$0.62	\$0	\$0.00	\$15,000	\$1.07	\$1,500	\$0.11	\$0	\$0.00	\$166,280	\$11.85
WADENA	\$0	\$0.00	\$0	\$0.00	\$10,000	\$1.06	\$3,500	\$0.37	\$1,300	\$0.14	\$121,793	\$12.90
WASECA	\$38,495	\$2.99	\$8,500	\$0.66	\$11,500	\$0.89	\$3,369	\$0.26	\$13,250	\$1.03	\$184,331	\$14.29
WASHINGTON	\$44,598	\$0.44	\$45,000	\$0.44	\$100,530	\$0.99	\$33,890	\$0.33	\$0	\$0.00	\$1,956,446	\$19.26
WILKIN	\$0	\$0.00	\$1,500	\$0.28	\$49,336	\$9.15	\$1,000	\$0.19	\$0	\$0.00	\$171,955	\$31.90
WINONA	\$1,840	\$0.05	\$6,500	\$0.18	\$115,200	\$3.19	\$65,920	\$1.83	\$0	\$0.00	\$771,270	\$21.37
WRIGHT	\$29,911	\$0.65	\$1,500	\$0.03	\$94,464	\$2.04	\$22,000	\$0.47	\$0	\$0.00	\$611,040	\$13.19
YELLOW MEDICINE	\$0	\$0.00	\$6,000	\$0.70	\$31,112	\$3.65	\$5,000	\$0.59	\$0	\$0.00	\$169,292	\$19.85
TOTAL	\$3,635,038	\$1.13	\$3,508,100	\$1.09	\$8,028,219	\$2.50	\$2,764,684	\$0.86	\$1,125,652	\$0.35	\$65,540,294	\$20.43

NOTE: 1) THE TOTALS LISTED IN THIS TABLE ARE FROM THE STATE-APPROVED COUNTY MENTAL HEALTH PLAN.

2) THE SCREENING SERVICES COLUMN INCLUDES BOTH PRE-PETITION SCREENING AND RESIDENTIAL SCREENING.

3) THE PER CAPITA COLUMN IS CALCULATED BY DIVIDING THE EXPENDITURES BY THE NUMBER OF COUNTY RESIDENTS 18 YEARS OR OLDER AS COUNTED IN THE 1990 CENSUS.

4) SOME COUNTIES LISTED OTHER SERVICES IN THEIR COUNTY PLANS. THESE TOTALS ARE LISTED IN THE OTHER COLUMN.

5) RULE 12 FUNDING IS EXCLUDED FROM THIS TABLE BECAUSE IT WOULD DISTORT THE COMPARISON BETWEEN COUNTIES; RULE 12 IS BASED ON LOCATION OF THE FACILITY, NOT THE CLIENT'S COUNTY OF FINANCIAL RESPONSIBILITY.

ADULT MENTAL HEALTH PROJECTED COUNTY EXPENDITURES FOR 1990

COUNTY	RULE 36 (EXCL. RULE 12)		ACUTE CARE HOSPITAL		REG. TX. CENTER		ALL SCREENING*		ALL OTHER*		TOTAL (EXCL. RULE 12)	
	EXPENDIT.	PER CAP*	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP	EXPENDIT.	PER CAP
AITKIN	\$10,645	\$1.12	\$7,000	\$0.74	\$27,159	\$2.87	\$1,800	\$0.19	\$0	\$0.00	\$189,780	\$20.05
ANOKA	\$141,000	\$0.83	\$100,800	\$0.60	\$356,400	\$2.11	\$70,000	\$0.41	\$0	\$0.00	\$2,201,908	\$13.01
BECKER	\$54,680	\$2.77	\$8,000	\$0.40	\$61,492	\$3.11	\$4,400	\$0.22	\$0	\$0.00	\$345,172	\$17.46
BELTRAMI	\$6,682	\$0.28	\$1,548	\$0.06	\$63,216	\$2.62	\$15,083	\$0.62	\$15,310	\$0.63	\$483,043	\$20.00
BENTON	\$61,236	\$2.90	\$0	\$0.00	\$56,566	\$2.68	\$8,537	\$0.40	\$0	\$0.00	\$328,104	\$15.52
BIG STONE	\$800	\$0.17	\$0	\$0.00	\$20,713	\$4.46	\$3,000	\$0.65	\$0	\$0.00	\$81,452	\$17.54
BLUE EARTH	\$2,520	\$0.06	\$59,019	\$1.42	\$181,565	\$4.36	\$19,744	\$0.47	\$0	\$0.00	\$910,026	\$21.85
BROWN	\$17,025	\$0.87	\$10,000	\$0.51	\$51,955	\$2.65	\$8,500	\$0.43	\$0	\$0.00	\$347,575	\$17.75
CARLTON	\$0	\$0.00	\$0	\$0.00	\$43,491	\$2.07	\$10,000	\$0.48	\$0	\$0.00	\$321,449	\$15.27
CARVER	\$20,400	\$0.61	\$20,100	\$0.60	\$20,000	\$0.60	\$10,328	\$0.31	\$18,900	\$0.57	\$461,097	\$13.80
CASS	\$14,787	\$0.93	\$18,779	\$1.18	\$82,882	\$5.23	\$4,837	\$0.30	\$0	\$0.00	\$374,592	\$23.62
CHIPPEWA	\$7,047	\$0.73	\$1,000	\$0.10	\$24,771	\$2.57	\$3,800	\$0.39	\$0	\$0.00	\$262,673	\$27.23
CHISAGO	\$28,700	\$1.36	\$0	\$0.00	\$36,499	\$1.73	\$2,600	\$0.12	\$0	\$0.00	\$257,742	\$12.21
CLAY	\$10,000	\$0.26	\$32,500	\$0.86	\$118,222	\$3.13	\$14,686	\$0.39	\$204,683	\$5.42	\$710,814	\$18.81
CLEARWATER	\$11,700	\$1.99	\$13,914	\$2.36	\$3,125	\$0.53	\$3,130	\$0.53	\$0	\$0.00	\$125,724	\$21.35
COOK	\$0	\$0.00	\$0	\$0.00	\$9,810	\$3.35	\$5,000	\$1.71	\$28,980	\$9.88	\$137,447	\$46.88
COTTONWOOD	\$0	\$0.00	\$15,000	\$1.60	\$30,839	\$3.28	\$19,405	\$2.07	\$0	\$0.00	\$186,479	\$19.86
CROW WING	\$0	\$0.00	\$3,000	\$0.09	\$246,750	\$7.63	\$25,000	\$0.77	\$0	\$0.00	\$745,988	\$23.08
DAKOTA	\$293,115	\$1.52	\$202,193	\$1.05	\$119,240	\$0.62	\$94,514	\$0.49	\$0	\$0.00	\$2,610,719	\$13.52
DODGE	\$13,186	\$1.22	\$7,400	\$0.69	\$3,552	\$0.33	\$2,250	\$0.21	\$3,250	\$0.30	\$131,425	\$12.19
DOUGLAS	\$0	\$0.00	\$1,000	\$0.05	\$60,000	\$2.87	\$2,500	\$0.12	\$0	\$0.00	\$204,500	\$9.79
FILLMORE	\$12,500	\$0.83	\$2,300	\$0.15	\$14,307	\$0.95	\$2,818	\$0.19	\$0	\$0.00	\$140,767	\$9.39
FMW	\$9,913	\$0.26	\$40,776	\$1.08	\$87,622	\$2.33	\$22,323	\$0.59	\$0	\$0.00	\$760,782	\$20.23
FREEBORN	\$0	\$0.00	\$25,000	\$1.02	\$45,960	\$1.87	\$9,000	\$0.37	\$0	\$0.00	\$551,860	\$22.50
GOODHUE	\$22,200	\$0.76	\$0	\$0.00	\$40,500	\$1.39	\$2,455	\$0.08	\$0	\$0.00	\$484,057	\$16.55
GRANT	\$1,200	\$0.26	\$4,000	\$0.86	\$5,200	\$1.12	\$1,200	\$0.26	\$10,207	\$2.21	\$90,964	\$19.65
HENNEPIN	\$1,386,589	\$1.75	\$1,279,246	\$1.61	\$2,030,332	\$2.56	\$1,431,732	\$1.80	\$370,859	\$0.47	\$19,224,267	\$24.22
HOUSTON	\$28,599	\$2.17	\$3,600	\$0.27	\$16,220	\$1.23	\$6,500	\$0.49	\$0	\$0.00	\$162,171	\$12.30
HUBBARD	\$0	\$0.00	\$30,000	\$2.76	\$26,910	\$2.48	\$4,500	\$0.41	\$0	\$0.00	\$209,310	\$19.29
ISANTI	\$8,500	\$0.48	\$1,200	\$0.07	\$27,306	\$1.53	\$6,000	\$0.34	\$37,501	\$2.11	\$315,046	\$17.69
ITASCA	\$32,124	\$1.10	\$0	\$0.00	\$69,552	\$2.37	\$39,815	\$1.36	\$0	\$0.00	\$551,813	\$18.83
JACKSON	\$1,519	\$0.18	\$11,339	\$1.33	\$9,425	\$1.10	\$19,950	\$2.34	\$0	\$0.00	\$117,823	\$13.79
KANABEC	\$9,341	\$1.05	\$2,400	\$0.27	\$26,550	\$2.98	\$3,225	\$0.36	\$30,067	\$3.37	\$176,492	\$19.79
KANDIYOHI	\$0	\$0.00	\$0	\$0.00	\$201,406	\$7.26	\$8,700	\$0.31	\$12,000	\$0.43	\$848,699	\$30.61
KITSON	\$3,050	\$0.72	\$12,000	\$2.82	\$4,860	\$1.14	\$520	\$0.12	\$0	\$0.00	\$81,918	\$19.23
KOOCHICHIING	\$0	\$0.00	\$1,800	\$0.15	\$25,100	\$2.07	\$2,240	\$0.18	\$8,000	\$0.66	\$282,446	\$23.25
LAC QUI PARLE	\$2,900	\$0.44	\$900	\$0.14	\$24,466	\$3.73	\$2,250	\$0.34	\$0	\$0.00	\$142,600	\$21.72
LAKE	\$11,550	\$1.47	\$0	\$0.00	\$660	\$0.08	\$1,200	\$0.15	\$0	\$0.00	\$100,880	\$12.80
LAKE OF WOODS	\$424	\$0.14	\$9,456	\$3.21	\$3,602	\$1.22	\$1,698	\$0.58	\$0	\$0.00	\$24,405	\$8.28
LE SUEUR	\$13,230	\$0.81	\$6,500	\$0.40	\$47,865	\$2.92	\$6,000	\$0.37	\$0	\$0.00	\$274,340	\$16.75
MCLEOD	\$22,000	\$0.97	\$44,500	\$1.96	\$59,578	\$2.62	\$7,000	\$0.31	\$0	\$0.00	\$311,638	\$13.70
MAHNOHEN	\$2,651	\$0.76	\$1,800	\$0.52	\$16,802	\$4.84	\$1,650	\$0.48	\$0	\$0.00	\$100,566	\$28.98
MARSHALL	\$9,200	\$1.18	\$15,400	\$1.97	\$16,398	\$2.10	\$1,500	\$0.19	\$0	\$0.00	\$128,098	\$16.37
MEeker	\$3,000	\$0.20	\$2,800	\$0.19	\$73,849	\$5.02	\$10,000	\$0.68	\$0	\$0.00	\$286,785	\$19.48
MILLE LACS	\$25,000	\$1.89	\$0	\$0.00	\$28,000	\$2.12	\$8,500	\$0.64	\$0	\$0.00	\$257,700	\$19.47
MORRISON	\$153	\$0.01	\$253	\$0.01	\$116,615	\$5.73	\$8,345	\$0.41	\$0	\$0.00	\$333,422	\$16.39
MOWER	\$5,000	\$0.18	\$50,000	\$1.80	\$61,851	\$2.22	\$7,500	\$0.27	\$0	\$0.00	\$686,415	\$24.66

COMMONLY USED ABBREVIATIONS

ADA	Americans with Disabilities Act
AMI-MN	Alliance for the Mentally Ill of MN
CSP	Community Support Program
CSSA	Community Social Services Act
DHS	Department of Human Services
GA	General Assistance
GAMC	General Assistance Medical Care
IMD's	Institutions for Mental Diseases
MA	Medical Assistance, Medicaid, Title XIX
MDMDA	Minnesota Depressive and Manic Depressive Association
MHA	Mental Health Association
MHAC	Mental Health Advisory Council
MSA	Minnesota Supplemental Aid
NAMI	National Alliance for the Mentally Ill
RTC	Regional Treatment Center (State Hospital)
SAM	Schizophrenia Association of Minnesota
SPMI	Serious and Persistent Mental Illness
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TD	Tardive Dyskinesia
TDD	Telephone Device for the Deaf
DRS	Division of Rehabilitation Services

**Many of these terms are defined in the glossary, workbook,
Appendices Tab, page 18A.*

GLOSSARY

RESOURCES FOR THIS WORKBOOK

SPECIAL THANKS TO:

Adams, Chris, Minnesota Depressive and Manic Depressive Association

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Conley, Pat, Association of Minnesota Counties

Houlton, Nancy, Mental Health Resources

Dakota County Advocacy Workshop

Kelso, Kathy, executive director Mental Health Association

Project Overcome

Schleppegrell, Norma, chair, State Mental Health Advisory Council

Storck, Jerry, research analyst specialist, Department of Human Services

Weinstock, Bruce, director, State Mental Health Advisory Council

Woehrlin, Molly, Rice County Commissioner

Zakelj, John, supervisor, technical services, Department of Human Services

ADDITIONAL THANKS

To local advisory council members throughout Minnesota, and their chairs, who welcomed the director and associate director of this project to their meetings, and many of whom actively worked to recruit participants for training sessions.

WRITTEN RESOURCES

Amidei, Nancy, So You Want to Make A Difference: A Key to Advocacy. OMB Watch: 1991.

Bayless, Betty; Buffington, Erica; Tews, Jean, Citizens In Action, League of Women Voters: 1988.

Roberts, Bruce B., Ph.D. and Thorsheim, Howard I, Ph.D., Empowering Leadership. St. Olaf College: 1987.

Flanigan, Barbara, Monitoring Mental Health Services at the County Level. League of Women Voters: 1989

Flanigan, Barbara, Serving Minnesota's Mentally Ill. League of Women Voters: 1987.

Advocacy. OMB Watch: 1991.

A Handbook for Members of Advisory Committees, Association for Retarded Citizens Minnesota, Residential Services Committee: June, 1982.

In Counties We Trust, Association of Retarded Citizens: No date.

Leadership In Mental Health, Hubert H. Humphrey Institute of Public Affairs, Reflective Leadership Center.

Report to the Governor and Legislature, prepared by Kathy Kelso; Norma Schleppegrell, Chair: 1991

Takkunen, Candy, Raising Minnesota's Leaders, A Collection of Leadership Development Lessons.

Covey, Stephen R., 7 Habits of Highly Effective People. No Date

MENTAL HEALTH RESOURCES

MENTAL HEALTH ORGANIZATIONS

Alliance for the Mentally Ill of Minnesota

Jane Mastro-Sadovsky, Executive Director
1595 Selby Avenue #103
St. Paul, Minnesota 55104
Phone: (612) 645-2948

Mental Health Association of Minnesota

Kathy Kelso, Executive Director
328 E. Hennepin Avenue
Minneapolis, MN 55414
Phone: (612) 331-6840
1-800 862-1799

Mental Health Law Project

430 1st Ave. N., Suite 300
Minneapolis, Mn 55401-1780
Phone: (612) 332-1441
1-800 292-4150

Minnesota Depressive and Manic Depressive Association

328 E. Hennepin Ave. 2nd Floor
Minneapolis, MN 55414
Phone: (612) 370-7933

Minnesota Statewide Consumer's Network

Leave message for Shirley on answering machine.
% Hiawatha Center
4200 28th Ave. S.
Minneapolis, MN 55406
Phone: (612) 724-7761

The Office of the Ombudsman for Mental Health & Retardation

202 Metro Square Building
7th & Robert
St. Paul, MN 55101
Phone: (612) 296-3848
1-800 652-9747

PACER Center

4826 Chicago Ave. S
Minneapolis, MN 55417
Phone: (612) 827-2966
1-800-537-2237

Schizophrenic Association of Minnesota

6950 France Ave. S., Suite 215
Minneapolis, MN 55435
Phone: (612) 922-6916

DEPARTMENT OF HUMAN SERVICES, MENTAL HEALTH DIVISION

Assistant Commissioner for Community Mental Health and RTC Administration

James Stoebner
444 Layfayette Rd.
St. Paul, MN
Phone: (612) 296-2710

State Advisory Council on Mental Health

Bruce Weinstock, Director
Minnesota Department of Human Services
(address above)
Phone: (612) 297-4163

State Advisory Council on Mental Health

Cindy Hart, Chair
Minnesota Department of Human Services
(address above)
Phone: (612) 496-3009 (home)

BOOKS ON THE MENTAL HEALTH SYSTEM

Serving Minnesota's Mentally Ill.

Barbara Flanigan. Clear, concise description of the Minnesota mental health system, definition of mental health terms, rules, and the Minnesota Comprehensive Mental Health Act. A must read for advocates. League of Women Voters of Minnesota Education Fund, 1987.

League of Women Voters

550 Rice Street

St. Paul, MN 55103

Monitoring Mental Health Services At The County Level: A Workbook.

Handbook used in the League of Women Voter's Mental Health Monitoring Project. A good tool for advocates to assess mental health services at the county level. League of Women Voters (address above)

With Open Arms: A Story of Community Support for People who are Mentally Ill.

Sylvestre, Gene and Pat Samples, Mental Health Advocates of Minnesota: 1984. 147 pages, available from The Alliance for the Mentally Ill-Minnesota.

A story of community support for people who are mentally ill.

Care of the Seriously Mentally Ill: A Rating of State Programs.

Torrey E. Fuller, M.D., Karen Erdman, Sidney M. Wolfe, and Laurie Flynn. Published by the Public Citizen Health Research Group and the National 1990. 192 pages, \$10.00.

Order from: **National Alliance for the Mentally Ill**

2102 Wilson Boulevard, Suite 302

Arlington, VA 22201

You are Not Alone: Understanding and Dealing with Mental Illness.

Clara Claiborne Park and Leon N. Shapiro, M.D. Little Brown and Company: 1976.

Descriptions of mental illnesses, and how to move through the system that treats them.

Room Enough For Everyone: People With Mental Illness and Community-Based Group Homes.

Minnesota Mental Health Law Project, March, 1992 (address above)

BOOKS ON MENTAL ILLNESS

Diagnostic and Statistical Manual of Mental Disorders.

Third Edition, Revised. American Psychiatric Press, Washington, D.C: 1987.

DSM made available to the public. Definitions of serious mental illnesses.

SCIENCE AND RESEARCH

The Broken Brain: The Biological Revolution in Psychiatry.

Andreasen, Nancy. New York, Harper and Row: 1984 278 pages, pb, \$9.45.

A clear understandable explanation of the advances in brain research as it relates to mental illness.

PUBLIC POLICY

Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill.

Isaac, Rael and Virginia Armat. New York, The Free Press: 1990. 436 pages, pb, \$23.70.

A well-researched attack on the psychiatrists who deny the reality of mental illness and the body of law that allows involuntary commitment only for dangerousness.

The Mentally Ill in Jail: Planning for Essential Services.

Steadman, Henry J. Dennis W. McCarty and Joseph P. Morrissey. New York, Guilford Press: 1989. 242 pages, \$30.00.

A review of research on treatment programs for mentally ill persons in jails in 43 cities and towns.

Nowhere To Go. The Tragic Odyssey of the Homeless Mentally Ill.

Torrey, E. Fuller. New York, Harper & Row: 1988. 256 pages, pb, \$8.50.

History of the deinstitutionalization of mentally ill persons.

DEPRESSION, MANIC-DEPRESSION

Depression. Corporate Experiences and Innovations.

Vaccaro, Veronica A., Washington Business Group on Health Prevention Leadership Forum, 777 North Capitol Street, N.E., Suite 800, Washington, DC 20002.

Published by D/ART depression prevention initiative of the National Institute of Mental Health, a 30 page booklet about depression in the workplace.

Depression: The Mood Disease.

Mondimore, Francis M. Baltimore, The Johns Hopkins University Press: 1990. 225 pages, \$15.25.

Offers authoritative and comprehensive evidence that serious depression is a no-fault, biochemical disorder. Written for lay persons with accounts of cases that the author has managed. A hopeful book.

Feeling Good. The New Mood Therapy.

Burns, David D., M.D. William Morrow, New York: 1980. pb, \$5.99.

A look at patterns of perception that create and perpetuate depression. A "how to" book that has helped many people change their own thought patterns that can lead to worsening depressive symptoms.

From Sad to Glad.

Kline, Nathan. New York, Random House: 1981. 278 pages, pb, \$3.95.

An early account of manic depressive illness that focuses on outstanding persons who have suffered from the illness. More recent books are more comprehensive, but many people have found this book helpful in their recovery.

Manic-Depressive Illness.

Goodwin, Frederick K, M.D. and Kay R. Jamison, PhD. New York, Oxford University Press: 1990. 938 pages, \$61.75.

Though this book is expensive, it is a definitive overview of bipolar illness. Written for professionals, it is quite accessible to families and consumers.

Moodswing: The Third Revolution in Psychiatry.

Fieve, Ronald. New York, Bantam Books: 1976. 244 pages, pb, \$4.95.

The first book on the subject written for the general audience that is now somewhat out-of-date but many people with manic-depressive illness still carry it like a bible.

Overcoming Depression.

Papolos, D. and Janice Papolos. New York, Harper & Perennial, Revised Edition: 1992. 393 pages, pb, \$9.45.

Description of the disease, diagnosis, research, treatments. Practical and realistic.

Silencing The Self: Women and Depression.

Jack, Dana Crowley Cambridge, MA, Harvard University Press: 1991, 233 pages, \$19.95.

Examines why women are far more likely than men to suffer major depression in adulthood. A study of how women view themselves, and the role society asks them to play.

SCHIZOPHRENIA

Straight Talk for Families and Friends.

Walsh, Maryellen. New York, E.P. Dutton: 1988. 264 pages, pb, \$3.75.

Written by the mother of a schizophrenic son, this book deals with treatment and services in realistic terms, urges families to become agents of change.

Schizophrenia Genesis: The Origins of Madness.

Bottessman, Irving I. New York, W.H. Freeman: 1990. 298 pages, pb, \$14.95.

A geneticist of world standing, the author presents state-of-the-art views on the genetic elements in Schizophrenia. Technical.

Surviving Schizophrenia: A Family Manual.

Torrey, E. Fuller. Revised Edition. New York, Harper and Row: 1988. 460 pages, pb \$11.40.

Has become the handbook for persons with schizophrenia and their families. Describes the illness comprehensively and in understandable terms and has practical suggestions for families.

OTHER DIAGNOSES

The Boy Who Could Not Stop Washing His Hands.

Rapoport, Judith L. New York, E.P. Dutton: 1988. 260 pages, \$8.95.

A discussion of obsessive-compulsive disorder by the chief of child psychiatry at the National Institute of Mental Health. The author believes that OCD is an hereditary brain disorder. Effective treatment combines medication with behavior therapy.

The Good News about Panic, Anxiety, and Phobias.

Gold, Mark S., M.D. New York, Villard Books: 1989. 325 pages, \$18.00.

An optimistic and informative overview on the diagnosis and treatment of panic and anxiety, written in language understandable to all.

I Hate You—don't leave me. Understanding the Borderline Personality.

Kreisman, Jerold J., M.D. and Hal Straus. Body Press, Los Angeles: 1989. 184 pages, pb \$4.50.
Very little literature is available on this troubling disorder. Explanations of the symptoms of borderline personality and the inclusion of coping skills should be helpful to both family and consumers.

The Siege: The First Eight Years of An Autistic Child.

Park, Clara Claiborne. Little Brown and Company, 1982. Out of print, but should be available at your library.

The Sound of a Miracle.

Stehli, A. Avon: 1991, \$4.99. Good understandable description of autism.

CHILDREN AND ADOLESCENTS

Advocacy on Behalf of Children With Serious Emotional Problems.

Friedman, Robert M., Alobert Duchnowski, and Elissa Henderson. Springfield, Il, Chas. C. Thomas: 1989. 152 pages, \$29.95. Conference papers from 10 experienced advocates for change in the so-called "service system" for children with serious mental illness. The book provides useful information on mental illnesses, building coalitions for advocacy, and the legislative and judicial processes.

A Guidebook for Parents of Children with Emotional Disorders.

PACER Center, Inc., Minneapolis, 1991. (Address above) Free to parents of a child with an emotional disorder, \$10.00 to others. Helpful information about emotional and behavioral illnesses. Listing of programs and services in Minnesota.

Children and Adolescents with Mental Illness: A Parents' Guide.

McElroy, Evelyn. Kensington, MD, Woodbine House: 1988. 221 pages, pb, \$12.30.
Help in deciding about therapists, hospitals, dealing with crises, educational and legal rights of children.

Coping with Teenage Depression: A Parents' Guide.

McCoy, Kathy. New American Library: 1985. 352 pages, pb, \$4.95.

Help For Your Child: A Parents guide to Mental Health Services.

Brehm, Sharon, Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1978.

The Hyperactive Child, Adolescent, and Adult: Attention Disorder Through The Lifespan.

Wender, Paul. New York, Oxford Univ. Press: 1987. 172 pages, \$6.95.
The third version of a classic book about attention deficit disorder by a distinguished psychiatrist who states that ADD may extend into adulthood. He describes the symptoms and treatment and asserts that ADD is a disorder in brain chemistry.

Is Your Child Depressed?

Herskowitz, Joel. New York, Pharos Books: 1988.

Neurobiological Disorders in Children and Adolescents.

Peschel, Enid and Richard, Howe, James and Carol, editors. New Jossey-Bass: 1992. 138 pages, pb, \$17.00. A summary of recent scientific data about neuro biological disorders in children and adolescents. Discussion of treatment approaches based on new findings, particularly pharmacological treatments.

FAMILIES AND COPING STRATEGIES

Alternatives: A Family Guide to Legal and Financial Planning for the Disabled.

Russell, L. Mark. Evanston, IL, First Publications: 1982

Coping with Mental Illness in the Family: A Family Guide.

Hatfield, Agnes B. (Second Edition) Order from National Alliance for the Mentally Ill: 1990. 90 pages, pb, \$4.50.

A new edition of a classic that helps families understand and cope with mental illness. Covers diagnoses, causes, and prognoses of mental illnesses. If you can just get one book, this is it.

Families as Allies in Treatment of the Mentally Ill.

Lefley, Harriet, Editor. Washington, D.C. American Psychiatric Press: 1990. 272 pages, pb, \$15.15.

A quality textbook for teaching professionals that could be very helpful to family members involved in education about mental illness.

Family Education in Mental Illness.

Hatfield, Agnes. New York, Guilford Press: 1990. 212 pages, \$15.95.

A book for professionals that is also a resource for families. It provides the curriculum content and methodology for educating families. Content is based on family needs as identified by the author's research: knowledge of mental illness, coping skills, and support in crises and in planning for the future. Well organized, clearly written, research-based, and comprehensive.

Hidden Victims.

Johnson, Julie. New York, Doubleday: 1988. 194 pages, \$16.10

An eight stage healing process for siblings, spouses, parents and adult children who are often the "hidden victims" of mental illness.

Nothing To Be Ashamed Of.

Dinner, Sherry. New York, Lothrop, Lee & Shepard: 1989. 212 pages, \$7.95.

A comprehensive book for teenagers with a mentally ill family member. In direct, clear language, the author explains the causes and treatment of schizophrenia, affective disorders, anxiety disorders, and Alzheimer's disease. The author encourages readers to cultivate their own lives, keep talking to their parents, and accept the situation.

Strategies: A Practical Guide For Dealing with Professionals and Human Service Systems.

Shields, Craig U. Richmond Hill, Ontario, Human Services Press: 1987.

NARRATIVES

A Brilliant Madness: Living With Manic Depressive Illness.

Duke, Patty and Hochman, Gloria, Bantam Books: 1992. 277 pages, \$22.50

An interweaving of Patty Duke's personal struggle with manic-depressive illness and Gloria Hochman's clear description of what this illness is (and is not).

Darkness Visible: A Memoir of Madness.

Styron, William. Random House: 1990. 86 pages, \$15.95

A moving account of his experience of unipolar depression by the author of *The Confessions of Nat Turner* and *Sophie's choice*. Styron's mastery of language makes this one of the most compelling books about how it feels to experience severe depression. For family members or friends who want to better understand depression and the devastating effect it can have on an individual.

Experiences of Patients and Families: First Person Accounts.

Arlington, VA, NAMI: 1989. 89 pages, pb, \$5.00.

Reprinted from *Schizophrenia Bulletin* and *The New York Times*.

The Four of Us: A Family Memoir.

Elizabeth Swados. Farrar, Straus and Giroux, New York: 1991.

Powerful, insightful book by the author whose brother was diagnosed with schizophrenia. Not being a burden to her parents carried a price for her.

Is There No Place on Earth for Me?

Sheehan, Susan. Boston, Houghton Mifflin, 1982

My Sister's Keeper.

Margaret Moorman. W.W. Norton: 1992. \$21.95.

Common dreads, doubts and uncertainties that come with a sibling having mental illness.

SUICIDE

Suicide Survivors.

Wroblewski, Adina. Minneapolis, MN., Afterwords: 1992. 154 pages, \$14.95

A book that offers comfort and suggestions to ease the pain of suicide and hasten healing.

Suicide: Why?

Wroblewski, Adina. Minneapolis, MN., Afterwords: 1989. \$12.30.

Links suicide with mania and schizophrenia as well as major depression. Book lists warning signs, and is concerned with suicide prevention, also includes statistical information.

DRUGS, PSYCHIATRIC MEDICATIONS

Carbamazepine and Manic Depression: A guide. (Revised Edition). Madison, WI, Univ of WI.

Lithium Information Center: 1988. 34 pages, pb, \$3.50.

A guidebook in question-and-answer format about a medication frequently prescribed for bipolar patients who cannot use lithium.

The Essential Guide to Psychiatric Drugs.

Gorman, Jack M. New York, St. Martin's Press: 1990. 398 pages, pb, \$14.20.

Psychopharmacologist provides basic information on 123 drugs used for psychiatric illnesses, sleep disorders, and substance abuse.

Lithium and Manic Depression.

Lithium Information Center. Revised Edition, University of Wisconsin, Madison, WI, 1990. 32 pages.

Lithium Treatment of Manic Depressive Illness: A Practical Guide.

Schou, Mogens. New York, Karger Publ: 1986, 39 pages. \$10.00

Answers to the day-to day questions that arise in lithium treatment by the Danish scientist who pioneered in using lithium for manic depressive illness.

Psychiatric Drugs and their Effect on the Mentally Ill Persons.

Bouricius, Jean K. Arlington, VA, NAMI: 1989. 116 pages, bp, \$8.50.

A handbook for patients and families, with information about dosages, side-effects and interactions with other drugs and food.

LEGAL AND FINANCIAL

Disability and the Family: a Guide to Decisions for Adulthood.

Turnbull, J. Rutherford, Paul H. Brook Publish Co: 1989. 432 pages, \$29.00.

A guide for families of disabled persons about planning for the future. It covers legal issues, government disability programs, wills and trusts, housing and employment and advocacy. Most cases cited are of retarded persons, but the information is immediately applicable to persons with mental illnesses.

SSI and Social Security Disability: Securing and Protecting Your Benefits.

Chicago, Protection and Advocacy, Inc: 1989. 22 pages, pb \$1.00 donation.

A publication of a private, not-for-profit organization in Illinois. It clarifies disability programs and provides guidance in securing benefits by dealing with eligibility and the application process.

OTHER

Dual Diagnosis of Major Mental Illness and Substance Disorder.

Minkoff, Kenneth, and Robert E. kDrake, Editors. San Francisco, Jossey-Bass: 1991. 116 pages, pb, \$15.15. Dual diagnosis is so common that clinicians expect to find it. This book is firmly grounded in research, has chapters by professionals who discuss treatment and describe some innovative programs.

Freudian Fraud. The Malignant Effect of Freud's Theory on American Thought and Culture.

Torrey, E. Fuller. Harper Collins Publishers: 1992. 362 pages, \$25. Dr. Torrey has jumped into the fray again. The subtitle explains what the book is about, time will determine its value.

Nutrition and Mental Illness.

Pfeiffer, Carl C. Healing Arts Press, Rochester, Vt.: 1987.

Pathways to Partnership: Awareness and Resource Guide on Mental Illness.

Shifrin, Jennifer.. St. Louis, Mo. Interfaith Ministries and Prolonged Mental Illnesses: 1990. 26 pages, paper \$2.85. How to strengthen religious ministry to mentally ill persons and their families, for Protestants, Catholics and Jews.

Toxic Psychiatry.

Breggin, Peter R., M.D. New York, St. Martin's Press: 1991. 449 pages, \$24.95.

"A psychiatrist's devastating critique of how the 'new Psychiatry' is damaging millions of people."

REPORTS, PERIODICALS AND JOURNALS**Advocating For Insurance Reform.**

National Alliance for the Mentally Ill Handbook. Order from NAMI (address above) \$10.00.

Three-Year Plan for Services for Persons with Mental Illness

Revised, September 1989. Minnesota Department of Human Services, Mental Health Division.

1990 Report to the Governor and Legislature

State Advisory Council on Mental Health

Minnesota Department of Human Services, Mental Health Division.

Innovations

National Alliance for the Mentally Ill and Public Citizen Health Research Group. \$20.00 per year, quarterly. Order from National Alliance for the Mentally Ill.

Three or four articles per issue about innovative programs of services for persons with serious mental illnesses. Most programs discussed provide multiple services; all of them merit replication. Contacts for further information are included.

NAMI Advocate

Newsletter for the National Alliance for the Mentally Ill. Published bimonthly

Newsletter is sent to NAMI members. The newsletter has current information about mental illness, research, pending legislation, new books about mental illness reviewed.

Address above.

Mental Health Advocate

Publication of the Alliance for the Mentally Ill of Minnesota.

Published bimonthly. A fine newspaper covering the mental health scene in Minnesota, personal accounts, research, education, legislative issues.

Newspaper comes with membership to AMI-MN, or \$15.00 for Advocate alone. Sliding scale to \$5.00 for persons on fixed income.

Address above.

VIDEOS ON MENTAL ILLNESS

Silent No More—Families Speak Out About Mental Illness. 30 min. Family members talk about mental illnesses and their effect on family relationships, hopes, frustrations. Produced by Alliance for the Mentally Ill—Minnesota.

Depression. 60 min. Production shown on 20/20. Good explanation of the biological basis of depressive illness.

Full of Sound & Fury: Living with Schizophrenia. 54 minutes. Experiences of three people with diagnosis of schizophrenia. MacArthur Library.

A Place To Come Back To. 29 min. Mental Illness and the church. Interviews with family of a young man with schizophrenia, how the church can help. Seraphim Communications. 1-800-733-3413

Four Lives. 60 min. Introduced by Patti Duke. Follows the lives of four persons with manic-depressive illness. Shows one woman in manic and then depressive stage of illness. Helpful to persons who want to better understand this illness. MacArthur Library.

When The Music Stops: The Reality of Serious Mental Illness. Approx 25 min. Talks about major mental illnesses. Basic information, biological causes explained.

A good video to use for a public presentation for people who don't know much about mental illnesses.

Lionel Aldridge keynote Address. 44:03 min. Former Greenbay Packer talks about the way he deals with his paranoid schizophrenia. Funny, lovely man—empowering monologue, wonderfully encouraging for persons with mental illness.

Windows into the Brain. 15 min. Interview with Dr. Lewis Judd, Director, National Institute of Mental Health.

Anyplace But Here. Documents the plight of mental patients fit for discharge who find themselves in a community unprepared to accept or care for them. The dilemma of being "as scared of getting well as of remaining ill." MacArthur Library.

With Open Arms. 54 min. Explanation of the Community Support Programs that are available to persons who have a serious and persistent mental illness. Produced by Alliance for the Mentally Ill-MN.

Nobody Knows. 45 min. Describes depressive illness, exploring biological, genetic and other factors, and suggests the church's role in understanding and supporting persons who suffer from depression. Seraphim Communications. 1-800-733-3413

The Challenges of Schizophrenia. 63 min. Dr. Fred Frese, now a Ph.D. psychologist, shares his own personal story about schizophrenia, how he deals with relapse, how he manages his illness with humor and good sense. Produced by Alliance for the Mentally Ill-MN.

***Videos from the MacArthur Library are available at many community libraries. Ask your librarian for a listing.**

PARLIAMENTARY PROCEDURE AT A GLANCE

To Do This: ¹	You Say This:	May You Interrupt Speaker?	Must It Be Seconded?	Is The Motion Debatable?	Is The Motion Amendable?	What Vote Is Required?
Adjourn Meeting.	"I move that we adjourn."	No	Yes	No	No	Majority vote
Recess the Meeting.	"I move that we recess until . . ."	No	Yes	No	Yes	Majority vote
Complain about noise, room temp., etc.	"Point of privilege."	Yes	No	No ²	No	No vote ³
Suspend temporary consideration of something.	"I move we table it."	No	Yes	No	No	Majority vote
End Debate.	"I move the previous question."	No	Yes	No	No	Two-thirds vote
Postpone consideration of something.	"I move we postpone this matter until. . ."	No	Yes	Yes	Yes	Majority vote
Having something studied further.	"I move we refer this matter to a committee."	No	Yes	Yes	Yes	Majority vote
Amend a Motion.	"I move that this motion be amended by . . ."	No	Yes	Yes	Yes	Majority vote
Introduce Business (an original main motion).	"I move that. . ."	No	Yes	Yes	Yes	Majority vote

1. The motions above are listed in established order of precedence.
2. In this case, any resulting motion is debatable.
3. Chair decides.

To Do This: ¹	You Say This:	May You Interrupt Speaker?	Must It Be Seconded?	Is This Motion Debatable?	Is This Motion Amendable?	What Vote Is Required?
Object to procedures or violation of rules.	"Point of Order."	Yes	No	No	No	No vote; Chair decides.
Request Information.	"Point of Information"	Yes, if urgent.	No	No	No	No vote. Answering or acknowledging a question.
Ask for another vote to verify a voice vote.	"I call for a division of the house" or just call "Division"	No ²	No	No	No	None
Object to considering some undiplomatic or improper matter.	"I object to consideration of this question."	No	No	No	No	2/3 vote (in the negative) to prevent consideration
Take up a matter previously tabled.	"I move we take from the table. . ."	No	Yes	No	No	Majority vote
Reconsider something already disposed of.	"I move we reconsider the vote on . . ."	No ³	Yes	Yes ⁴	No	Majority vote
Consider something out of its scheduled order.	"I move we suspend the rules and consider . . ."	No	Yes	No	No	2/3 vote
Vote on a ruling by the chair.	"I appeal the chair's decision."	Yes	Yes	Yes	No	Majority vote
Nominate for an officer or delegate position.	"I nominate. . ."	No	No	No	No	Usually fixed in by-laws.

1. The motions, points and proposals listed above have no established order of precedence. Any of them may be introduced at any time - except when the meeting is considering one of the top three matters on the other side.

2. But divisions must be called for before another motion is started.

3. Must be made by one who voted on prevailing side.

4. If the motion to which it is applied is debatable.

MINNESOTA ELECTED OFFICIALS IN NATIONAL OFFICE

Senators

Dave Durenberger

1020 Plymouth Bldg.
12 South Sixth Street
Minneapolis, MN 55402
(612) 370-3382 or 1-800-752-4226
FAX (612) 370-3395

154 Russell Office Bldg.
Washington, D.C. 20510
(202) 224-3244

Paul Wellstone

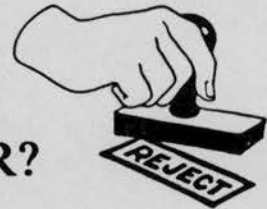
2550 University Ave. W.
Suite 100 North
St. Paul, MN 55114
(612) 645-0323 FAX (612) 645-0704

702 Hart Office Bldg.
Washington D.C. 20510-2303
(202) 224-5641 or (202) 224-1239
FAX (202) 224-8438

Congressional Delegation

1st District 108 West Park Square Owantonna, MN 55060 1-800-862-8632 Tim Penny 436 Cannon House Office Bldg. Washington, D.C. 20515 (202) 225-2472	5th District 462 Federal Courts Bldg. 110 South Fourth St. Minneapolis, MN 55401 (612) 348-1649 FAX (612) 348-1647 Martin Sabo 2201 Rayburn House Office Bldg. Washington, D.C. 20515 (202) 225-4755
2nd District Southtown Plaza 452 First St. S. Montivideo, MN 56265 (612) 269-9311 David Minge 1508 Longworth House Bldg. Washington D.C. 20515 (202) 225-2331 FAX (202) 226-0836	6th District 2013 Second Ave. N. #30 Anoka, MN 55303 (612) 427-5921 FAX (612) 422-0561 Rod Grams 713 Longworth House Office Bldg. Washington, D.C. 20515 (202) 225-2271 FAX (202) 225-9802 7th District 714 Lake Ave., Suite 107 Detroit Lakes, MN 56501 (218) 874-5056 FAX (218) 847-5109 Collin Peterson 1133 Longworth House Office Bldg. Washington, D.C. 20515 (202) 225-2165 FAX (202) 225-1593
3rd District 8120 Penn Ave. S. Bloomington, MN 55431 (612) 881-4600 Jim Ramstad 322 Cannon House Bldg. Washington, D.C. 20515 (202) 225-2871	8th District 231 Federal Bldg. Duluth, MN 55802 (218) 727-7474 FAX (218) 254-5132 James Oberstar Chiselm City Hall 316 West Lake St. Chilsholm, MN 55719 (218) 254-5761 FAX (218) 828-1412 Brainerd City Hall 501 Laurel St. Brainerd, MN 56401 (218) 828-4400 2209 Rayburn House Office Bldg. Washington, D.C. 20515 (202) 225-6211
4th District Galtier Plaza 75 Fifth St. SE #727 Box 100 St. Paul, MN 55101 (612) 224-4503 FAX (612) 224-0575 Bruce Vento 2433 Rayburn House Office Bldg. Washington, D.C. 20515 (202) 225-6631	

WHAT CAN YOU DO IF AN SSI DECISION SEEMS UNFAIR?



YOU HAVE THE RIGHT TO APPEAL AN SSI DECISION IF YOU BELIEVE IT WAS UNFAIR (*Anytime your SSI benefits are reduced or terminated, or your application is denied, you must be sent a written notice of that decision and of your right to appeal it*):

- To appeal you must send your written request for an appeal to the Social Security Administration (SSA) within **60 days** of getting the notice.
- If you don't appeal, the decision will take effect and you'll lose your right to appeal.
- If you want to keep getting your SSI benefits while waiting for your appeal to be held, you **MUST** make that written request within **10 days** of getting the notice; so you should act as soon as possible after getting the notice!
- You can have an attorney or advocate represent you in your appeal or you can represent yourself. Since SSI rules are complicated we strongly recommend you get legal help as early in the appeals process as possible. Check with community advocates, legal services offices or organizations serving elderly, blind or disabled persons to learn about free or low-cost legal help in your area.

THERE ARE FOUR POSSIBLE STEPS IN THE APPEAL PROCESS. THE FIRST IS CALLED "RECONSIDERATION" (*It is simply a reexamination of the facts in your file*):

- You should file a written request for reconsideration and include with it any additional evidence you have.
- A reconsideration can be either a case review, an informal conference, or a formal conference depending on the issue. You have a right to an informal conference unless your denial was because SSI did not find you disabled, or because of a change in your medical condition, in which case you may only request a case review.
- A formal conference is reserved for cases where benefits have been reduced.
- An informal conference is a review of your case file plus the chance for you to be there and to present witnesses or more evidence; records of the conference become part of your case file.
- A case review is a thorough review of all evidence in your file plus any new written evidence offered by you or your advocate; anyone who requests it can have a case review.
- Regardless of the type of reconsideration, be prepared; write out a statement of your facts including any new evidence.
- A formal conference is similar to a hearing but it is held before a Social Security employee; you can subpoena witnesses, examine the case record and present witnesses.

IF YOU BELIEVE THE RECONSIDERATION DECISION WAS UNFAIR, YOU CAN REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE (*The most important step in the whole process—its outcome will affect any following appeals*):

- A hearing is so important that we recommend you get a lawyer or advocate to help you; any evidence you present at the hearing will be part of your record which will be reviewed by any later appeals council or court.
- You must file a written "Request for Hearing" with Social Security within 60 days of the notice of your reconsideration decision.

WINNING A HEARING REQUIRES PREPARATION; YOUR SOCIAL SECURITY CASE FILE WILL BE TRANSFERRED TO THE BUREAU OF HEARINGS AND APPEALS ONCE YOU HAVE REQUESTED A HEARING (*It contains your medical records, written statements and forms you've submitted to SSA, and any correspondence sent to you by SSA; you can review this file before your hearing*):

- If you believe any of these exhibits is wrong, inappropriate or needs to be explained, you should be prepared to argue this at your hearing; any written evidence you have to support your position should be given to the Judge several days before the hearing.
- If any of the medical exhibits say you are not disabled, it will be necessary that you counter that statement with a written statement from another physician.
- It will help you in presenting your case at your hearing if you make a written outline of your position. Include in the statement the facts, the decision you're appealing, a list of your evidence, and any laws that support your position. Give a copy of this outline to the Judge.



YOU WILL GET THE JUDGE'S WRITTEN DECISION IN THE MAIL IN A REASONABLE TIME AFTER THE HEARING. WHEN YOU GET THE DECISION, IF YOU ARE DISSATISFIED YOU CAN REQUEST A REVIEW BY THE APPEALS COUNCIL IN WASHINGTON, D.C. (*If you haven't gotten the judge's decision in three months, call SSA or your attorney*):

- To request a review by the Appeals Council, you must file a written "Request for Hearing Decision/Order" within 60 days of receiving notice of the hearing decision; get the form from your SSA Office.
- If you can, include with the request new documents or evidence you want considered, but don't delay your request because you can't get the evidence together.
- Appeals Council review generally is a review of the entire record of your case file plus any additional written evidence.

IF THE APPEALS COUNCIL REVIEWS YOUR CASE AND YOU ARE DISSATISFIED, YOU CAN APPEAL TO FEDERAL COURT. *You would need an attorney to help you with this step.*

(A Fact Sheet of the Community Legal Education Program of the Legal Aid Society of Minneapolis. This is not meant to give a complete answer to an individual legal problem. If you need legal help, see your family attorney or call your legal services office which serves low-income persons.) 11/90

COLLABORATION CONTINUUM

NETWORKS

COORDINATION

COOPERATION

COLLABORATION

PARTNERSHIP

COMMUNITY PARTNERSHIP

The loosest type of community linkage is a network system. Networks serve primarily to foster and facilitate communication between and among agencies and community groups. Effective total community networks provide the forums through which each agency and group has contact with each other agency and group. As a result of such contact and sharing of information, groups are in the position to develop higher level or closer linkages.

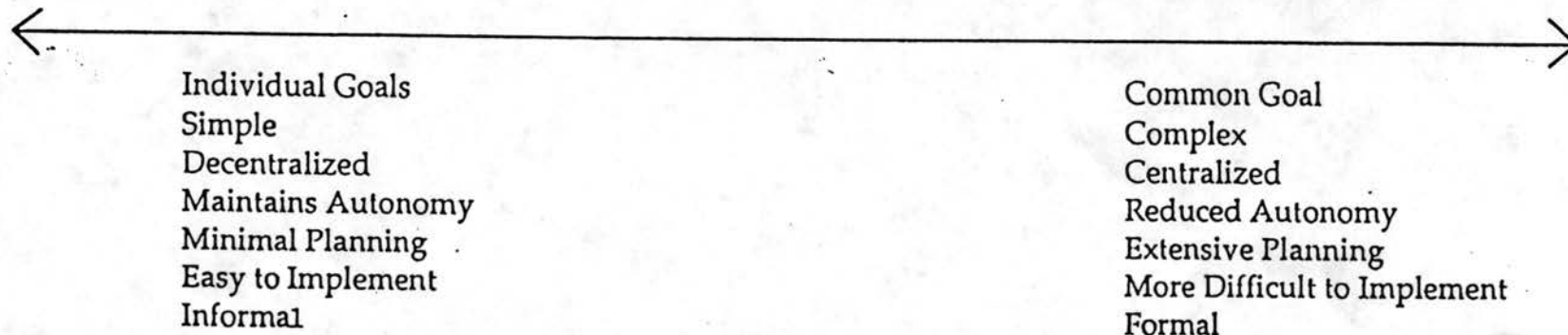
Coordination occurs when two or more agencies or groups take action as a result of the increased communication developed from being part of a network. Agencies may determine that one or the other is better able to perform a certain service and a decision is made to allow that agency to do so. Coordination can include referral between agencies and the joint publishing of calendars or resource materials.

Cooperation represents a higher level of linkage than that of coordination. When two or more agencies cooperate to provide a service or conduct a project, each agency gives up some of its autonomy in exchange for certain benefits-cost savings, ability to serve a larger clientele, increased recognition or feelings of satisfaction in being able to have a larger impact on the community.

The next higher level of interactive activity is that of collaboration. In collaboration the autonomy of the agencies is more limited and the common goal becomes as important as the identity of the agency or group. Joint powers agreements between local governmental units and Community Education to provide recreation services are examples of collaboration.

Partnerships are developed for specific issues and have a goal structure that transcends the goals of the participating agencies and groups. For example, community agencies and groups may determine that raising employment skills of unskilled individuals is an important community goal and they may develop a plan in which education, business and social service agencies work together to meet that goal. In a partnership arrangement, the partners mutually contribute resources to solve the identified problem.

Community partnership projects often combine all levels of linkage and inter-active activity, from simple networking through partnerships, to accomplish a specific purpose. The ideal community partnership occurs when all actors come together to identify community problems and to determine the role each agency or group will play in solving the problems.



Adapted from Building Community Partnerships Through Community Education
by

Marilyn Kerns and Martha Stanley

LEADER'S GUIDE AND CHECKLIST

TIPS FOR MEETING LEADERS

Remember, good meetings don't just happen. They are carefully thought out, well-executed events that affect the way your group or organization runs. Here are some final tips to help you, as a meeting leader, to improve communication:

Do:

- start and finish on time
- know what you want to say
- have your materials ready
- talk the participants' language
- make your presentation simple and to the point
- keep the meeting lively and moving forward
- speak clearly
- be confident and enthusiastic
- take a break if the meeting runs too long
- close on a positive note
- make sure everyone understands what has been decided

Don't:

- dominate a meeting
- let people drift off into other subjects
- get upset when people disagree with you
- try to be funny when you are not
- make fun of anyone
- allow arguments





ILLUSTRATIONS
Ingrid McCutcheon

THE ART OF DELEGATING

Delegating is one of the most critical elements in the management of nearly all organizations and programs. Successful delegating helps to involve all members in the activities of the group. Delegating is critical in accomplishing a variety of group activities, yet it is a difficult concept to implement.

Benefits of Delegating

First, let's look at the two major benefits to an organization:

1. Members feel they are a vital part of the organization.

People join a group to contribute something to the organization. Not many people are content to make decisions for a group in which they volunteer. If they have a part in the actual implementation of the jobs that need to be done, they feel they have contributed something worthwhile to the organization. Often people have a limited amount of time and are willing to do part of a task. This makes them feel they are contributing to the whole.

2. The group can accomplish more.

Delegating also allows the group to accomplish more tasks than would be possible if only one person did them alone. Getting more done makes the group members feel good about their input and about their program. They continue to make the program a success.

Difficulties in Delegating

Leaders may have difficulty delegating responsibility for these reasons:

- They may feel they are slighting their jobs as leaders/chairs if they delegate tasks to others.
- They may feel members don't have enough information to do the tasks adequately.
- It is easier for them to do it themselves than to tell someone else how to do it and then follow up to see that it is done.
- They may want recognition for doing it themselves.
- They think they have all the good ideas.

On the surface, these may seem like selfish reasons for not delegating tasks. However, many leaders may not be aware of the benefits of delegating or may not know how to delegate.

TEN STEPS TO DELEGATING EFFECTIVELY

The following ten steps will help any leader multiply the effectiveness of the organization.

1. Define responsibilities clearly. Describe freedoms and limitations. This allows for consistency.
2. When delegating, delegate complete segments rather than bits and pieces.
3. Maximize strengths by choosing the right people for the appropriate task. Determine strengths and weaknesses of volunteers and staff and delegate accordingly.
4. Provide adequate feedback. Be honest and accurate in assessment of how they are doing. Emphasize what went wrong, not who did it.
5. Set goals and performance standards together.
6. Provide support through sharing knowledge, information, and plans with them.
7. Give those with responsibility for implementing a program a voice in the decision making. Freely consult with those involved.
8. Commend and encourage. Reward accomplishments.
9. Let go! Fully delegate and allow for personal success or failure. Delegation also involves the transfer of authority.
10. Thank-you's after the job is done should acknowledge the contribution.

Remember: "Delegation does not eliminate work, it changes it."

How To Set Up A Telephone Tree

Telephone trees are easy to set up. If a tree is enacted, no one person needs to call more than three or four other people. Follow the sequence of calling from the top down. The person at the top of the list initiates the first three calls, then these people become the callers on the level below.

When the telephone tree is activated, it is important that you call the names that appear under your name quickly. Procrastination can make the whole process break down.

Call people who appear under your name where it is underlined.

E. Brown 645-5412
H . Maize 662-7140
C. Green 645-9642
M. White 663-5466

H. Maize
Smith
McMaster
Allen

C. Green
Fobes
Lutz
Olsen

M. White
Johnson
Wood
Lloyd

Smith
1.
2.
3.

Fobes
1.
2.
3.

Johnson
1.
2.
3.

McMaster
1.
2.
3.

Lutz
1.
2.
3.

Wood
1.
2.
3.

Allen
1.
2.
3.

Olsen
1.
2.
3.

Lloyd
1.
2.
3.

-

The LWV NIMH Leadership Project of _____ County(ies)
have planned a meeting on (date) _____ at
(time) _____ to be held at (place) _____.

[illegible]

Names of leader(s):



ILLUSTRATIONS
Ingrid McCutcheon

THIS IS A
DIFFICULT MEMBER -

HANDLE WITH CARE

Every association has one: a difficult person. This is the member who complains about association programs but never offers solutions; the delegate who stands up at convention and spends 45 minutes lambasting the officers and directors; or the board member who goes off on his or her own, speaking for the association without the authority to do so. Fortunately, difficult members are few. Unfortunately, the havoc they wreak can be quite large.

If you have ever had to face a difficult member, you know how frustrating and potentially demoralizing the experience can be. But there are general strategies and specific techniques which can help you cope. By understanding them and adopting a constructive response yourself, you can influence their behavior. This will make the group environment less strained and more productive.

WANT SOME HELP? LOOK INSIDE FOR:

- GENERAL STRATEGIES
- TIPS ABOUT SPECIFIC DIFFICULT MEMBERS

GENERAL STRATEGIES FOR HANDLING DIFFICULT MEMBERS

1. Assess the situation. Is the person genuinely difficult or just cranky for a short time?
2. Stop wishing the person were different. You can't change it. It's not even a good idea to try.
3. Put some distance between yourself and the difficult behavior. Develop a detached view of that difficult person while he or she is in the process of being difficult. By giving yourself some distance, you get a better perspective.
4. Formulate a plan for interrupting the situation. You can't change the behavior of the other person, but you can change yours.
5. Put your strategy into operation. Plan your timing and prepare for the confrontation.
6. Monitor the progress of your strategy so that you can make adjustments to it when or if it becomes necessary.
7. If your strategies for coping don't work, abandon your efforts. Don't wait until the situation has done you more harm.

Regular communication with them, diversionary activities for them, and strength to be firm with them are good prevention mechanisms to minimize the damage difficult members can do to an organization, to the morale of its members and to its program.

SPECIFIC TECHNIQUES FOR COPING WITH DIFFICULT PEOPLE



COMPLAINERS gripe incessantly, but they never try to do anything about what they complain about. This is either because they feel powerless to do so or because they refuse to bear the responsibility for a solution. Use this strategy to turn a complainer into a problem-solver:

- Listen attentively even though it will be very difficult.
- Acknowledge what the complainer says by paraphrasing the complaints.
- Don't agree with the complaints.
- Be prepared to interrupt and take control of the situation. Complainers love to ramble.
- Use limiting responses that will pin the complainer to specifics.
- Avoid the accusation-defense-reaccusation sequence where you defend an accusation and then are reaccused. This can be like an error loop in a computer program that goes on and on and on.
- State the facts without comment and without apology.
- Switch to problem-solving.
- Be prepared to begin this strategy from the beginning several times. Complainers are slow learners.



SUPER-AGREEABLES are always very reasonable, sincere, and supportive. At least in your presence. But they don't produce what they say they will produce. And sometimes they even act contrary to what they have led you to expect.

- Make honesty non-threatening. They are afraid you don't want to hear the truth.
- Be personable if you can and only if you mean it.
- Don't allow them to make unrealistic commitments when you know they couldn't possibly fulfill them.
- Be prepared to compromise so that you are both in a win situation.
- Listen to their humor. They often hide the truth there.



NEGATIVISTS object to everything. They assert that whatever you propose won't work or is impossible. All too often their effect on you is to completely deflate any optimism you might have for a project.

- Avoid getting drawn into their attitude.
- State your own realistic optimism.
- Don't agree with them.
- Don't hurry to propose solutions.
- Use their negativism constructively. It never hurts to have a devil's advocate.
- Be prepared to take on the project by yourself if you can't change their attitudes.



SILENT-UNRESPONSIVES answer every question you might have and every plea for help that you make with a yep, a no, or a grunt, and sometimes with an I-don't-know. A longer answer you will not get. You can:

- Ask open-ended questions.
- Use the friendly, silent stare.
- Pause for long periods, inviting them to fill the void.
- Comment on what is happening in the discussion.
- Recycle the conversation if necessary.
- Break the tension by helping them to say what they are thinking.
- Set time limits on the length of the discussion.



INDECISIVES can ruin a program because they put you off until it is too late to do anything about it. They put off making a decision until the decision is made for them. They also won't let go of anything until it is perfect, which it never is. To get around them, try this:

- Bring the issues out in the open and make it easy for them to be direct. Pursue all signs of indecision.
- Help them solve the problem or problems.
- Place all the alternatives in rank of importance.
- Emphasize the importance of quality and service.
- Give them lots of support after they have finally made a decision.
- If it is at all possible, keep control of what you are working on.
- Watch for signs that they are being overloaded by the pressure to make a decision.



HOSTILE-AGGRESSIVES try to bully and overwhelm you by bombarding you. They make cutting remarks or throw temper tantrums when they don't get their own way (which they are convinced is the only way). To cope with hostile-aggressives:

- Stand up for yourself, without being threatening.
- Give them time to run down.
- Don't worry about being polite, just charge in and make your point.
- Get their attention, but carefully; don't startle them.
- Have them sit down; this will make them less aggressive.
- Speak for your own point of view; don't attack them.
- Avoid a head-on fight.
- Be prepared to be friendly. Hostile-aggressives are often very friendly after you have stood up to them.



KNOW-IT-ALL EXPERTS believe and want you to believe that they know all there is to know about anything worth knowing. They are usually condescending, imposing, or pompous. And, in all likelihood, they will make you feel like an idiot. You can blunt their effect, if you:

- Do your homework on the subject.
- Listen to and acknowledge what they say.
- Question them firmly, but don't confront them. They hate being wrong.
- Avoid being a counter-expert.
- Let them be the expert they think they are.

References:

"This is a Difficult Member - Building Effective Strategies for Crisis Management," Elected Leader, Spring 1983.
Warden, J., Warden and Associates. Anchorage, AK

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For information contact: FCL at the Western Rural Development Center, Oregon State University, Corvallis.

GROUP PROCESS
CONFLICT

THIS IS A DIFFICULT MEMBER -
HANDLE WITH CARE

 **Family
Community
Leadership**
8-85



GUIDELINES FOR HANDLING DIFFICULT PEOPLE IN GROUPS



1. RECOGNIZE THAT BEHAVIOR IS GOAL-ORIENTED.
2. REJECT THE BEHAVIOR BUT NOT THE PERSON.
3. RECOGNIZE THE PROBLEM MAY BE BOTH AN INDIVIDUAL AND A GROUP PROBLEM.
4. HELP THE PERSON FIND AN APPROPRIATE WAY TO PARTICIPATE.
5. WORK WITH PEOPLE OUTSIDE THE GROUP TO RESOLVE PROBLEMS.
6. HELP THE GROUP ARRIVE AT GROUP RECOGNIZED OPERATING PROCEDURES.
7. RECOGNIZE THAT CONFLICT CAN BE CONSTRUCTIVE AS WELL AS DESTRUCTIVE.
8. HELP THE GROUP DEVELOP PROCEDURES FOR SOLVING THE PROBLEM.
9. ASSESS YOUR OWN BEHAVIOR IN REACTION TO THE BEHAVIOR OF THE DIFFICULT PERSON.
10. REMEMBER THAT PREVENTION IS THE BEST INSURANCE POLICY.

Reference:
Reprint, 1984. John Warden, Warden and Associates, Anchorage, AK.

GROUP PROCESS
CONFLICT

SUPPLEMENT A

THIS IS A DIFFICULT MEMBER - HANDLE WITH CARE

 Family
Community
Leadership

SEVEN CATEGORIES OF DIFFICULT PEOPLE

1. COMPLAINERS
2. SUPER-AGREEABLES
3. NEGATIVISTS
4. SILENT-UNRESPONSIVES
5. INDECISIVES
6. HOSTILE-AGGRESSIVES
7. KNOW-IT-ALL EXPERTS