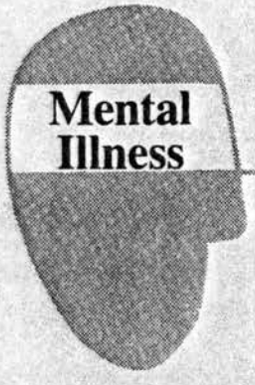
League of Women Voters of Minnesota Records

Copyright Notice:

Version 3
August 20, 2018

MONITORING MENTAL HEALTH SERVICES

AT THE COUNTY LEVEL:
A WORKBOOK



in Minnesota

The League of Women Voters
of Minnesota Education Fund

MONITORING MENTAL HEALTH SERVICES AT THE COUNTY LEVEL: A WORKBOOK

Prepared by the League of Women Voters of Minnesota.
Published by the League of Women Voters
of Minnesota Education Fund.

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

1989

ISBNO-0-961356685

CONTRIBUTORS:

This publication was made possible by a major gift from the McKnight Foundation.

Additional support was provided by
the B.C. Gamble and P.W. Skogmo Foundation,
the Mahadh Foundation,
House of Hope Presbyterian Church
Burlington Northern Foundation
representing the Burlington Northern Inc. subsidiary companies:

BN Motor Carriers Inc.,
Burlington Northern Railroad Company,
El Paso Natural Gas Company,
Glacier Park Company,
Meridian Minerals Company,
Meridian Oil Inc.
Plum Creek Timber Company Inc.

PROJECT COORDINATOR:
Margit Johnson

WRITER AND EDITOR:
Barbara Flanigan

LWV COMMITTEE:
Marcia Brown, Pat Bugenstein, Gerri Gustafson, Dorothy Holmes, Rose Krauser, Mari Lowe, Donna McDonald, Elaine Saline, Lois Van Dyke, Margaret Ueland, Bee Vennes.

CONTENTS

GLOSSARY

Acute Care Hospital . A short-stay health care facility licensed by the state for the treatment of emergency, chronic or short-term illness, disease or other health problem.

Acute mental illness . A mental illness that is serious enough to require prompt intervention. (1987 Statute.)

Affective Disorder . A disturbance of mood which has a manic or depressive syndrome not due to any other physical or mental disorder. Major affective disorders include bipolar disorder (manic depression) and major depression.

Bipolar Affective Disorder . See Manic Depression.

Board and Lodging . A licensing category applying to all facilities which provide rooms and/or meals. These facilities are inspected for safety and sanitation standards, but not licensed to provide medical or health care. These facilities do not provide mental health programs, although some provide limited activity programs and assist their residents in using community resources. In a number of these facilities, especially in Minneapolis and St. Paul, a majority of residents have been hospitalized for mental illness.

Borderline Personality Disorder . A personality disorder in which there is instability in a variety of areas, including interpersonal behavior, mood, and self-image. Interpersonal relations are often intense and unstable with marked shifts of attitude over time. Frequently there is impulsive and unpredictable behavior that is potentially self damaging. During periods of extreme stress psychotic symptoms may occur. There is often considerable interference with social or occupational functioning.

Case Management . The Comprehensive Mental Health Act (Minnesota Statutes, section 245.462, subdivision 3), as amended in 1988, defines case management activities for persons with mental illnes as "activities that are coordinated with the community support services program...and are designed to help people 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 activities include developing an individual community support plan, referring the person to needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

An expanded definition was suggested in 1976 by the Joint Commission on Accreditation of Hospitals:

> Case management services are activities aimed at linking the service system to a consumer and coordinating the various system components in order to achieve a successful outcome. The objective of case management is continuity of services...Case management is essentially a problem-solving function designed to ensure continuity of services and to overcome systems rigidity, fragmented services, misutilization of certain facilities and inaccessibility.

Community Social Services Act (CSSA) . Legislation passed in 1979 which shifted the responsiblity for planning and implementing human service programs from the state level to the local level. CSSA is a block grant replacing a variety of categorical funds dedicated to specific health and social purposes. CSSA funds incorporate federal Title XX funds ($45 million annually) state dollars ($50 million annually) and county tax dollars ($200 million annually). An average of twenty percent of CSSA funds, approximately $60 million in FY 1988, goes toward mental health services.

Community Support Services Program (CSP) . Programs offering community support to persons with mental illness originally encouraged by the National Institute of Mental Health. (In Minnesota Comprehensive Mental Health Act, Minnesota Statutes, section 245.462, subdivision 6.) a "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the clinical supervision of a mental health professional designed to help people with serious and persistent mental illness to function and remain in te community. A community support services program includes;

(1) client outreach,
(2) medication management,
(3) assistance in independent living skills,
(4) development of employability and supportive work opportunities,
(5) crisis assistance,
(6) psychosocial rehabilitation,
(7) help in applying for government benefits, and
(8) the development, identification, and monitoring of living arrangements.

The community support services program must be coordinated with case management activities.

Continuum of Care . The availability to clients in a geographic area of a comprehensive array of preventive, emergency, diagnostic, treatment, and rehabilitative mental health services which offer varied amounts of support and care depending on the individual client's needs.

Decompensation . The deterioration of an individual's mental health severe enough to cause a significant increase in symptoms and a decrease in functioning.

Deinsitutionalization . The movement away from traditional institutional settings, particularly publicly operated facilities, for persons with mental illness and retardation and the concurrent expansion of community-based settings for the care of these individuals. Deinstitutionalization was supported by the conviction that persons would have an improved quality of life with "normalization" in the community than in institutional settings. (Deinstitutionalization also describes the decline in the population of state hospitals and the return of persons to the community without the creation of adequate community services.)

Delusion . A false personal belief based on incorrect ideas about reality and firmly adhered to in spite of proof to the contrary. Common types of delusion include:

1. being controlled by some external force
2. grandiosity - an exaggerated sense of the person's own importance, power, knowledge, or identity
3. jealousy
4. persecution
5. reference - events or objects have a special significance.
6. somatic - pertaining to the person's body.

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

Emergency 72 Hour Hold . The 1982 Commitment Act provides for a 72 hour hold (not including Saturdays, Sundays or legal holidays) in cases where persons with acute mental illness are "in imminent danger of causing injury to self or others if not immediately restrained." The patient must be given a medical examination within 14 hours. After 72 hours the hospital either 1) allows discharge, 2) allows voluntary admission, or 3) asks for prepetition screening, the first

step toward legal commitment, to be initiated. The court may issue a hold order for up to 14 days.

General Assistance (GA) . A state and county income program to low income persons who do not qualify for any federal programs. General Assistance recipients receive payments of $209 monthly.

General Assistance Medical Care (GAMC) . Health coverage for low income persons not eligible for other health care programs; supported from state and county funds.

Hallucination . A perception of the senses without the actual stimulation of the sensory organ. Types of hallucinations include:

1. auditory - voices, music, and other sounds
2. gustatory - taste
3. olfactory - smell
4. somatic - the perception of a physical experience within the body
5. tactile - feelings of touch on or under the skin
6. visual - sight.

IMDs (institutions for mental diseases) . According to federal legislation passed in 1988, IMDs are facilities which provide diagnosis, treatment or care to more than 16 persons who have mental illness. Persons between the ages of 22 and 64 who reside in IMDs do not qualify for Medicaid coverage for any medical services, or for case management. IMDs include hospitals, nursing homes and Rule 36 facilities.

Individual Community Support Plan . A written plan developed by a case manager on the basis of a diagnostic assessment. The plan identifies specific services needed by a person with a 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.

Individual Treatment Plan . A written plan of intervention, treatment, and services for a person with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the person with mental illness.

Major Depression . Persistent unhappiness characterized by

listlessness, loss of appetite, sleep disorders, thoughts of suicide, etc. A diagnosis of major depression requires that the person's behavior meet a number of specific criteria over a period of at least two weeks.

Manic Depression (or bipolar affective disorder) . A disorder in which an elevated, expansive or irritable mood alternates or intermingles with a depressive mood. The manic phase may be marked by increased activity, or restlessness, a flight of ideas, inflated self-esteem, (gandiosity, which may be delusional), a decreased need for sleep, and excessive involvement in activities which have a high potential for painful consequences.

Medical Assistance -(also known as Medicaid, MA or Title XIX) A matched federal, state, county program of medical insurance for persons receiving AFDC, SSI or meeting income eligibility guidelines.

Medicare . Federal health insurance for elderly and certain disabled persons (Title XVIII of the Social Security Act.)

Mental Health Practitioner . A mental health practitioner is a person providing services to persons with mental illness who is qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and has at least 2,000 hours of supervised experience in the delivery of services to persons with mental illness
(2) has at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness;
(3) is a graduate student in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness;
(4) holds a master's or other graduate degree in one of the behavioral fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness.

Mental Health Professional . A mental health professional is a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse with a master's degree in one of the behavioral sciences or related fields from an accredited college or university or its equivalent, who is licensed under Minnesota law (sections 148.171 to 148.285) with at least 4,000 hours of

post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under Minnesota law (section 148B.21, subdivision 6) or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: a psychologist licensed under Minnesota law (sections 148.88 to 148.98) who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under Minnesota law (chapter 147) and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry; or

(5) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Mental Illness . (As defined by the Minnesota Comprehensive Mental Health Act of 1987). An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a person's capability to function in primary aspects of daily living such as personal relations, living arrangements, work and recreation.

Mental Retardation . Significantly subaverage general intellectual functioning (an IQ of 70 or below) with onset before the age of 18. Mental retardation may result in deficits or impairments in adaptive behavior.

Minnesota Supplemental Aid (MSA) . Payments to supplement SSI funds for low income elderly and disabled persons, supported from state and county funds. Ordinarily these payments go to facilities to support residents rather than to the residents themselves.

Nursing Home . Facilities licensed to serve persons who require continuing nursing care as well as personal care and supervision. Nursing homes are licensed by the Minnesota Department of Health.

Psychosis (psychotic) . A severe impairment of the individual in relating to reality, often evidenced by delusions or hallucinations.

Regional treatment centers (RTCs) . Formerly known as state

hospitals, six of Minnesota's RTCs, at Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter and Willmar, serve persons with mental illness. The Minnesota Security Hospital at St. Peter has a capacity of 236 beds for patients judged mentally ill and dangerous.

Residential treatment facilities . See Rule 5 and Rule 36.

Rule 5 . State licensing rule establishing the requirements of residential treatment facilities for children and youth who are emotionally disturbed and/or behaviorally disordered. Forty-one residential treatment facilities were licensed under Rule 5 in April 1987.

Rule 12 . State funding stream which supports Rule 36 residential treatment facilities.

Rule 14 . State funding stream which supports community programs for mentally ill people other than Rule 36 facilities.

Rule 29 . Voluntary certification of mental health clinics and centers. Facilities must have a multi-disciplinary staff, a staff of at least four persons, and regular service of a psychiatrist and psychologist. Licensing ordinarily qualifies centers for private insurance reimbursment.

Rule 36 . First promulgated in 1974 Rule 36 sets licensing standards for programs in residential facilities for mentally ill adults. It ensures that, in addition to providing residents with room and board, facilities will offer appropriate programmatic services aimed at maximizing a resident's ability to function independently. Such facilities must obtain a license from the Department of Human Services.

Schizophrenia . A group of diseases characterized by delusions, hallucinations or a disordering of thought processes, an inability to think straight. When their more florid symptoms are absent, persons with schizophrenia may be characterized by a lack of emotion, apathy and inertia. At other times, persons may show no signs of the disorder.

Schizophrenia involves deterioration from the persons's previous level of functioning during some phase of the illness in such areas as work, social relations and self-care.

The age of onset of schizophrenia is before age 45, usually during adolescence or early adulthood.

Section 8 Lower-Income Rental Program . A housing assistance program, administered by the U.S. Department of Housing and

Urban Development, under which eligible families, handicapped and elderly persons pay no more than 30 percent of their income toward rent. The Section 8 Existing Housing Program, administered by the local housing authority, gives eligible tenants "Section 8 Certificates" for rental subsidy. When the tenant finds a suitable apartment, the local housing authority contracts with the landlord to pay the rental subsidy. Under the Section 8 New Construction Program, now repealed, HUD agreed to subsidize rents on units occupied by eligible lower income persons for approved developers.

Serious and Persistent Mental Illness . (under 1987 Minnesota law) applies to persons who have a mental illness who meet at least one of the following criteria:

1) the person has undergone two or more episodes of inpatient care for mental illness within the preceding 24 months;
2) the persons has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;
3) the person:
(i) has a diagnosis of schizophrenia, biploar disorder, major depression, or borderline personality disorder;
(ii) indicates a significant impairment in functioning; and
(iii) has a written opinion from a mental health professional stating that the person 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 person has been committed by a court as a mentally ill person under chapter 253b, or the patient's commitment has been stayed or continued.

Social Security Disability Income (SSDI) . A federal social security program for persons with disabilities who have worked a certain time in the past. Monthly payments vary according to the length of time worked and the person's income level during employment. Persons qualify if they have:

> Mental illness resulting in marked constriction of activities and interests, deterioration in personal habits or work-related situations, and seriously impaired ability to get along with other people.

SSDI recpients ordinarily qualify for either Medicare or Medicaid.

Supplemental Security Income (SSI) . A federal program for

persons with demonstrated disabilities which prevent productive work. SSI recipients usually qualify for Medical Assistance. Individual recipients currently receive payments of $369 monthly. SSI, in contrast to SSDI, is for individuals who have not worked extensively before the onset of their disability.

Supported Employment . Supported employment assumes that even persons with severe disabilities can do meaningful productive work in normal settings if that is what they choose to do and if they are given necessary supports. Supported employment helps persons with severe psychiatric disabilities maintain jobs in integrated employment settings by providing the needed job development, placement, training and support. Frequently job coaches are involved over the long term.

Tardive Dyskinesia (TD) . A disorder characterized by involuntary movements usually affecting the mouth, lips and tongue and sometimes the trunk and other parts of the body. TD generally occurs in about 15 to 20 percent of patients who have received antipsychotic drugs for many years; however it can occur in patients treated with these drugs for shorter periods. Once considered ireversable, TD has now been shown to improve in some cases.

Title XX . Federal "Social Service" funds passed through to county by state for use for low income persons and persons with handicaps.

PREFACE

This monitoring workbook is the second publication in a two year study of the "mental health system in Minnesota with particular emphasis on the availability and quality of community services" undertaken by the League of Women Voters of Minnesota. The first report Serving Minnesota's Mentally Ill: An Introduction was published in April 1988.

It is our hope that this workbook will support citizen monitoring activities by members of concerned organizations, including county Mental Health Advisory Councils, chapters of the Alliance for the Mentally Ill and the Mental Health Association, local Leagues of Women Voters and by members of the general public.

As a second component of the focus on monitoring the League of Women Voters of Minnesota Education Fund will offer four regional workshops in the fall of 1989 to all citizens interested in monitoring mental health services at the county level.

The workbook is divided into several parts. An introduction explains the concept of citizen monitoring. Part One suggests approaches to monitoring and gives ideas on how to proceed. Part Two lists the legal requirements for counties laid out by the 1987 Comprehensive Mental Health Act, as amended in the 1988 legislative session. This is intended as a baseline with which all interested citizens should be familiar. The State and County Information section provide information, including data on mental health programs, for all 87 Minnesota counties. The Master Checklist section contains the seven checklists which are intended to be monitoring tools. Lastly, there is a place for filing completed checklists for future reference.

It is our hope that this monitoring project will be longlasting and that it will evolve. As a first step toward meeting future needs, the League of Women Voters Education Fund will make available a checklist on child and adolescent services after the 1989 legislative session. (See Order Blank)

The League greatly appreciates the generosity of the individuals listed under "Resources" in sharing their time and expertise with us. The responsibility for the text, of course, rests with the League of Women Voters of Minnesota alone.

INTRODUCTION

This monitoring workbook is intended to help Minnesota citizens assess mental health services in their counties. It is primarily geared toward the evaluation of publicly funded programs, some of which are provided directly by counties and some of which are provided by private agencies under county contract. Services discussed are mainly those geared toward persons with acute mental illness and serious and persistent mental illness, groups which are given priority for service under the law. Persons with serious and persistent mental illness include individuals who would once have expected to spend much of their adult lives in state hospitals. However, the law requires counties to make services available to all persons with mental illness and to offer education and prevention services.

The focus is on monitoring services at the local level because the 1987 Minnesota Comprehensive Mental Health Act mandated that all Minnesota counties develop and coordinate an array of locally available affordable mental health services.

Researchers at the University of Minnesota estimate that between 22,000 and 29,000 Minnesotans have a chronic mental illness (this category generally coincides with "serious and persistent" mental illness.) According to one ranking, compared to other states Minnesota now ranks 33rd (up from 37th in 1986) in services for persons with serious mental illness. Because of the impetus from the 1987 law Minnesota is cited as one of six states "improving most impressively." This ranking is given in Care of the Seriously Mentally Ill, A Rating of State Programs by Drs. E. Fuller Torrey and Sidney Wolfe and Laurie M. Flynn published jointly by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill.

In addition to the ranking as 37th in 1986 a report by the Governor's Mental Health Commission in the same year declared that Minnesota had a "nonsystem" of mental health services. Also in 1986, the Legislative Audit Commission documented the lack of community services for many persons with mental illness who were discharged from regional treatment centers (formerly state hospitals).

These reports, as well as testimony at hearings on mental health services throughout Minnesota, convinced Governor Perpich and the Minnesota Legislature of the need to take action. The Minnesota Comprehensive Mental Health Act

mandated for the first time that all 87 counties provide a continuum of services for persons with mental illness.

In Minnesota, as in other states, the "deinstitutionalization" movement of the 1960's and 1970's saw the discharge of many persons with mental illness from state hospitals to the community. The number of persons with mental illness in state hospitals declined from a high of 11,500 in 1955 to a low of 1,200 in 1985. However, appropriate community services had failed to develop.

This monitoring project will attempt to help interested citizens determine the extent to which a complete range os community services of high quality is being established their county.

The county level of government is often the one least understood by citizens. Until the 1960s counties in Minnesota, as in the rest of the United States, were primarily concerned with "infrastructure" issues, often involving roads and bridges. Since the 1960's, however, when the old township relief system for support was shifted to the county level, counties have assumed the primary role in providing a wide variety of human services. Minnesota's social service system operates on a state supervised, county administered basis. Each county has great authority in creating, funding and operating services.

The 1979 Minnesota Community Social Services Act (CSSA) shifted much of the responsibility for allocating funds and planning and implementing human service programs from the state to the county level. CSSA monies are block grant funds for a variety of social services which incorporate Title XX federal funds as well as state and county dollars. In addition, counties administer designated funds specifically for community mental health services, including Rule 12 funds for Rule 36 adult residential treatment facilities and Rule 14 funds for community support programs.

Counties now have great responsibility in planning and delivering human services. However, county representatives report that federal and state mandates are frequently not accompanied by adequate appropriations. Moreover, the county tax base, which relies almost entirely on the property tax, is far less flexible than the tax base available to the state or federal governments. Because of the dependence of county revenues on the property tax, counties explain, revenues may fall at precisely the time when the need for social services rises. Incidents of child abuse and mental health problems, for instance, increased during the farm depression in much of rural Minnesota as tax revenues in the counties hardest hit declined.

MONITORING STRATEGIES

Several monitoring strategies may be used to assess the quality and quantity of mental health services at the county level.

Two of the approaches offered here focus on system-wide issues.

I. Monitoring may evaluate the extent to which actual county practice complies with the county mental health plan approved by the Mental Health Division of the Minnesota Department of Human Services (DHS). The 1987 Mental Health Act created many new responsibilities for counties.

The act states:

> The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable mental health services.

However, this mandate has not been interpreted, at least thus far, to mean that counties must take away funds from other programs to serve persons with mental illness. And counties assert that existing dollars cannot provide service for all who might qualify. Moreover, the state recognizes that developing services will take time, and has permitted a phase in period for some services. As one example, the state deemed service to 25 percent of the estimated number of residents with serious and persistent mental illness as sufficient at first.

For many counties, new services are a vast improvement over previous mental health programs. However commentators agree that even compliance with the 1987 law, as amended, does not ensure a complete array of effective services for all persons who need them.

II. A second systemwide monitoring approach would assess the extent to which services for persons with mental illnss approach a complete system of effective services for all persons who need them. This approach draws attention to the vision of an ideal system as a long term goal.

--Are the needs of all persons with acute and serious and persistent mental illness in the county being met?

--Does a full array of services exist?

--In each category of service what additional components does

the county need to have a good or an excellent system?

--Are there particular problems or gaps which need attention?

III. A third monitoring approach would assess the quality of individual programs and agencies which provide service to persons with mental illness. Monitoring of individual programs or agencies involves more than one site visit by a team of trained volunteer monitors.

A SHARED RESPONSIBILITY

If a county fails to provide a complete array of services of high quality to all persons with mental illness who need them this is not wholly or even primarily a failure of county government. Other levels of government share much of the responsibility for serving persons with mental illness in the community.

The federal government, through its income maintenance programs, SSI and SSDI, and through Medical Assistance, greatly affects the quality of life for many persons with mental illness in Minnesota. Small grants specifically for mental health services from the National Institute of Mental Health enhance service. The lack of a major federal fiscal commitment to community services for persons with mental illness, in contrast to a substantial committment for persons who are developmentally disabled (mentally retarded), has major repercussions on the availability of revenue for quality services. Federal housing policy also greatly impacts the supply of affordable housing for many persons with serious mental illness.

In Minnesota the Mental Health Division of the Department of Human Services is the major actor directly involved in planning for mental health services. However, other governmental bodies play a major role in shaping the lives of persons with serious and persistent mental illness. The Department of Human Services as a whole has a major impact on the lives of many people with mental illness, through its control of the regional treatment centers (state hospitals), its responsibility for rulemaking and licensing, and its administration of Medical Assistance and General Assistance and General Assistance Medical Care. The Minnesota Department of Jobs and Training plays a key role in providing employment opportunities for all persons with disabilities, including persons with mental illness. The Minnesota Department of Health, through its liscensure requirements, has a major influence on communal living arrangements for many persons with serious mental illness. Decisions by the Minnesota Legislature are key in the everyday life sitations of persons with mental illness.

In addition to governmental agencies, the activities and priorities of private agencies and groups, churches and civic clubs, United Way, business leaders and individual citizens help determine the climate of community acceptance and quality of life for persons with serious mental illness in the community.

Attitudes of acceptance and the expenditure of relatively small sums of money by private groups can often facilitate the successful integration of persons with mental illness in the community. The cooperation of two churches, one Catholic and one Lutheran, in Red Wing to provide a residential center and a drop in facility for persons with serious mental illness demonstrate what nongovernmental groups can accomplish.

OFFICIAL MONITORING

Monitoring of many county services, and of a number of private agencies and programs, is provided by the state of Minnesota. Each county mental plan is extensively reviewed by the Mental Health Division, by representatives of advocacy groups and by the State Advisory Council on Mental Health. Failure by counties to comply with the 1987 legislative mandate can result in the state witholding funds. As of October 1988 all 87 county plans submitted in January were finally approved, several after extensive alterations and considerable communication between the county and the Mental Health Division. Subsequent plans are due from the counties in August 1989 and then every two years.

Each county also submits separate plans for its residential treatment programs (Rule 36 facilities) and for its community support programs (Rule 14) which must be approved to qualify for those monies.

A special monitoring unit in the Department of Human Services reviews county documentation to make sure actual county practice, at least on paper, reflects the plan's objectives. This review includes contracts with private agencies providing service.

Many mental health programs and services are specifically monitored either by outside accrediting agencies or by different state licensing bodies. Psychiatric units in community hospitals and regional treatment centers are accredited by the Joint Committee on Hospital Accreditation (JCAH) and/or by the federal Health Care Financing Administration (HCFA). Community residential treatment programs (Rule 36s), also referred to as halfway houses, are licensed by the Department of Human Services. Vocational

rehabilitation programs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and community mental health centers are voluntarily certified by the Department of Human Services.

County contracts with private agencies ordinarily include reporting requirements designed to ensure at least minimal compliance with county program objectives.

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

Agencies receiving United Way funds or foundation funding must satisfy reporting requirements and participate in site visits.

Official procedures also exist for reporting abuse of persons with mental illness and for reporting complaints from persons with mental illness. These include reporting under the Vulnerable Adults Act and reporting to the Office of the Ombudsman for the Mentally Retarded and Mentally Ill.

LIMITS ON OFFICIAL MONITORING

However, most existing governmental mechanisms only ensure that minimal standards are met or take effect only after abuse has occurred on a case by case basis. Many licensing requirements emphasize basic health and safety considerations which, while important, are not designed to ensure a good quality of life or program effectiveness. Many persons with mental illness live in board and lodging facilities, particularly in the twin cities, which are licensed only for compliance with minimal health standards, with no licensure for program. Their program, or lack of program, is not officially addressed.

Legal licensing rquirements focus primarily on such factors as staff training, square footage, etc. rather than on the more elusive but equally important factors such as the outcomes of different programs and on the process. (See Governor's Mental Health Commission, Mandate for Action , 10-12.)

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 clients or the overall attitude of acceptance or nonacceptance of persons with mental illness in the community.

Only recently has the dimension of consumer satisfaction been addressed in official monitoring and licensing activities.

CITIZEN VOLUNTEERS AS MONITORS

Traditionally, the public has relied primarily on official accrediting or licensing bodies to assure quality in mental health services. When serious abuses have been reported the media has sometimes been involved, usually on a crisis basis. There is a current trend, however, toward systematic citizen participation in the monitoring process. The National Insitution of Mental Health has supported the concept of citizen participation in program evaluation. (See NIMH, Citizen Evaluation in Practice , 1984; and Peters, Lichtman and Windle, Citizen Roles in Community Health Center Evaluation , NIMH, 1979.)

Original federal legislation establishing community mental health centers mandated evaluation by citizen boards. In some parts of the country, governmental units depend volunteer monitors for official evaluation of subsidized programs. In Lancaster County, Pennsylvania, a volunteer citizen committe of the county Mental Health/Mental Retardation Board has conducted all agency evaluations within the MH/MR system since 1972. The committee uses the PASS (Program Analysis of Service System) instrument for program evaluation developed by Wolfensberger, which emphasizes integration of citizens within the community. Volunteers use PASS to assess outpatient services, inpatient services, residential facilities and vocational rehabilitation programs.

In Michigan the state provides mileage to volunteer parent monitoring committees of the Macomb-Oakland Regional Center which visit different group homes housing a total of more than 300 people with developmental disabilities on a regular basis.

Other unofficial but systematic volunteer monitoring initiatives include the Wisconsin Mental Health Law Project for monitoring nursing homes where persons with mental illness live and the Partnership for Quality Services developed by the Association for Retarded Citizens (ARC) Minnesota for monitoring a variety of programs. Local chapters of the Alliance for the Mentally Ill and federally supported advocacy agencies participate in monitoring of state hospitals and other services for persons with mental illness in other states.

POSSIBLE BENEFITS OF CITIZEN MONITORING

Volunteer monitoring is intended to supplement or enhance official governmental monitoring programs, not to challenge or supplant them.

In its Partnership for Quality Services materials the ARC emphasizes that volunteer monitoring is intended "to highlight program quality and determine changes or improvements within the service system."

> Volunteer citizens from the community can provide an independent, informal assessment of programs by visiting services as neutral observers; people who may have different expectations and concerns than those of professionals.

The Pennsylvania PASS program believed citizen evaluation teams "would be the most objective way of conducting evaluations on programs throughout the country." Citizen evaluation "also provides a means of citizen identification with the county programs." The citizen evaluation system has broadened the base of community understanding and support for county programs "yielding a service delivery system that is responsive to the needs of its citizens."

In the Michigan project the monitor's main responsibility is to evaluation the "feel" of each home, "its appearnace, atmosphere, warmth and overall sensitivity to important areas in the home's operation and the residents' well-being." Monitors do not assess individual client programs, procedure, compliance or performance toward standards that are reviewed by other agencies.

> The monitors are expected to look at each house and, in effect, ask themselves how it compares with their own, homes in the surrounding neighborhood, and their personal notion of what a group home should offer its residents. (Provencal and Taylor, "Security for Parents: Monitoring of Group Homes by Consumers," 40-41.)

The Wisconsin Coalition for Advocacy nursing home project emphasizes that a primary goal is to work cooperatively with nursing home staff to create a relationship of mutual support and cooperation which can furnish feedback on services from a different perspective, not formal regulations or "professional" standards, but basic assumptions about the needs and desires of individuals. The goal is to "generate creative ideas which will enhance the lives of residents."

All of these projects stress the importance of training volunteer monitors and the development and use of consistent evaluation tools. It is particularly important that citizen monitoring efforts respect the rights and dignity of program staff as well as of clients in the mental health system.

ADDITIONAL ADVANTAGES

Citizen monitoring/evaluation of services for persons with mental illness in Minnesota can serve several purposes. It can find and publicize areas of strength and creative approaches to county services. It can call attention to deficits in services which can be remedied within current budgetary limits. It can also document gaps in services which result from inadequate community and legislative support. Only by building a careful, documented case that there are deficits in current service can services be improved.

Attention from ordinary citizens throughout Minnesota is necessary to determine whether persons with mental illness are receiving what they need, both in terms of community attitudes and in terms of the availability of effective services.

The involvement of members of the general public in monitoring activities may also result in greater public understanding of mental illness and contribute directly to "destigmatizing" both the idea of the illness and the attitudes which many clients face. Citizen involvement is particularly important in building services. Government alone cannot legislate acceptance, creativity and sensitivity toward its citizens.

Calling attention to the needs of persons with mental illness and to the fact that persons with mental illness are more likely to be withdrawn and vulnerable than to be violent, does not cost a great deal of money. Churches and civic groups can help by educating their members, by sponsoring informational programs and in reaching out to persons with mental illness. County publications can include a focus on mental illness programs. Local newspapers can feature success stories and the need for an array of community services.

PART ONE

HOW TO PROCEED

Because of the great differences among Minnesota counties* in size, population and character issues in service delivery and monitoring stratgegies will vary from county to county. Counties differ in the major barriers to providing effective and complete mental health services. Urban counties face problems in coordinating services and reducing concentration of persons with mental illness in inner city areas. Rural counties often confront difficulties in covering large distances and in establishing a full range of services for a relatively small number of clients.

*Although "county" is used in the singular throughout this workbook, a number of counties in greater Minnesota combine to offer mental health services.

CREATING A MONITORING PROJECT

The creation of a monitoring effort at the county level will depend on local initiative. The League of Women Voters will hold four regional monitoring workshops in the fall of 1989 for all interested persons. Local mental health advisory councils, chapters of the Alliance for the Mentally Ill of Minnesota and of the Mental Health Association would all be logical groups to initiate and cooperate in a monitoring project.

Cooperation among a variety of groups and citizens will make the monitoring project more effective both by broadening the perspective and by increasing support for quality services. It is important to include consumers of mental health services, if possible. Involving interested citizens and representatives of local church groups and civic organizations in addition to representatives from groups directly concerned with mental illness will strengthen the monitoring project.

Monitoring even once is desirable, but monitoring will be most effective if it is sustained as a continuing project. If at all possible, commitment by groups and individuals for more than year is desirable.

GETTING TO KNOW YOUR COUNTY'S MENTAL HEALTH SYSTEM

Learning the Facts

How to Proceed

The first step in monitoring is to learn the basics about county mental health services. A good beginning is a working knowledge of the county's mental health plan, which should be available from the county social services department or in the local public library. Each county submitted its first mental health plan to the Mental Health Division of the Minnesota Department of Human Services in January 1988. The next county plans, for the calendar years 1990 and 1991, are due in August 989. Subsequent plans will be submitted every two years.

A knowledge of the estimated numbers of persons with serious mental illness in the county, per capita spending on mental health services, the number of persons in the regional treatment center (state hospital) system, particularly when compared to similar counties, will also be helpful. (See State and County Information)

Additional information about your county services may be obtained from the regional consultant to your region of the state from the Mental Health Division. (Their names and phone numbers appear on the map in State and County Information.)

Other resources for a better understanding of the county mental health system are the local chapter of the Alliance for the Mentally Ill and the Mental Health Association, if they exist in your county and are not already involved.

Meeting the Official Actors

Another key part of the process is making yourself known to the county mental health director and/or the human services director. Introduce yourself by phone or schedule an appointment, and explain your interest in county services. Ask if there are additional written materials on county mental health policies.

Throughout the monitoring project, it is important to communicate the project's goals and plans fully with county social services and/or commissioners and the mental health advisory committee. Emphasis should be placed on the cooperative nature of monitoring, interest in positive county programs, and the future possibility of using monitoring results to build public support for additional and improved services.

Remember that county human services staff are often very busy and lack strong clerical and logistical support. In small counties, particularly, it may take a long time to copy documents you wish simply because of a shortage of time and copiers.

Staff constraints also mean that smaller counties have few written policies on mental health services, or other human services. It may be necessary to attend county board meetings when mental health services are on the agenda.

You may wish to have your name added to the mailing list for county board meetings to alert you to discussions of mental health services. Attendance at meetings during the development of the county budget may be particularly helpful.

You may also ask to attend meetings of the county mental health advisory council to better understand the issues.

Special Considerations

Confidentiality and data privacy for information regarding persons who are mentally ill is required by Minnesota law and essential to protect the privacy of persons receiving mental health services. The names of clients receiving services and information about them cannot be given out unless the clients sign a waiver. These safeguards may present an obstacle to gathering some information. You should expect that the county will not reveal any names to you without waivers being signed by clients. Nor can service agencies or the county provide clients to interview without getting their written permission. Confidentiality may pose a particular problem when visits to residential facilities are suggested. Again, clients may not wish to participate.

Much systemwide information will be unaffected by concerns of confidentiality. And, in many cases, clients will agree to participation if this is presented in a positive manner and if the purpose of monitoring is clearly explained. In some cases numbers can be subsituted for client names in written materials. If county and agency personnel repeatedly cite confidentiality as an obstacle to sharing any knowledge, this may reflect their reluctance to cooperate.

Politeness is crucial in establishing a good mutual working relationship with county and agency staff. Ideally, the project will continue for some time. It is better to move slowly and persistently than to express impatience with county personnel and providers.

CHOOSING A MONITORING FOCUS

Monitoring county services for persons with mental illness should reflect each county's unique characteristics. One monitoring project may choose to concentrate on compliance with the county mental health plan as written. Another may focus on a particular issue like housing, or on the Rule 36 (adult residential treatment facility, halfway house)

facility, or the Rule 5 (child/adolescent residential treatment facility) facility because of local concern or interest. Still another may choose to use more than one approach. Since organizational arrangements vary from county to county, the target agency may vary even though the issues addressed will be similar.

How to Choose

Before deciding on a focus for monitoring or beginning formal monitoring consider

1. arranging an informational briefing from county personnel on services for persons with serious mental illness;

2. contacting the local county mental health advisory council for their suggestions;

3. interviewing knowledgeable citizens on the key issues they see in county services for persons with mental illness. These might include the the local Alliance for the Mentally Ill and the local chapter of the Mental Health Association if they are not already involved;

4. using the "Consumer Survey, Systems Checklist III" with a group of consumers of mental health servicesto elicit their opinons on the effectiveness and completeness of services and important unmet needs. Their views on what is needed may differ from the professionals and from other advocate groups.

Considerations in choosing a focus will include:

1. available people power;
2. time constraints, both on a monthly and yearly basis;
3. county patterns of service;
4. perceived gaps in service.

Monitoring activities in each county should be chosen partially on the basis of manageability. It will be more effective to monitor a less ambitious project consistently than to attempt too much and not be able to follow through.

Other factors in the decision may be a preference for dealing with systemswide issues--compliance with the 1987 legislation or completing a housing survey for instance--or a wish to get into the field and deal with consumers and providers on a face-to-face basis.

IMPLEMENTING THE CHOICE

Having chosen a focus the following steps are necessary:

1. choosing a team of a minimum of two persons for each interview or visit;

2. deciding on the checklist and specific questions to be used;

3. pre-training or thorough review of the questions beforehand;

4. agreeing on and committing to a certain number of visits necessary to accomplish the task; and

5. reporting the information discovered.

It is probably a good idea to select one person to be responsible for coordinating, monitoring and reporting the results.

Volunteer Obligations

1. It is important that persons monitoring demonstrate an objective approach to county officials and to agencies being monitored. Monitors should not be perceived as "having an axe to grind." Volunteers monitoring individual programs should neither be current clients of the agency, have family members served by the agency nor be employed by the agency.

2. Volunteers should be able to accept the view that monitoring is intended to be a cooperative venture between providers and monitors.

3. Monitors must be willing to devote a minimum amount of time to the project. They will need to familiarize themselves with the questionnaire used, with the county system, to attend interview(s) with officials or agencies, to attend followup interviews, if appropriate, and to help in writing up the monitoring results.

4. Monitors must also agree to respect the confidentiality of both staff and clients whom they meet while visiting an agency.

Some monitoring programs use an informal contract for volunteers to sign, which makes expectations clear.

Particular sensitivity and more time is necessary to prepare for site visits to monitor agencies or programs. Volunteers who will monitor specific agencies should be conversant in building cooperative approaches to the agency or program.

Deciding on Monitoring Questions

The following section, and the seven checklists in the Master Checklist section are intended to suggest projects to monitor within a county.

The questions on the checklists may be adjusted or augmented to meet specific county needs. Monitors may decide to omit whole sections or questions. However, because of the advantages of having some comparable questions from county to county, it is suggested that local additions to the checklist be added at the end, so that comparable data will be available.

Reporting on Monitoring

When beginning a monitoring project, groups may wish to announce their interest in mental health services in a letter to the editor of their local paper or by arranging for an article.

Copies of all completed checklists should be sent to the League of Women Voters Mental Health Monitoring Project, 550 Rice Street, St. Paul, MN 55103. (612) 224-5445.

This will enable results to be coordinated at the state level and also the circulation of ideas for creative approaches to service delivery.

Note: Although written reports may be compiled of trends shown by monitoring in different counties, specific counties and agencies will not be named in written materials when citing problems.

Systems checklists

Locally completed systems checklists should be shared with

--the county mental health director or the social service director or mental health director. This step should be taken before distributing the results more widely to prepare these policymakers against any surprises and to permit a final opportunity to correct any misunderstandings.

--the mental health advisory committee.

Depending on appropriateness, results may also go

--to the county commissioners.

--to state legislators representing the area.

--to the local newspaper.

Completed agency checklists should be shared with the agencies concerned.

MONITORING MANDATED SERVICES

A logical beginning to monitoring county services is to assess the actual implementation of each county's mental health plan. The minimum legal requirements for all counties are listed in Part Two. "Systems Monitoring I, Checklist for Mandated County Services" is in the "Master Checklists" section.

Monitoring the county plan should begin with an interview of the director of social services for the county, or the mental health division director to fill in this checklist.

An important additional step would be to interview a representative of one of the contracting agencies (depending on county size) to determine if the agency is actually providing the services which the county said it would purchase. In a number of counties, the community mental health center is the main service provider.

In addition to detailing the degree to which the county is providing mandated services, the checklist provides for assessing "important but not mandated services" and other features:

1. Particular strengths of county services, including creative approaches to enhance service delivery.

2. The identification of barriers perceived by the county to full implementation of services.

3. The identification of service gaps.

If gaps are found in mandated services, or if some services are not yet on line but are promised, additional visits should be planned to follow up on these questions.

Throughout the process, attention should be directed at finding particular strengths in the system, areas where the county is showing imagination and skill in meeting service needs.

ASSESSING THE DEGREE TO WHICH COUNTY SERVICES APPROACH THE IDEAL

The second level of systemwide monitoring activities assesses the extent to which county services go beyond the minimum mandate and approach the ideal. What would be required to

offer a complete array of effective services to all persons with serious and persistent mental illness who need them? Four monitoring guides, Systems Monitoring II, III, IV and V, deal with systemwide needs, consumer views on the adequacy of service, residential treatment/ housing options and vocational/social programs, respectively. Filling in these systems checklists will result in a partial needs assessment for the county.

Concerns about the quantity of services include, but are not limited to:

1. Failure to serve all persons with serious mental illness who would like services;

2. Gaps in the array of services;

3. A tendency to refer clients to existing programs rather than design programs with individual client needs in mind;

4. Time limits on services, with no other appropriate service for clients;

5. Admission restrictions to some programs which effectively deny service to the most seriously and persistently mentally ill persons;

6. Allocation of mental health dollars to programs serving persons who do not have serious and persistent mental illness before all the needs of persons with serious and persistent mental illness are met;

7. Gaps in the continuum of residential options;

8. Gaps in employment activities;

9. Failure to meet the needs of special populations.
--persons with a dual diagnosis of mental illness and chemical dependency
--persons with mental illness and disabilities like mental retardation and hearing impairment
--elderly people
--the farm population
--racial and ethnic minorities
--homeless people
--persons in the criminal justice system.

Systems Checklists I - V should be completed by interviewing county personnel and, if possible, by interviewing knowledgeable consumer groups, including local chapters of the Alliance for the Mentally Ill and the Mental Health Association and the local Mental Health Advisory Council.

Note: Before deciding a gap exists, it is essential to hear from more than one source; one person's experience may be the exception to usual experience.

AREAS OF SPECIAL CONCERN

Case Management

Case management is often described as the glue holding the system together since it can link clients with services. Minnesota law states that all persons with serious and persistent mental illness who want case management may have it. Beginning in 1989, Medical Assistance and General Assistance Medical Care funds will be available for case management for persons with serious and persistent mental illness for the first time.

Some questions to address to counties during and after 1989 are:

1. What is the average client/caseworker caseload? (Many experts recommend a maximum caseload of 30-35 but caseloads exceed 60 in a number of counties.)

2. Continuity--does one case manager have the clear responsibility for each client?

3. Is an assessment done for each client? Are the goals clearly linked to the assessment? Is ongoing evaluation done?

4. Is there a waiting list to get on a county caseload?

5. What proportion of persons with serious and persistent mental illness are receiving case management services?
   --of persons identified as having serious and persistent mental illness?
   --of the estimated number of persons with serious and persistent mental illness?

6. Has this proportion (or number) increased since 1988?

7. How are clients followed over time?

8. Is there evidence that case managers are referring clients to a variety of services?

9. Is there evidence that case management is closely linked to community support services?

Liaison with the Police/and or Sheriff and Corrections

The first encounter many persons with mental illness have with public services, especially during acute episodes, is with the police or sheriff. A number of persons with mental illness are in jails. Yet police officers receive little or no training in dealing with mental illness.

1. Is there an ongoing attempt by county mental health services to inservice peace officers and corrections officials about mental illness?

2. Is there a specific procedure for handling persons with mental illness who are picked up by the police?

3. Does a qualified mental health professional screen new detainees in both adult and juvenile detention?

4. Are procedures established to minimize the time persons with mental illness spend in correctional facilities in your county?

5. Is the jail ever used to hold persons with mental illness because county programs and/or facilities specifically designed for persons with mental illness are insufficient?

Income Barriers

Another important factor in measuring quality of life for persons with mental illness in the community is how far their income will provide for a decent life.

1. Can most people with serious and persistent mental illness in your county afford decent housing? decent clothes?

2. Are budgetary services and other helps for persons with serious and persistent mental illness sufficient?

Tracking and Research

1. What steps is the county taking to see if programs work for clients?

2. How much does the county know about its clients with mental illness? Does it know which programs work? Does it know how many clients go back and forth to the regional treatment centers?

3. Does the county have an estimate on how much service different clients need?
   --the duration of service?
   --the variety of services?
   --the intensity of services?

General Public Acceptance

1. How widely is the sense of commitment to humane community services for persons with mental illness spread? Are churches involved? civic groups?

2. Are the needs of persons with mental illness or success stories of persons with mental illness in the community explained at public meetings? at meetings of organizations? in newsletters?

3. What kind of articles does the local newspaper have about mental health? mental illness?

Use of Creative Low-Cost Techniques

1. Is the county making use of relatively inexpensive trained laypersons and/or volunteers to help in mental health delivery? (One possibility is the use of trained lay staff (the Rhinelander model) as in Winona's supportive care workers. Another option is the training of volunteers to work with clients on a one-to-one basis as in the national "Compeer" model being developed in Ramsey County.

2. What about imaginative solutions that don't cost much? A coffee shop in The Winona CMHC building which serves all the offices in the building hires clients who have mental illness, thus employing clients and heightening public awareness at the same time.

The Availability of RTCs and Residential Treatment Programs

Systems Checklist III is designed to measure residential treatment/housing availability in each county.

Common questions raised are:

1. Are there people ready for transfer to RTCs from acute care hospitals who cannot be admitted because there are no available beds in the RTC?

2. Are people ready for discharge from the RTC who cannot leave because there are no places for them in the community?

3. Are there waiting lists for Rule 36 facilities?

The Availability of Housing

The shortage of housing options for persons with mental illness in the community is frequently raised.

1. In a number of communities residential programs designed specifically for persons with mental illness, transitional supported apartments, etc., are not sufficient to serve all who need them.

2. Persons with serious and persistent mental illness, most of whom have low incomes, must compete with other low income persons for a shrinking supply of decent, affordable housing.

A growing body of opinion contends that stability of housing is particularly important for persons with mental illness. If they require additional services because their illness worsens, more services should be provided to them allowing them to stay in their own homes. If they must go to an acute care hospital, an RTC or a residential treatment program, they should return home as soon as possible. Some argue that the frequent moves necessitated by current time limits on housing contribute directly to the deterioration of peoples mental health.

Common questions raised are:

1. Are people ready for discharge from Rule 36 (halfway house) programs in the community who have no appropriate place to go in the community?

2. Are people discharged from acute care hospitals placed in appropriate programs or housing?

3. Are there long waiting lists for housing programs in the community?

4. Are there any long term support housing arrangements, where people would not be expected to graduate or move on?

8. Is a full range of housing options available in the community?

MONITORING AGENCIES AND PROGRAMS

The third suggested approach to monitoring services is to assess the quality of services and programs for persons with mental illness. Such an approach emphasizes site visits to agencies, with the use of trained volunteers and a carefully developed questionnaire. Two checklists are offered for use in monitoring agencies. Agency/Program Checklist I is intended for assessing residential treatment programs, group living arrangements, and vocational programs in the community. Agency/Program Checklist II, Observing in Insitutions is intended for use when visiting a regional treatment center (state hospital).

Agencies of particular interest might include community mental health centers, day treatment programs, residential treatment programs, clubhouses and dropin centers. Board and care and board and lodging homes where persons with mental illness live which are not licensed for mental health programs might also be good choices for monitoring. In addition, groups may wish to monitor conditions in the regional treatment center serving their community.

Note: It is important when visiting agencies or programs to realize that shortcomings which may exist may be temporary or be the direct result of inadequate budgets.

Focus of Agency Monitoring

In general, the monitoring questions presented in this workbook emphasize "human" or "quality of life" factors, rather than technical aspects of mental health treatment or the administrative and financial strengths of the agency. These checklists incorporate many of ARC Minnesota's Partnership for Quality Services "quality of life" indicators as the focus of site visits.

1. Environment. The environment should be comfortable, appropriate to its function and reflect the age and life styles of the people served.

2. Rights. Each individual's rights should be respected. Services should teach people about their rights and assist them in exercising these rights by encouraging individual choice, preference and decision making.

3. Use of community resources. People should be integrated into the community and use resources to their maximum potential.

4. Personal Relationships. People should have opportunities to develop a variety of personal and social relationships.

5. Staff Involvement. Staff should be well-trained, well-supported and treat consumers with dignity and respect.

6. Commitment to Personal Growth. People should have a variety of opportunities for personal growth.

Agency Visits

Successful monitoring of agencies or programs depends on establishing cooperation between the monitoring team and the agency.

An interview should be arranged with the agency to explain the purpose of monitoring. The checklist can be shared at this time. It should be made clear that an ongoing relationship will be desirable. The agency may wish to check with its board of directors, its staff and residents before agreeing to participate in monitoring.

It is essential that the confidentiality of clients be respected both during and after the visit. If the agency agrees to participate, they will ask clients for waivers. Those clients who do not wish to participate may be absent during the visit or in their rooms. Monitors should refrain from discussing the clients with other individuals. They should also respect any confidences shared by staff. Areas in which programs might need improvement, in the view of monitors, should not be shared unofficially in the community.

Arrangements should be made for sharing the results with the agency involved before other individuals or groups. They should also be forwarded to the League of Women Voters Monitoring Project. Directors and staff should be assured that information learned through monitoring will not be given to official bodies or problems published citing the name of the agency.

A forthright and mutually acceptable relationship with the agency to be monitored is highly desirable.

Visiting Regional Treatment Centers

Some advocates in Minnesota, as in other states, are very critical of regional treatment centers. They report that the sheer size of the facilities makes them institutional rather than homelike and also assert that treatment is not individualized. available. However, it is important to realize that regional treatment centers have operated within very tight budgets and, in some cases, in antiquated facilities. Currently there is widespread agreement that Anoka Regional Treatment Center should be razed and a new one constructed.

To gain a complete picture of RTCs it is important to see all units if possible. Some units may be more pleasant and less restrictive than others, determined in part by the severity of the patients' illness.

To get the full picture it is desirable to arrange to speak with a group of patients, if possible. Although we tend to be conditioned to accept the opinions of persons in authority, consumers of RTC services often have valuable observations about the quality of life and opinions on which policies are

working and which are not.

It is also important to arrange an interview with the client advocate who reports to the Ombudsman for the Mentally Retarded and the Mentally Ill to learn the pattern of concerns expressed by patients and perceived by the advocate.

Since a number of counties refer clients to the same regional treatment center, monitoring groups may wish to arrange for a combined visit.

PART TWO

WHAT EACH COUNTY MUST PROVIDE

(This section is based almost entirely on the State of Minnesota, Department of Human Services, "Instructional Bulletin #87 - 53D," the county mental health plan format used for the 1988 county plans, and Department of Human Services, Mental Health Division, Three Year Plan for Services for Persons with Mental Illness , January 1989.)

The 1987 Comprehensive Mental Health Act, as amended in the 1988 legislative session, requires all 87 Minnesota counties to provide a complete range of services for persons with mental illness, and to serve all persons with serious and persistent mental illness who reside in their county. However each county is only obligated to provide services to the extent of its resources. (emphasis ours)

Priorities

Counties are to develop services for persons with mental illness according to the following priorities:

1. locally available emergency services;

2. locally available services to all persons with serious and persistent mental illness and all persons with acute mental illness;

3. specialized services regionally available to meet the special needs of all persons with serious and persistent mental illness and all persons with acute mental illness;

4. locally available services to persons with other mental illness; and

5. education and preventive mental health services targeted at high-risk populations.

Maintenance of Effort

Counties must demonstrate a maintenance of effort. They must continue to spend for mental health services "an amount equal to the total expenditures shown in the county's approved 1987 Community Social Services Act plan under State CSSA, Title XX and County Tax for services to persons with mental illness plus the total for Rule 5 facilities/for children/ under target populations other than mental illness in the approved 1987 CSSA plan."

If counties receive new funds for mental health expenditures currently funded from CSSA funds, the Mental Health Act requires that the CSSA funds be used for additional mental health services. (This is particularly important as counties receive federal and state Medical Assistance funding starting in 1989.)

Deadlines

Counties were required by law to make all services described below available by July 1, 1988 with two exceptions: case management services have a deadline of January 1, 1989 and screening has a deadline of January 1, 1991.

Counties were required to submit their first county plan showing compliance with the 1987 legislation to the Mental Health Division of the Minnesota Department of Human Services in January 1988. County plans for plan for calendar years 1990 and 1991 are due in August 1989. Subsequent plans will be submitted every two years.

Confidentiality

Various Minnesota statutes, including the Data Privacy Act, safeguard the confidentiality of persons receiving mental illness services from public agencies. In 1988, the protection of confidentiality was somewhat weakened by legislative language amending the 1987 Comprehensive Mental Health Act bill. Mental health providers (including mental health centers and other private agencies) "must actively attempt" to gain clients' consent to release their names and home addresses to their county's social services department. Denial of access to names and addresses of persons receiving mental health services has been disputed by a number of counties in the past. If they pay for such services, they argue, then they have the right to know what they are buying.

MENTAL HEALTH ADVISORY COUNCILS

Each county must establish a local mental health advisory council or a mental health subcommittee of an existing advisory council.

Membership

Council members must reflect "a broad range of community interests". Each council must include "at least one consumer, one family member of a person with mental, illness, one mental health professional, and one community support services program representative."

One-county advisory councils must have at least four members. The Mental Health Division recommends that multi-county advisory councils have at least six members.

(The Mental Health Division recommends that county commissioners and heads of county social service departments be ex officio rather than voting members of the mental health advisory councils.)

Functions

The council or mental health subcommittee must meet at least quarterly to "review, evaluate, and make recommendations regarding the local mental health system."

Annually the local advisory council or mental health subcommittee must arrange for input from the regional treatment center (formerly state hospital) review board regarding coordination of care between the regional treatment center and community-based services.

> "The county board shall consider the advice of its local mental health advisory council or mental health subcommittee of an existing advisory council in carrying out its authorities and responsibilities."

Each county reports to the 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 should identify the three top unmet needs in the county. The county also lists three unmet needs identified by other needs assessment processes.

REQUIREMENTS FOR ALL SERVICES

Counties are required to offer a number of services to persons with mental illness. Counties must meet certain requirements for all services.

1. Counties must list the budgeted total expenditures for the service from all sources both for services provided directly by the county and provided under contract (not including Medical Assistance and General Assistance Medical Care monies except for case management.)

2. Counties must list the number of contact hours or days

and the number of clients served.

3. Counties must base services on individual clinical needs, cultural and ethnic needs, and other special needs of individuals being served. Services must be accessible to all age groups.

4. Counties must make services available on a sliding fee scale basis and serve members of the "working poor" who do not qualify for Medical Assistance or General Assistance Medical Care but who have no private insurance.

5. Counties must inform the public that specific services are available and hom to call if they wish to request such services.

6. Counties are required to show how different services to a client will be linked and/or coordinated to assure that clients may move from one service to another that is more appropriate.

7. The state asks for clarification in instances where projected expenditures for any service by counties appear to be inadequate or where the contact hours with clients appear insufficient.

EDUCATION AND PREVENTION SERVICES

(Note: The order in which different services are listed here generally follows county plan format; it does not always reflect the relative importance of different services.)

County boards must provide or contract for education and prevention services for persons in their counties.

Education and prevention services:

1. Provide information regarding mental illness to the general public or special high-risk target populations;

2. Increase understanding and acceptance of problems associated with mental illness;

3. Increase people's awareness of the availability of resources and services;

4. Improve people's skills in dealing with high-risk situations known to affect people's mental health and functioning.

5. Prevent the development or deepening of mental illness.

Target Population

Education and prevention services must be accessible to all persons residing in the county and to identified high-risk groups. (e.g., victims of sexual assault; adolescents expressing suicidal ideation; victims of serious, unanticipated economic distress; families of AIDS victims; children of alcoholics, homeless people, etc.)

Counties must list the number of --

--workshops/seminars/classes provided.
--the number of participants at these workshops,
--newsletters provided
--media activities (radio, newspaper, television)
--brochures

Identify High Risk Groups

Each county must also identify up to three special high risk groups to be served and the activities to be provided.

Funding

Funding for education and prevention services is available primarily from CSSA funds

24-HOUR EMERGENCY SERVICES

County boards must provide or contract for enough emergency services within the county to meet the needs of persons in the county who are experiencing an emotional crisis or mental illness. (Clients may be required to pay for services on a sliding fee scale.)

> Emergency services means an immediate response service available on a 24-hour seven day a week basis for persons having psychiatric crisis or emergency.

Emergency services must include assessment, intervention, and appropriate case disposition.

Intended population

Emergency services must be accessible to all persons in the county--both residents and non-residents--with an emotional crisis or mental illness.

Emergency hotline

Counties must provide an emergency hotline for mental illness crises.

The hotline setting may be located in 1) an acute care hospital 2) a rule 36 facility or 3) another facility.

If counties decide to use the 911 emergency number they must provide special training in handling mental health emergencies.

Counties must include a TDD (telephone device for the deaf) in their emergency line.

Staffing

A mental health professional must be available by consultation (at least by telephone) within 30 minutes after an emergency call is placed.

Objective

24 hour emergency services are intended to:

1. Promote the safety and emotional stability of people with mental illness or emotional crises;

2. Minimize further deterioration of people with mental illness or emotional crises;

3. Help people with mental illness or emotional crises to obtain ongoing care and treatment; and

4. Prevent placement in settings that are more intensive, costly, or restrictive than necesary and appropriate to meet client needs.

Funding

Funding for emergency services uses a combination of Rule 14 monies, CSSA monies, and third party or medical assistance (MA) reimbursement of face to face sessions.

OUTPATIENT SERVICES

County boards must provide or contract for 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 their ability to pay.

Outpatient services are mental health services (excluding day treatment and community support services programs) provided by or under the clinical supervision of a mental health professional to persons with a mental illness who live outside a hospital or residential treatment setting. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management, and psychological testing.

Outpatient Services:

1. Conduct diagnostic assessments;
2. Conduct psychological testing;
3. Develop or modify individual treatment plans;
4. Make referrals and recommend placements as appropriate;
5. Treat a person's mental health needs through therapy;
6. Prescribe and manage medication; and
7. Prevent placement in settings that are more intensive, costly, or restrictive than necessary and appopriate to meet client needs.

Target Population

Outpatient services must be accessible to emotionally and behaviorally disturbed children and adults with serious and persistent mental illness, acute mental illness and other mental illness.

Initial appointments must be provided within three weeks unless special requests are made for particular days, times, or therapists which prevent timely initial appointments.

Outpatient services must be provided by an organization with a multidisciplinary staff consisting of: psychiatrists, licensed consulting psychologists; and other mental health professionals.

Staff must meet professional qualifications defined in the Mental Health Act.

Mental health practitioners must be clinically supervised by mental health professionals.

The state requires that counties provide a minimum of 4 hours of outpatient service per client per year.

Funding for outpatient services is available from third party

reimbursers, MA, GAMC, client fees and CSSA.

COMMUNITY SUPPORT SERVICES PROGRAMS (CSPs)

Before August 1987, only 47 counties received Rule 14 grants from the state to develop community support services programs. Much of the new 1987 appropriaton funded development of community support services in the remaining 40 counties. All Minnesota counties except one accepted funds.

> Community support services are "services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the clinical supervision of a mental health professional designed to help people with serious and persistent mental illness to function and remain in the community. A community support services program is coordinated with case management activities provided to persons with serious and persistent mental illness.

All community support services program must include the following components:

1. Client outreach
2. Medication management
3. Assistance in independent living skills
4. Employability and supportive work opportunities
5. Crisis assistance
6. Psychosocial rehabilitation
7. Help in applying for government benefits
8. Development, identification, and monitoring of living arrangements

Currently all counties provide CSP services, but there is recognition of the need for more funds to meet all needs. The Governor's Budget for 1990-1991 includes an increase in CSP funding.

County boards must provide or contract for sufficient community support services within the county to meet the needs of persons with serious and persistent mental illness residing in the county.

Objectives

The community support services program must be designed to improve the ability of persons with serious and persistent mental illness to

1. Work in a regular or supported work environment.
2. Handle basic activities of daily living;
3. Participate in leisure time activities;
4. Set goals and plans;
5. Obtain and maintain appropriate living arrangements; and
6. Reduce the use of more intensive, costly, or restrictive placements both in number of admissions and lengths of stay as determined by client need.

The individual community support plan must state for each client:

1. The goals of each service
2. The activities for accomplishing each goal;
3. A schedule for each activity; and
4. The frequency of face-to-face client contacts, as appropriate to client need and the implementation of the community support plan.

The plan must base the goals on the client's diagnostic assessment.

Target Population

Community support services must be accessible to all adults with serious and persistent mental illness. (Although community support services must also be available to emotionally disturbed children, the following requirements apply to adults only.)

In the plan counties must describe how the community support service components are linked into the county's overall community support system and how multiple providers (if used) coordinate service components. They must also show how case managers will be linked to the community support program and how the individual community support plan will be developed and coordinated among components and providers.

Funding

Funding for community support programs is available from Rule 14, GAMC, client fees, third party reimbursement, CSSA, and the Department of Jobs and Training. Each of these funding sources, other than Rule 14 and CSSA, has strict requirements as to which of the subcomponents of the community support programs it will fund.

DAY TREATMENT

Day Treatment services are a structured program of intensive therapeutic and rehabilitative services

> at least one day a week for a minimum of a three hour time block that is provided in a group setting by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment services are not part of inpatient or residential services, but may be part of a community support services program.

Persons may be required to pay a fee for community support services, case management services and day treatment services.

The requirement that counties provide a day treatment program may be waived if

1. An alternative plan of care exists through the county's community support program for clients who would otherwise need day treatment services,

2. Day treatment, if included, would be duplicative of other components of the community support program, and

3. County demographics and geography make the provision of day treatment cost ineffective and unfeasible.

Funding

Funding for day treatment is available through third party reimbursers, MA, GAMC, client fees, Rule 14 and CSSA. Third party payors, MA and GAMC funds should be utilized before CSSA and Rule 14 dollars. 1988 legislation permits the use of MA funds for day treatment in county contracted providers other than Rule 28 approved community mental health centers.

RESIDENTIAL TREATMENT

County boards must provide or contract for enough residential treatment services in the community (not including acute care hospitals or regional treatment centers) to meet the needs of all persons with mental illness residing in the county. Residential treatment services include intensive and structured residential treatment with length of stay based on client residential treatment need. Services must be as close to the county as possible.

> Residential treatment is a 24 hour per day residential program under the clinical supervision of a mental health professional, other than an acute care hospital or regional treatment center. Such a program must be licensed as a residential

treatment facility for mentally ill persons under MN Rules, parts 9520.0500 to 9520.0690 (Rule 36) for adults, 9545.0900 to 9545.1090 (Rule 5) for children.

Objectives

1. Prevent placement in settings that are more intensive, costly, or restrictive than necessary (particularly hospitals) and appropriate to meet clients needs;

2. Help clients achieve the highest level of independent living;

3. Help clients gain the necessary skills to be referred to a community support services program or outpatient services; and

4. Stabilize crisis admissions.

Target Population

Rule 36 residential treatment must be accessible to adults with serious and persistent mental illness. A limited number of crisis beds are provided in some Rule 36 residential treatment facilities for adults with acute mental illness

Rule 5 residential treatment must be accessible to emotionally and/or behaviorally disturbed children.

All adults with serious and persistent mental illness needing Rule 36 residential treatment and all children who are emotionally or behaviorally disturbed and in need of Rule 5 residential treatment will be placed or referred for placement in a licensed facility as close to the county as possible and appropriate to client need.

All residential treatment services for both children and adults must be clinically supervised by a mental health professional.

Counties must describe how Rule 36 residential treatment will be coordinated with the community support program.

Counties must describe how Rule 5 residential treatment will be linked and followed up by working with families.

Counties are cautioned if they provide residential treatment service either to too small a number of children and adults or to too many persons. The state also monitors the length of stay.

Funding

The 1987 Legislature appropriated new Rule 12 funds to develop three new Rule 36 facilities in rural areas. In addition to Rule 12, funding is available from CSSA funds and from Title IV-E for children and adolescent residential treatment. MA or insurance monies cannot be used for most residential treatment.

ACUTE CARE HOSPITAL INPATIENT TREATMENT

County boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible to meet the needs of persons with mental illness residing in the county.

> Acute care hospital inpatient treatment means short term medical, nursing and psychosocial services provided in an acute care hospital licensed under Minnesota Statutes, Chapter 144.

Objectives

1. Stabilize the mental health and medical condition of people with acute or serious and persistent mental illness;

2. Improve functioning; and

3. Facilitate appropriate referrals, follow-up, and placements.

Target Population

Children and adults with acute mental illness.

Funding

Funding for acute care hospital inpatient services is available from third party reimbursers, MA, GAMC, and client fees. Counties must use CSSA dollars to fund the admission of individuals needing the service but not qualifying for other funding. This often occurs when clients are placed on 72 hour holds under the Commitment Act.

REGIONAL TREATMENT CENTER (RTC) INPATIENT SERVICES

> Regional treatment center inpatient services means

> the medical, nursing, or psychosocial services provided in a regional treatment center (formerly state hospital) operated by the state.

In 1988 six Minnesota regional treatment centers at Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter and Willmar served people with mental illness. (The Minnesota Security Hospital at St. Peter has 236 beds for persons judged mentally ill and dangerous.) A major overhaul of the state regional treatment center is now being undertaken.

The state must make sufficient regional treatment center inpatient services available to people with mental illness throughout the state.

Objectives

1. Stabilize the mental health medical condition of the person with mental illness;

2. Improve functioning;

3. Strengthen family and community support; and

4. Facilitate appropriate discharge, aftercare, and follow-up placements in the community.

Intended Population

Adults with serious and persistent mental illness and acute mental illness for whom community resources are not adequate or appropriate, as determined by the mental health professional conducting the screening.

Counties must describe how they will assure that discharge planning will occur prior to discharge and how clients with be linked with necessary community based services.

CASE MANAGEMENT

> Case management activities are designed to help people 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 activities must be coordinated with the community support services program.

Case management:

1. Assists with access to needed medical, social, education, vocational and other necessary services.

2. Obtains a diagnostic assessment.

3. Develops an individual community support plan.

4. Refers clients to needed mental health and other services.

5. Coordinates services.

6. Monitors the delivery of services.

By January 1989 case management activities must be available to all persons with serious and persistent mental illness residing in each county.

Case managers must be persons with a bachelor's degree in one of the behavioral sciences or related fields and 2,000 hours of supervised experience providing services to persons with mental illness. A case manager with a bachelor's degree but without 2,000 hours of supervised experience must complete 40 hours of training approved by the Department of Human Services and receive weekly clinical supervision from a mental health professional until the 2,000 hours of supervised experience are completed. In all other cases clinical supervision must be provided monthly.

Funding

Funding for case management will be available through MA for MA-eligible clients; this is expected to bring in approximately $3,000,000 in federal funds. Funding for non-MA eligible clients is available from Rule 14 and county funds (under CSSA).

SCREENING

By January 1, 1991 county boards must screen all persons before they may be admitted for treatment of mental illness to a residential treatment facility, an acute care hospital, or informally admitted to a regional treatment center if public funds are used to pay for the services . Screening prior to admission must occur within 10 days. If a person is admitted for treatment of mental illness on an emergency basis to a residential treatment facility or acute care hospital or held for emergency care by a regional treatment center under Minnesota Statutes 253B.05, subd. 1, screening must occur within 5 days of admission. The screening process and placement decision must be documented.

Objectives

Screening intended to

1. Ensure admission is necessary;

2. Ensure that the length of stay is as short as possible consistent with client need;

3. Ensure that a case manager is immediately assigned to persons with serious and persistent mental illness; and

4. Ensure that an individual community support plan is developed.

Intended Target Populations

All persons using public funds who are referred to residential treatment (Rule 36 and Rule 5), acute care inpatient and regional treatment centers for voluntary treatment of mental illness.

All persons conducting screening must be mental health professionals.

Mental health professionals conducting the screening must not be affiliated with admitting facilities.

Funding

The 1988 Legislature delayed implementation of screening services until January 1991 pending a report on implementation plans, affected individuals, and funding mechanisms to the 1990 Legislature.

ADDITIONAL MENTAL HEALTH SERVICES

Counties must also report additional service provided to meet the mental health needs of clients and intended target populations for additional services.

SERVICE COORDINATION

Counties must describe how all the service components in their plan are coordinated to ensure client continuity of care.

FUNDING SUMMARY

Counties must provide a summary of expenditures for all mental health services.

Counties must also submit a Summary of Revenues:

County tax/State CSSA/Title XX
Title IV-E
Rule 12
Rule 14
Federal MH Block Grant
Client Fees (collected by county)
Other (specify)

CSSA Sub-Total

Medical Assistance (for case management)

GA/MSA (for Rule 36)

Other

PROVIDER INFORMATION SHEETS

With their plans counties must provide to the Mental Health Division of DHS sheets listing information for each contracted provider which is either a sole provider of service or where the contract is for $10,000 or more.

OTHER LEGAL MANDATES

Prepetition screening Each county must provide a process for screening persons recommended for involuntary commitment. Before a petition for commitment is filed a screening team must conduct a preliminary investigation. The team must

1. interview the proposed patient and others who appear to know about his/her condition;

2. identify the alleged conduct which is the basis for the application; and

3. identify, explore and list the reasons for rejectng or recommending alternatives to voluntary placement.

Under new language passed in 1988, the court must commit the patient "to the least restrictive (facility) program which can meet treatment needs."

> In deciding what is the least restrictive program, the court shall consider a range of treatment alternatives including, but not limited to, community based residential treatment, foster care, partial hospitalization, acute care hospital and regional treatment center services. The court

> shall also consider the proposed patient's willingness to participate in the treatment offered. The court shall not commit to a facility or program that is not capable of meeting the patient's needs.

Case managers must monitor outpatient commitment. The case manager may petition for a reopening of the commitment hearing if a patient fails to comply with the terms of an order for community based nonresidential treatment "or if the proposed treatment is not being provided." The case manager is to ensure continuity of care and coordinate plans for the aftercare program.

Children and adolescents . In their 1988 plans counties reported how they expect to serve the special needs of children and adolescents for several services. In 1988 the Minnesota Legislature mandated the creation of a "unified, accountable, comprehensive children's mental health system" (M.S.245.698). The 1988 law created a Children's Mental Health Subcommittee to the State Mental Health Advisory Council. The state MHAC has held hearings throughout the state on the mental health needs of children and adolescents.

The Mental Health Division is currently engaged in a major planning effort and collecting data via a needs assessment survey sent to all county social service directors. New legislation in the 1989 legislative session will almost certainly specify additional steps which counties must take to serve children and youth who need mental health services.

RESOURCES

Special thanks to Al Oertwig, Mary Jo Verschay, and John Zakelj of the Mental Health Division of the Minnesota Department of Human Services and Ruth Mueller of the Alliance for the Mentally Ill of Minnesota for cheerfully sharing information, ideas and advice throughout the development of this workbook. We also greatly appreciate the interest and support of Representative Gloria Segal and Norma Schleppegrell, chair, State Advisory Council on Mental Health.

We are grateful to the following people for taking the time to read and comment on drafts of this workbook:

Judy Bowers, Louise Brown, Loyce Brown, Millie Casperson, Joyce Gelle, Maureen Heaney, William Holden, Helen Klanderud, Doug Krueger, Elizabeth Lofgren, Ruth Mueller, Faye Sargent, Norma Schleppegrell, Duane Shimpach, Joyce Schut, Mary Jo Verschay, Molly Woehrlin and John Zakelj.

The following people shared information for this project:

Pat Carlson, Human Services Director, Olmsted County

Dianne Greenley, managing attorney, Mental Health Advocacy, Wisconsin Coalition for Advocacy Wisconsin Mental Health Law Project

Shirley Hokanson, Ombudsman for the Mentally Retarded and Mentally Ill

Chuck Krueger, Minnesota Alliance for the Mentally Ill

Paul McCarron, Anoka County Commissioner, member, Minnesota Mental Health Advisory Council

Mary Olympia, advocate, Mental Health Association of Minnesota

Duane R. Shimpach, director, Human Services Board of Faribault, Martin, Watonwan Counties

Pat Siebert, supervising attorney, Minnesota Mental Health Law Project

Jerry Storck, research analyst specialist, Mental Health Division, Department of Human Services

Jean Swanson, project director, Partnership for Quality Services Monitoring Project, Association for Retarded Citizens of Minnesota

Dave Wagner, Northwest Hennepin Human Services Council

BIBLIOGRAPHICAL NOTE

For a view of Minnesota's mental health system we consulted:

Governor's Mental Health Commission, Recommendations. Mandate for Action , February 1986.

Office of the Legislative Auditor, Program Evaluation Division, Deinstitutionalization of Mentally Ill People , 1986.

Torrey, E. Fuller, M.D., Sidney M. Wolfe, M.D., and Laurie M. Flynn, Care of the Seriously Mentally Ill , A Rating of State Programs, Second Edition: 1988, A Joint Publication of Public Citizen Health Research Group and the National Alliance for the Mentally Ill.

For a more complete bibliography see, League of Women Voters of Minnesota, Serving Minnesota's Mentally Ill: An Introduction , 1988.

* * * * *

The information about mandated services comes mainly from the following state publications:

Mental Health Program Division, Minnesota Department of Human Services

-- Report to the Legislature. February 1989

-- Three Year-Plan for Services for Persons with Mental Illness January 1989.

--DHS Instructional Bulletin #87-53d, September 3, 1987, Subject: County Mental Health Plan Format.

--DHS Instructional Bulletin #89-69A, February 3, 1989. Information for developing the local CSSA and Mental Health plan for calendar years 1990 and 1991 and the Title XX Intended Use Report for federal fiscal year 1990.

* * * * *

Particularly helpful in formulating the checklists included in this workbook and in understanding citizen volunteer monitoring were:

Association for Retarded Citizens Minnesota, Partnership for Quality Services General Monitoring Tool, adapted from "Monitoring Community Residences - Guidelines", copyright 1984, ARC Ohio, for more information call Jean Swanson, ARC Minnesota, (612) 827-5641.

Bibliography

Bogdan, Robert, and Steven J. Taylor, "Observing in Institutions," Center on Human Policy, Division of Special Education and Rehabilitation, Syracuse University. Prepared for the Developmental Disability Rights Center of the Mental Health Law Project and the Center on Human Policy, 216 Ostrom Avenue, Syracuse, New York, 13210, (315) 423-3851.1979-80, under HEW, Office of Human Development, Grant of National Significance, 354P71332/3-01.

Bradley, Valerie J., Mary Ann Allard, Virginia Mulkern and Paul Nurczynski and Emily Ayers Cravedi, National Institute of Mental Health, Citizen Evaluation in Practice , A Casebook on Citizen Evaluation of Mental Health and Other Services, U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, DHHS Publication No. (ADM) 84-1338, 1984.

Ernst and Whinney, "Study of Housing and Support Service Needs of Minnesotans with Severe and Persistent Mental Illness," prepared for the Mental Health Division of the Minnesota Department of Human Services, February 1988.

Kastner, Rick, and Marilyn Lee Olds, "Citizen Evaluation Using Program Analysis of Service Systems (PASS), Lancaster County Mental Health/Mental Retardation Drugs/Alcohol.

Lancaster County Office of Mental Health/Mental Retardation, "Citizen Evaluation utilizing Program Analysis of Service Systems (PASS) Review Process, in Community Mental health Journal , spring 1981, by Nancy R. Dinkel, Joan W. Zinober, and Eugenie W. Flaherty.

Michigan public mental health guidelines, particularly "Rights of Recipients in Community Residences."

Provencal, Gerald and Ruth Taylor, "Security for Parents: Monitoring of Group Homes by Consumers," Exceptional Parent , December 1983, 39-44.

Shimpach, Duane, R., "In Counties We Trust, We Really Oughta Wanna Partnership, " 7/9/87 revised 9/19/88. Available from Duane Shimpach, director, Human Services Board of Faribualt, Martin, Watonwan Counties, 218 Lake Avenue, P.O. Box 938, Fairmont, Minnesota 56031, (507) 238-4757.

Torrey, Wolfe and Flynn, cited above.

Wisconsin Coalition for Advocacy, "Nursing Home Citizen Monitoring Project," Contact Susan Tess. 16 North Carroll St., Suite 400, Madison WI. 53703.

* * * * *

Useful as background were:

Bibliography

Alliance for the Mentally Ill of Minnesota - one page checklist "Possibilities for Services in Your County."

Commission on Accreditation of Rehabilitation Facilities, Standards Manual for Organizations Serving People with Disabilities , copyright 1988 by the Commission on Accreditation of Rehabilitation Facilities, 2500 North Pantano Road, Tucson, Arizona 85715 (602) 886-8575.

Jackson County, Wisconsin, "Observations and Recommendations," A Report of the Assessment of Mental Health, Developmental Disabilities, and Alcohol & Other Drug Abuse Services to Children and Adults in Jackson County, September 8, 1986, Jackson County HSD Board & Staff, 221 Main Street, P. O. Box 457, Black River Falls, Wisconsin, 54615.

Learning about Normalization through PASS 3, Participant's Workbook, Responsive Systems Assocaites, 58 Willowick Drive, Decatur, Georgia, 30038, (404) 987-9785.

Mental Patients Alliance of Central New York, Syracuse, New York, and Richard H. Hutchings Pyschiatric Center, 620 Madison Street, Syracuse, New York.

The National Alliance for the Mentally Ill (AMI), "Questionnaire regarding services for the seriously mentally ill."

Peters, Suzanne, Stuart A. Lichtman, and Charles Windle, Citizen Roles in Community Mental Health Center Evaluation , U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Mental Health, 5600 Fishers Lane, Rockville, Maryland 20857.

South Carolina Protection and Advocacy System, "Team Advocacy Project Information Sheet," and survey material, Jane Windham, Team Advocacy Coordinator, 1823 Gadsden Street, Columbia, South Carolina, 29201, (803) 779-5363.

Wolfensberger, Wolf, and Linda Glenn, PASS 3, Program Analysis of Service Systems, a method for the quantitative evaluation of human services, Field Manual, third edition 1975, 1978 reprint, National Institute on Mental Retardation, sponsored by the Canadian Association for the Mentally Retarded. Issued and distributed by the National Institute on Mental Retardation, York University Campus, 4700 Keele Street, Downsview Toronto, Canada, M3j 1P3 (416) 661-9611.

ORDER BLANK

Child/Adolescent Checklist

The LWV Mental Health committee plans to prepare a checklist on child/adolescent mental health services following the 1989 legislative session.

If you wish to order a copy of this checklist, please enclose $1 and return this blank by July 1, 1989 to the League of Women Voters of Minnesota.

Copies of Other Checklists

Additional copies of the monitoring checklists in the workbook are also available from the League office for the cost of reproducing and handling.

Please send me a copy of the children/adolescent mental health services checklist. I enclose $1.

Please send me additional copies of the monitoring checklists contained in this workbook. I understand that I will be billed.

Name

Address

Send to:

League of Women Voters of Minnesota
550 Rice Street
St. Paul, MN 55103

STATE AND COUNTY INFORMATION

Map showing Minnesota State Regional Treatment Center Catchment Areas

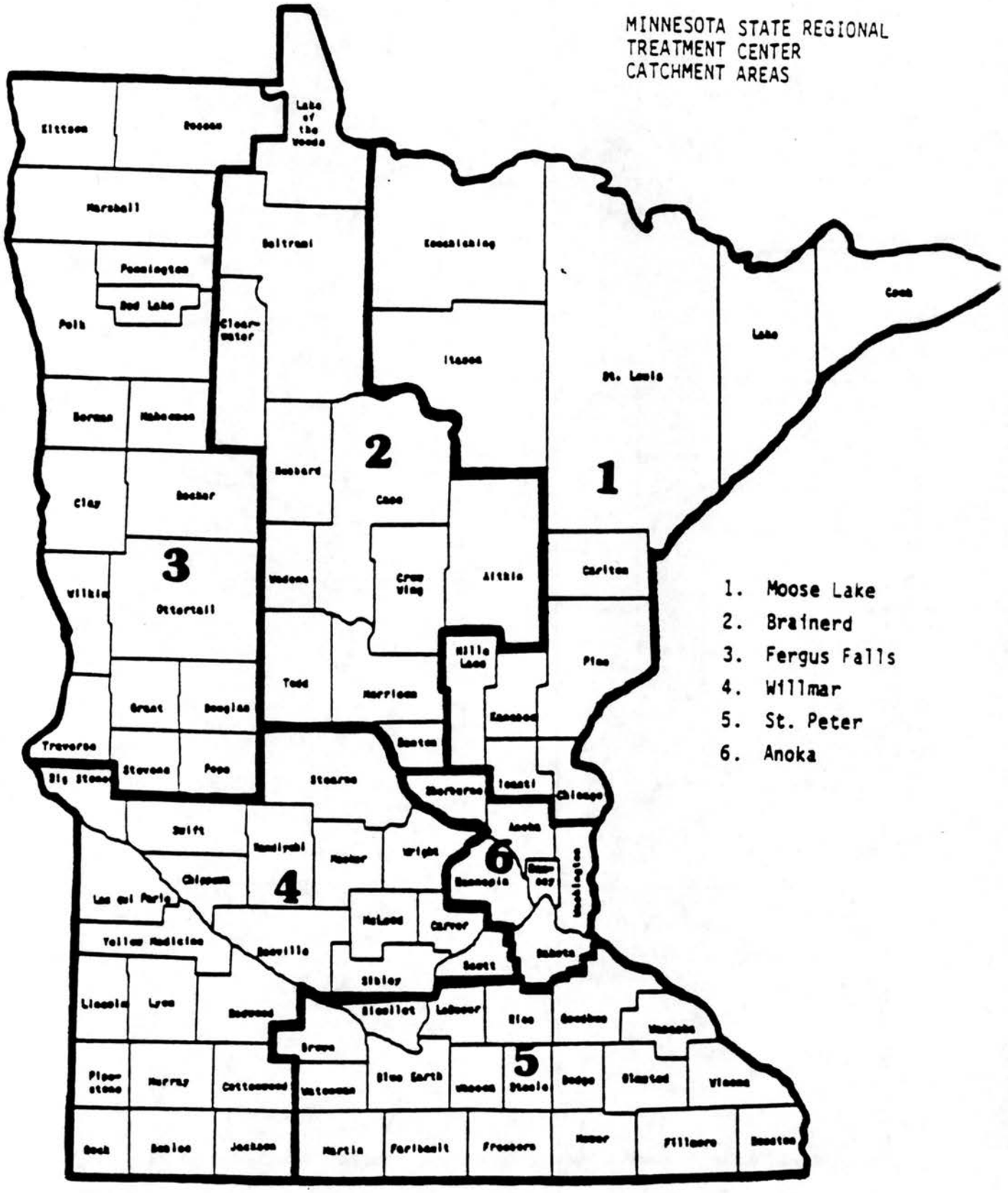
Map Listing Mental Health Division Regional Consultants

Rama S. Pandey and Soonhae Kang, "Prevalence Estimates of Mental Disorders for Minnesota Counties"

Per Capita Expenditures for 1989 MN Services for County Plans

Planned Service Use per 10,000 Population for 1989 from Mental Health Plans

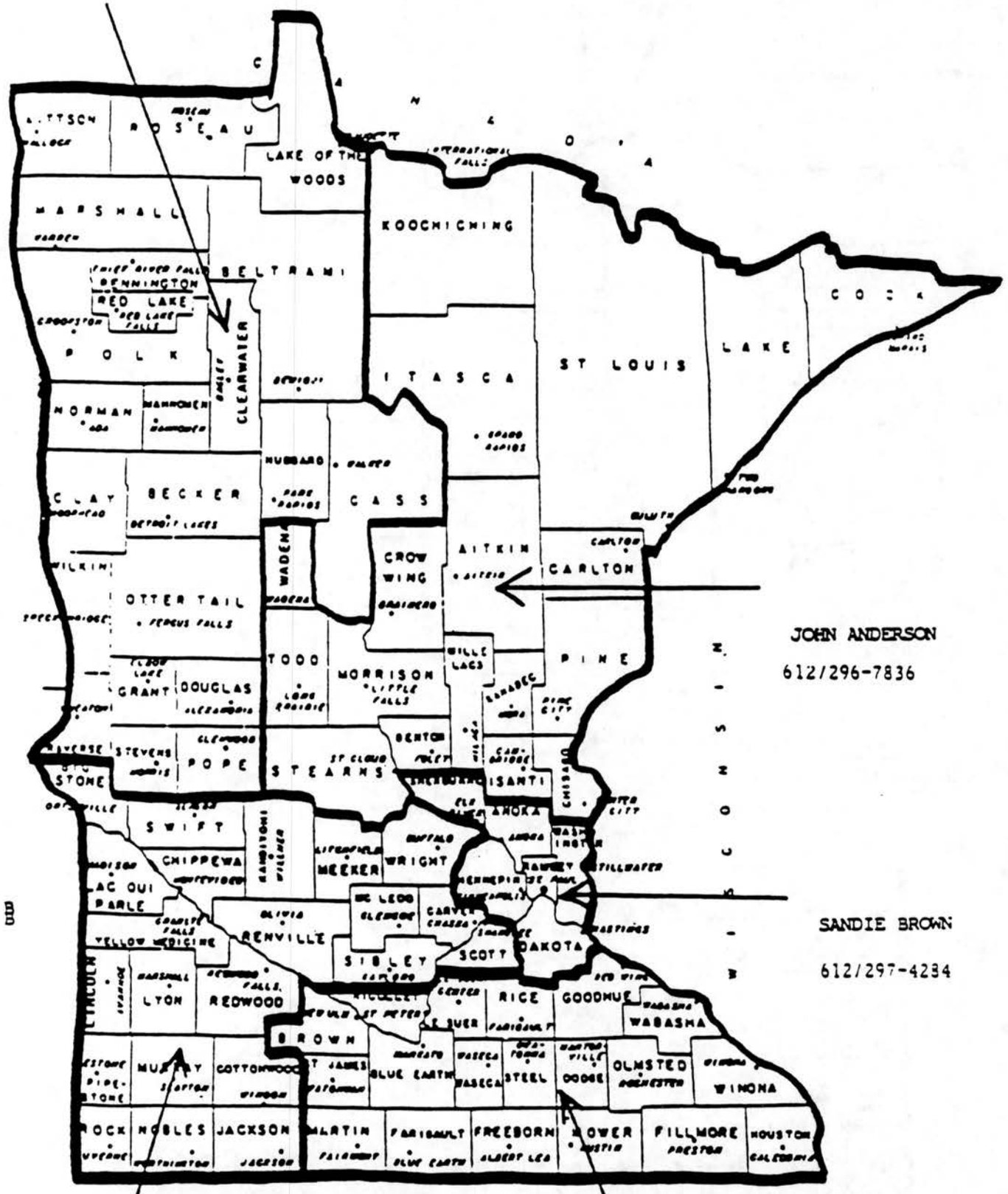
MINNESOTA STATE REGIONAL
TREATMENT CENTER
CATCHMENT AREAS



1. Moose Lake
2. Brainerd
3. Fergus Falls
4. Willmar
5. St. Peter
6. Anoka

DAN MYHRE
612/296-8980

MENTAL HEALTH DIVISION REGIONAL CONSULTANTS



JOHN ANDERSON
612/296-7836

SANDIE BROWN
612/297-4234

DWIGHT PETERSON
612/297-4568

BARB PETERSON
612/297-4549

PREVALENCE ESTIMATES OF MENTAL DISORDERS FOR MINNNESOTA COUNTIES

PREPARED BY

Rama S. Pandey, PH.D.
Professor
School of Social Work
University of Minnesota

Soonhae Kang
Research Assistant
Doctoral Student
School of Social Work
University of Minnesota

SUBMITTED UNDER CONTRACT #89255

TO

MINNESOTA DEPARTMENT OF HUMAN SERVICES

SEPTEMBER 1987

Prevalence Estimates:

In the following tables, six-month prevalence estimates of DIS/DSM-III disorders for Minnesota counties are computed by sex, age and race These estimates are based on U.S. prevalence rates. The age-groups include 18-24; 25-44; 45-64; and 65 and over. Specific categories of mental disorders include schizophrenia, affective disorders, personality disorders, severe cognitive impairment, and phobia. Prevalence estimates are given for total population as well as for special populations such as Black , American Indian, Hispanic, adolescents and Asian refugees. The estimates for these populations are computed on the basis of any DIS disorder except substance use disorders. These estimates are given in the range of lower and upper limits.

Table 1 presents six-month prevalence estimates of mental disorders and serious mental illness for adult population. These estimates are based on NIMH (ECA and other studies) rates for any mental disorder and serious mental illness. These rates are computed within a range of 12.6% for lower limit (LL) and 19% for upper limit (UL). The serious mental illness is estimated at the rate of .75% for the lower limit (LL) and 1.0% for the upper limit (UL).

The prevalence estimates for special populations are given in Tables 2,3,4,5 and 6. The counties with adult population 100 and over are included in these tables. The prevalence rates for U.S. adult population are applied to compute the county estimates for special populations. These prevalence rates are computed at two levels:

	Lower Limit (%)	Upper Limit (%)
Any disorder covered	12.6	19.0
Schizophrenia	0.6	1.2
Affective disorders	4.6	6.5
Personality disorders	0.6	1.3
Cognitive impairment (severe)	1.0	1.3
Phobia	5.4	13.4

The county profile of the prevalence estimates is given in a separate table for each county. These estimates are computed for specific mental disorders by sex and age. The county profiles indicate that women are more vulnerable to affective disorders and phobia, and cognitive impairment is more prevalent among the elderly.

The Ratio of Untreated to Treated Cases :

It should be clearly understood that county estimates of specific psychiatric disorders indicate the population in need. Only a segment of the estimated population is diagnosed and receives treatment from different sources. An analysis of U.S. epidemiological studies on the ratio of treated to untreated cases in true prevalence estimates found that only about 25 percent of those found to be suffering from a clinically significant disorder had ever been in treatment. Large proportions, perhaps 75 percent, of individuals suffering from any psychiatric

disorder have never been in treatment. For the more severe psychotic disorders, as many as 45 percent of cases, and for schizophrenia, about 20 percent cases, have never received treatment from a mental health professional. Furthermore, many individuals who receive treatment, are not true psychiatric cases. It is assumed that most of the true cases who receive treatment, are the acute and serios psychiatric cases. The county population with mental disorders should reflect these national trends.

A number of cells in the county tables give very small figures. The county estimates of specific psychiatric disorders should be read in terms of diagnosis, severity and duration. A low estimate figure may be associated with high severity, seriousness and cost of treatment. Furthermore, the prevalence estimates indicate that certain sex, age and race groups are more vulnerable to one or other type of mental disorder.

Prevalence Estimates of Mental Disorders for Minnesota Counties

1985 Population Estimates:

The prevalence estimates of specific mental disorders are computed for 1985 population age 18 and over. The 1985 population estimates are based on 1980 Census figures which are multiplied by the percent of change during 1980-85. (see Population Notes, August 1986, Office Of State Demographer). These change rates might vary from group to group. Since no other 1985 population estimates are available in specific sex, age and race categories corresponding to national surveys, the population estimates given here are the best available estimate of actual population increase in 1985.

Prevalence Rates:

The prevalence estimates of mental disorders for counties are computed on the basis of six-month prevalence rates of DIS/DSM disorders for estimated number and percent of U.S. civilian population. The NIMH Epidemiologic Catchment Area (ECA) Program gives these prevalence rates of psychiatric disorders by sex, age and race. The survey was conducted in five sites including New Haven, Baltimore, St.Louis, North Carolina and Los Angeles. The sampled population, sample size, and prevalence rates in three sites are available for comparative analysis. As the ECA sample size is not true representative of community population in indicated sex, age and race categories, the prevalence rates are computed on the basis of sampled population in three sites. It is assumed that the sampled population weight should very closely approximate the actual census count of population in specific categories within the sampled area. The U.S. prevalence rates of DIS/DSM disorders based on total sampled population are given below:

Mental Disorder	Men				Women			
	Age Group, Years				Age Group, Years			
	18-24	25-44	45-64	65+	18-24	25-44	45-64	65+
Schizophrenia	1.3	0.9	0.6	0.0	1.0	2.0	0.5	0.4
Affective Disorder	4.6	4.9	3.0	1.3	7.4	10.2	7.0	3.8
Personality Disord.	2.4	2.2	0.2	0.4	0.8	0.5	0.0	0.0
Cognitive Impair. (severe)	0.4	0.3	0.8	5.5	0.5	0.2	1.1	4.1
Phobia	4.7	3.9	5.4	2.9	11.3	12.8	7.5	6.3

Table 1: Six-Month Prevalence Estimates of DIS/DSM-III Disorders and Chronic Mental Illness for County Population Age 18 and Over

County	1985 Pop. Estimates Adult	Any Disorders		Chronic Mental Illness	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit
AITKIN	9,669	1,218	1,837	73	97
ANOKA	139,125	17,530	26,434	1,043	1,391
BECKER	21,278	2,681	4,043	160	213
BELTRAMI	24,049	3,030	4,569	180	240
BENTON	18,179	2,291	3,454	136	182
BIG STONE	5,760	726	1,094	43	58
BLUE EARTH	40,048	5,046	7,609	300	400
BROWN	20,165	2,541	3,831	151	202
CARLTON	19,687	2,481	3,741	148	197
CARVER	27,540	3,470	5,233	207	275
CASS	15,171	1,912	2,883	114	152
CHIPPEWA	10,647	1,342	2,023	80	106
CHISAGO	18,854	2,376	3,582	141	189
CLAY	36,927	4,653	7,016	277	369
CLEARWATER	6,200	782	1,179	47	62
COOK	3,199	403	608	24	32
COTTONWOOD	9,851	1,241	1,872	74	99
CROW WING	30,406	3,831	5,777	228	304
DAKOTA	145,940	18,388	27,729	1,095	1,459
DODGE	10,293	1,297	1,956	77	103
DOUGLAS	21,440	2,701	4,074	161	214
FARIBAULT	13,557	1,708	2,576	102	136

County	1985 Pop. Estimates Adult	Any Disorders		Chronic Mental Illness	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit
FILLMORE	15,364	1,936	2,919	115	154
FREEBORN	25,012	3,152	4,752	188	250
GOODHUE	28,072	3,537	5,334	211	281
GRANT	5,247	661	997	39	52
HENNEPIN	722,256	91,004	137,229	5,417	7,223
HOUSTON	13,207	1,664	2,509	99	132
HUBBARD	10,727	1,352	2,038	80	107
ISANTI	17,169	2,163	3,262	129	172
ITASCA	30,348	3,824	5,766	228	303
JACKSON	9,730	1,226	1,849	73	97
KANABEC	8,548	1,077	1,624	64	85
KANDIYOHI	28,680	3,614	5,449	215	287
KITTSON	4,904	618	932	37	49
KOOCHICHING	11,438	1,441	2,173	86	114
LAC QUI PARLE	7,520	948	1,429	56	75
LAKE	8,211	1,035	1,560	62	82
LAKE OF THE WOODS	2,767	349	526	21	28
LE SUEUR	16,190	2,040	3,076	121	162
LINCOLN	5,500	693	1,045	41	55
LYON	18,388	2,317	3,494	138	184
MCLEOD	21,102	2,659	4,009	158	211
MAHNOMEN	3,643	459	692	27	36
MARSHALL	8,703	1,097	1,654	65	87
MARTIN	17,666	2,226	3,357	132	177
MEEKER	14,667	1,848	2,787	110	147
MILLE LACS	12,827	1,616	2,437	96	128

County	1985 Pop. Estimates Adult	Any Disorders		Chronic Mental Illness	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit
MORRISON	19,704	2,483	3,744	148	197
MOWER	28,632	3,608	5,440	215	286
MURRAY	7,786	981	1,479	58	78
NICOLLET	20,225	2,548	3,843	152	202
NOBLES	15,421	1,943	2,930	116	154
NORMAN	6,566	827	1,248	49	66
OLMSTED	69,105	8,707	13,130	518	691
OTTER TAIL	39,785	5,013	7,559	298	398
PENNINGTON	9,811	1,236	1,864	74	98
PINE	14,483	1,825	2,752	109	145
PIPESTONE	8,093	1,020	1,538	61	81
POLK	24,155	3,044	4,589	181	242
POPE	8,490	1,070	1,613	64	85
RAMSEY	340,045	42,846	64,608	2,550	3,400
RED LAKE	3,437	433	653	26	34
REDWOOD	13,165	1,659	2,501	99	132
RENVILLE	13,772	1,735	2,617	103	138
RICE	33,949	4,278	6,450	255	339
ROCK	7,425	936	1,411	56	74
ROSEAU	9,362	1,180	1,779	70	94
ST. LOUIS	150,405	18,951	28,577	1,128	1,504
SCOTT	33,078	4,168	6,285	248	331
SHERBURNE	22,620	2,850	4,298	170	226
SIBLEY	11,006	1,387	2,091	83	110
STEARNS	79,410	10,006	15,088	596	794
STEELE	21,479	2,706	4,081	161	215

County	1985 Pop. Estimates	Any Disorders		Chronic Mental Illness	
	Adult	Lower Limit	Upper Limit	Lower Limit	Upper Limit
STEVENS	8,219	1,036	1,562	62	82
SWIFT	8,852	1,115	1,682	66	89
TODD	17,307	2,181	3,288	130	173
TRAVERSE	3,731	470	709	28	37
WABASHA	13,377	1,686	2,542	100	134
WADENA	9,500	1,197	1,805	71	95
WASECA	13,133	1,655	2,495	98	131
WASHINGTON	81,815	10,309	15,545	614	818
WATONWAN	8,583	1,081	1,631	64	86
WILKIN	5,842	736	1,110	44	58
WINONA	34,675	4,369	6,588	260	347
WRIGHT	40,804	5,141	7,753	306	408
YELLOW MEDICINE	9,308	1,173	1,769	70	93
TOTAL	2,982,434	375,787	566,662	22,368	29,824

Table 2: Six-Month Prevalence Estimates of DIS/DSM-III Disorders for Black Population Age 18 and Over

County	1985 Pop. Est.	Six-Month Prevalence Estimate: Any Disorder LL	Any Disorder UL	Schizophrenia LL	Schizophrenia UL	Affective Disorders LL	Affective Disorders UL	Personal. Disorders LL	Personal. Disorders UL	Cognitive Impairment LL	Cognitive Impairment UL	Phobia LL	Phobia UL
Anoka	255	32	48	1	3	11	16	1	3	2	3	13	34
B.Earth	105	13	20	0	1	5	7	0	1	1	1	5	14
Dakota	801	101	152	5	9	37	52	5	10	8	10	43	107
Hennepin	20594	2594	3912	123	247	947	1338	123	267	205	267	1112	2759
Olmsted	281	35	53	2	3	13	18	1	3	3	3	15	37
Pine	137	17	26	1	1	6	9	1	1	1	1	7	18
Ramsey	8970	1130	1704	53	107	412	583	54	116	89	116	484	1201
St.Louis	593	74	112	3	7	27	38	3	7	6	7	32	79
Sherburne	139	17	26	1	1	6	9	1	2	1	2	7	18
Stearns	117	14	22	0	1	5	7	1	1	1	1	6	15
Washington	469	59	89	3	5	21	30	2	6	4	6	25	63
Total	32461	4086	6164	192	385	1490	2107	192	418	321	417	1749	4345

Footnote: Computation procedure for 1985 population estimates, prevalence rates and prevalence estimates are described in the text of this document.
LL=Lower Limit
UL=Upper Limit

Table 3: Six-Month Prevalence Estimates of DIS/DSM-III Disordrs for Hispanic Population Age 18 and Over

County	1985 Pop. Est.	Six-Month Prevalence Estimate: Any Disorder LL	Any Disorder UL	Scizophrenia LL	Scizophrenia UL	Affective Disorders LL	Affective Disorders UL	Personal. Disorders LL	Personal. Disorders UL	Cognitive Impairment LL	Cognitive Impairment UL	Phobia LL	Phobia UL
Anoka	691	87	131	4	8	31	45	4	9	7	9	37	93
Blue Earth	210	26	40	1	2	9	13	1	2	2	2	11	28
Clay	283	35	53	1	3	13	18	1	3	3	3	15	38
Dakota	1158	146	220	7	14	53	75	7	15	11	15	62	155
Faribault	150	19	28	1	2	7	6	1	2	1	2	8	20
Freeborn	486	61	92	3	6	22	31	3	6	5	6	26	65
Hennepin	4948	623	940	29	59	227	321	29	49	29	6	267	663
Kandiyohi	115	14	21	0	1	5	7	0	1	0	1	6	15
Omstead	360	45	64	2	4	16	23	2	4	4	4	19	48
Polk	267	33	50	1	3	12	17	1	3	2	3	14	35
Ramsey	5276	664	1002	31	63	242	342	31	68	52	68	284	706
Rice	140	17	26	1	1	6	9	1	2	1	2	7	18
St. Louis	455	57	86	2	5	20	29	2	6	4	6	24	61
Scott	126	16	24	0	1	5	8	0	1	1	1	7	17
Stearns	250	31	47	1	3	11	16	1	3	2	3	13	33
Steele	140	18	27	1	1	6	9	1	2	1	2	8	19
Washington	615	77	117	3	7	28	40	3	8	6	8	33	82
Winona	130	16	24	0	1	6	8	0	1	1	1	7	17
Total	15806	1985	2992	88	184	729	1027	88	185	132	200	848	2113

Footnote: Computation procedure for 1985 population estimates prevalence rates and prevalence estimates are described in the text of the document.
LL= Lower Limit
UL= Upper Limit

Table 4: Six-Month Prevalence Estimates of DIS/DSM-III Disorders for American Indian Population Age 18 and Over

Six-Month Prevalence Estimate

County	1985 Pop. Est.	Any Disorder LL	Any Disorder UL	Schizophrenia LL	Schizophrenia UL	Affective Disorders LL	Affective Disorders UL	Person. Disorders LL	Person. Disorders UL	Cognitive Impairment LL	Cognitive Impairment UL	Phobia LL	Phobia UL
Anoka	601	75	114	3	7	27	39	3	8	6	8	32	74
Becker	963	121	183	5	11	44	62	5	13	9	13	52	129
Beltrami	2060	259	391	12	24	94	134	12	26	20	26	111	276
Carlton	447	56	85	2	5	20	29	2	5	4	5	24	60
Cass	1026	129	195	6	12	47	67	6	13	10	13	55	137
Clearwater	306	38	58	2	4	14	20	2	4	3	4	16	41
Cook	189	24	36	1	2	8	12	1	2	2	2	10	25
Dakota	260	32	49	1	3	12	17	1	3	2	3	14	35
Hennepin	5853	737	1112	35	70	269	380	35	76	58	76	316	784
Hubbard	126	16	24	0	1	5	8	0	1	1	1	7	17
Itasca	578	73	110	3	7	26	37	3	7	5	7	31	77
Koochiching	188	23	35	1	2	8	12	1	2	2	2	10	25
Mahnomen	563	71	107	3	6	26	36	3	7	5	7	30	75
Mille Lacs	272	34	51	1	3	12	17	1	3	2	3	14	36
Pine	157	19	30	1	2	7	10	1	2	1	2	8	21
Polk	138	17	26	1	1	6	9	1	1	1	1	7	18
Ramsey	1635	206	310	9	19	75	106	9	21	16	21	88	219
St.Louis	1541	194	292	9	18	71	100	9	20	15	20	83	206
Washington	236	29	45	1	3	11	15	1	3	2	3	12	31
Total	17137	1969	3545	96	200	746	1110	96	217	165	217	920	2237

Footnote: Computation procedure for 1985 population estimates, prevalence rates and prevalence estimates are described in the text of this document.

PREVALENCE ESTIMATES OF CHILDHOOD MALADJUSTMENT

The definition of "psychiatric disorder" for children lacks precision and comparability. The concept of childhood maladjustment is used here for a broad range of clinical phenomena including "problem children" and "emotionally disturbed children" as well as children described as "most seriously maladjusted." The prevalence rates of childhood maladjustment given below are based upon several studies conducted from 1928 to 1975 . These studies are characterized by heterogeneity of both method and concept. However, there is surprisingly little difference in the average rates reported by investigators. Based on a review of these studies which use a multimethod, multistage approach Gould, Wunsch-Hitzig and Dohrenwend in the book Mental Illness in the United States - Epidemiological Estimates (1980) estimate the rates of childhood maladjustment to be:

	Median	Range
Both Sexes	16.5%	6.8% - 25.4%
Males	15.7%	13.0% - 18.3%
Females	18.5%	10.8% - 26.2%

Table 5 gives the prevalence estimates of childhood maladjustment for county population. These estimates are based on the range of prevalence rates described above for male and female children.

Table 5: **Estimates of Childhood Maladjustment for County Population Age 17 and Under**

County	Children 1985 Pop. Est.		Childhood Maladjustment			
			Male		Female	
	Male	Female	Lower Limit	Upper Limit	Lower Limit	Upper Limit
AITKIN	1,936	1,785	252	354	193	468
ANOKA	39,109	37,364	5,084	7,157	4,035	9,789
BECKER	5,135	4,712	668	940	509	1,235
BELTRAMI	5,045	4,831	656	923	522	1,266
BENTON	4,507	4,340	586	825	469	1,137
BIG STONE	1,082	1,090	141	198	118	285
BLUE EARTH	6,773	6,435	880	1,239	695	1,686
BROWN	4,218	3,889	548	772	420	1,019
CARLTON	4,587	4,255	596	839	460	1,115
CARVER	6,766	6,371	880	1,238	688	1,669
CASS	3,091	3,083	402	566	333	808
CHIPPEWA	2,139	2,036	278	391	220	533
CHISAGO	4,955	4,558	644	907	492	1,194
CLAY	6,544	6,299	851	1,198	680	1,650
CLEARWATER	1,516	1,387	197	277	150	363
COOK	591	547	77	108	59	143
COTTONWOOD	2,018	1,960	262	369	212	513
CROW WING	6,299	6,185	819	1,153	668	1,621
DAKOTA	37,972	36,983	4,936	6,949	3,994	9,690
DODGE	2,493	2,475	324	456	267	648

County	Children 1985 Pop. Est.		Childhood Maladjustment			
			Male		Female	
	Male	Female	Lower Limit	Upper Limit	Lower Limit	Upper Limit
DOUGLAS	4,269	4,190	555	781	452	1,098
FARIBAULT	2,684	2,488	349	491	269	652
FILLMORE	3,300	2,959	429	604	320	775
FREEBORN	5,074	4,863	660	928	525	1,274
GOODHUE	6,156	5,761	800	1,127	622	1,509
GRANT	977	954	127	179	103	250
HENNEPIN	121,280	116,703	15,766	22,194	12,604	30,576
HOUSTON	2,937	2,845	382	537	307	745
HUBBARD	2,318	2,308	301	424	249	605
ISANTI	4,588	4,321	596	840	467	1,132
ITASCA	7,158	6,640	930	1,310	717	1,740
JACKSON	1,923	1,805	250	352	195	473
KANABEC	2,053	1,997	267	376	216	523
KANDIYOHI	5,753	5,455	748	1,053	589	1,429
KITTSON	950	898	124	174	97	235
KOOCHICHING	2,653	2,514	345	485	271	659
LAC QUI PARLE	1,420	1,398	185	260	151	366
LAKE	1,736	1,635	226	318	177	428
LAKE OF THE WOODS	602	519	78	110	56	136
LE SUEUR	3,883	3,690	505	711	399	967
LINCOLN	1,171	1,135	152	214	123	297
LYON	3,942	3,533	512	721	382	926
MCLEOD	4,758	4,420	619	871	477	1,158
MAHNOMEN	1,000	975	130	183	105	256
MARSHALL	2,157	1,945	280	395	210	510

County	Children 1985 Pop. Est.		Childhood Maladjustment			
			Male		Female	
	Male	Female	Lower Limit	Upper Limit	Lower Limit	Upper Limit
MARTIN	3,489	3,236	454	638	349	848
MEEKER	3,292	3,170	428,	603	342	831
MILLE LACS	3,097	2,691	403	567	291	705
MORRISON	5,288	5,110	687	968	552	1,339
MOWER	5,609	5,342	729	1,026	577	1,400
MURRAY	1,770	1,675	230	324	181	439
NICOLLET	4,083	3,886	531	747	420	1,018
NOBLES	3,234	3,098	420	592	335	812
NORMAN	1,349	1,286	175	247	139	337
OLMSTED	14,804	14,170	1,924	2,709	1,530	3,713
OTTER TAIL	7,926	7,343	1,030	1,450	793	1,924
PENNINGTON	2,097	1,977	273	384	214	518
PINE	3,360	3,121	437	615	337	818
PIPESTONE	1,608	1,603	209	294	173	420
POLK	5,177	4,850	673	947	524	1,271
POPE	1,683	1,612	219	308	174	422
RAMSEY	61,685	58,974	8,019	11,288	6,369	15,451
RED LAKE	843	869	110	154	94	228
REDWOOD	2,831	2,726	368	518	294	714
RENVILLE	2,933	2,758	381	537	298	723
RICE	6,878	6,597	894	1,259	712	1,728
ROCK	1,585	1,586	206	290	171	416
ROSEAU	2,232	2,048	290	408	221	537
ST. LOUIS	28,630	27,194	3,722	5,239	2,937	7,125

County	Children 1985 Pop. Est.		Childhood Maladjustment			
	Male	Female	Male		Female	
			Lower Limit	Upper Limit	Lower Limit	Upper Limit
SCOTT	9,377	8,729	1,219	1,716	943	2,287
SHERBURNE	6,120	5,953	796	1,120	643	1,560
SIBLEY	2,360	2,329	307	432	251	610
STEARNS	18,333	17,124	2,383	3,355	1,849	4,486
STEELE	4,660	4,492	606	853	485	1,177
STEVENS	1,560	1,487	203	286	161	389
SWIFT	1,943	1,841	253	356	199	482
TODD	4,255	4,079	553	779	441	1,069
TRAVERSE	739	717	96	135	77	188
WABASHA	3,031	2,888	394	555	312	757
WADENA	2,202	2,177	286	403	235	570
WASECA	2,916	2,676	379	534	289	701
WASHINGTON	22,440	21,240	2,917	4,107	2,294	5,565
WATONWAN	1,655	1,567	215	303	169	411
WILKIN	1,322	1,189	172	242	128	311
WINONA	6,338	5,983	824	1,160	646	1,568
WRIGHT	11,414	11,040	1,484	2,089	1,192	2,892
YELLOW MEDICINE	1,840	1,644	239	337	178	431
TOTAL	619,505	590,608	80,536	113,369	63,786	154,739

DRAFT-7/11/88

PER CAPITA EXPENDITURES FOR 1989 MH SERVICES FROM COUNTY PLANS

COUNTY	TOTAL	EDUC & PREVENT.	EMERGENCY	OUTPATIENT	CASE MANAGE	CSP	RULE 5 & RULE 36	ACUTE HOSP	RTC	ALL OTHER
ANOKA RTC										
ANOKA	$12.96	$0.05	$0.70	$1.80	$0.83	$2.10	$6.19	$0.35	$0.93	$0.00
DAKOTA	$16.34	$0.08	$1.28	$4.41	$2.19	$2.29	$4.55	$0.72	$0.25	$0.57
HENNEPIN	$29.85	$0.10	$0.43	$6.11	$1.90	$2.83	$12.68	$0.05	$1.24	$4.51
RAMSEY	$32.56	$0.19	$1.19	$4.78	$2.81	$5.81	$13.68	$1.86	$1.48	$0.74
SHERBURNE	$12.77	$0.06	$0.28	$3.91	$1.53	$1.96	$1.24	$0.82	$1.16	$1.82
WASHINGTON	$17.84	$0.09	$0.69	$3.61	$1.58	$2.53	$4.55	$0.23	$0.68	$3.87
TOTAL/AVG	$20.39	$0.10	$0.76	$4.11	$1.81	$2.92	$7.15	$0.67	$0.96	$1.92
BRAINERD RTC										
AITKIN	$19.43	$0.22	$0.97	$4.47	$1.71	$1.97	$6.72	$1.13	$1.84	$0.39
BELTRAMI	$29.04	$0.19	$0.36	$4.15	$1.99	$4.99	$10.94	$1.22	$2.09	$3.11
BENTON	$13.17	$0.05	$0.11	$2.30	$0.58	$2.35	$4.75	$0.91	$1.64	$0.48
CASS	$18.01	$0.09	$0.38	$4.23	$3.04	$1.97	$4.65	$0.09	$2.66	$0.91
CLEARWATER	$17.52	$0.17	$0.22	$3.22	$3.89	$2.19	$5.59	$0.67	$1.00	$0.58
CROW WING	$27.45	$0.11	$0.28	$4.02	$2.76	$3.45	$10.34	$0.11	$5.06	$1.31
HUBBARD	$13.92	$0.29	$0.45	$2.90	$1.48	$3.61	$1.74	$1.03	$1.33	$1.09
LAKE OF WOODS	$7.97	$0.15	$0.31	$4.31	$0.46	$0.08	$0.44	$0.10	$2.05	$0.06
MORRISON	$21.68	$0.17	$0.23	$4.16	$0.89	$4.10	$9.51	$0.13	$1.57	$0.91
TODD	$13.11	$0.08	$0.04	$6.09	$1.18	$0.98	$2.95	$0.43	$0.97	$0.39
WADENA	$22.51	$0.39	$0.18	$3.01	$1.82	$3.29	$12.72	$0.36	$0.29	$0.43
TOTAL/AVG	$18.53	$0.18	$0.32	$3.90	$1.80	$2.64	$6.40	$0.56	$1.87	$0.88
FERGUS FALLS RTC										
BECKER	$15.31	$0.13	$0.13	$5.97	$0.96	$1.00	$4.86	$0.58	$1.60	$0.08
CLAY	$20.35	$0.05	$0.16	$5.20	$0.70	$1.23	$10.89	$0.41	$1.51	$0.19
DOUGLAS	$12.70	$0.10	$0.67	$3.14	$0.83	$1.24	$5.68	$0.13	$0.81	$0.10
GRANT	$15.01	$0.71	$0.13	$4.41	$0.92	$3.26	$1.03	$0.00	$0.89	$3.65
KITTSON	$15.56	$0.15	$0.46	$1.29	$2.32	$4.56	$4.74	$1.21	$0.53	$0.30
MAHNOMEN	$15.82	$0.18	$0.27	$3.60	$1.02	$5.19	$3.24	$0.36	$1.62	$0.36
MARSHALL	$12.96	$0.24	$1.43	$0.91	$0.32	$0.96	$6.28	$1.29	$1.03	$0.51
NORMAN	$23.73	$0.55	$0.55	$6.07	$2.21	$3.09	$5.08	$2.21	$2.87	$1.10
OTTER TAIL	$18.77	$0.09	$0.16	$5.55	$0.55	$1.62	$8.19	$0.13	$1.88	$0.60
PENNINGTON	$31.53	$0.53	$0.37	$2.16	$0.70	$1.49	$13.35	$6.46	$1.42	$5.06
POLK	$24.53	$0.06	$0.28	$4.41	$0.88	$3.34	$12.83	$0.81	$1.58	$0.34
POPE	$12.36	$0.19	$0.10	$4.02	$1.03	$1.71	$3.25	$0.62	$0.72	$0.73
RED LAKE	$16.86	$0.08	$0.39	$1.07	$1.42	$5.40	$5.07	$1.46	$1.48	$0.49
ROSEAU	$8.08	$0.13	$0.29	$1.46	$0.73	$1.46	$1.53	$1.31	$0.80	$0.38
STEVENS	$26.14	$0.09	$0.07	$0.90	$2.70	$2.77	$14.92	$1.08	$1.98	$1.64
TRAVERSE	$35.41	$0.29	$0.00	$2.95	$1.77	$5.40	$16.90	$0.44	$3.34	$4.31
WILKIN	$22.63	$0.31	$0.18	$7.36	$1.04	$3.42	$3.68	$3.68	$2.68	$0.29
TOTAL/AVG	$19.28	$0.23	$0.33	$3.56	$1.18	$2.77	$7.15	$1.30	$1.57	$1.18

DRAFT-7/11/88

PER CAPITA EXPENDITURES FOR 1989 MH SERVICES FROM COUNTY PLANS

COUNTY	TOTAL	EDUC & PREVENT.	EMERGENCY	OUTPATIENT	CASE MANAGE	CSP	RULE 5 & RULE 36	ACUTE HOSP	RTC	ALL OTHER
MOOSE LAKE RTC										
CARLTON	$21.30	$0.51	$0.70	$5.10	$1.40	$2.15	$8.61	$0.18	$2.09	$0.56
CHISAGO	$14.52	$0.07	$0.12	$3.80	$0.35	$1.20	$4.05	$4.01	$0.36	$0.56
COOK	$25.90	$0.83	$0.84	$9.23	$4.93	$7.38	$0.10	$1.78	$0.63	$0.18
ISANTI	$12.93	$0.08	$0.40	$6.08	$0.76	$1.14	$3.00	$0.19	$0.46	$0.82
ITASCA	$16.75	$0.18	$0.84	($0.00)	$3.41	$6.79	$3.88	($0.00)	$1.19	$0.46
KANABEC	$18.85	$0.20	$0.12	$4.91	$0.79	$3.80	$5.83	$0.48	$1.98	$0.75
KOOCHICHING	$27.35	$0.31	$0.61	$5.08	$4.46	$1.98	$10.09	$0.50	$1.55	$2.78
LAKE	$16.02	$1.09	$0.82	$6.13	$1.10	$2.71	$4.09	$0.00	$0.06	$0.02
MILLE LACS	$17.20	$0.32	$0.27	$3.70	$2.01	$1.71	$6.75	$0.16	$1.88	$0.40
PINE	$22.66	$0.05	$0.10	$5.19	$1.91	$1.75	$10.98	$0.19	$2.06	$0.42
ST LOUIS	$26.27	$0.16	$0.25	$3.63	$3.50	$2.80	$12.93	$0.31	$2.22	$0.49
TOTAL/AVG	$19.98	$0.34	$0.46	$4.80	$2.24	$3.04	$6.39	$0.71	$1.32	$0.68
ST. PETER RTC										
BLUE EARTH	$17.41	$0.30	$0.54	$2.98	$1.71	$3.36	$5.37	$0.27	$2.43	$0.45
BROWN	$19.95	$0.29	$0.12	$4.28	$2.50	$1.89	$8.21	$0.43	$1.52	$0.71
DODGE	$11.83	$0.10	$0.04	$3.74	$2.38	$1.46	$3.26	$0.33	$0.39	$0.13
FILLMORE	$10.07	$0.07	$0.23	$2.80	$0.84	$1.55	$2.20	$0.66	$0.86	$0.86
FMW	$16.39	$0.08	$0.02	$3.13	$1.65	$3.06	$5.09	$0.94	$2.04	$0.39
FREEBORN	$27.20	$0.12	$0.16	$8.95	$1.17	$1.56	$11.42	$0.91	$1.23	$1.68
GOODHUE	$30.52	$0.13	$2.01	$13.57	$0.97	$5.08	$6.77	$0.00	$1.18	$0.80
HOUSTON	$14.28	$0.10	$0.21	$5.03	$1.21	$3.51	$2.64	$0.84	$0.58	$0.16
LE SUEUR	$11.57	$0.25	$0.21	$2.40	$0.85	$0.85	$4.88	$0.42	$1.56	$0.14
MOWER	$31.38	$0.15	$0.25	$8.56	$1.02	$5.41	$12.23	$2.17	$1.12	$0.46
NICOLLET	$14.00	$0.57	$0.35	$3.01	$1.59	$1.77	$4.24	$0.32	$1.70	$0.46
OLMSTED	$23.81	$0.45	$2.50	$3.21	$2.26	$2.45	$5.49	$0.11	$1.94	$5.40
RICE	$13.97	$0.04	$0.42	$3.26	$0.67	$0.97	$7.25	$0.29	$0.69	$0.38
STEELE	$21.01	$0.08	$0.11	$4.59	$1.34	$0.52	$11.59	$0.37	$1.11	$1.32
WABASHA	$15.08	$0.10	$0.16	$3.62	$0.88	$3.13	$5.98	$0.47	$0.57	$0.18
WASECA	$15.80	$0.09	$0.12	$3.45	$1.55	$0.27	$4.84	$0.28	$1.31	$3.90
WINONA	$21.20	$0.05	$0.43	$2.78	$3.02	$1.73	$10.68	$0.21	$1.11	$1.19
TOTAL/AVG	$18.56	$0.17	$0.46	$4.67	$1.51	$2.27	$6.60	$0.53	$1.25	$1.10

DRAFT-7/11/88

PER CAPITA EXPENDITURES FOR 1989 MH SERVICES FROM COUNTY PLANS

COUNTY	TOTAL	EDUC & PREVENT.	EMERGENCY	OUTPATIENT	CASE MANAGE	CSP	RULE 5 & RULE 36	ACUTE HOSP	RTC	ALL OTHER
WILLMAR RTC										
BIG STONE	$22.25	$0.13	$0.52	$3.22	$3.35	$3.95	$9.31	$0.41	$1.03	$0.32
CARVER	$20.62	$0.44	$0.38	$7.75	$1.19	$2.16	$7.71	$0.24	$0.55	$0.19
CHIPPEWA	$28.47	$0.21	$0.65	$8.93	$2.88	$4.81	$8.24	$0.14	$2.10	$0.51
COTTONWOOD	$22.32	$0.39	$0.20	$6.53	$1.02	$2.93	$8.29	$0.24	$2.49	$0.23
JACKSON	$14.77	$0.46	$0.30	$1.37	$0.76	$1.79	$7.40	$0.45	$0.45	$1.78
KANDIYOHI	$38.75	$1.65	$0.64	$7.02	$1.25	$6.32	$15.30	$0.35	$4.91	$1.30
LAC QUI PARLE	$14.78	$0.70	$1.44	$4.83	$1.25	$2.75	$1.18	$0.30	$2.13	$0.20
MCLEOD	$13.09	$0.16	$0.56	$5.10	$0.99	$0.53	$3.22	$0.66	$1.58	$0.30
MEEKER	$28.93	$1.34	$0.65	$3.81	$1.94	$4.26	$11.71	$1.18	$3.53	$0.50
NOBLES	$27.96	$0.37	$0.19	$7.03	$1.75	$2.72	$12.23	$1.64	$1.78	$0.26
PIPESTONE	$16.52	$0.38	$0.20	$6.29	$0.99	$2.53	$5.44	$0.36	$0.22	$0.13
REDWOOD	$21.47	$0.27	$1.36	$5.64	$1.08	$2.17	$6.61	$0.98	$2.81	$0.54
REGION 8 NORTH	$22.21	$0.34	$0.39	$4.83	$1.71	$3.66	$7.35	$1.02	$2.46	$0.45
RENVILLE	$24.44	$1.51	$0.73	$4.58	$2.19	$3.80	$8.58	$0.19	$2.45	$0.42
ROCK	$17.93	$0.39	$0.15	$5.77	$0.96	$2.66	$6.30	$0.27	$1.27	$0.13
SCOTT	$16.04	$0.09	$0.43	$6.03	$1.57	$1.51	$4.65	$0.80	$0.72	$0.24
SIBLEY	$15.84	$0.39	$0.65	$4.27	$0.78	$1.85	$4.79	$0.78	$0.99	$1.36
STEARNS	$11.23	$0.03	$0.10	$3.20	$0.62	$2.28	$2.20	$0.43	$1.97	$0.40
SWIFT	$23.61	$1.27	$1.27	$7.91	$2.25	$4.12	$4.86	$0.24	$1.29	$0.41
WRIGHT	$9.08	$0.11	$0.09	$2.02	$0.62	$1.40	$3.32	$0.00	$1.13	$0.39
YELLOW MEDICINE	$20.31	$0.30	$0.34	$4.11	$0.63	$2.56	$9.07	$0.95	$1.42	$0.95
TOTAL/AVG	$20.51	$0.52	$0.53	$5.25	$1.42	$2.89	$7.04	$0.55	$1.78	$0.52
STATE TOTAL/AVG	$19.51	$0.29	$0.46	$4.46	$1.58	$2.73	$6.81	$0.73	$1.52	$0.94

DRAFT-7/11/88

PLANNED SERVICE USE PER 10,000 POPULATION FOR 1989 FROM MENTAL HEALTH PLANS

COUNTY	COUNTY POPULATION	EMERGENCY CONTACTS PER 10,000 POP	OUTPATIENT CLIENTS PER 10,000 POP	RULE 36 ADULTS PER 10,000 POP	RULE 5 CHILD. PER 10,000 POP	ACUTE HOSP ADULTS PER 10,000 POP	ACUTE HOSP CHILD. PER 10,000 POP	RTC ADULTS PER 10,000 POP	RTC CHILD. PER 10,000 POP
ANOKA RTC									
ANOKA	219,230	172.8	74.6	5.7	8.9	13.3	3.5	2.7	0.0
DAKOTA	228,716	191.5	99.7	6.6	1.1	7.9	1.7	2.3	0.2
HENNEPIN	967,455	807.9	160.2	10.4	4.3	15.5	2.4	5.2	0.1
RAMSEY	465,287	743.6	168.1	18.2	21.5	0.0	2.9	5.7	0.2
SHERBURNE	35,781	17.0	257.1	2.8	1.7	10.6	2.8	4.5	2.2
WASHINGTON	127,912	45.0	159.1	4.9	1.8	6.4	1.3	3.0	0.3
TOTAL/AVG	2,044,381	329.7	153.1	8.1	6.6	9.0	2.4	3.9	0.5
BRAINERD RTC									
AITKIN	13,421	171.4	69.3	2.2	2.2	7.5	1.5	11.9	0.7
BELTRAMI	33,720	62.3	188.0	5.9	2.1	1.8	1.2	14.5	1.5
BENTON	27,455	32.8	80.9	4.4	2.9	5.8	2.9	10.9	1.1
CASS	21,300	14.1	183.1	7.0	1.4	11.7	0.9	17.8	0.9
CLEARWATER	9,018	4.4	108.7	2.2	3.3	8.9	4.4	13.3	3.3
CROW WING	43,508	27.6	149.4	6.2	0.7	20.7	9.2	27.6	4.6
HUBBARD	15,529	64.4	39.9	3.2	0.0	7.7	0.6	7.7	0.6
LAKE OF WOODS	3,895	0.0	77.0	2.6	2.6	2.6	2.6	15.4	2.6
MORRISON	30,228	113.5	253.7	3.0	2.6	4.6	4.6	9.3	2.6
TODD	25,456	4.7	174.8	4.3	0.4	2.7	1.2	4.3	0.8
WADENA	13,748	36.4	87.3	14.5	0.7	21.8	4.4	8.7	0.0
TOTAL/AVG	237,278	48.3	128.4	5.1	1.7	8.7	3.0	12.9	1.7
FERGUS FALLS RTC									
BECKER	31,258	64.0	192.0	1.6	0.6	2.6	0.0	22.4	1.3
CLAY	49,256	23.3	183.5	4.1	6.1	15.8	1.0	13.4	0.4
DOUGLAS	29,953	50.1	140.2	9.7	2.7	12.0	6.7	10.0	0.0
GRANT	7,055	14.2	153.1	2.8	1.4	5.7	1.4	7.1	0.0
KITTSON	6,589	151.8	45.5	3.0	1.5	6.1	3.0	7.6	0.0
MAHNOMEN	5,561	64.7	143.9	3.6	5.4	7.2	7.2	21.6	1.8
MARSHALL	12,675	86.8	29.2	1.6	3.9	5.5	0.8	7.9	0.0
NORMAN	9,062	55.2	82.8	5.5	2.2	8.8	4.4	16.6	1.1
OTTER TAIL	54,970	91.0	196.1	4.7	1.1	1.8	0.9	20.0	0.7
PENNINGTON	13,683	657.8	62.1	3.7	0.7	83.3	21.9	9.5	0.0
POLK	34,102	26.4	132.0	5.0	2.6	17.6	1.5	11.7	1.2
POPE	11,698	42.7	128.2	4.3	1.7	4.3	0.9	3.4	0.9
RED LAKE	5,062	49.4	35.6	5.9	2.0	7.9	2.0	11.9	2.0
ROSEAU	13,736	72.8	29.1	1.5	0.7	5.8	0.7	7.3	0.0
STEVENS	11,128	35.9	71.9	9.0	1.8	18.0	3.6	18.0	0.9
TRAVERSE	5,088	39.3	29.5	3.9	2.0	3.9	2.0	15.7	0.0
WILKIN	8,157	63.7	91.9	6.1	3.7	4.9	2.5	15.9	2.5
TOTAL/AVG	309,033	93.5	102.7	4.5	2.4	12.4	3.6	12.9	0.7

DRAFT-7/11/88

PLANNED SERVICE USE PER 10,000 POPULATION FOR 1989 FROM MENTAL HEALTH PLANS

COUNTY	COUNTY POPULATION	EMERGENCY CONTACTS PER 10,000 POP	OUTPATIENT CLIENTS PER 10,000 POP	RULE 36 ADULTS PER 10,000 POP	RULE 5 CHILD. PER 10,000 POP	ACUTE HOSP ADULTS PER 10,000 POP	ACUTE HOSP CHILD. PER 10,000 POP	RTC ADULTS PER 10,000 POP	RTC CHILD. PER 10,000 POP
MOOSE LAKE RTC									
CARLTON	28,541	105.1	227.7	9.8	0.7	3.5	2.1	15.1	0.4
CHISAGO	28,668	39.1	26.2	3.1	2.1	3.5	2.1	4.2	0.3
COOK	4,350	275.9	827.6	4.6	4.6	4.6	9.2	11.5	0.0
ISANTI	26,299	9.5	456.3	1.9	5.7	1.5	0.8	7.6	0.8
ITASCA	43,914	400.8	45.5	7.3	0.9	12.3	1.6	5.5	0.0
KANABEC	12,630	7.9	133.0	5.5	1.6	5.5	4.8	11.1	1.6
KOOCHICHING	16,155	128.8	53.2	6.8	4.3	11.1	0.6	15.5	0.0
LAKE	11,425	45.5	192.6	0.9	0.9	13.1	2.6	1.8	0.0
MILLE LACS	18,671	27.9	160.7	4.3	3.2	10.7	2.1	9.6	1.1
PINE	20,900	12.0	124.4	4.8	1.0	5.7	1.4	12.0	2.4
ST LOUIS	203,069	41.9	246.2	5.2	2.0	18.7	3.2	9.4	0.3
TOTAL/AVG	414,622	99.5	226.7	4.9	2.4	8.2	2.8	9.4	0.6
ST. PETER RTC									
BLUE EARTH	52,768	663.3	180.4	3.0	2.3	6.6	0.0	11.6	0.2
BROWN	28,015	53.5	133.9	3.6	2.5	7.1	0.7	7.9	0.7
DODGE	15,210	3.9	197.2	9.2	1.3	0.7	0.7	5.9	1.3
FILLMORE	21,443	28.0	63.0	15.4	2.3	8.9	1.4	4.7	0.5
FMW	54,141	3.9	67.2	3.7	1.7	6.5	1.5	7.4	0.6
FREEBORN	34,587	17.3	172.3	4.9	4.0	7.2	1.4	4.6	0.0
GOODHUE	40,075	56.1	239.6	8.2	7.5	3.5	0.7	5.2	0.2
HOUSTON	19,072	220.2	209.7	10.5	1.0	5.2	9.4	7.9	1.0
LE SUEUR	23,607	44.1	403.3	5.5	1.3	8.5	4.2	16.1	1.7
MOWER	39,243	254.8	254.8	9.4	6.9	10.2	2.5	7.6	0.0
NICOLLET	28,278	0.0	212.2	3.5	5.3	2.8	1.8	5.3	0.0
OLMSTED	98,850	186.6	253.2	14.9	0.0	11.1	0.5	8.8	0.2
RICE	47,599	0.0	45.2	3.4	2.1	1.7	0.6	4.8	0.2
STEELE	30,726	9.8	260.4	15.0	1.6	6.5	2.6	10.1	0.7
WABASHA	19,352	25.8	180.9	3.1	2.6	2.6	1.6	3.1	1.0
WASECA	18,644	2.1	182.4	4.3	2.1	7.5	2.1	5.4	1.1
WINONA	46,795	42.7	235.1	11.1	7.1	25.6	2.1	6.8	0.6
TOTAL/AVG	618,405	94.8	193.6	7.6	3.0	7.2	2.0	7.2	0.6

DRAFT-7/11/88

PLANNED SERVICE USE PER 10,000 POPULATION FOR 1989 FROM MENTAL HEALTH PLANS

COUNTY	COUNTY POPULATION	EMERGENCY CONTACTS PER 10,000 POP	OUTPATIENT CLIENTS PER 10,000 POP	RULE 36 ADULTS PER 10,000 POP	RULE 5 CHILD. PER 10,000 POP	ACUTE HOSP ADULTS PER 10,000 POP	ACUTE HOSP CHILD. PER 10,000 POP	RTC ADULTS PER 10,000 POP	RTC CHILD. PER 10,000 POP
WILLMAR RTC									
BIG STONE	7,760	38.7	54.1	9.0	1.3	11.6	1.3	11.6	0.0
CARVER	41,586	86.6	158.7	3.6	8.4	5.8	2.6	4.8	0.2
CHIPPEWA	14,560	92.7	278.2	13.0	4.8	10.3	2.1	8.9	1.4
COTTONWOOD	13,640	448.7	203.8	12.5	7.3	11.7	3.7	8.8	0.7
JACKSON	13,239	9.1	56.7	2.3	3.8	7.6	0.8	0.8	0.0
KANDIYOHI	39,879	1363.1	234.5	38.9	20.8	17.6	3.0	51.2	0.8
LAC QUI PARLE	10,129	69.1	143.2	9.9	3.9	2.0	2.0	9.9	0.0
MCLEOD	30,415	184.1	139.7	2.0	1.0	11.5	3.3	14.5	0.7
MEEKER	21,110	379.0	293.7	23.7	21.3	3.8	1.4	15.6	2.8
NOBLES	21,395	738.5	144.9	16.4	2.8	13.6	2.8	7.0	0.5
PIPESTONE	11,155	237.6	197.2	7.2	2.7	8.1	2.7	1.8	0.9
REDWOOD	18,443	35.2	204.4	2.7	2.2	10.8	2.2	13.6	1.1
REGION 8 NORTH	44,242	40.2	182.2	4.1	2.0	9.0	1.8	10.2	0.0
RENVILLE	19,213	338.3	234.2	18.2	12.5	0.0	0.0	10.4	2.1
ROCK	10,442	507.6	181.0	7.7	3.8	7.7	1.0	4.8	0.0
SCOTT	52,255	5.7	200.9	4.6	3.8	4.6	0.8	3.1	0.0
SIBLEY	15,461	7.8	200.5	3.9	2.6	2.6	1.3	7.8	0.0
STEARNS	115,786	34.5	229.7	3.5	0.7	7.3	2.0	11.2	1.2
SWIFT	12,445	128.6	401.8	9.6	6.4	3.2	1.6	8.8	0.8
WRIGHT	64,455	16.1	153.6	1.2	2.6	7.8	2.8	7.8	1.2
YELLOW MEDICINE	12,684	24.4	197.1	2.4	2.4	1.6	1.6	11.0	0.0
TOTAL/AVG	590,294	227.9	194.8	9.3	5.6	7.5	1.9	10.6	0.7
STATE TOTAL/AVG	4,214,013	139.6	168.1	6.7	3.5	8.8	2.6	10.1	0.8

MASTER CHECKLISTS

Systems Monitoring I, Checklist for Mandated County Services

Systems Monitoring II, Checklist for a Complete or Ideal Service System

Systems Monitoring III, Consumer Survey

Systems Monitoring IV, Residential Treatment/Housing Checklist

Systems Monitoring V, Vocational/Social Services

Agency/Program Checklist I

Agency/Program Checklist II, Observing in Institutions

These lists may be reproduced for use in monitoring interviews.

Systems Monitoring I

CHECKLIST FOR MANDATED COUNTY SERVICES

(To be filled out after interviews with county human services staff and/or contracted agencies.)

For each topic there is a section on what the law mandates counties to provide and an additional section listing services which are important but not mandated by law.

County

Names, addresses and phone numbers of Reporters

Organizations involved in monitoring

Name(s) of Person(s) Interviewed (Please also include titles and addresses)

Date(s) of interview(s)

Local Mental Health Advisory Council

Get a list of advisory council members. If possible, talk to the chair or a council member.

Mandated :

1. Do the council members reflect "a broad range of community interests"?

Yes No

If no, please specify.

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 responsibilitiies?

Yes No

If no, please specify.

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

Yes No

Comments:

6. Are barriers cited 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 (if it is for one county) and at least six members (for a multicounty advisory council)?

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, please comment.

5. Does the council review the long-range priorities for county mental health programs?

Yes No

--If so, does it provide feedback?

Yes No

6. How often does the council meet?

-Is this sufficient to participate actively in the planning process?

Yes No

7. Is attendance good at MHAC meetings?

Yes No

--Do most of the members actively participate?

Yes No

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

Yes No

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

Yes No

10. Do council members understand "maintenance of effort"?

Yes No

11. Does the advisory council have a process for communicating with interested citizens?

Yes No

12. Does the advisory council respond to requests from advocacy groups, consumers, interested citizens?

Yes No

Comments:

Education and Prevention Services

Mandated :

1. Is the county providing services designed to educate the general public about mental illness?

Yes No

If yes, please specify.

--to increase people's awareness of the availability of resources and services?

Yes No

If yes, please specify.

-- to improve people's skills in dealing with high-risk situations known to affect people's mental health and functioning?

Yes No

2. Is the county providing services to educate special high-risk target populations about mental illness?

Yes No

If yes, please specify.

3. How many workshops/seminars/classes are provided?

--How many people participated?

--Were newsletters provided?

Yes No

4. Did the county initiate any media activities (radio, newspaper or television)?

Yes No

5. Did the county develop brochures to inform the public?

Yes No

--If yes, how were these distributed?

6. How did the public know education and prevention services were available?

--Were the activities advertised?

Comments:

Does the county report barriers to implementing education and prevention services?

Yes No

--If so, what are they?

Important but not Mandated :

1. Is there evidence that the county is actively cooperating with local advocacy groups in education and prevention?

Yes No

Describe:

2. Is there evidence of county involvement in education efforts with civic groups?

Yes No

--with the clergy?

Yes No

--with other specific groups?

Yes No

--If yes, please specify.

3. Are relatively inexpensive, simple methods being tried? (phone stickers or pencils with emergency numbers, for instance)

Yes No

--Please specify.

4. Does the county newsletter, if any, devote space to education about mental illness?

Yes No

5. How much money did the county spend on education and prevention activities?

6. What proportion of the general public do they believe was reached by these activities?

High Risk Groups

Each county identified up to three high risk groups to be served July 1,. 1988-December 31, 1988.

1. How were these high risk groups being served?

Three additional high risk groups were identified to be served from January 1, 1989 - December 31, 1989.

2. How were these high risk groups served?

24 Hour Emergency Service

Mandated :

1. Is the county providing an immediate response service available on a 24-hour, seven day a week basis for persons having psychiatric crisis or emergency?

Yes No

--If not, why not?

2. Is there a separate emergency number for mental health

crises?

Yes No

3. If not, have persons answering the 911 number been trained to respond appropriately in cases of mental illness?

Yes No

4. Does the county provide telephone accessibility for severely hearing impaired persons through a TDD (telephone device for the deaf)?

Yes No

--If not, why not?

5. Is a mental health professional available for consultation at least by telephone in 30 minutes?

Yes No

6. Does the public know emergency services are available and whom to call?

Yes No

--How did the county publicize these services?

7. How many contacts did the county have on its emergency mental health hot line?

8. What efforts has the county made to assure that 24 hour emergency services are available and accessible to special populations?

--to children (0-17 years)?

--to the elderly (65+)?

--to minorities:

--blacks?

--American Indians?

--Southeast Asians?

--Chicanos?

--to hearing impaired citizens?

9. What is the county fee policy for emergency services?

Does the county report particular barriers to providing emergency services?

Yes No

--If so, what are they?

Comments:

Important but not Mandated :

1. Has the county developed a protocol with peace officers and corrections determining the treatment and placement of persons with acute mental illness in corrections?

Yes No

2. Has the county social services division (or another agency) provide training or inservice to police and corrections personnel on mental illness?

Yes No

Outpatient Services

Mandated :

1. 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.)

Yes No

2. Are enough mental health professionals available?

Yes No

If not, why not?

3. Are initial appointments provided within three weeks unless special requests by the client (for particular days, time or therapists) prevent timely initial appointments?

Yes No

--If not, please elaborate

4. Are outpatient services provided by an organization(s) with a multidisciplinary staff?

Yes No

5. Are mental health practitioners clinically supervised by mental health professionals?

Yes No

6. Is the county making outpatient services available and accessible to special populations?

--to children (0-17 years)?

Yes No

--to the elderly (65+)?

Yes No

--to minorities:

--Blacks

--American Indians

--Southeast Asians

--Chicanos

--Other special populations, as identified by county.

7. Does the public know oupatient services are available and whom to call?

Yes No

8. Does the county have a sliding fee scale policy for outpatient services?

Yes No

Comments:

Does the county report barriers to offering outpatient services?

Yes No

If so, what are they?

Important but not Mandated :

1. Does the county provide a minimum of 4 hours of outpatient service per client per year?

Yes No

2. Are all clients who request them receiving outpatient services?

Yes No

--If not, please explain.

2. Are outpatient services provided as long as clients need them?

Yes No

--if not, please explain.

--Or, are services routinely discontinued after a certain period of time (18 months or 2 years) regardless of client need?

Yes No

3. Are there waiting list for regular appointments?

Yes No

If so, how long are they?

Community Support Services

Community support services include a wide range of possible programs and supports.

Mandated :

1. Does the county provide each of the following activities?

--client outreach

Yes No

--medication management

Yes No

--assistance in independent living skills

Yes No

--development of employability and supportive work opportunities

Yes No

--crisis assistance

Yes No

--psychosocial rehabilitation

Yes No

--help in applying for government benefits

Yes No

--development, identification and monitoring of living

arrangements

Yes No

2. Does the county provide for linkage among various service providers?

Yes No

--How is this accomplished?

3. Does the public know community support services are available and whom to call to access services?

Yes No

--How is this knowledge disseminated?

4. What is the county fee policy for community support services?

Comments:

Does the county report barriers to providing community support service?

Yes No

--If so, what are they?

Day Treatment

Mandated

1. Are day treatment services available at least one day a week for a minimum of three hours for clients with serious and persistent mental illness?

Yes No

--If not, please explain.

(Counties may receive a waiver from including day treatment services within the county.)

Comments:

Does the county report barriers to providing day treatment?

Yes No

If so, what are they?

Case management

Mandated

1. Does the county provide case management activities for all persons with serious and persistent mental illness?

Yes No

--If not, how many are served?

--What is the estimate of unserved persons?

--Why are these persons not served?

--Are there plans to reach these persons in the future?

Yes No

--Explain.

2. What proportion of persons with serious and persistent mental illness are receiving services?

--Has this proportion increased since 1987?

Yes No

3. Does case management help people gain access to needed medical, social, educational, recreational, vocational and other necessary services?

Yes No

4. Is there a diagnostic assessment for each client?

Yes No

5. Is there an individual community support plan for each client?

Yes No

6. Is the individual community support plan based on the diagnostic assessment?

Yes No

7. Are all clients referred to necessary services?

Yes No

8. Are services coordinated?

Yes No

If so, how?

9. Are services monitored?

Yes No

If so, by whom? How often?

10. Are case managers knowledgeable about community resources?

Yes No

11. Is the county making efforts to assure that community support services and case management services are available and accessible to special populations?

Yes No

If yes, please specify.

13. How are multiple providers coordinating service components?

14. How are case managers linked to the community support program?

Comments:

Does the county report barriers to providing case management?

Yes No

If so, what are they?

Important but not Mandated :

1. What is the worker/client caseload for case management for persons with serious mental illness? (materials published by the state of Minnesota and national organizations estimate that a maximum caseload should be 30 to 35.)

2. Is there continuity of care as persons move among programs?

Yes No

3. Do most clients continue with the same case manager?

Yes No

4. Do the same case managers continue with clients who hae serious and persistent mental illness when they move from the community to hospital settings?

Yes No

5. Are there written agreements between hospitals and outpatient facilities specifying continuity of care and responsibilities?

Yes No

6. Is there evidence that case managers are referring clients to a variety of services?

Yes No

7. Is there systematic, random sampling by management to see if service coordination is being achieved?

Yes No

8. Are community support plan goals acceptable to client?

Yes No

--How is ongoing evaluation of plan goals achieved?

Assertive Case Management

9. Are professionals assigned to make regular visits to local jails and prisons to provide care for individuals with serious mental illness?

Yes No

10. Do outreach workers make regular visits to public shelters and to street locations to provide care for individuals with serious mental illness?

Yes No

11. Have outpatient commitment and continuous treatment teams virtually abolished the subgroup of homeless individuals with serious mental illness?

Yes No

12. Do home health workers and public health nurses make regular home visits to elderly and disabled individuals with serious mental illness thereby allowing them to continue living at home?

Yes No

13. Do case managers visit clients with serious and persistent mental illness in their homes?

Yes No

Comments:

Does the county report barriers in the creation of community support services?

Yes No

--If so, what are they?

Residential Treatment (Rule 36s and Rule 5s)

Mandated :

1. Does the county contract for enough residential treatment services in the community (Rule 36 facilities for adults and Rule 5 for children) to meet the needs of all persons with mental illness residing in the county?

Yes No

If no, please explain.

2. Is the stay based on client needs?

Yes No

--Or are definite time limits placed on service?

Yes No

3. Are services as close to the county as possible?

Yes No

--How close is that?

4. How is Rule 36 residential treatment coordinated with the community support program?

5. How is Rule 5 residential treatment and follow up linked to working with families?

6. How does the public know residential treatment (Rule 5 for children and adolescents and Rule 36 for adults) is available and who to call to access services?

7. What is the county fee policy for residential treatment?

8. What is the county doing to assure residential treatment services are available and accessible to special populations?

--to minorities:

--Blacks?

--American Indians?

--Southeast Asians?

--Chicanos?

--to hearing impaired persons?

--other special population identified by the county?

Comments:

Does the county report barriers to providing residential treatment services?

Yes No

--If so, what are they?

Acute Care Hospital Inpatient Treatment

(Note: There is a trend toward authorizing the use of RTCs for acute care in those areas where the development of a psychiatric inpatient facility in small community hospitals is not feasible.)

1. Does the county provide acute care hospital inpatient treatment in an acute care licensed facility for clients who need this service?

Yes No

--If not, please explain.

2.What efforts has the county made to assure acute care inpatient treatment is available and accessible to special populations?

3. How is acute care hospital inpatient treatment coordinated with other community based services for adults?

4. How is the county coordinating acute care hospital inpatient treatment with other community based services for children?

5. Does the public know acute care inpatient treatment is available and whom to call to access services?

Yes No

--If so, how?

6. What is the fee policy for acute care inpatient treatment?

Comments:

Does the county report barriers to providing acute care inpatient service?

Yes No

--If so, what are they?

Regional Treatment Center (RTC) Inpatient Services

1. Is the county referring all persons who need it for treatment in regional treatment centers?

Yes No

--If not, please explain.

2. Does the county participate in discharge planning for all its clients?

Yes No

--If not, why not?

3. Are clients in Regional Treatment Centers linked with necessary community based services?

Yes No

--If so, how?

4. What efforts is the county making to assure regional treatment center inpatient treatment is available and accessible to special populations?

5. Does the public know regional treatment center inpatient treatment is available and whom to call to access services?

Yes No

--How is this accomplished?

Comments:

Does the county report barriers to providing regional treatment center inpatient services?

Yes No

--If so, what are they?

Important but not mandated

1. Is the county referring noticeably more or fewer clients to RTCs than other comparable counties?

Yes No

If so, why?

Screening

(Counties are not mandated to provide screening before

January 1, 1991)

Additional Services Provided by Counties

1. Are counties providing additional services to clients with mental illness?

--If so, what are they?

Service Coordination

2. How is the county coordinating service components outlined throughout this document to ensure client continuity of care?

OTHER LEGAL MANDATES

Confidentiality

1. Do county practices comply with the Data Privacy Act?

Yes No

--Please specify procedures taken to safeguard clients' privacy.

2. Do providers allow clients to refuse to sign a waiver permitting the county to have their name and address?

Yes No

3. Is there an absence of discussion of clients by names by county commissioners at public meetings?

Yes No

Comments:

Important but not mandated

1. Does the county use confidentialty as an excuse for not providing assertive case finding and coordination?

Yes No

--Please explain.

Serving Persons with Serious and Persistent Mental Illness

(Note: the 1987 Comprehensive Mental Health Act, as amended in 1988 gives high priority to serving all clients with serious and persistent mental illness.)

1. What proportion of the mental health budget is devoted to clients with serious and persistent mental illness?

2. Are the needs of all clients with acute and serious and persistent mental illness met before persons wth other mental illness?

Yes No

Prepetition Screening

1. Is there an active prepetition screening team in your county?

Yes No

--If not, please explain.

2. Are clients monitored when they are committed to outpatient services?

Yes No

--How is this accomplished?

3. Is there evidence that clients are committed to the least restrictve settings appropriate?

Yes No

4. Does prepetition screening regularly refer clients to other services when it believes there are not grounds to pursue commitment proceedings?

--How many people are being referred?

Comments:

Does the county report barriers to providing prepetition screening and outpatient commitment?

Yes No

--If so, what are they?

Important but not mandated

1. Does prepetition screening report a lack of sufficient options in the community for referral?

Yes No

--Amplify.

County Views

1. Are there programs and services of which the county is particularly proud?

--publicly funded programs?

--other programs?

Please specify.

2. Overall, what obstacles does the county report as particularly serious in developing a full range of county services?

Additional Comments

Systems Monitoring - II

CHECKLIST FOR COMPLETE OR IDEAL COUNTY SERVICEs

To be filled out with information from county human services staff and/or contracted agencies, advocacy groups and knowledgeable citizens.

County

Names of Reporters (Please also list addresses and phone numbers)

Name(s) of Persons Interviewed (Please also list titles and addresses)

Date(s) of interview(s)

---

1. What is the estimated number of persons with serious and persistent mental illness in the county?

2. What percentage of people with serious and persistent mental illness are receiving services?

--Why is this?

* * * *

1. Are there people from the county ready for discharge from the regional treatment center who cannot leave because there

are no places for them in the community?

Yes No

If yes, how many are there?

2. Are there people ready for discharge from Rule 36 (halfway house) facilities in the community for whom there is no suitable or affordable housing in the community?

Yes No

--If yes, please explain.

3. Are people discharged from acute care hospitals placed in appropriate programs?

Yes No

If not, please explain.

4. Are there waiting lists for community programs?

Yes No

If yes, please specify.

5. Are county appropriations for mental illness housing services increasing to meet increased demand?

Yes No

--What is the prospect for increased appropriations in the future?

6. Are there special housing needs which county services address inadequately? or not at all?

Yes No

If yes, please specify.

7. Is a full range of housing options available in the community? (See Systems Monitoring IV for a full listing of these)

Yes No

8. Is a full range of vocational programs available?

Yes No

9. Is concern expressed that entrance requirements to some programs work to exclude those persons with the most severe mental illness?

Yes No

Specify.

Case Management

Beginning in 1989 Medical Assistance and General Assistance Medical Care funds will be available for case management for persons with serious and persistent mental illness for the first time. Under the law all persons with serious and persistent mental illness who want case management must have it. Case management is often described as the glue holding the system together. It is regarded as an essential part of a quality system of care.

1. What is the average client/caseworker caseload? (State materials and national organizations recommend that caseloads should not exceed 30 or 35 but a number of counties have caseloads of 60)

2. Continuity--does one person have the clear responsibility for each client?

Yes No

--If not, why not?

3. Is an assessment done for each client?

Yes No

--Are the goals clearly linked to the assessment?

Yes No

--Is ongoing evaluation done?

4. Is there a waiting list to get on a county caseload?

Yes No

--If yes, how long is this?

5. What proportion of persons with serious and persistent mental illness are receiving case management services?

Yes No

6. Has this proportion (or number) increased since 1988?

7. Are clients cases closed even though they may need services in the future?

Yes No

Specify.

8. How are clients followed over time?

9. Is there evidence that case managers are referring clients to a <u>variety</u> of services?

Yes No

10. Is there evidence that case management is closely linked

to community support services?

Yes No

--Please specify.

11. Does case management systematically reach out to homeless persons in shelters and on the streets?

Yes No

--If not, why not?

12. Do case managers make regular visits to jails and prisons to provide care for individuals with serious mental illness?

Yes No

--If not, why not?

13. Are persons with serious mental illness homeless in your county?

Yes No

If so, how many?

Community Support Program

1. Is a complete range of community support services available in the county?

Yes No

--If not, what is needed?

2. Counties must describe how they will coordinate community support services and case management. Is there evidence that these are in fact well coordinated?

Yes No

--If not, please specify.

3. Is public transportation readily available for persons with serious and persistent mental illness?

Yes No

--If not, are special transporation services available for persons with mental illness? (These could include volunteer drivers, special vans, etc.)

Yes No

Please specify.

Comments:

Available Mental Health Professionals

1. Does the county have difficulty in hiring and retaining mental health professionals to work with persons with serious and persistent mental illness?

--psychiatrists
Yes No

--psychologists
Yes No

--psychiatric nurses
Yes No

--psychiatric social workers
Yes No

If yes, what are seen as the barriers to attracting mental

health professionals?

--salary or reimbursement levels?

Yes No

Explain:

--geographical location?

Yes No

Explain:

Other:

Serving Populations with Special Needs

1. Is there general agreement that services are available to meet the needs of most persons with dual diagnoses or special needs?

--persons who have a dual diagnosis of chemical dependency and mental illness?

Yes No

--persons who have a dual diagnosis of mentally retardation and mental illness?

Yes No

--persons who are hearing impaired and mentally ill?

Yes No

--farmers and their families who are experiencing mental illness?

Yes No

--elderly people with mental illness?

Yes No

--homeless people?

Yes No

--persons with special language and/or cultural needs?

--Southeast Asians?

Yes No

--American Indians

Yes No

--blacks?

Yes No

--persons in corrections?

Yes No

--Other (specify)

Yes No

If not, what services are needed?

Comments:

Liaison with the police/and or sheriff and Corrections

1. Is there an ongoing attempt on the part of county mental health services to inservice peace officers and corrections officials about mental illness?

Yes No

--If yes, how is this accomplished?

2. Is there a specific procedure for handling persons with

mental illness who are picked up by the police?

Yes No

3. Are procedures established to minimize the time persons with mental illness spend in correctional facilities in your county?

Yes No

4. Are persons detained in the adult and juvenile detention systems systematically screened for mental illness?

Yes No

4. Is jail ever used to hold persons with mental illness because county programs and/or facilities specifically designed for persons with mental illness are insufficient?

Yes No

Comments:

Tracking and Research

1. What steps is the county taking to see if programs work for clients? Is there a system for tracking the "progress" of clients?

Yes No

2. How much does the county know about its clients with mental illness?

--Does it know which programs work? Does it have a system for assessing which programs work for clients?

--Does it know how many clients go back and forth to the RTCs? How often?

3. Does the county have an estimate on how much service different clients need?

Commitment

1. Is the county beginning to use more forms of "outpatient commitment" in the community?

Yes No

Please specify.

2. Is it possible for persons to commit themselves volunarily for treatment to regional treatment centers (state hospitals)?

Yes No

--If not, explain why.

3. Does prepetition screening report available community services to which to refer persons who need support but do not meet the criteria for commitment?

Yes No

--If not, please explain.

General Public Acceptance

1. How widely is the sense of commitment to humane community services for persons with mental illness spread?
--Are churches involved?

--civic groups?

--Explain.

2. Are the needs of persons with mental illness or success stories of persons with mental illness in the community at meetings highlighted at public meetings?

Yes No

--in newsletters?

3. Does the local newspaper have positive articles about persons with mental illness?

Yes No

Use of Creative Low-Cost Techniques

1. Is the county making use of relatively inexpensive trained laypersons and/or volunteers to help in services to persons with mental illness?

Yes No

If yes, please specify.

2. Is the county using imagination to advertise the mental health hotline?

Yes No

--Please specify.

3. Are there examples of imaginative solutions to problems that may not be very expensive?

(As an example a coffee shop in the building where the Winona Community Mental Health Center is located, fulfills the dual function of giving employment to persons with mental illness and helping to overcome people's stereotypes about mental

illness.)

Yes No

If yes, please specify.

4. Are private groups or agencies helping to provide programs for persons with mental illness in the community?

(Example, in Red Wing, a Catholic Church and a Lutheran Church have donated buildings for a dropin center and a group home. Plymouth Congregational Church, near downtown Minneapolis, has operated a drop in center two afternoons a week for more than 10 years with no outside funding.)

IMDs (Institutions for Mental Diseases)

Federal regulations now specify that residential facilities which offer diagnosis, treatment or care to more than 16 persons with a primary diagnosis of mental illness are IMDs (institution for mental diseases) and that persons residing there may not qualify for Medical Assistance. This applies to large Rule 36 facilities and to some nursing homes.

1. Is your county seriously affected by this ruling?

Yes No

Please explain.

2. How is the difference between Medical Assistance funding and General Assistance funding for these clients being made up?

3. Will some persons have to move from their existing residential facility?

Yes No

--If so, what provisions have been made for their placement?

4. Is the county making an attempt to downsize facilities?

Yes No

Please explain.

Nursing Homes

(New federal legislation mandates that as of January 1, 1989 persons under 65 who are mentally ill may not be admitted to a nursing home unless their physical and medical needs are such taht they require the level of services provided by a nursing facility and the individual does not require active treatment.

All nursing home applicants must be screened before admission and all nursing home residents must be reviwed annually to determine whether or not nursing home placement is appropriate. Residents who no longer need nursing facility care must be discharged in a "safe and orderly" manner." The state has requested an extension of the April 1, 1990 deadline for such discharges.)

1. Does this affect mentally ill persons in your community?

Yes No

If yes, what plans are being made for alternative placement?

Identify Gaps in Services

1. Are gaps reported in the service system?

Yes No

--If so, what are they?

2. How does the county suggest that these could be addressed?

Systems Checklist III

CONSUMER SURVEY

(These questions are partially based on the consumer survey conducted by Ernst and Whinney for the Mental Health Division.)

County

Names, addresses and phone numbers of Reporters

Organizations involved in monitoring

Number of Consumers

Location

Date

---

1. What do consumers like best about local services?

2. What do consumers like least?

3. If consumers could improve one service, what would it be?

--housing

--regular

--supported

--residential treatment programs (Rule 36s)

--how?

--regular medical services

--crisis services (elaborate)

--mental health services (specify)

--case management

--help with cooking, shopping, etc.

--help with getting and keeping a job

--recreational/social activities

--other

--What would they change?

4. Generally, do consumers think services are well designed for them?

Yes No

--If not, please explain.

3. Do consumers feel safe and secure?

Yes No

--If not, please explain.

4. Do consumers report problems in getting presentable clothes to wear?

Yes No

--If yes, please explain.

5. Do consumers report problems getting food for each day?

Yes No

--If yes, please explain.

6. Do consumers have at least one friend to trust?

Yes No

7. Do consumers have a chance to do things for fun?

Yes No

-- If not, please explain.

8. Do consumers have enough medical support (for ordinary medical concerns) available?

Yes No

--If not, what is the problem?

9. Do consumers have enough mental health support?

Yes No

--If no, what is missing?

--psychiatrist?

--psychologist?

--case manager?

--day treatment?

--other?

10. Do consumers have transportation available to go where they want to go?

Yes No

--If not, please explain.

11. Are consumers generally satisfied with their quality of life?

Yes No

--If not, please explain.

12. Do consumers have medications that help them?

Yes No

--If not, please elaborate.

13. Do consumers receive the help they need in obtaining government benefits (SSI, SSDI, GA, Medical Assistance, etc.)?

Yes No

-- If not, please elaborate.

12. How many consumers have met in the last month with--

--a psychiatrist?

Yes No

--a social worker or caseworker?

Yes No

--with a medical doctor?

Yes No

13. Have consumers received help in the last month--

--managing medication?

Yes No

--with cooking, shopping or budgeting?

Yes No

14. Within the last month have consumers participated in fun activities?

Yes No

--If yes, were these arranged by an agency or mental health program?

Yes No

Housing

1. How many consumers live on their own?

--Are they satisfied with their arrangements?

--if not, why not?

--neighborhood?

--actual apartment?

--other

2. If consumers live with other adults are they satisfied with,

--neighborhood?

Yes No

--actual faciliity?

Yes No

--privacy?

Yes No

--If not, please explain

--Are the other residents compatible, friendly, etc?

Yes No

2. Do consumers report difficulty in finding suitable housing they can afford?

Yes No

--If Yes, have they received help in finding housing?

Yes No

--Specify.

3. Is subsidized low and moderate income housing available in their community?

Yes No

--Is Section 8 housing available?

Yes No

4. Do many consumers have to live with their parents when they would prefer to live on their own?

Yes No

5. Do consumers believe they are getting enough help to enable them to manage to live on their own?

Yes No

--If not, what do they need?

Vocational

1. Do consumers feel they have enough support in seeking employment?

Yes No

--If not, what do they need?

2. Do they believe they are being helped to find work at their ability level?

Yes No

--If not, please specify?

3. If consumers believe they cannot handle paid employment now, are they being encouraged to do volunteer work?

Yes No

--Is occupational therapy available?

Yes No

Social/Recreational

1. Do consumers have enough social activities?

Yes No

--If not, please elaborate.

--Are these arranged by an agency, with friends, how? Please specify.

2. Do consumers have access to a dropin center?

Yes No

--If not, would they like to have a dropin in center available?

Yes No

3. Do consumers have planned activites available (ex. bowling, volleyball, camping, etc.)?

Yes No

--If not, would they participate if activities were availble?

Yes No

4. Do consumers have enough money to pay for recreation?

Yes No

--Is this a big problem?

Yes No

Additional Comments

Systems Checklist - IV

RESIDENTIAL TREATMENT/HOUSING CHECKLIST

(These questions are based in part on those in Torrey and Wolfe, 1988)

County

Date

Names of Reporters (Please also list your addresses and phoe numbers)

Name(s) of Person(s) Interviewed (Please also list their titles, organizations and addresses)

Note : In the past the ideal for persons with mental illness has been presented as a continuum of housing options including residential treatment. As the person gets better, this view holds, he or she will progress to more independent living situations. However, there is now a body of opinion which questions this view. It supports "housing as housing" divorced from treatment for the most part. It asserts that people do better if they have stability in housing. Even if they must go to the hospital, they should be able to return to the same place. This view holds that services could be increased if a person's illness worsened.

However, there may still be some persons who need support in their residence at least part of the time.

* * * *

(The goal for all who are able should be living on their own or with others of their choice in permanent, normal housing.)

1. Is there a continuum of housing facilities available with varying levels of supervision depending on individual needs?

Yes No

If not, where are the gaps?

Please check whether or not persons in your county with serious and persistent mental illness have access to the following housing options:

Residential Treatment

a. regional treatment centers (RTCs) on hospital grounds?

Yes No

b. does the county report difficulty finding enough places in RTCs for county residents who need this service?

Yes No

c. Crisis beds for persons experiencing acute episodes of mental illness?

Yes No

--How many?

--Is this number adequate?

Yes No

d. Community residential treatment programs (Rule 36 or halfway houses)

--Category I --how many?

--Category II --how many?

--Is this number sufficient?

Yes No

--If no, please explain.

Housing with Support

e. Fairweather Lodges (like Tasks Unlimited, lodges for mentally ill persons who work together during the day)?

Yes No

--How many people?

f. working farms

Yes No

g. adult foster family care?

Yes No

--How many?

--Is this sufficient?

h. board-and-care homes?

Yes No

--How many places?

--Is this sufficient?

i. board and lodging facilities?

Yes No

--How many persons with mental illness live there?

--Is the number sufficient?

j. apartment programs with varying levels of supervision?

Yes No

--How many places?

--Is this sufficient?

--Do apartment programs have time limits on length of

stay?

k. long-term supported housing?

Yes No

--How many places?

--Is this sufficient?

l. consumer run housing options?

Yes No

--How many?

m. respite facilities (especially for persons who otherwise live with their families)?

Yes No

--How many?

--Is this sufficient?

2. Do county officials see gaps in the housing continuum?

Yes No

--If yes, please specify.

--Which gaps do they view as most serious?

3. Are there time limits on clients' stays in various housing options?

Yes No

--Is this a problem?

Yes No

--If yes, please explain.

4. How many adults with serious and persistent mental illness live with their families?

Regular Housing

1. Do you know how many persons with serious and persistent mental illness live on their own?

Rule 36 Community Residential Treatment Programs

1. How many Rule 36 places are occupied by persons from your county?

2. Are your Rule 36 places (facilities) full?

Yes No

3. Are there waiting lists for Rule 36 facilities where your county residents receive treatment?

Yes No

--If yes, how long are the waiting lists?

4. Are there county residents ready for discharge from Regional Treatment Centers (formerly state hospitals) who must wait because there is no place for them in the community?

Yes No

5. Are there persons in your Rule 36 facilities who are ready to leave but for whom no suitable community housing exists?

Yes No

6. Do persons lose their place in Rule 36 facilities if they go to the hospital?

Yes No

Nursing Homes

1. How many nursing home residents in your county have a diagnosis (primary or secondary) of mental illness?

2. How many are:

--65 and older?

--under 65?

3. How many of those 65 and over have medical and/or physical needs which require nursing home care?

--How many of those under 65?

4. What steps is the county taking to meet the needs of persons with mental illness who are discharged from nursing homes?

--Please specify?

Unlicensed Board and Care Facilities

1. How many persons with mental illness in your community live in board and care facilities licensed only for health purposes (not for program purposes) ?

--Are they happy with this arrangement?

Low Cost/Subsidized housing

1. Some persons with mental illness can live successfully in regular apartments but their low income may a barrier to finding such housing.

--Are there decent affordable apartments in your county for persons with mental illness?

Yes No

In sufficient numbers?

--Is appropriate subsidized housing available in your county?

Yes No

--Is Section 8 housing available?

Other

1. Does the county provide help to persons seeking housing?

Yes No

--Is this felt to be sufficient?

2. Do individuals play a role in housing selection?

Yes No

3. Are homemaker services available for aging seriously mentally ill individuals to allow them to remain in their own homes as long as possible?

Yes No

4. Are assertive case management services available to support persons in their homes?

Yes No

5. Are there specific plans on paper for housing individuals living with their families when the supporting family members have died?

Yes No

--Specify.

County Attitudes

1. Is the county particularly proud of any particular housing program?

--If so, please specify.

2. What does the county see as the major barriers to providing adequate housing options in the county?

Be specific.

Systems Monitoring - V

VOCATIONAL/SOCIAL SERVICES

(These questions are based in part on those in Torrey and Wolfe, 1988)

County

Names, addresses and phone numbers of Reporters

Organizations involved in monitoring

Name(s)of Persons interviewed (Please also include titles and addresses)

Date(s) of Interview(s)

Vocational and psycho/social services are part of the community support program to be provided by all counties.

* * * * *

Vocational Rehabilitation

Many persons with serious mental illness can hold regular jobs. Others do well in supported employment or sheltered workshops. Still others can benefit from volunteer or worklike activites.

1. Please check which services are available to clients with serious and persistent mental illness.

--vocational assessment

Yes No

--vocational exploration (e.g. internships, job shadowing)

Yes No

--career counseling and planning

Yes No

--job seeking training

Yes No

--job skills training

Yes No

--job development and sharing

Yes No

--sheltered workshops

Yes No

--transitional employment

Yes No

--supported employment

Yes No

-for groups of clients

Yes No

-for individuals

Yes No

--competitive employment

Yes No

--consumer-run businesses

Yes No

--Are more of some services needed? If so, which are they?

2. Are there waiting lists for these services? (Ideally, vocational services should be available with little or no waiting for 100 percent of individuals who wish to use them.)

Yes No

--If so, how long are they?

--Are any steps being taken to reduce them?

3. Do entrance criteria to programs permit persons with very serious mental illness to participate?

Yes No

--Please explain.

4. Do persons with serious mental illness in your county have access to training and help from the MN Department of Jobs and Training (DRS)?

Yes No

--If so, is this satisfactory?

5. Do employers in your community regularly employ persons with serious mental illness?

Yes No

--Explain.

6. Are volunteer placements available for clients with

serious and persistent mental illness?

Yes No

-Explain.

Educational Rehabilitation

1. Is retraining (or training) in living skills, e.g. shopping, budgeting, cooking, nutrition, housekeeping, use of public transportation, available?

Yes No

--Is it available to all who need it?

Yes No

2. Are courses set up on a formal basis with systematic evaluation of patients to insure that patients have the necessary skills to live and work in their chosen environment?

Yes No

--Explain.

3. Is there provision for resuming formal education, e.g. GED., college?

Yes No

--Explain.

Social Rehabilitation and Recreation

1. Are there clubhouses, e.g. Fountain House model like Vail Place in Hopkins and Minneapolis? (In the clubhouse model, clients actually join the clubhouse and make a commitment to its activities.)

Yes No

--Are they available to all who wish them?

(Ideally, such services should be available with little or no waiting for 100 percent of individuals who wish to use them.)

2. Are drop-in centers available? (Drop-in centers, as the name suggest, generally do not expect a commitment for continuing participation from clients.)

Yes No

Explain.

3. Is there companionship therapy, 1 to 1 friendship, like the Compeer program which utilizes volunteers?

Yes No

4. Is there a consumer-run social center and activities?

Yes No

5. Are there regularly scheduled social activities for clients who wish to use them, e.g. trips organized by clubhouse?

Yes No

Explain.

6. Is information available on regular communitiy activities for those who wish to use them., e.g. churches, YMCA, hiking clubs, concerts?

Yes No

7. How are community programs accessed? Does someone go with clients or only give them information?

Yes No

--Is a Y shared membership purchased?

8. Are special programs available in rural areas to counteract social isolation of patients?

Yes No

Explain.

9. Is there evidence of churches reaching out to adults with mental illness?

Yes No

Explain.

County Concerns

1. Are there vocational and social programs of which the county is especially proud?

Yes No

--If yes, please specify.

2. Does the county report barriers to the creation of more complete vocational and social services?

Yes No

--If yes, what are they?

Agency/Program Checklist - I

(Especially suited for monitoring residential facilities including Rule 36 residential treatment centers and other communal living arrangements. Those sections marked with * may also be used to monitor other programs, like vocational, psychosocial or drop in programs.)

(This checklist draws heavily on the ARC Minnesota materials, on Torrey and Wolfe, 1988, on Michigan materials and on the Wisconsin Nursing Home Project)

County

Names of Reporters (Please also give addresses and phone numbers)

Organizations involved in Monitoring

Agency or Program Visited

Address

Phone

Date(s) Observed

Staff Interviewed (Please give names and full titles)

Corporation Operating agency

Address

Administrator

Phone

---

* Physical Environment

(ARC) The physical and social environment should be comfortable and assert the humanity of the people who use the service. The service site should not draw any undue attention to the location or the consumers. The site should blend in with the rest of the surrounding area.

* Location

1. Is the service site easily accessible to public transportation?

Yes No

Or, is it isolated due to poor transporation options?

Yes No

--Explain.

2. Is the service site located in an area that is "undesirable" due to a high crime rate or poor services?

Yes No

--Explain

3. Is the service site located in an area where there is excessive congregation of other people with special needs?

Yes No

4. Is the service site located close to a variety of relevant community resources and services?

Yes No

Overall, how would you rate the location of the site?

Poor Adequate Good Excellent

Comments:

---

* Site Exterior

1. Does the service site look like the others in the area?

Yes No

-- Or, does it stand out as odd, drawing undue attention to the people who use the service (big signs, etc.)

Yes No

2. Is the physical structure appropriate for the type of service that is provided?

Yes No

3. Is the building well kept up?

Yes No

4. Is the yard maintained in a way to invite visitors?

Yes No

5. Does the exterior of the building convey an image of isolation and separation from even close neighbors (such as an excessive amount of fencing)?

Yes No

6. From the outside, can you tell this site serves persons with mental illness?

Yes No

Overall, how would you rate the site exterior?

Poor Adequate Good Excellent

Comments:

---

* Site Interior (Concerns, homelike or institutional, cleanliness)

1. Is the service site comfortable? If you used this site would you feel comfortable most of the time?

Yes No

2. Are the furnishings appropriate for the function of the service site?

Yes No

3. Is the site divided into recognizable, functional areas? (Ex: does the living room look like a living room, a breakroom like a breakroom, etc.) Are rooms used in odd or unusual ways?

Yes No

4. Are areas properly lit, heated, and furnished for their purpose?

Yes No

5. Is there air conditioning? (Air conditioning is particularly important for many persons with mental illness because psychotropic medication interferes with the control of body temperature)

Yes No

6. Do things work (appliances, etc.)?

Yes No

--Or is there an excessive level of disrepair?

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

Yes No

8. Is the inside of the building free of unpleasant odors?

Yes No

9. Is the inside of the building clean and inviting?

Yes No

10. Is the interior of the building homey?
Yes No

--Or, is the atmosphere institutional?

Yes No

10. Is there sufficient space for individual quiet activity as well as noisier group activity?

Yes No

11. Is there adequate storage space, some of which is lockable, for personal possessions of clients?

Yes No

12. Would <u>you</u> use this service?

Yes No

<u>Bedrooms/Bathrooms</u>

13. Are bedrooms decorated individually?

Yes No

14. Do beds have clean linen?

Yes No

15. Are adequate linen supplies available?

Yes No

16. Are toilets, sinks, bathtubs and showers clean and operable?

Yes No

17. Do bathrooms provide privacy? (shower curtains, shower stalls, etc.)

Yes No

Overall, how would you rate the site interior?

Poor Adequate Good Excellent

Comments:

---

* Treatment/Programming

1. How are treatment plans developed?

--Is the individudal involved in treatment planning?

--Are family members involved in treatment planning?

--How are goals communicated to the individual?

2. How often are treatment plans reviewed/updated?

3. Who is responsible for seeing that individuals are working toward and attaining "habilitation" goals?

4. Do residents use community resoures as part of their "treatment plan"?

--How many residents?

--what kinds of community resources?

--how often?

--are residents involved in community activities and using

community resources they will need or use after they leave the facility?

5. how much time do residents spend in the community compared to time in the facility?

Rights Issues

1. Do residents have privacy?

Yes No

2. Do staff and others knock before entering rooms?

Yes No

3. --Are residents rights posted?

Yes No

--Where?

4. How are residents informed of their rights?

5. When are residents informed of their rights?

6. Are residents made aware of the Vulnerable Adults Act, the Ombudsman's Office, and the Minnesota Mental Health Advocacy Project?

Yes No

--Do residents and families receive pamphlets on these programs?

--How? Please specify.

7. Is there mandatory staff training on resident rights?

Yes No

--How often is training held?

9. Please describe the residents' grievance procedure.

--When was the last time anyone used it?

--what was the outcome?

10. Does the staff encourage people served to exercise their full range of rights?

Yes No

--If yes, how?

11. To what extent do the people served determine their own lives?

--For example, do people

--choose the movie they want to go to?

Yes No

--decide what night to go bowling?

Yes No

--Determine what type of job to apply for?

Yes No

* Facility Rules

12. Are there facility or unit rules?

--Are the rules for all residents?

--How are the rules communicated to residents?

--Are the rules posted?

--Do residents have input into formulation of the rules?

13. Are the rules so rigid that "normal" staff and visitors might not meet them? (Example: are residents prohibited from having a glass of wine at a holiday dinner?)

Yes No

14. Is there a resident council? If so:
--Who is on it?

--How are they appointed?

--How often do they meet?

--What do they do?

15. Does the facility have seclusion rooms?

Yes No

16. Are there written policies for restraint and seclusion?

--What types of restraints are used?

--When is restraint or seclusion used?

What is the most common reason?

--How often is restraint/seclusion used for an "emergency" situation?

--what is an "emergency"?

--who decides?

17. How is the use of restraint/seclusion documented?

18. Does the staff pride itself on being able to calm disturbed patients without using restraint or seclusion?

Yes No

19. Do you think residents could easily maintain a sense of self-worth and dignity living in this facility?

Yes No

Telephone and Mail Privileges

1. May clients make phone calls at any time?

Yes No

2. Is only a pay phone available?

Yes No

3. Are there restrictions on the number of phone calls?

Yes No

--Are calls limited to certain days of the week?

Yes No

--Are calls limited to certain times of the day?

Yes No

--Are there any other limitations?

--If there are restrictions, what is the rationale for these restrictions?

4. May clients use the telephone in private?

Yes No

5. Are there restrictions on residents' mail?

Yes No

If yes, specify.

Visitors

1. Are residents allowed to have visitors of their choice and privacy in visits?

Yes No

--When? How often?

--Are there any special procedures?

2. Are residents allowed to leave the facility to visit family or friends?

Yes No

--Are there restrictions?

Yes No

Control of Money

1. Do residents control their own money?

Yes No

--If not, who does?

2. If some residents do control their money and others do not, how is this determined?

3. Do residents have access to their money whenever they want?

Yes No

4. Can they spend their money as they choose?

Yes No

5. Is access to their money contingent on any "program"?

Yes No

Voting

1. Are clients encouraged in exercising their right to vote in elections?

Yes No

2. Do staff invite speakers on electoral issues, etc. to encourage voting?

Yes No

* Confidentiality

1. How is confidentiality respected in the agency?

Specify

2. Is personal information about individuals or programs posted on the walls or the bulletin boards?

Yes No

Medications

1. Are residents systematically informed about the medications they are taking?

Yes No

2. Can residents refuse medications?

--How often does it happen?

3. Are possible negative side effects explained to the residents?

Yes No

4. Who administers medications?

5. Who reviews medications? How often?

* Behavioral Programming

1. Are behavior management programs used?

Yes No

2. What type of programs are in effect?

3. Do behavioral programs focus on positive reinforcement?

Yes No

4. Are behavior programs individualized?

Yes No

5. How many people are on behavior programs?

6. Who is involved in developing the program?

7. How are behavior management programs implemented and monitored?

8. Are there criteria for getting out of the program or successfully completing the program?

Yes No

9. Does the facility have a behavior management program review committee?

Yes No

10. Is there staff training on behavior management?

Yes No

--Are all staff involved?

Yes No

--Is attendance mandatory?

Yes No

--When was training last held?

* Staff

1. Are staff applicants screened to ensure their credentials are valid, they have no criminal history, there are no allegations of patient abuse in prior employment, etc.?

Yes No

2. Are personality characteristics of applicants (e.g., genuineness, empathy, warmth) used as important criteria for selection?

Yes No

3. Do clients and families have any part in screening applicants for employment?

Yes No

4. Is there intensive, ongoing staff training?

Yes No

5. What academic training do staff have?

6. Do staff have previous experience with persons with mental illness?

Yes No

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

Yes No

Comments:

8. How many staff have quit or were terminated recently (in the last month, six months, year)?

9. What are the procedures for staff dismissal?

10. Does staff morale appear high?

Yes No

11. Do all staff have the ability to clearly understand and communicate in English?

Yes No

12. Have any allegations of abuse been lodged against staff by clients?

Yes No

--If yes, what was done about this? What happened?

13. Is staff sufficient to ensure good care?
Yes No

14. Are staffing patterns on weekends and at night sufficient for good resident care?

Yes No

15. What is the administrative chain of command? Is it clear to staff, consumers, family members and advocates?

Yes No

--Is there a policies and procedures handbook?
Yes No

16. Does there appear to be a strong sense of cooperation among staff members and the administration?

Yes No

Overall, how would you rate the qualifications and number of staff?

Poor Adequate Good Excellent

Comments:

---

* Staff-Client Interaction

1. Do staff talk to clients in a respectful and age appropriate way?

Yes No

2. Do staff talk about clients with a sense of respect and appropriateness?

Yes No

3. Do staff use labels when referring to people being served?

Yes No

4. Did staff interact with residents in a respectful, sincere manner?

Yes No

5. Did staff interact with residents on a personal basis?

Yes No

6. Do staff spend much time talking informally to clients?

Yes No

--Or do they tend to talk together, concentrate on charting, etc?

Community Integration

1. To what extent do staff promote direct, personal contact between people served and the general public?

--How is this done?

2. When people use community resources, are they provided an appropriate level of support?

Yes No

3. Does the program actively teach people to use community resources?

Yes No

4. To what extent are clients in this program reintegrated in the community?

--work placement in the community?

--Supervised and unsupervised social/recreational activities in the community?

--use of transportation in the community?

--use of community resources?

--coordination with any specific housing programs?

--other

Other

1. Is dining noninstitutional in feeling?

Yes No

2. Do clients have clothing which fits and is kept separately?

Yes No

3. Do clients appear well groomed?

Yes No

--If no, please comment.

Staff Comments

1. If staff could change anything about the agency (program, unit), what would it be?

2. What would staff not want to see changed?

3. What is staff particularly proud of in this agency (program)?

4. What barriers do staff see to improving the program (agency, etc.)?

Please specify.

Additional Comments

Agency/Program Checklist II

OBSERVING IN REGIONAL TREATMENT CENTERS

(These questions draw on Bogdan and Taylor, "Observing in Institutions," Torrey and Wolfe, 1988, and the ARC Partnership materials)

County

Name of Institution

Address Phone

Reported by (Please list Names and Addresses)

Organizations Monitoring

Names of Staff Interviewed (Please also list full titles)

Date(s) observed

Physical Environment

1. Where is institution located?

2. Is it near a population center?

Yes No

3. Is it easily accessible to family members and visitors?

Yes No

4. Is it close to shopping centers and public recreation areas?

Yes No

5. Is transportation easily available to and from the institution?

Yes No

Comment:

6. How old are the buildings?

7. Are the buildings well maintained?

Yes No

8. Is there a fence or a wall around the institution?

Yes No

9. Are there bars on the windows?

Yes No

10. What do the signs on the grounds say?

11. What are the grounds like?

--clean?

--are there plantings?

12. Do many residents use the grounds?

Yes No

13. What is the temperature like in the institution?

--Is there air conditioning? (Note: Air conditioning is

important because many psychotropic drugs interfere with the body's ability to regulate heat.)

Yes No

14. Are unpleasant odors are present in the institution?

Yes No

--If so, comment.

15. Are staff offices different from the buildings where residents live?

Yes No

Living Space

1. How is living space arranged on the ward? (i.e, dormitory, dayroom or living area/private rooms)?

2. How many residents sleep in a room?

3. Is the ward clean?

Yes No

4. Is the ward attractive?

Yes No

5. Is the ward comfortable and homelike?

Yes No

6. How different does the ward look from the average home?

7. Is the ward appropriately furnished and decorated?

Yes No

8. Is the furniture comfortable?

Yes No

9. Do the beds have pillows and bedspreads?

Yes No

--Do the beds have fitted sheets?

Yes No

10. Do the residents have their own closets and dressers?

Yes No

11. Are there curtains, pictures, rugs wastebaskets, and other normalized decorations and furnishings?

Yes No

--If no, what is lacking?

12. Who decides on decorations and furnishings?
--residents?

Yes No

--staff?

Yes No

--administrators?

Yes No

13. Are residents free to decorate their own living space?

Yes No

14. Can residents open windows?

Yes No

15. Is the ward crowded?

Yes No

Policies

1. What is the average length of stay in the institution?

2. How many clients are readmitted in the same year they are discharged?

3. What literature is provided to family members and guardians?

4. Can commited residents become voluntary residents?

Habilitation and Treatment

1. Does each resident have an individual habilitation (addressing living skills, vocational skills, etc.) plan containing long-term and short-term objectives?

Yes No

2. Does each resident's plan include a recommendation for community placement as well as a specific post-institutionalization goal?

Yes No

3. Is the plan developed by qualified staff?

--reviewed annually?

4. Are residents and/or their guardians involved in the development of this plan?

Yes No

5. Has each resident received a comprehensive social, psychological, educational and medical evaluation?

--How often are those evaluations conducted?

6. Is a specific hospital staff member assigned to each resident as case manager?

Yes No

--Who is responsible for seeing that the resident is working toward and attaining habilitation goals?

6. Does post-discharge planning begin the day of admission and involve the patient and family?

Yes No

7. Is a county case manager regularly involved in planning for each patient?

Yes No

--If not, why not?

--If no, in what percentage of cases do they believe county

case managers are involved?

8. Are residents involved in full-time programming?

--educational and developmental programming?

Yes No

--occupational therapy?

Yes No

--physical therapy?

Yes No

--vocational rehabilitation?

Yes No

--psychological counseling?

Yes No

--recreation?

Yes No

--work programs?

Yes No

9. Do residents receive training and assistance in acquiring skills necessary for more independent living? (e.g., personal hygiene, washing clothes, making beds, cooking, budgeting?)

Yes No

----How is this training provided?

10. Do residents have opportunities to be involved in social and leisure time activities?

--alone?

Yes No

--in small groups?

Yes No

Residents' Quality of Life

1. Are residents provided with eyeglasses, hearing aids, hearing aid batteries, prosthetic devices, wheelchairs and walkers?

Yes No

---If not, what is lacking?

2. Are there any signs of unattended cuts, sores, or bruises?

Yes No

3.Do residents or families complain about untreated physical ailments or dental needs?

Yes No

4. Do residents receive prompt and adequate medical treatment for physical ailments?

Yes No

The Use of Restraint and Seclusion

1. Does the facility have seclusion rooms?

2. Are there written policies for restraint and seclusion?

--What types of restraints are used?

--When is restraint or seclusion used?

What is the most common reason?

3. Are restraint and seclusion used mostly on admission wards?

Yes No

--Or are they used on most wards?

Yes No

4. How often is restraint/seclusion used for an "emergency" situation?

--how is "emergency" defined?

--who decides?

5. How is the use of restraint/seclusion documented?

6. Does the staff pride itself on being able to calm disturbed patient without using restraint or seclusion?

Yes No

Behavioral Modification

1. Are behavior management programs used?

2. What type of programs are in effect?

3. Do behavioral programs focus on positive reinforcement?

4. Are behavior programs individualized?

5. How many people are on behavior programs?

6. Who is involved in developing the program?

7. How are behavior management programs implemented and monitored?

8. Are there criteria for getting our of the program or graduating from the program?

9. Does the facility have a behavior management program review committee?

10. Is there mandatory staff training on behavior management?

Yes No

--When was training last held?

11. Are residents subjected to behavior modification programs which serve staff convenience rather than the good of the resident?

Yes No

Staff Qualifications

1. Are staff applicants screened to ensure their credentials are valid, they have no criminal history, there are no allegations of patient abuse in prior employment, etc.?

Yes No

2. Are personality characteristics of applicants (e.g., genuineness, empathy, warmth) used as important criteria for selection?

Yes No

3. Do clients and families have any part in screening applicants for employment?

Yes No

4. Is there intensive, ongoing staff training?

Yes No

5. Are staff characterized by adequate academic credentials?

Yes No

6. Do staff have previous experience with persons with mental illness?

Yes No

7. Does the institution experience difficulty in attracting and retaining professional staff?

--psychiatrists?

Yes No

--psychologists?

Yes No

--psychiatric nurses?

Yes No

--social workers?

Yes No

Comments:

8. How many staff have quit or were terminated recently (in the last month, six months, year)?

9. What are the procedures for staff dismissal?

10. Do all staff have the ability to clearly understand and communicate in English?

Yes No

11. Is job advancement partially determined by quality of patient care, not just administrative skills?

Yes No

12. Have any allegations of abuse been lodged against staff by clients?

Yes No

--If yes, what was done about this? What happened?

13. Is staff sufficient to ensure good care?

Yes No

14. Are staffing patterns on weekends and at night sufficient for good patient care?

Yes No

15. What is the administrative chain of command? Is it clear to staff, consumers, family members and advocates? Is there a policies and procedures handbook?

16. Does there appear to be a strong sense of cooperation among staff members and the administration?

Yes No

Staff/Patient Interaction

1. Are there official or unofficial staff and resident territories (special areas that belong exclusively to staff or residents?

Yes No

2. what are these places like?

3. Is there a clear division between "staff and patients" between "we and they" marked by attitude, territory?

4. Do staff talk to patients in a respectful and age appropriate way?

Yes No

5. Do staff talk about clients with a sense of respect and appropriateness?

Yes No

6. When do staff members talk to residents? (i.e., only during planned activities, or when client initiates request?)

7. Do staff talk to residents in a commanding or patronizing tone of voice?

Yes No

8. Do staff members treat residents' time as valuable, try to not keep them waiting?

Yes No

9. Do staff members raise their voices when talking to residents?

Yes No

10. Are residents ignored by staff members or treated as if they were not present?

Yes No

11. Do staff members gossip about residents?

Yes No

12. How do staff members refer to residents? (first name or last name?

--Is this reciprocal?

Yes No

Daily Routines

1. Do residents spend time in a number of different settings over the course of the day?

Yes No

2. What is the schedule of daily life compare with life in the community? (Would you say it is normalized or institutionazlied?)

--When do residents get up, bathe, and go to sleep?

3. To what extent are daily routines individualized?

--Do residents do things en masse?

4. What is a typical weekday for a resident?

--A typical weekend?

5. What are mealtimes like?

--Is food appetizing and nutritious?

Yes No

--Do residents have a choice of foods at each meal?

Yes No

--Is the atmosphere institutional?

Yes No

--Is there enough time to eat so that residents may have a leisurely meal?

Yes No

6. Do staff members eat with residents?

Yes No

7. Is there a canteen or snack bar?

Yes No

--who uses this?

8. Is there a place where residents may go to be alone?

Yes No

9. Do residents ever leave the institution during the course of a day?

Yes No

10. Do residents maintain their own living quarters?

Yes No

Clothing

1. Do residents have their own clothing?

Yes No

--Does their clothing look normal?

2. Are residents' clothes clean?

Yes No

3. Are all residents dressed?

Yes No

4. Is outdoor clothing available?

Yes No

5. Is there a difference between staff members clothing and residents' clothing?

Yes No

Personal Appearance and hygiene

1. Are residents well groomed enough not to attract attention?

Yes No

2. Are hair styles appropriate for patients' age and sex?

Yes No

3. Do residents have control over their appearance and hair

styles?

Yes No

4. What personsal hygiene items are available for residents to use?

5. Are residents assisted, when appropriate, in grooming and personal hygiene?

Yes No

6. Are residents encouraged to learn to do things for themselves?

Yes No

7. Are the bathrooms clean and free of odor?

Yes No

8. Is there toilet paper in the bathrooms?

Yes No

9. Are there toilet seats on the toilets?

Yes No

10. Are there soap and towels in the bathroom?

Yes No

11. Are there stalls with doors around the toilets?

Yes No

12. Are there shower curtains or doors?

Yes No

Residents' Rights

1. Are residents provided with privacy?

Yes No

2. Do staff members knock before entering residents' rooms?

Yes No

3. Are residents asked if they mind having outsiders visit their residence?

Yes No

4. Do residents have their own money and property?

Yes No

5. How is their money handled?

6. Are there any rules concerning mail?

Yes No

--Is mail censored?

Yes No

7. Are residents free to make phone calls in private?

Yes No

8. Are residents allowed to have visitors of their choice?

Yes No

Treatment

1. Is there an individual treatment plan for each patient?

Yes No

2. Is the individual treatment plan formulated with input by the patient unless he/she refuses to be involved?

Yes No

3. Is the family ivolved in its formulation unless they refuse to be involved?

Yes No

4. On initial admission is there a complete diagnostic assessment of each patient including neurological, psychological and laboratory examinations?

Yes No

5. Are physicians skilled in prescribing and monitoring medications for psychiatric disorders?

Yes No

6. Are all available medications tried where indicated, minimum maintenance doses set and possible side effects monitored? (e.g. is there an annual thyroid check for patients on lithium)?

Yes No

7. Are blood levels regularly used to measure antipsychotic and antidepressant drug use?

Yes No

8. Is a regular screening mechanism used for tardive dyskinesia? (Tardive dyskinesia is an involuntary neurological condition which can arise after psychotric drug use and which is sometimes irreversible).

Yes No

9. Are specialized tests (like magnetic resonance imaging) available where indicated?

Yes No

10. Do patients receive medical and dental care on a regular basis?

Yes No

Specialized Programs

1. Are there specialized programs for dual diagnoses including

--persons with mental illness and mental retardation

Yes No

--persons with mental illness and substance abuse

Yes No

--psychiatric patients with legal charges

Yes No

--specialized needs, e.g. deafness, vision impaired, pregnancy?

Yes No

Other

1. Are patients educated about their illness, avoidance of relapses, medications, etc.?

Yes No

2. Are patients legal rights protected by the ombudsman? Is there access to legal assistance?

Yes No

Recreation

1. Are exercise, occupational therapy, recreational therapy and other activities regularly scheduled?

Yes No

2. Are recreational facilities and equipment available to patients?

Yes No

3. How often are these available?

Observations of Activities (To be filled out about one ward)

1. How many people are on the unit?

2. How many staff are on the unit?

3. How many staff are interacting with clients?

4. How many staff are engaged in separate work, charting, visiting with each other, etc.?

5. What are patients doing?

---Number of people engaged in activities?

---Number of people watching TV or setting in day room?

---Number of people sleeping?

6. Do people show negative side effects from medications?

Yes No

--Describe

--Number of people

7. Was anyone in seclusion?

Yes No

--how many people?

--for how long?

--did staff check on person?

Yes No

How often?

8. Was anyone in restraints?

Yes No

--how many people?

--what kind of restraints?

--for how long?

--did staff check on person? How often? What did they do?

Staff Comments

1. If staff could change anything about the agency (program, unit), what would it be?

2. What would staff not want to see changed?

3. What is staff particularly proud of in the RTC?

4. What barriers do staff see to improving the program (agency, etc.)?

Please specify.

Views of the Client Advocate

Each RTC has an client advocate who reports to the Office of the Ombudsman for the Mentally Retarded and the Mentally Ill. Although the Ombudsman's Office now receives complaints from other residential facilities, 80 to 90 percent of all complaints still come from the regional treatment centers.

Arrange time during your visit(s) to the RTC to meet with the ombudsman and hear his/her report of patterns of complaints in that regional treatment center.