League of Women Voters of Minnesota Records

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INTRODUCTION

Definition: MONITOR: a person who observes, notices, listens, and tries to understand.

Welcome to the League of Women Voters of Minnesota Education Fund Mental Health Monitoring Project. By giving of your time to learn about mental illness and complete a monitoring assignment, you are providing a valuable and needed service to consumers, service providers and the community at large. Some of you will already have experience with mental health services while others will be learning about the difficulties faced by the mentally ill for the first time. If this is new to you, don't panic. The knowledge you gain and the experiences during monitoring will be positive and rewarding.

This volunteer packet includes:

Procedures for monitors
- A 'how to' set of instructions.
- Duties of Project Coordinators.
- Sample letters
- Sample vouchers
- Interview Techniques

Do's and Don'ts

Vulnerable Adults Act Policy

Confidentiality Policy

Agreements

Glossary

Acronyms

Resources

Bibliography

Self Test (optional)

Evaluation forms

Additional information from other organizations and agencies are also included.

Thank you for the time you are giving to make this exciting project possible.

Note: This project will not look at acute care units or individual or group therapy sessions.

Volunteer procedures:

1. Attend training session(s) and read your monitoring guidelines.

2. Meet with your coordinator and other monitors to;

   a) form teams of two or three monitors.
   b) decide where and what your team will monitor.
   c) go over checklists.
   d) choose a team leader for first visit.

3. Arrange an appointment for a preliminary meeting with the service provider at your chosen monitoring site. The team leader should do this. After the date is set, report the date, time and who you will meet with to your coordinator. Be sure to have proper spelling for names, correct titles, addresses and phone numbers.
   Note: If you are interviewing county officials, see 'The Professional Interview' at the end of this procedure outline.

4. At the preliminary meeting:

   a) Explain the project.
   b) Sign a service provider agreement.
   c) Release forms are not required by state law to view a program because you will not look at records and will give plenty of time for consumers who wish to leave a facility to do so. However if the service provider has release forms that he/she would like signed, sign them at this time.
   d) Make an appointment for your first visit.
   e) Leave copies of the checklist(s) that you will be using with the service provider. You may wish to interview the service provider at this time and/or at meetings during your two visits at the facility.
   f) Report dates of the first visit to your coordinator.

5. Make your first visit. (Allow 45 minutes or less for each visit.)

   a) Visit with a positive attitude.
   b) Be thoughtful and courteous.
   c) Assume that the service providers care.
   d) Respect the rights and wishes of the consumers who have agreed to have you visit them.
   e) LOOK! ASK! LISTEN!
   f) Ask yourself, "Would I like to live, work or participate in this program?"
   g) Review 'Interview Techniques' in this packet.
   h) Do not carry checklists with you during visits. (No clip boards etc.) If you must take notes, do so discreetly. Remember, you are a visitor, not an inspector or regulator. You may have checklists when talking with staff in their offices.

6. Meet with the service provider at close of the first visit and get staff imput.

7. Thank service provider, consumers and staff. A thank you note would be very nice. It need not be formal.

8. Arrange for a second visit.

9. Meet with your team to fill out checklists, evaluation forms, ect. and return forms to coordinator within five days. Report date and time of second visit to coodinator.

10. The Team leader should call and re-affirm second visit time at least one week before the scheduled visit.

11. Make the second visit. Use the same focus as with the first visit.

12. At the end of the second visit have a final follow-up meeting with the service provider. Give positive feedback if possible. Overall review of your findings will be given by your project coordinator.

13. Thank the service providers, consumers and staff.

14. Meet to fill out final checklists, evaluation forms, etc. Note any changes from first visit.

15. Give all report materials to coordinator.

The Professional Interview:

1. The team leader should arrange an appointment for a meeting and report the date, time and who you will meet with to your coordinator. Be sure to have proper spelling for names, correct titles, addresses and phone numbers.

2. When you make the appointment, explain why you want to interview the official/professional and ask if they would like to have a copy of the checklist(s) you will be using. If they would like to see it ahead of time send it to them.

3. Visit with a positive, professional attitude. Dress as if going to a job interview. Ask and LISTEN.

4. You may carry checklist(s) with you. Take notes. Do not use tape recorders.

5. At the end of the interview, thank the official/professional for their time. Ask if you may contact them within six months to see if any changes have occured.

6. Report back to your project coordinator and request that a formal thank you note be sent.

7. Meet with your team to fill out or add information to the checklist(s).

8. Decide on the date, time and method (phone call, visit) for a second contact.

9. Give report materials to coordinator. This should be done within five days of the visit.

10. After the second contact, report any changes to your coordinator for the final report. Let your coordinator know if a review of your findings is requested.

Note: This project will not look at acute care units or individual or group therapy sessions.

A rule of thumb: When walking through residential facilities and visiting with clients, do not carry checklists. When interviewing professionals, officials, service providers and staff in their offices you may use your checklist.

Date:

Service Provider
address

Dear_____,

The League of Women Voters of_____,
is conducting a Mental Health Monitoring Project in _____
County as part of the LWVMN Education Fund Mental Health Monitoring
Project funded by the McKnight Foundation.

The objective of the project is to enhance community services for persons with mental illness by fostering cooperation with county officials and service providers, and recognizing areas of strengths and creativity, as well as deficiencies.

Our monitors would like to include your program in this project.
_____, will be contacting you to make an
appointment to explain the project and set appropriate times to visit
your facility (agency).

If you have any questions after meeting with _____,
and our monitoring team please to contact me at:

Thank you for your assistance.

Sincerely,

Project Coordinator

Date:

Service Provider
address

Dear_____,

The League of Women Voters of Minnesota Education Fund and _____(Local League) thank you for participating in the Mental Health Monitoring Project.

Without the assistance of you and the many other service providers throughout the state, this project would not have been possible.

We especially thank the consumers associated with your program. Their willingness to share their experience with our monitors is invaluable.

A copy of the final report on this project will be sent to you after it is completed in July, 1991. If you would like to review the findings of our monitoring team, please contact me.

Again, thank you for you time and cooperation.

Sincerely,

Project Coordinator

Date

Name
Address

Dear Commissioner_____:

The League of Women Voters of _____ has been awarded a passthrough grant from the League of Women Voters of Minnesota Education Fund to conduct a monitoring project of mental health services in _____ county. The funding is from a grant awarded to the LWVMN Education Fund by the McKnight Foundation. Our focus will be on cooperating with county officials and service providers to work toward stronger community services for persons with mental illness in keeping with the 1987 Comprehensive Mental Health Act for Adults and the 1989 Comprehensive Mental Health Act for Children. As you may know, the Minnesota Association of Counties was one of the co-sponsors for our four monitoring workshops held in the fall of 1989.

The project will utilize checklists developed by the League of Women Voter of Minnesota through an initial McKnight grant. Although the checklists provide for noting concerns about the adequacy of services, considerable emphasis is also placed on highlighting creative solutions and programs that work well. In addition, an attempt will be made to note barriers to providing services, one of which may be inadequate funding. At the conclusion of the project we expect to report our findings at both the local and state levels. (Negative findings about specific programs will ordinarily only be shared with the provider and lumped together in reporting.)

All volunteer monitors will receive training. We will make every effort to safeguard the rights of clients in programs and the sensibilities of staff.

In addition to members of the League of Women Voters, volunteer monitors will include members of _____.

We would be most happy to answer any questions you may have about the project and look forward to working with the county in an attempt to heighten public understanding of the problems which face persons with serious mental illness in the community and to being part of the solution.

Sincerely,

Project Coordinator

Duties:

1. Arrange Training Session(s).

2. Meet with monitors to:
   a) form teams
   b) assign programs
   c) choose checklists

3. Send a list of programs and facilities to be visited to the LWVMN Project Director. This will prevent an agency, facility or program from being visited by more than one monitoring project. Teams made up of monitors from more than one county may be created to monitor Rule 36's and RTC's.

4. Send a letter announcing the project to all programs, agencies, officials and facilities to be visited. (See sample letter)

5. Keep track of appointment and visit dates and times.

6. After receiving the first reports, send evaluations and progress reports to the LWVMN Project Director.

7. Trouble shoot. Be available if a problem should arise.

8. At the beginning of your project you may release news of the project to local papers, pointing out goals and objectives.

9. Check with team leaders to ensure that appointments for the second visits have been made.

10. Keep track of second visit dates and times.

11. Send a formal thank you letter to each service provider within one week of the second visit. Include an offer to review the findings of the monitoring team. (See Sample letter)

12. After receiving final reports, send copies to the LWVMN Project Director.

13. Help distribute general state wide findings.

14. Other duties may be assigned by your local League President.

VOUCHERS

Some Monitors will be asked to keep records of expenses by their Project Coordinators. Enclosed are sample vouchers that may be useful to you. If you are asked to keep records, make sure you save all receipts and attach them to completed vouchers.

Auto Mileage Record				
Date	Start	Stop	Miles	Tolls & Parking

Total Miles_____ Parking_____

TOTAL @ _____¢ per mile_____

Total Auto Expense_____

Name:_____

Expense Record				
Date	Phone	Child Care	Other	Totals

Total Expenses_____

Name: _____

INTERVIEW TECHNIQUES

1. Ask open ended questions.

2. Listen . Many of us have a tendency to equate the worth of what is said with the way in which it's said. In other words, the content-delivery equation colors our judgment of the value of what we listen to. We often make the mistake of suspending our critical faculties when the delivery is effective.
   Conversely, although it's difficult to listen to a speaker who fails to express him or herself adequately, we must still dig for content.

3. Listen with questions in mind. Focus on your purpose. Ask yourself:
   * What's the speaker saying?
   * What does it mean?
   * What point is the speaker trying to make?
   * Am I getting the whole story?
   * Are the points being backed up?
   * Is this fact? Opinion? Assumption? Generalization?
   * Is the speaker leaving anything out?
   * Are my biases blocking my listening?

4. The person you interview should perceive you as someone helping to develop the meaning in the situation.

5. Evaluation, positive or negative, affects the meaning a speaker will give you.

6. Paraphrase to check your understanding. Paraphrase meaning, not words.

7. Keep a positive attitude. Be confident.

Do's and Don'ts

DON'T:

use the monitoring project as a platform to LOBBY.

use names of any consumers.

visit individual consumers without another monitor or staff member present.

use clipboards and carry checklists through facilities.

change standard monitoring proceedure.

DO:

respect consumers rights!

visit with an open mind.

give checklists and any information requested about the project to service providers.

act as informally and unobtrustively as possible.

keep your coordinator informed!

LOBBYING ADDENDUM

Lobbying is interpreted as advocating with public officials or in the media for political change.

Since the mental health monitoring project is an Education Fund project, funded as an educational program, it must not involve lobbying. It is not permitted to state that the LWV Mental Health Monitoring Project advocates specific changes in laws, regulations or funding, or that you represent the LWV Mental Health Monitoring Project and advocate specific changes in laws, reguations or funding.

Information gathered by monitoring teams may not be used for lobbying for the duration of the project. After June 1991, when the education fund grant has ended, a final report will be published and made available to the general public.

IT IS CRUCIAL THAT THE MONITORING PROJECT NOT BE CONNECTED WITH ANY LOBBYING ACTIVITY!

A note on publication.

It is the intent of the project to educate, form coalitions and improve the services to the mentally ill.

Public relations and the news media play an important role if we are to succeed in our objectives.

By sponsoring informational meetings about mental illness, with the cooperation of service providers, agencies, consumers and advocates, part of our goals can be realized. If these meetings become forums for lobbying or for targeting programs lacking the level of quality we would all like to see, the cooperation of service providers and the objectivity of the project could be damaged. This is also true of press releases. Newspaper editors will want to print items about the project. Make sure the news releases you submit are objective, educational, and positive. This is an EDUCATION FUND project. This is not a forum for lobbying.

LWVMN MENTAL HEALTH MONITORING PROJECT POLICY

for

MINNESOTA VULNERABLE ADULTS ACT

Vulnerable Adults are Persons age 18 or older who:

--live in licensed facilities such as nursing homes, hospitals, treatment centers for chemical dependency, mental retardation, mental illness or physical disabilities

--receive services from licensed facilities such as developmental achievement centers or home health agencies

--are in a family setting and would not by themselves report abuse or neglect because of impaired physical or mental function, or because of emotional status.

Definition

Physical abuse: conduct that produces pain or injury and is not accidental, or use of aversive and deprivation methods without following proper procedures.

Verbal abuse: repeated conduct that produces mental or emotional stress.

Sexual abuse: violation of criminal sexual conduct or prostitution statues.

Exploitation: illegal use of vulnerable adult's person or property through undue influence, duress, deception or fraud.

Caretaker neglect: failure of care taker to provide necessary food, clothing, shelter, health care or supervision.

Self-neglect: absence of necessary food, clothing, shelter, health care or supervision.

Exploitation thru neglect: absence of necessary financial management, that might lead to explortation.

(Adapted from "People Who Need People",Minnesota Department of Human Services, 1985 and ARC Volunteer Workbook)

PROJECT POLICY

Any Volunteer monitor who has reason to suspect abuse or neglect will notify the Project Director at 612-224-5445, LWVMN, 550 Rice Street, St. Paul, MN 55103, within 24 hours.
If the Project Director is not in the office when you call give your name and phone number and let the state office personel know you wish to report a Vulnerable Adults Act violation. You will be contacted as soon as possible.

LWVMN MENTAL HEALTH MONITORNG PROJECT POLICY

for

CONFIDENTIALITY

As monitors we will not look into any consumer records, progress reports, medication records, ect.

We will not use names of consumers in reports or in conversation at any time.

We will respect the right of consumers to refuse to speak with us at all times.

We will not use the names of staff members or facilities in any discussion of deficiencies unless authorized to do so by staff and facility directors.

Any violation of the Confidentiality Policy will disqualify a monitor from participating in the project.

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.

ACRONYMS

CSP	Community Support Services Program
CSSA	Community Social Services Act
DHS	Department of Human Services
GA	General Assistance
GAMC	General Assistance Medical Care
IMD's	institutions for mental diseases
MA	Medical Assistance, Medicaid, Title XIX
MHAC	Mental Health Advisory Council
MSA	Minnesota Supplemental Aid
RTC	Regional Treatment Center (State Hospital)
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TD	Tardive Dyskinesia
TDD	telephone device for the deaf

RESOURCES

Special thanks to the following people for their contribution of time, materials and information to this training packet.

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BIBLIOGRAPHY

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Self Test

Circle the correct letter.

1. Rule 5 and Rule 36 refers to state licensing standards for:
   a) Residential Treatment Facilities
   b) Residential Treatment Centers
   c) Mental Health Professionals
   d) Case Management

2. Bipolar affective disorder is commonly known as:
   a) Manic Depression
   b) Major Depression
   c) Hallucination
   d) Psychosis

3. CSP is:
   a) Community Social Services Program
   b) Central States Power
   c) Community Support Services Program
   d) Community Supplemental Security Plan

Match the following by placing the correct letter (a,b,c,d,e, f or g) in the blank.

1. Bipolar Affective Disorder ____

2. Community Support Services Program ____

3. Community Social Services Act ____

4. Regional Treatment Centers ____

5. Lower-Income Rental Program ____

6. Federal "Social Service" funds ____

7. Psychosis ____

Answers:
a) CSP b) Section 8 c) RTC d) psychotic e) CSSA f) Manic Depression
g) Title XX

Answers: (1-a, 2-a, 3-c, 1-f, 2-a, 3-e, 4-c, 5-b, 6-g, 7-d)

PROGRESS REPORT AND CHECKLIST EVALUATION

DATE:

COUNTY:

CONTACT PERSON:
ADDRESS:
PHONE NUMBER:

COUNTY SOCIAL SERVICES DIRECTOR:

COUNTY MENTAL HEALTH ADVISORY CHAIR:

NAMES OF PEOPLE INTERVIEWED/FACILITIES MONITORED AND DATES OF INTERVIEWS:

WHAT WAS THE SUBJECT OR FOCUS OF YOUR MONITORING?

SUMMARIZE BRIEFLY HOW YOU GATHERED THE NECESSARY INFORMATION.

LIST THE 3 STRONGEST FEATURES OF THE SERVICE, PROGRAM OR FACILITY YOU MONITORED:
1.

2.

3.

LIST UP TO 3 IMPROVEMENTS WHICH COULD BE MADE ON THE SERVICE, PROGRAM OR FACILITY YOU MONITORED:
1.

2.

3.

DID YOU HAVE ANY PROBLEMS WITH THE CHECKLISTS? YES NO
IF YES GIVE NAME OF CHECKLIST:
PAGE NUMBERS:
QUESTION NUMBERS:
PROBLEM:

TRAINING EVALUATION

Please take a moment to fill out this questionnaire. It will help us do a better job providing training to volunteers in the future. Thank you.

How would you evaluate the contents of the training packet?

Poor Fair Good Excellent

Was the presentation clear and informative?

Yes No

Were all your questions answered?

Yes No If not, what questions do you have that should be included?

Comments:

Name:
Address:
Phone Number:

There may be a great fire in our soul, but no one ever comes to warm himself at it, and the passers-by see only a little bit of smoke coming through the chimney, and pass on their way. Now, look here, what must be done, one must tend that inward fire, have salt in oneself, wait patiently yet with how much impatience for the hour when somebody will come and sit down near it - to stay there maybe?

Vincent Van Gogh

Constable: The Letters of Vincent Van Gogh (3rd edn, Fontana, 1970), ed. Mark Roskill.

The following words are from Richard Jameson. He developed the symptoms of schizophrenia at the age of 22 while acting the part of a madman in a play. In 1961 he was President of the Oxford University Dramatic Society. He had won scholarships to Winchester school and Magdalen College, Oxford.

"It is being out of control, not necessarily depressed or elated but in a dream world and unable to get through to anybody else who thinks you're mad.....Yes, I was mad and what a terrible situation I was in. It was like being clothed with a strait-jacket almost automatically. I realized that nothing I could say or do at that moment would alter the fact.... they were quite right in saying that I was mad and they weren't."

Of his fantasy world he remembers:

"My mother was in league with the Queen to dupe the public into bying things like calendars and watches - there's no such thing as time. She started Richard Shops for me. And she had various crimes on her plate and I imagined a courtroom scene above my flat. I could hear every word of this trial and the buzz of the electrodes as they tortured my mother. And there was a BBC matron sort of type who was in charge of the court and she said, 'Do you want to say anything, Richard?' And I said, 'Yes, I do,' and I said this and that and the other and then she relayed it back to the Court because they couldn't hear. She said, 'Richard says such and such a thing,' and then my mother made some sort of garbled comment and it went on, I should say, for about half an hour. And my mother's tongue was cut out and she came down the steps screaming and yelling with her tongue cut out and was taken off to prison or something like that. Oh no, she didn't go to prison, she went to build her own walled garden. Most people were tortured or killed but she had the privilege of building

her own walled garden from the inside, you see, so you eventually wall yourself in. Quite painless until you die of starvation in the end."

"I knew what it felt like to be God as I'd acted the part in a play."

" I was the star of a huge film that was being made all over London with hidden microphones. And I found myself sitting in a cafe somewhere and talking to the hidden microphones, until the proprietor slung me out. It was marvellous when I went to Queensway Ice Rink and went on the ice and there were camera bulbs popping away and I thought, 'Oh, this is terrific, they're doing the whole thing,' and in fact it was one of those automatic photographic machines, you know, doing its popping away. But everything fitted into my dream and I was on cloud number nine."

It's been over 20 years since his first attack and he was admitted to ten hospitals before he was admitted to a small therapeutic community and helped with drugs. He began to recover. On being asked if he is cured:

"It's been a matter of bouts, you know, bouts for various reasons, interspersed by say a couple of years or five years of perfect health. I've just been out of hospital for five or six years and I'm just due for my next bout. I hope it doesn't happen. I very much hope it doesn't happen because I'm making desperately sure that I'm all right all the time."

Gilling, Dick and Brightwell, Robin, The Human Brain, Facts On File, Inc. 460 Park Avenue South, New York, N.Y. 10016. 1982. pp. 147-161.

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Thief River Falls, MN 56701
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MH County Advisory Council
Mental Health Division
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MH County Advisory Council
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Chairperson, Mower County
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9/89

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Brooklyn Park, 55444
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July 18, 1989

Primary
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McGregor, MN 55760

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Grand Marais, MN 55604

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% Debbie Olson
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Hennepin County AMI
Ms. Barbara Coleman
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Mpls., MN 55410

Hiawatha Valley AMI
Mr. Don Kaufman
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Winona, MN 55987

Houston County AMI
Mr. Bill Schutz
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Caledonia, MN 55921

Iron Range AMI
Dan Mattila
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Itasca County MHAC/AMI
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% Marian Mayerhofer
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Elk River, MN 55330

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Fridley, MN 55432

GOODHUE COUNTY AMI
% Mr. Jim Cook
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Red Wing, MN 55066

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Mary L. Pfeffer
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Waconia, MN 55387

CROW WING CTY. AMI
% Harold Olson
Star Rt. Box 209
Deerwood, MN 56444

DAKOTA CTY. AMI
% Jean Brown
2007 Sibley Ct.
Brunsville, MN 55337

LOCAL AMI GROUPS	TIME	MEETING PLACE	CONTACT PERSONS
Aitkin County Mental Health Advocates	*(no set time)*	*(no set place)*	Liz Perrine (218) 426-3332
Anoka County AMI	2nd Thurs., 7:30 p.m.	Fridley Library 410 N.E. Mississippi St.	Dan Brodhead (612) 572-8483 Romma Maloy (612) 784-5022
Carver County AMI	3rd Thurs., 7 p.m.	Moravian Church 209 2nd St. E., Waconia	Alice Haller (612) 448-6543
Cook County AMI	2nd Tues., 7 p.m.	Congregational Church, Fireside Room, Grand Marais	Beryl Schroeder (218) 387-2910
Crow Wing County AMI (Brainerd)	last Tues., 7 p.m.	St. Joseph's Hospital, Brainerd	Harold & Lu Olson (218) 546-6268
Dakota County AMI	2nd Mon., 7:15 p.m.	Norwest Bank, South St. Paul	Millie Martineau (612) 450-1284 Jean Brown (612) 894-4240
Duluth Area AMI	3rd Tues., 7 p.m.	HDC, 1401 E. 1st St.	Debbie Olson (218) 525-5884
Goodhue County AMI	3rd Mon., 3:30 p.m.	Dakota House, Red Wing	Jim Cook Sr. (612) 388-3206 Dorothy Holmes (612) 388-9389
Hennepin County AMI	3rd Fri., 7:30 p.m.	Mt. Olivet Lutheran Church, Mpls. 50th St. & Knox Ave. S.	AMI/MN (612) 645-2948
Hiawatha Valley AMI (Winona)	3rd Mon., 7:30 p.m.	Winona Co. Off. Bldg., Conf. R. A 202 W. 3rd St.	Don Kaufman (507) 454-2366 Kevin O'Brien (507) 452-9307
Houston County AMI	1st Mon., 10 a.m.	Houston Co. Court House	Bill Schutz (507) 724-5397 Jerome Gilson (507) 495-3171
Iron Range AMI	*(no set time)*	*(no set place)*	Pat Lamppa or Dan Mattila (218) 741-4714
Itasca County MHAC/AMI	4th Thurs., 4:30 p.m.	Central School, Grand Rapids, Downstairs Mtg. Room	Patti Stanley (218) 326-6881
Milaca Area AMI	4th Thurs., 7:30 p.m.	Fairview Milaca Hospital, Milaca	Mary Fehring (612) 983-6724 Carol Hass (612) 396-3333
Mora Area AMI	2nd Tues., 7:30 p.m.	Kanabec Co. Hospital, Mora	Kay McCarty (612) 679-2285
Mower County AMI	4th Thurs., noon	Adult Community Treatment Program	Joan Lindquist (507) 433-2303 Dorl Kallman (507) 433-7479
Pine County AMI	3rd Tues., 7:30 p.m.	Zion Lutheran Church	Ray Schultz (612) 629-3193
Ramsey County AMI	1st Thurs., 7 p.m.	Mary Hall (next to St. Joseph's Hospital)	Sue Peterson (612) 290-9807
Rice County AMI	2nd Fri., 1:15 p.m.	Northfield/Faribault	Marilyn Carver (507) 645-8175
Rochester Area AMI	3rd Thurs., 7:30 p.m.	Ability Bldg. Center 1911 N.W. 14th St.	Wayne & Joyce Schut (507)282-6676.
SAM/AMI	3rd Mon., 7:30 p.m.	6950 France Ave. So., Mpls., Conference Room	Dorothy Bates (612) 922-6916 Ruth Johnson (612) 593-5375
Scott County AMI	1st Mon., 7 p.m.	First MN Savings, 738 E. 1st Ave., Shakopee	Marian Mayerhofer (612) 445-2382 Kathy Anderson (612) 447-8603
St. Cloud Area AMI	3rd Tues., 7:30 p.m.	Central MN MH Ctr.	Gerri Gustafson (612) 251-3842
Washington County AMI	2nd Tues., 4:30 p.m.	HSI, 7066 Stillwater Blvd. N., Oakdale	Eileen Herbert (612) 459-6973
Wright County AMI	1st Mon. 7 p.m.	Comfort Inn, Monticello	Arleen Hoglund (612) 295-2866 Loren Blackwell (612) 427-0969

REACH Group Roster

*Because variations could occur, be sure to call the Contact Person to verrify meeting time and location.

9-89

Town	Day/Time	Meeting Location	Contact Person	Phone #
Albert Lea	4th Thursday 7:00 pm	Trinity Lutheran Church 501 South Washington	Virginia Anderson Helen Bucklin	(507) 373-4532 (507) 377-2136
Alexandria	3rd Monday 7:00 pm	Douglas County Hospital (Aux. room) 111 17th Avenue East	Ron Nielson Irene Lorenz	(612) 763-3058 (612) 763-7074
Bemidji	1st Tuesday 6:30 pm	Apartment 3 900 15th Street	Ruby Anderson	(218) 759-1399
Bloomington	4th Tuesday 7:30 pm	Creekside Community Center (Lib.) 9801 Penn Avenue South	Pat Bugenstein Phyllis Abrahams	(612) 888-5309 (612) 881-4343
Buffalo	2nd Tuesday 7:00 pm	Buffalo Courthouse(Annex)	Wright County Social Services	(612) 339-6881
Crookston	4th Monday 7:30 pm	Our Savior's Lutheran Church 217 South Broadway	Esther Vandervort Lyla Newhouse	(218) 281-7716 (218) 281-3575
Duluth I (family & friends)	2nd Thursday 7:30 pm	Hwy. Host meeting room Hwy. 35 &27th Avenue West	MHA of Duluth	(218) 726-0793
Duluth II (parents)	2nd Thursday 7:30 pm	Human Development Center 1401 East 1st Street	MHA of Duluth	(218) 726-0793
Elk River	2nd Tuesday 7:00 pm	Sherburne County Social Services Courthouse Drive & Hwy. 10	Wayne Munday	(612) 441-3571
Fairmont	4th Thursday 7:30 pm	Grace Lutheran Church (lounge) 300 South Grant	Phyllis Martin	(507) 764-2519
Fargo/Moorhead	2nd Monday 7:30 pm	Mental Health Association 506 Robert Street	MHA of N.D.	(701) 237-5871
Little Falls	3rd Wednesday 7:00 pm	New Courthouse, Room 2	Alice Przybilla Cathy Honer	(612) 632-5960 (612) 632-2941
Mankato	2nd Monday 7:30 pm	Immanual-St. Joseph's Hospital Conference room D, 1st floor	Winston &Shirley Grundmeier Jane & John Foster	(507) 388-7246 (507) 345-4892
Milaca	1st Tuesday 7:00 pm	Trinity Lutheran Church 735 2nd Street	Mary Fehring	(612) 983-6724

REACH Group Meeting Schedule (continued)

Minneapolis, NE	2nd &4th Tuesday 6:45 pm	Eastside Neighborhood Services 1929 2nd Street NE	Joyce Dougherty	(612) 333-5178
Minneapolis, So.	1st & 3rd Monday 7:30 pm	Bethlehem Lutheran Church (rm.221) 4100 Lyndale Avenue South	Mary DeLong Georgette Ario	(612) 825-8628 (612) 824-7675
Oakdale	2nd Thursday 7:30 pm	Washington County Human Serv. 7066 Stillwater Blvd.	Margaret Kaufhold Phil Martin	(612)739-0760 (612)779-5057
Owatonna	3rd Monday 7:00 pm	Associated Church 800 Havanna Road	Ginna & Oren Anderson	(507) 451-5141
Robbinsdale	2nd Thursday 7:00 pm	Elim Lutheran Church 40th & West Broadway	Joyce DeMathew	(612) 559-0553
Rochester	2nd & 4th Monday 7:30 pm	Bethel Lutheran Church 810 3rd Avenue S.E.	Carol Steffenson Gerald & Maridell Gilreath	(507) 282-0351 (507) 282-7047
St. Cloud	3rd Monday 7:00 pm	United Church of Christ 8th Avenue & 4th Street South	Jan & Rich Hannig Dolores Pokela	(612) 252-1690 (612) 252-9245
South St. Paul	2nd & 4th Wed. 7:00 pm	Da-Trac 161 North Concord, Suite 320	Joan Schierman	(612) 451-6840
Wadena	1st Monday 7:00 pm	Nothern Pines 418 North Jefferson	Northern Pines	(218) 631-2462
Willmar	2nd Thursday 7:30 pm	St. Mary's Catholic Church 713 West 12th Street	Judy Schneekloth	(612) 235-4577

For further information, contact:

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~~Helen Klanderud~~ Nadine Phillips
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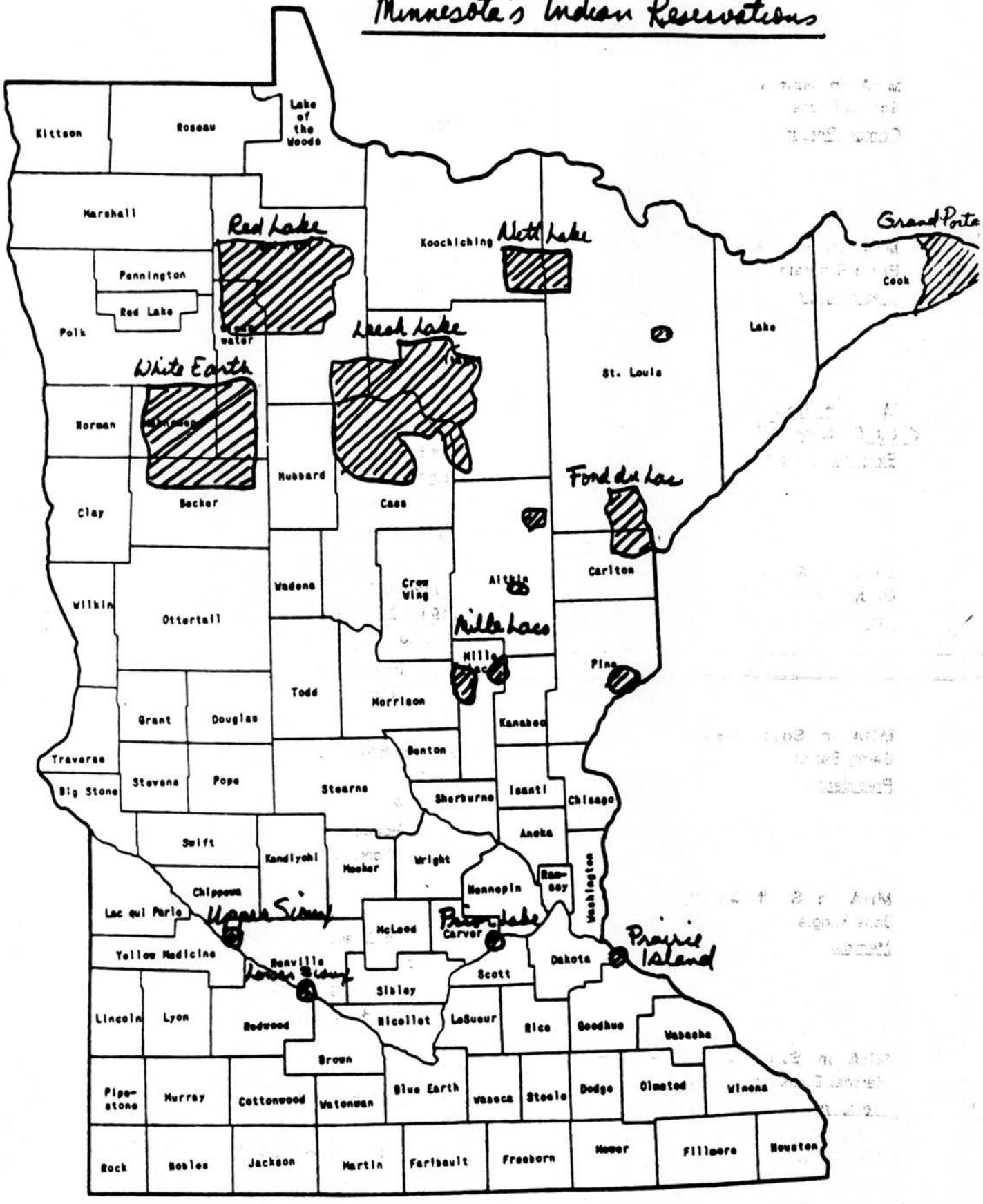
Minnesota's Indian Reservations



LWV of Minnesota Education Fund, 550 Rice Street, St. Paul 55103

MONITORING VOLUNTEER GUIDELINES

The League of Women Voters of Minnesota Mental Health Monitoring Project proposes the following guidelines for volunteer monitors. It is our conviction that a mutual understanding of expectations can result in serious monitoring efforts of high quality.

Volunteer Monitors should:

--participate in training when offered.

--thoroughly familiarize themselves with the checklists before monitoring visits.

--approach officials, service providers and consumers with an open mind.

--make every effort to respect the good will of those interviewed.

--treat all visits and reports with confidentiality.

--monitor in teams of three or two; never in groups of more than three in areas where consumers live or work.

--act as informally and unobtrustively as possible in programs serving clients.

--arrive promptly for monitoring appointments.

--make monitoring visits and prepare written reports only as a member of a monitoring team.

--respect consumer's (client's) right to refuse access to personal space or to decline to talk with monitors.

--visit with individual consumers (clients) only when staff or another monitor are present.

--notify the team leader if unable to be present for a scheduled visit. This should be done as early as possible to permit rescheduling of the visit if ncessary.

Morley House

by Tom Rogers

Introduction

Many people assume that mental illness is more prevalent in metropolitan areas than it is in rural areas. They think smaller towns, where there's a more relaxed pace, are more conducive to good mental health.

However, the incidence of mental illness in a smaller town is just as high as it is in an urban center. Somewhere around 15% of any population—urban or rural—suffers from mental illness. This figure doesn't exclude Goodhue County by any means.

But the statistics on the whole area of mental illness don't take into account an important consideration about Goodhue County. They don't show how the people of Goodhue County have pulled together to deal with mental health issues in their county. Statistics can't tell that story.

People in rural communities probably don't treat the stigma of mental illness with the same openness as it's treated by urbanites. This may be in the nature of things. But, what *is* certain is the advantage that an area like Goodhue County has in terms of *doing* something about mental illness.

Because of the cohesiveness found in smaller towns, if and when the residents there decide to act, you're going to get action! Larger cities simply don't have this unity of spirit.

Goodhue County advocates have this unity, and in the last couple of years, they've taken advantage of it. Thus, Goodhue County was chosen to be the subject for the following article.

Hopefully, concerned parties in other counties will utilize the Goodhue County model as they attempt to initiate community programs of their own.

Dorothy Holmes...

It was about five years ago that grass roots organizations concerned with mental health issues started forming in Goodhue County. These embryonic organizations were composed of frustrated consumers who had found that services for dealing with mental illness were either extremely limited or non-existent.

"We really started from scratch," commented Dorothy Holmes, president for both the Goodhue County Chapter of MHAC and the Mental Health Advisory Committee for Goodhue County.

Dorothy added, "The strides being made here are due to the efforts of concerned citizens and consumers of mental health services who could see the large number of families needing services. Available housing for mental health clients was an identified need."

Two years ago, Dorothy approached Regina Nicolosi, president of the Parish Council for St. Joseph's Catholic Church in Red Wing, about this problem of housing. Dorothy suggested that the upstairs rooms of Morley House, owned by St. Joseph's, be used as a residence for recovering mentally ill persons who needed a place to reside.

"I was really pleased when Dorothy made the suggestion," Regina recalled, "because I was hoping that we could use the place for something like this."

Nothing happens overnight and such was the case for the new Morley Hosue program. When final arrangements were adequately worked out many months later, Morley House had its first resident.

Karen Fiss...

Karen Fiss, a young woman who was working through her emancipation from her family, moved in on June 1, 1981. Before moving in, Karen's attitude about Morley House was ambivalent. She knew she needed some support and a place to live and didn't have much money, so Morley House was an alternative.

"The place was pretty run down," Karen explained, revealing her hesitancy, "and I had the idea that there would be stigma attached to living there."

Karen, who had been hospitalized several times for problems she'd experienced in the past five years, discussed her situation with Regina and decided to move in.

Looking back now, Karen's glad she did. She described her stay at Morley House as her "first taste of independence," since she'd never been on her own before.

She explained, "What really made a difference was taking that first big step toward independence. By living alone, I was forced to feel more comfortable being alone as well as to seek out friends and things to do on the outside."

Karen stayed at Morley House for four months. She moved out in late September of '81. She has not been hospitalized nor had any major problems since that time.

"I think the independence and being responsible for my own actions was the most significant factor in making a recovery from my previous situation," Karen pointed out.

While at Morley House, described by her as "a real dump at the start," Karen scrubbed, painted, and "generally fixed the place up." She received help with these jobs from members of the Red Wing community, another example of the community involvement in this project.

"Nobody knew who was responsible for what," Karen recalled with a smile, "so this held things up for a while, but many community members pitched in to help out."

Three individuals that Karen singled out in particular for their contributions were Regina Nicolosi, Nick Even, and Sara Ousky.

Sara Ousky...

Sara Ousky has been involved with Morley House because she is both a social worker with Goodhue County Social Services and a co-chairperson of the social concerns committee of St. Joseph's Church.

Because of her dual role, Sara said "it was easier to generate enthusiasm when a real need for housing for the chronically mentally ill sprang up about a year ago."

"The clients involved rent from the Church, so the program is reality-based," Sara said. "It's the same as renting from a regular landlord."

But the Morley House residential project is only one of many encouraging developments in the field of mental health to occur in Goodhue County, according to Sara.

The Goodhue County Community Support Program (CSP), headquartered in the downstairs offices at Morley House, is one of the most encouraging of those encouraging developments.

Nick Even...

Coordinator for CSP is Nick Even, who pointed out that CSP is funded under Department of Public Welfare (DPW) Rule 14, which pertains to new, experimental community programs. The Rule 14 legislation was proposed originally by MHAC.

"It was the parents of mentally ill persons who wrote the first draft of our Rule 14 grant request," Even said. "After several revisions, they submitted it to the county commissioners who in turn approved it."

In effect, according to Even, "the whole program started from the bottom up rather than from the top down, following the pattern of grass roots involvement. Because of this, the broad base of support at the bottom gives the whole thing a community-based spirit and also a sense of responsibility about what comes after."

Another important consideration Even mentioned is the dual focus of the program. "We approach the whole problem as a family concern," he said, "because in most cases the family is hurting, confused, and frustrated as well as the individual involved.

"When families are included, often their immediate reaction is that they are being blamed. They conclude that if they can be part of the solution, they therefore must have been part of the problem. We explain that we don't know what causes mental illness, but that we do believe that how families respond to their loved ones with emotional problems can be helpful in their recovery, and especially so in the early stages of onset.

"You see, we're not trying to develop a cadre of professional services to meet the needs of the mentally ill individual and the individual's family, but rather to develop a therapeutic community that will meet the needs of everybody."

Nick said the grass roots character of CSP contributes to its effectiveness. "It takes a long time to get a project going from the grass roots level, but once you get it going, it works so much better than when the professionals do it on their own," he explained.

Joan Close and Bob Glasenapp...

Outreach facilitators for CSP are Joan Close and Bob Glasenapp. Bob, who's been with the program since last October, explained its basic purpose: "Our main focus is to smooth the transition between hospitalization and community living. We do this by helping our clients develop the necessary coping skills for daily living.

"We sit down with individuals and try to develop goals that are part of an individualized program plan. The process is a joint effort. We realize that the main responsibility for making changes that will lead to success lies within the individual. We try to provide the guidance and direction to help people realize their potential for making changes and improving their lives."

Joan has been with CSP since it began a year and a half ago and is given much credit for getting it go-

ing in the right direction

She pointed out that "our program is growing very rapidly. Our client load has doubled in the last six months. We continue to offer new services, such as a prepetition screening team, which we hope will assist those who are experiencing crises in their families.

"Another facet of our program are the regular meetings that are held on Tuesdays for Cannon Falls residents who are in need of our services."

Areas that CSP concentrates on include long-term supportive counseling, crisis assistance, social and recreational activities, community living skill training, housing assistance, coordination of services, and job development.

Bob mentioned that he and Joan work closely with the sheltered workshop (Interstate Rehabilitation Center) since they recognize that the positive benefits individuals receive from being employed can be a major factor in the recovery process.

The social recreation group, which meets on Wednesday afternoons, was formed in response to a specifc need. "The population we serve has a tendency to become isolated from people. Thus, we try to provide opportunities for them to socialize with others," Bob explained.

Said Joan, "Ours is a flexible program. We're responding to what the community wants. Admittedly, there are a lot of things to be done, but we're building a foundation that will allow us to see to it that those things are accomplished.

"When I step back and look at what's been built in the last year and a half, I can see that we're serving people whose needs just weren't being met before.

"An effort such as ours is successful because so many providers, consumers, and concerned people in the community are getting involved. This is a very gratifying development for all of us."

Frank Chesley...

Frank Chesley, Goodhue County Commissioner, said the county board and Goodhue County Social Services "are supportive of and interested in the role that CSP can fulfill in solving mental health problems."

Under Rule 14 guidelines, the county pays 10% of the cost for an experimental program like CSP. The program is in the second year of a projected three-year span. The county commissioners feel that the money spent for CSP is well invested.

"We at the governmental level feel the program is a cost-effective and a proper way to rehabilitate and serve persons with chronic mental illness," Frank said.

Even though he feels positive about the program, Frank admits it is early to assess its overall impact. But he is sure that it will succeed, for a number of reasons.

"It is still early for evaluation," he explained, "but when it has an opportunity to operate at a level that it is capable of, it will demonstrate that it is an effective alternative to institutional care.

"The program has the potential for brining the problem of mental illness, which has always been an under-the-carpet thing, to the attention of the general public. I don't think we can go wrong doing this. I think the program will receive even more attention and support as its effectiveness is demonstrated."

Dave Wooden...

Dave Wooden, director of rehabilitation services for Interstate Rehabilitation Center, was a member of the group that originally drafted the Rule 14 grant request. That was about two years ago. Dave feels a lot has changed since then.

"As far as I'm personally concerned, I see a lot of persons in the community who had unmet needs. Now these needs are being met, because of CSP and the Mental Health Core Team," he said.

The Mental Health Core Team is a conglomeration of organizations that have come together to pool their various areas of expertise to come up with practical solutions. The Core Team meets twice a month on Thursday mornings.

Dave added, "The thing about recent developments here is that we now have the cooperation and coordination that's needed to get the job done."

Regina Nicolosi...

About the St. Joseph's project upstairs at Morley House, Regina Nicolosi said "a lot of volunteer work by members of the parish, along with Karen, really upgraded the physical structures of the house."

The next person that moves into Morley House will be the fifth person to benefit from the residential part of the program.

"I think the combination of CSP offices being downstairs and the residential program being upstairs works very well," Regina commented.

Although St. Joseph's doesn't have any immediate plans for another program like Morley House, Regina said she hopes other churches in the area will follow suit.

"After all, we didn't start this program to blow our own trumpet, but to serve persons in need. As such, we're hoping other churches will imitate our program," she explained.

LaVonne Lommel and Howard Cook...

The landlords representing St. Joseph's are LaVonne Lommel and Howard Cook. LaVonne works on long-range goals while Howard handles the immediate concerns at Morley House.

"It's real nice to see people able to leave and live on their own. It gives us a feeling of satisfaction as well as them," LaVonne said.

"Howard is retired, has a lot of time, and lives close to Morley House, so he's an ideal person to do the screening of potential residents as well as to look after

the upkeep of the building.

"At first, there wasn't much going on, but things have really picked up recently. It's been a very satisfying experience for me," Howard said.

Conclusion

To close this story of advocacy in Goodhue County, here are summary statements by individuals already mentioned in this article. These statements reflect how these people view their efforts and give some indication of how they've achieved certain goals in a relatively short period of time.

It is hoped that others elsewhere who are trying to change the present mental health system and build community support have gained insight and inspiration from what advocates have accomplished in Goodhue County.

• **Frank Chesley:** *"The success of the experimental program is due in large part to the dedicated interest of so many concerned participants who contribute their time and efforts to mental health advocacy."*

• **Sara Ousky:** *"Things have changed dramatically in the last two years for the chronically mentally ill in our county. Agencies and community people have banded together to develop plans and services for the mentally ill."*

• **Dave Wooden:** *"When I began working in vocational rehabilitation twelve years ago here in Red Wing, there wasn't much in the way of resources for the mentally ill. I've seen a real turnabout in the whole picture and I'm very pleased to see it happen."*

• **Bob Glasenapp:** *"I've found the community in Red Wing to be very concerned about mental health issues. The Goodhue County Chapter of Mental Health Advocates Coalition and especially Dorothy Holmes, have played a key role in informing the community about mental health issues."*

• **Dorothy Holmes:** *"The Goodhue County families that were so important in getting things started here could never have done it without the leadership of the MHAC and the direction of Pat Solomonson."*

• **Regina Nicolosi:** *"I really feel that what we're doing here is at the core of Christianity, because Morley House is there to serve fellow human beings."*

• **Joan Close:** *"Goodhue County is rich in the most important resource of all, its people. They are willing to learn and explore alternatives to traditional approaches in treating mental illness."*

(This reporter would like to especially thank Dorothy Holmes for the efforts she contributed to make this article possible.)

DAKOTA HOUSE TO OPEN THIS FALL . . . . .

The Dakota House, located at 317 Dakota Street in Red Wing, will be the site for a day services program and drop in center offered through the Goodhue County Community Support Program. The two programs are extensions of the existing services offered through the Community Support Program. The Community Support Program will continue to offer transitional living assistance through the Morley House located at 410 West 7th Street.

The Dakota House, owned by St. Paul's Lutheran Church, will be rented by the Community Support Program starting September 1st. The house should be ready by the middle of September to begin program services.

Fund Raising Efforts

Through the efforts of the Red Wing Ecumenical Social Ministry Network, an available home was located this spring that fulfilled the space and program needs of the CSP. Now, with the help of a local artist, the Social Ministry has been involved in a fund raising effort to provide furnishings for the Dakota House. Red Wing artist Len Guggenberger has donated an original print that is being sold at a reduced price, with proceeds going to the Social Ministry Network for the Dakota House. A special thanks is in order to Sandy Carrington, Ione Hager and Mary Freier for all of their hard work and leadership! In addition, thanks to all of the volunteers from the following churches who combine to form the Ecumenical Social Ministry Network: St. Paul's Lutheran, St. Joseph's Catholic, Christ Episcopal, First Baptist, First Lutheran, First United Methodist, First Presbyterian, Concordia Lutheran and United Lutheran.

Dakota House Program and Services

The Dakota House program will be multi-dimensional in nature. One segment of the program will be a 3-day a week structured day services program. The day services program will be designed to address the needs of people who have been unsuccessful at maintaining sheltered employment, and experience difficulty meeting the usual customary demands of day to day living. Day services will be specifically designed to serve those people who have little or no structure in their lives and experience reoccurring symptoms of mental illness. The purpose of the services provided will be to enable individuals to maximize their ability to live in the community and reduce the risk of rehospitalization. Personal growth opportunities will be offered through group exercises and classes, discussions, and educational materials. Client educational groups will include topics such as communication skills, medication awareness, cooking and nutrition, money management, and personal problem solving. In addition, the Dakota House will have a craft room where individuals can work on crafts or projects during their leisure time. A certified occupational therapy assistant has been hired on a contract basis to assist with program development as well as facilitating group activities.

Drop In Center

During the past six years the Morley House downstairs area has been used as a "drop in" place for people to stop by and meet their friends. Since the Morley House also provides transitional living for a maximum of four men, the space for various activities has become overcrowded. Because of the space limitations, the Drop In Center program will be held at the Dakota House starting in the month of September.

The overall purpose of the Drop In Center program is to promote socialization and to provide opportunities to maintain and further develop interpersonal relationships and social skills. The Drop In Center at the Dakota House will be a place off the street where people can come to relax, talk, play cards, go on a group outing, and participate in various other recreational activities that can be done in a group setting or on an individual basis. The Dakota House is a place where time can be used constructively, a social life can be developed and enjoyed, and the needed support is provided. Program recipients will be encouraged to participate on a client advisory council to make suggestions and recommendations pertaining to program activities.

NOTE: Rule 36 Facilities are licensed by the state as residential treatment facilities to serve adults with mental illness.

Category I Facilities provide intensive treatment, almost all of which is in-house.

Categoy II Rule 36 Facilities provide less intensive treatment; residents participate in programs in the community.

STATUS OF CURRENT MENTAL HEALTH RESIDENTIAL PROGRAMS IN MINNESOTA

DECEMBER 1988

Prepared by the Mental Health Program Division

Minnesota Department of Human Services

County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health License
Anoka	Community Options	5384 Northeast 5th Street Fridley, MN 55421 (612) 572-2437	14	I	SLF
Beltrami	Spruce Woods	718 - 15th Street Northwest P.O. Box 631 Bemiji, MN 56601 (218) 759-1223	12	I	SLF
Blue Earth	Horizon Home, I	306 Byron, Box 3032 Mankato, MN 56001 (507) 625-7879	10	II (Rule 35/36)	B+L
	Horizon Home, II	347-319 Hickory Street Mankato, MN 56001 (507) 625-7879	14	II (Rule 35/36)	SLF
Brown	Nova Home	1310 South German New Ulm, MN 56073 (507) 354-2174	12	I	B+L
Carlton	Eagle Lake Home	South Highway 73 Route 1, Box 65 Cromwell, MN 55726 (218) 644-3685	25	II	B+I
Clay	Gull Harbor	1704 Belsly Boulevard Moorhead, MN 56560 (218) 233-8068	14	I	SLF
Crow Wing	Woodview Residential Services of Brainerd	2421 Pine Street Brainerd, MN 56401 (218) 828-0074	16	I	SLF

[1] I = Category I
II = Category II

[2] BCH = Boarding Care Home
SLF = Supervised Living Facility
B+I = Board and Loding

County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health license
Dakota	Guild South (612) 291-0067	312/314 - 2nd Street North South St. Paul, MN 55075	5	II	B+L
		316/316-1/2 - 2nd Street North South St. Paul, MN 55075	5	II	B+L
		318 - 2nd Street North South St. Paul, MN 55075	5	II	B+L
Dakota - Rice	Theodore I	1312-1314 Livingston Avenue West St. Paul, MN 55118 (612)457-6999	10	I	SLF
	Theodore II	3820 - 74th Avenue East Inver Grove Hts., MN 55075 (612) 450-1634	6	II	B+L
Douglas	St. Luke's Home	222 - 9th Avenue West Alexandria, MN 56308 (612) 763-3912	25	II	SLF
Freeborn	Rathjen House	Rural Route 3, Box 45A Albert Lea, MN 56007 (507) 373-6730	15	I	SLF
Hennepin	Anchor House	1506 Emerson Avenue North Minneapolis, MN 55411 (612) 529-2040	13	II	B+L

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II = Category II

[2] RCH = Boarding Care Home
SLF = Supervised Living Facility
B+L = Board and Lodging

County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health License
Hennepin	Andrew Care Home	1215 South 9th Street Minneapolis, MN 55404 (612) 333-0111 (Includes 10 Rule 12 beds in special needs unit.)	212	I	BCH & ICF
	Bill Kelly House	3104 East 58th Street Minneapolis, MN 55417 (612) 726-1502	16	I	SLF
	Breckinridge House	7314 Bass Lake Road New Hope, MN 55428 (612) 536-8134	16	II	B+L
	Bristol Place, Inc.	202 Ridgewood Minneapolis, MN 55408 (612) 871-0805	15	II	B+L
		400 Ridgewood Minneapolis, MN 55408	22	II	B+L
		209 Groveland Minneapolis, MN 55403	8	II	B+L
		219 Groveland Minneapolis, MN 55403	13	II	B+L
	Carlson-Drake House	5414 West Old Shakopee Cir. Bloomington, MN 55437 (612) 888-5611	12	I	SLF

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County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health[2] License
Hennepin	Janus Treatment Residence (612) 854-8060	8041 - 12th Avenue South Bloomington, MN 55425	12	I	SLF
		8101 - 12th Avenue South Bloomington, MN 55425	12	I	SLF
	Journey House	18135 - 13th Avenue North Plymouth, MN 55447 (612) 476-6410	6	I	SLF
	March House	3159 Park Avenue South Minneapolis, MN 55407 (612) 822-2165	20	II	B+L
	Northwest Residence	4408 - 69th Avenue North Brooklyn Center, MN 55429 (612) 566-3650	14	II	B+I
	Oak Grove Care Center	131 Oak Grove Avenue Minneapolis, MN 55403 (612) 871-5800	21	II	BCH
	Oasis	6739 Golden Valley Road Golden Valley, MN 55427 (612) 544-1447	18	I	SLF
	Passageway (Community Involvement Program)	4735 Clear Spring Road Minnetonka, MN 55345 (612) 938-3439	20	II	B+I

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County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health License
Hennepin	Re-entry House	5812 Lyndale Avenue South Minneapolis, MN 55419 (612) 869-2411	28	I	SLF
	Sentinel	2122 Portland Avenue South Minneapolis, MN 55404 (612) 874-8845	17	II	B+L
	Tasks Unlimited Training Center	3020 Clinton Avenue South Minneapolis, MN 55408 (612) 823-0156	12	I	SLF
	Welcome Home Respite Care	7170 Bryant Lake Drive Eden Prairie, MN 55344 (612) 829-5880	16	II	B+L
	Wellspring Therapeutic Community, Inc.	245 Clifton Avenue Minneapolis, MN 55403 (612) 870-3787	24	I	SLF
Itaska	Esther House	213 - 11th Street Southeast Grand Rapids, MN 55744 (218) 326-0993	15	I	SLF
Kandiyohi	Green Lake Manor	263 Lake Avenue North Spicer, MN 56288 (612) 796-2417	25	II	B+L
	St. Francis Halfway House	202 South 3rd Street Box 75 Atwater, MN 56209 (612) 974-8850	14	I	SLF

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County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health License
Kandiyohi	Temporary Residence	1125 South East Sixth Street P.O. Box 787 Willmar, MN 56201 (612) 235-4613	9	I (Rule 5/36)	SLF
	Willmar Health Care Center - Northside Residence	500 Russell Avenue Willmar, MN 56201 (612) 235-3181	35	II	RCH
Lyon	Patricia L. Duffy Apartments	1230 Birch Street Marshall, MN 56288 (507) 532-5402	12	I	SLF
Meeker	Red Castle	405 North Armstrong Litchfield, MN 55355 (612) 693-6318	15	I	SLF
Morrison	Whiteshell Group Home	505 - 12th Street Northeast P.O. Box 101 Little Falls, MN 56345 (612) 632-4242	15	I	SLF
Mower	Hecla House	1000 - 2nd Avenue Northeast Austin, MN 56912 (507) 433-5569	10	II	B+L
Olmsted	Crisis Receiving Unit	2116 Campus Drive Southeast Rochester, MN 55904 (507) 288-8750	8	I	SLF

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County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health License
Olmsted	Quarry Hill Treatment	2116 Campus Drive Southeast Rochester, MN 55904 (507) 285-7050	16	I	SLF
	THOMAS House, Inc.	15 - 6th Avenue Southeast Rochester, MN 55901 (507) 287-2024	16	II	B+L
Otter Tail	St. William's Annex	Soo Street P.O. Box 54 Parkers Prairie, MN 56361 (218) 338-4671	20	I	SLF
Pennington	Northern Lights Community Residence	324 East Tenth Street Thief River Falls, MN 56701 (218) 681-8706	15	I	SLF
Pine	Grindstone Lodge	P.O. Box 400 Hinckley, MN 55037 (612) 384-7416	16	II	B+L
Polk	Northwestern Apartments	100 Gretchen Lane Crookston, MN 56716 (218) 281-5256	18	II	B+L
Ramsey	Dayton Boarding Care	740 Dayton Avenue St. Paul, MN 55104 (612) 228-1051	26	II	BCH
	Family Style, Inc.	398 Duke St. Paul, MN 55102 (612) 222-6602	21	I	BCH
		23 other buildings in the vicinity	109	II	B+L

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County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health[2] License
Ramsey	Guild Hall	286 Marshall St. Paul, MN 55012 (612) 291-0067	85	II	SLF
	Guild Hall Apartments	268 Marshall Avenue St. Paul, MN 55102 (612) 291-0067	14	II	SLF
	Hewitt House	1593 Hewitt St. Paul, MN 55104 (612) 645-9424	22	I	B+L
	Hoikka House	238 Pleasant St. Paul, MN 55102 (612) 222-7491	108	I	RCH
	Marshall Residence	1489 Sherburne Avenue St. Paul, MN 55104 (612) 645-4924	10	II	B+I
	New Foundations	796 Capitol Heights St. Paul, MN 55103 (612) 221-9880	20	I	B+L
	Oakland Boarding Home	97 North Oxford St. Paul, MN 55104 (612) 227-7781	32	II	B+L
	Peterka Boarding Home	513 Portland St. Paul, MN 55102 (612) 228-9719	15	II	B+I

[1] I = Category I
II = Category II

[2] RCH = Boarding Care Home
SLF = Supervised Living Facility
B+L = Board and Lodging

County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health License
Ramsey	Petra Howard House	700 East 8th Street St. Paul, MN 55106 (612) 771-5575	14	I (Rule 36/80)	SLF
	Pineview Residence	69 North Milton St. Paul, MN 55104 (612) 227-1333	22	II	RCH
Rice	Gull House	501 Seabury Lane P.O. Box 917 Faribault, MN 55021 (507) 334-5561	5	II (Rule 5/36)	B+L
	New House	9 - 2nd Street Northwest P.O. Box 917 Faribault, MN 55021 (507) 334-5561	6	II (Rule 5/36)	B+L
	Sixth Street House	2426 Northwest 6th Street P.O. Box 917 Faribault, MN 55021 (507) 334-5561	5	II (Rule 5/36)	B+L
Rock	Unity House	1224 - 4th Avenue Worthington, MN 56187 (507) 372-7671	12	I (Rule 8/35/36)	SLF
St. Louis	Arrowhead House	225 North 1st Avenue West Duluth, MN 55806 (218) 722-5031	25	II	B+L
	Merrit House	120 North Third Avenue P.O. Box 470 Biwabik, MN 55708 (218) 865-6381	20	I	SLF

[1] I = Category I
II = Category II

[2] RCH = Boarding Care Home
SLF = Supervised Living Facility
B+L = Board and Loding

County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health[1] Residential Program	Type of Health License
St. Louis	Parkside Homes	Box 358 - 30 Center Street Soudan, MN 55782 (218) 753-5876	35	II	B+L
	Riverview Homes, Inc.	McCamus Road P.O. Box 349 Brookston, MN 55711 (218) 453-5522	30	I	SLF
Stearns	Northway Group Home	1509 North 24th Avenue St. Cloud, MN 56303 (612) 252-8648	10	II	B+L
Steele	Safe Harbour	250 East Main Street Owatonna, MN 55060 (507) 455-2444	11	I	SLF
Stevens	Parkview	539 Pacific Avenue Hancock, MN 56244 (612) 392-5830	14	II	SLF
	Williams	762 Union Avenue Hancock, MN 56244 (612) 392-5212	12	II	SLF
Wadena	Woodview Residential Services of Wadena	Route 1, Box 124 P.O. Box 573 Wadena, MN 56482 (218) 631-2878	13	I	SLF
Washington	Beeman Place	3819 Laverne Avenue North Lake Elmo, MN 55042 (612) 770-2224	15	I	SLF

[1] I = Category I
II = Category II

[2] BCH = Boarding Care Home
SLF = Supervised Living Facility
B+L = Board and Loding

County in Which Facility is Located	Name of Facility	Address and Telephone of Facility	MI Resident Capacity	Type of Mental Health Residential Program[1]	Type of Health License
Winona	Broadway Center	73 West Broadway Winona, MN 55987 (507) 454-4341	9	I	SLF
	Hiawatha Hall	725 West Broadway Winona, MN 55987 (507) 454-7711	13	II	B+L
	Wenonah Hall	221 East 4th Street Winona, MN 55987 (507) 454-7711	10	II	B+L

SRF/MH

[1] I = Category I
II = Category II

[2] BCH = Boarding Care Home
SLF = Supervised Living Facility
B+L = Board and Loding

Children's Checklist I
FIRST NEW MANDATED SERVICES

County

Names, addresses and phone numbers of Reporters

Organizations involved in monitoring

Name(s) of persons interviewed (Please include titles and addresses or phone numbers)

Date(s) of interview(s)

LOCAL CHILDREN'S MENTAL HEALTH ADVISORY COUNCIL

(Councils should have been established by October 1, 1989)

Has your county board, either individually or with other county boards, established 1) a local children's mental health advisory council OR 2) children"s mental health subcommittee of the existing local mental health advisory council, OR 3) has it included persons on its existing advisory council who are representatives of children's mental health interests?

Yes No

Which type of Children's Advisory Council has your county established?

Single county

Multi-county

Separate Children's Advisory Council

Subcommittee of existing Advisory Council

New children's representatives on existing Council

However formed, the Children's Advisory Council must include at least one person from each of the following groups.

Does your county council include

1) a former client in a mental health program as a child or adolescent?

Yes No

2) the parent of a child or adolescent who is eligible for case management?

Yes No

3) a children's mental health professional?

Yes No

4) a representative of minority populations residing in the county which are of significant size?

Yes No

5) a representative of the Local Coordinating Council?

Yes No

6) a provider of Family Community Support Services?

Yes No

If some of these questions were answered "no", does the county plan to recruit persons in these categories to council membership?

Yes No

Comments:

Does the county report barriers to forming a Children's Mental Health Advisory Council including the required members?

Yes No

If so, what are they?

LOCAL COORDINATING COUNCIL

(Formation of Local Coordinating Councils at the county level is required by January 1, 1990.)

Has your county formed a Local Coordinating Council?

Yes No

If, No, why not? Please explain.

If the county has formed a Local Coordinating Council are there representatives from

1) mental health services

Yes No

2) social services

Yes No

3) correctional services

Yes No

4) education services

Yes No

5) health services

Yes No

6) vocational services

Yes No

If the answer to some of these representatives is "no," why is this. Please explain.

Does the county report barriers to establishing a coordinating council?

Yes No

If so, what are they?

LOCAL MENTAL HEALTH PLAN FOR CHILDREN

Did your county submit the Local Mental Health Plan for Children by November 15, 1989?

Yes No

If not, why not?

Does the county report barriers to submitting the plan?

Yes No

If so, what are they?

League of Women Voters of Minnesota Education Fund 10/16/89

A SUMMARY Of
MINNESOTA COMPREHENSIVE CHILDREN'S MENTAL HEALTH ACT 1989

(Minnesota Statutes 245.487 - 245.4887)

(This discussion draws heavily on the Minnesota Department of Human Services (DHS) Mental Health Division "Three-Year Plan for Services for Persons with Mental Illness," revised August 1989 and on
"Overview of the Minnesota Comprehensive Children's Mental Health Act," July 7, 1989, and other materials from Joan Sykora, Mental Health Division, DHS)

* * * * *

The passage of the Minnesota Comprehensive Children's Mental Health Act in 1989 represents a major new initiative. It mandates a comprehensive and coordinated delivery system by 1992. The legislation incorporates much of the CASSP (Children Adolescent Service System Program) service model developed by the National Institute of Mental Health. This model stresses a comprehensive set of services and coordination at all levels among the different agencies and systems which service children with mental illness.

The legislation was designed to accomplish three primary goals:

1. Mandate a comprehensive set of services throughout the state so that all children receive services based upon their individual level of need;

2. Establish mechanisms at the state, local and individual case level for coordination among agencies serving children with mental health needs; and

3. Establish advisory councils at the state and county levels, assuring input from parents, providers, advocates and others.

THE NEED FOR SPECIAL CHILDREN'S LEGISLATION

The 1987 Comprehensive Mental Health Bill applies to all persons with mental illness in Minnesota, but it gives priority to persons with "serious and persistent mental illness." Because of the definition of this term, very few emotionally disturbed children qualified for such service. Moreover, the 1987 bill failed to provide for working with families, a crucial component in serving emotionally disturbed children. Nor did it address the need for coordinating the many agencies dealing with most emotionally disturbed children--the mental health system, schools, corrections, and the courts, etc.

The Children's Subcommittee of the State Mental Health Advisory Council, formed in September 1988, conducted seven public hearings on the needs of children and adolescents with emotional

disturbance from December 1988 through February 1989. In addition to the need for family involvement and coordination of mental health services with other services for children, several other themes emerged:

- Available funding in both the private and public sectors, rather than the need of the child for service, now often determines the type of services children receive.

- Many counties outside the metropolitan area have limited local services and funding, and few trained professionals.

- Paperwork, financial disincentives, and other barriers often postpone the access of a child to services until a crisis exists.

- Early intervention by professionals is needed.

Many testified to two systems needs:

1) to coordinate existing services and 2) to develop and provide additional mental health services specifically for children and adolescents. (See Minnesota State Advisory Council on Mental Health, "Report: Public Hearings on Children's Mental Health Issues," March 1989.)

The Department of Human Services surveyed county social service directors on current mental health services for youth and on the needs they perceived for mental health services in their counties. The following table identifies needed services ranked on a statewide basis. Services listed as most necessary were as follows:

Type of Service	# of Counties expressing need	
Therapeutic Foster Care	50	64%
Therapeutic Home Based Services	47	60%
Prevention	46	59%
Day Treatment	40	51%
Early Identification and Intervention	39	50%
Case Management	30	38%
Assessment and Outpatient	27	35%
Residential Treatment	19	24%
Regional Treatment Centers	14	18%
Emergency Services	12	15%
Inpatient Hospitalization	12	15%

The county study found that both mental health and other support services for children and youth with severe emotional disturbances are in some cases totally unavailable or insufficient to meet the needs.

STATE RESPONSIBILITIES

The State Mission:

The mission of the Department of Human Services (DHS) on behalf of children with emotional disturbance and their families is to ensure the creation of a unified, accountable, comprehensive children's mental health service system. Implementation of the service system must take place by January 1, 1992.

Information to Counties:

The Department (DHS) will provide each county with information about the predictors and symptoms of children's emotional disturbances and information about groups identified as at risk of developing emotional disturbance to assist in planning for services. (M.S. 245.4872, subd. 2 and subd. 3.)

Coordination at the State Level:

The Department of Human Services must convene quarterly meetings with the Commissioners, or designees of commissioners, of the Departments of 1) Human Services, 2) Health, 3) Education, 4) Commerce, 5) State Planning and 6) Corrections and 7) a representative of the Minnesota District Judges Asssociation Juvenile Committee, to coordinate planning, funding and implementation of services.

COUNTY RESPONSIBILITIES

Required Services in Each County and Implementation Dates:

- Education and Prevention -- Current
- Emergency Services -- Current
- Outpatient Services -- Current
- Residential treatment services -- Current
- Acute care hospital inpatient services -- Current
- Screening for inpatient and residential treatment -- Current
- Early identification and intervention -- 1/1/91
- Professional home-based family treatment -- 1/1/91
- Case management services -- 7/1/91
- Family community support services -- 7/1/91
- Day treatment services -- 7/1/91
- Benefits assistance -- 7/1/91
- Therapeutic foster care -- 1/1/92

Rights Protection:

No service shall be provided unless consent to the services is obtained.

No information about the child/family shall be disclosed without informed written consent, unless required to do so by statute. Procedures must be established to ensure that the names and

addresses of children receiving mental health services and their families are released only under very specific conditions (such as to service providers).

A child or a child's family who requests services must be advised of services available and the right to appeal. (M.S. 245.4886)

Local Advisory Group:

Every county must establish a local children's mental health advisory council (LAC) in one of three ways. The county must:

1. Establish a separate Children's Mental Health Advisory Council, or

2. Create children's mental health subcommittee of the existing local mental health advisory council, or

3. Add representatives of children's mental health interests to the existing Mental Health Advisory Council.

Membership on the LACs must include at least:

1. One person who was in a mental health program as a child or adolescent;
2. one parent of a child or adolescent with severe emotional disturbance;
3. one children's mental health professional;
4. representatives of minority populations of significant size residing in the county;
5. a representative of the children's mental health local coordinating council; and
6. one family community support services program representative.

The advisory council must meet at least quarterly to review, evaluate, and make recommendations regarding the local children's mental health system.

Continuation of Services:

Counties must continue to provide case management, community support services, and day treatment to children with serious and persistent mental illness as required by the Comprehensive Mental Health Act of 1987. By August 1, 1989, counties must notify providers of services to children eligible for case management, day treatment, and community support services under the Comprehensive Mental Health Act of their obligation to refer children for service. (M.S. 245.487, subd. 5.)

Local Agency Coordination:

By January 1, 1990 each county must establish a local coordinating council (LCC) at the county level, including representatives of the "local system of care":

1. mental health services
2. social services
3. correctional services
4. education services
5. health services
6. vocational services
7. Indian Reservation Authority (where a reservation exists within the county)
8. juvenile court (when possible)
9. law enforcement (when possible)

The members of the council must meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances.

The council must provide at least:

1. Interagency agreements to coordinate the delivery of services to children.
2. An annual report to the council on the unmet children's needs and service priorities.
3. An annual report on information collected by the LCC, including:

a. a description of services provided through each of the service systems represented on the council;

b. various sources of funding for services and the amounts actually expended.

c. a description of the numbers and characteristics of the children and families served during the previous year.

d. an estimate of unmet needs.
(M.S. 245.4872, subd. 3 and M.S. 245.4875, subd. 6.)

(In late 1988 eight counties in Minnesota were funded to start developing LCCs and a comprehensive set of children's mental health services. The counties were: Carver, Isanti, Itasca, Kandiyohi, McLeod, Mower, Olmsted and Ramsey.)

Individual Case Coordination:

The case manager is required to coordinate with any other person responsible for the planning, development, and delivery of social services, education, corrections, health or vocational services for the individual child. (M.S. 245.4872, subd. 4.)

Diagnostic assessment:

The case manager must arrange for a diagnostic assessment, determine the child's eligibility for family community support services, develop an individual family community support plan, perform a functional assessment, and provide for service

coordination for the child. (M.S. 245.4881.)

SERVICE ELIGIBILITY

A significant departure from the adult 1987 Mental Health Bill is the emphasis on early intervention.

All Minnesota children may receive education and prevention services, early identification and intervention services and emergency services.

Children who are found to be emotionally disturbed may also receive outpatient services.

Definition of Emotional Disturbance:

Emotional disturbance is defined as an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that:

1. is listed in specific code ranges of the International Classificiation of Diseases (ICD-9), current edition, or in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD) current edition; and

2. seriously limits a child's capacity to function in primary aspects of daily living, such as personal relations, living arrangements, work, school, and recreation (S. 245.4871, subd. 15.)

* * * *

Severe Emotional Disturbance:

To be eligible for case management and family community support services a child must meet the definition of emotional disturbance and one of the following:

1. Admission within the last three years (This is included in an effort provide follow-through coordination to children who have been removed from the home) or is at risk of being admitted to inpatient or a residential treatment program for an emotional disturbance, or

2. Receipt of treatment for an emotional disturbance by a Minnesota resident through the interstate compact (in another state),or

3. A determination by a mental health professional that the child has:

(i) psychosis or clinical depression;
or
(ii) risk of harming self or others as a result of an emotional disturbance;

or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year, or

4. As a result of an emotional disturbance, significantly impaired home, school or community functioning of a child that has lasted at least one year, or, in the written opinion of a mental health professional presents substantial risk of lasting one year. (M.S. 245.4871, subd. 6.)

FUNDING FOR CHILDREN'S MENTAL EALTH SERVICES

In the past, children's mental health services at the county level have been funded largely through the Community Social Services Act (CSSA) block grant fund. This fund, consisting of federal, state, and county dollars, has supported a variety of services. Other mental health services have been provided to children through the Medicaid (MA) system. But, because an array of services was not available in all areas of the state, DHS requested new state dollars to bring about the balanced development of several services in areas of the state where they were needed.

The 1989 Legislature appropriated $2.3 million in new funds for children's mental health services for the 1990-91 biennium. In addition the Legislature appropriated funding for one staff position for children's mental health within DHS.

Additional funding will be necessary to fully implement the Comprehensive Children's Mental Health Act. The Department of Human Services estimates that the Legislature will need to appropriate $11 million in the next biennium to fund newly mandated children's mental health services.

MINNESOTA CHILDREN'S POPULATION*, 1990

(BY AGE AND COUNTY)

COUNTIES	COUNTY POPULATION	CHILDREN POPULATION	% OF CTY POPULATION	AGE OF CHILDREN 0 - 4	5 - 9	10 - 14	15 - 17 Projected	S EMOT DIST 5%	EMOT DIST 11.8%
AITKIN	14,094	3,505	24.87%	899	905	1,051	650	175	403
ANOKA	228,906	64,552	28.20%	17,826	17,659	18,115	10,952	3,228	7,424
BECKER	33,386	9,285	27.81%	2,435	2,464	2,713	1,673	464	1,068
BELTRAMI	34,679	9,767	28.16%	2,783	2,713	2,659	1,612	488	1,123
BENTON	29,269	8,783	30.01%	2,641	2,496	2,414	1,232	439	1,010
BIG STONE	7,334	1,918	26.16%	543	558	527	290	96	221
BLUE EARTH	54,515	14,876	27.29%	4,897	4,500	3,425	2,054	744	1,711
BROWN	28,782	8,020	27.86%	2,388	2,378	2,073	1,181	401	922
CARLTON	31,952	8,825	27.62%	2,375	2,496	2,509	1,445	441	1,015
CARVER	45,281	12,170	26.88%	3,468	3,209	3,466	2,027	608	1,400
CASS	24,107	6,343	26.31%	1,709	1,697	1,851	1,086	317	729
CHIPPEWA	15,065	4,297	28.52%	1,184	1,298	1,244	571	215	494
CHISAGO	34,522	10,159	29.43%	2,716	2,654	2,997	1,792	508	1,168
CLAY	50,581	13,933	27.55%	4,337	4,169	3,370	2,057	697	1,602
CLEARWATER	9,359	2,724	29.10%	738	737	797	452	136	313
COOK	4,411	1,003	22.74%	277	284	279	163	50	115
COTTONWOOD	14,529	3,871	26.64%	971	1,052	1,235	613	194	445
CROW WING	47,715	12,758	26.74%	3,532	3,510	3,620	2,096	638	1,467
DAKOTA	256,510	72,020	28.08%	20,264	20,246	19,983	11,527	3,601	8,282
DODGE	16,975	5,438	32.04%	1,531	1,599	1,560	748	272	625
DOULGAS	32,542	9,029	27.75%	2,605	2,512	2,484	1,428	451	1,038
FARIBAULT	18,760	4,757	25.36%	1,247	1,313	1,468	729	238	547
FREEBORN	36,321	9,546	26.28%	2,715	2,730	2,653	1,448	477	1,098
FILLMORE	22,017	6,076	27.60%	1,642	1,752	1,721	961	304	699
GOODHUE	42,062	11,382	27.06%	3,112	3,174	3,232	1,865	569	1,309
GRANT	7,047	1,899	26.95%	513	556	547	283	95	218
HENNEPIN	953,537	223,418	23.43%	69,854	69,926	52,607	31,031	11,171	25,693
HOUSTON	19,298	5,492	28.46%	1,590	1,644	1,462	796	275	632
HUBBARD	15,806	4,182	26.46%	1,101	1,060	1,259	762	209	481
ISANTI	31,233	9,424	30.17%	2,521	2,522	2,675	1,706	471	1,084
ITASCA	48,479	13,486	27.82%	3,573	3,609	4,005	2,299	674	1,551
JACKSON	13,043	3,301	25.31%	827	884	1,014	576	165	380
KANABEC	14,561	4,367	29.99%	1,285	1,227	1,156	699	218	502
KANDIYOHI	41,490	10,906	26.29%	3,179	2,951	3,002	1,774	545	1,254
KITTSON	6,299	1,582	25.12%	409	422	498	253	79	182
KOOCHICHING	18,184	5,163	28.39%	1,379	1,443	1,458	883	258	594
LAC QUI PARLE	10,384	2,809	27.05%	742	841	814	412	140	323
LAKE	12,100	3,085	25.49%	777	906	956	446	154	355
LAKE OF WOODS	3,720	981	26.36%	279	284	255	163	49	113
LE SUEUR	25,124	7,256	28.88%	2,106	2,077	1,998	1,075	363	834
LINCOLN	8,018	2,213	27.60%	566	599	683	365	111	254
LYON	26,063	7,108	27.27%	1,970	1,960	2,036	1,142	355	817
MCLEOD	31,369	8,759	27.92%	2,394	2,464	2,490	1,411	438	1,007
MAHNOMEN	5,200	1,553	29.86%	379	398	496	280	78	179
MARSHALL	13,031	3,821	29.32%	1,001	1,059	1,153	608	191	439
MARTIN	25,367	6,731	26.53%	1,847	1,965	1,895	1,024	337	774
MEEKER	22,170	6,342	28.61%	1,762	1,765	1,787	1,028	317	729
MILLE LACS	20,462	6,003	29.34%	1,720	1,683	1,713	887	300	690
MORRISON	30,450	9,315	30.59%	2,572	2,525	2,741	1,477	466	1,071

MINNESOTA CHILDREN'S POPULATION*, 1990

(BY AGE AND COUNTY)

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MOWER	39,738	10,107	25.43%	2,869	2,855	2,808	1,575	505	1,162
MURRAY	10,772	3,066	28.46%	791	863	938	474	153	353
NICOLLET	28,831	8,314	28.84%	2,435	2,415	2,197	1,267	416	956
NOBLES	21,429	5,680	26.51%	1,619	1,618	1,569	874	284	653
NORMAN	8,784	2,438	27.76%	613	682	753	390	122	280
OLMSTED	101,165	27,612	27.29%	8,762	8,268	6,728	3,854	1,381	3,175
OTTER TAIL	56,938	14,635	25.70%	3,940	4,098	4,239	2,358	732	1,683
PENNINGTON	15,783	4,485	28.42%	1,246	1,284	1,260	695	224	516
PINE	21,855	6,301	28.83%	1,784	1,719	1,800	998	315	725
PIPESTONE	10,923	2,878	26.35%	774	791	848	465	144	331
POLK	35,093	9,600	27.36%	2,642	2,668	2,731	1,559	480	1,104
POPE	12,094	3,300	27.29%	875	925	995	505	165	380
RAMSEY	459,219	111,115	24.20%	34,904	33,185	27,223	15,803	5,556	12,778
RED LAKE	5,346	1,555	29.09%	425	407	473	250	78	179
REDWOOD	18,897	5,279	27.93%	1,444	1,542	1,511	782	264	607
RENVILLE	19,843	5,181	26.11%	1,333	1,408	1,615	825	259	596
RICE	49,653	14,281	28.76%	4,137	4,147	3,693	2,304	714	1,642
ROCK	10,684	3,132	29.31%	884	902	867	479	157	360
ROSEAU	13,226	3,888	29.40%	1,101	1,097	1,094	596	194	447
ST LOUIS	212,060	55,185	26.02%	14,351	16,486	16,255	8,093	2,759	6,346
SCOTT	54,418	15,239	28.00%	4,058	3,990	4,514	2,677	762	1,752
SHERBURNE	45,719	13,535	29.61%	3,745	3,578	3,793	2,419	677	1,557
SIBLEY	15,335	4,450	29.02%	1,192	1,277	1,299	682	222	512
STEARNS	119,634	37,200	31.09%	11,598	11,411	9,008	5,183	1,860	4,278
STEELE	32,892	9,361	28.46%	2,735	2,708	2,537	1,381	468	1,077
STEVENS	11,295	3,058	27.07%	857	851	864	486	153	352
SWIFT	12,792	3,544	27.70%	967	992	1,060	525	177	408
TODD	27,004	8,041	29.78%	2,154	2,137	2,422	1,328	402	925
TRAVERSE	5,058	1,296	25.62%	367	364	350	215	65	149
WABASHA	21,197	6,120	28.87%	1,763	1,776	1,677	904	306	704
WADENA	15,074	4,282	28.41%	1,175	1,139	1,234	734	214	492
WASECA	20,221	6,184	30.58%	1,818	1,837	1,677	852	309	711
WASHINGTON	143,062	38,883	27.18%	10,210	10,376	11,390	6,856	1,944	4,472
WATONWAN	11783	3,249	27.57%	906	974	915	454	162	374
WILKIN	8220	2,386	29.03%	671	709	654	352	119	274
WINONA	47824	13,558	28.35%	4,275	4,091	3,171	2,021	678	1,559
WRIGHT	78043	24,950	31.97%	7,279	6,889	6,874	3,908	1,247	2,869
YELLOW MEDICINE	12875	3,340	25.94%	863	910	1,036	531	167	384
TOTAL	4,370,888	1,160,938	26.56%	336,743	336,244	310,218	177,683	58,047	133,508

*NOTE: BASED ON PROJECTIONS BY STATE DEMOGRAPHER, MAY 1983

interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' calls. This right is limited where medically inadvisable, as documented by the attending physician in a patient's care record. Where programmatically limited by a facility abuse prevention plan pursuant to the Vulnerable Adults Protection Act, section 626.557, subdivision 14, clause 2, this right shall also be limited accordingly.

PERSONAL PROPERTY

Patients may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

SERVICES FOR THE FACILITY

Patients shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

PROTECTION AND ADVOCACY SERVICES

Patients shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

ADDITIONAL RIGHTS IN RESIDENTIAL PROGRAMS THAT PROVIDE TREATMENT TO CHEMICALLY DEPENDENT OR MENTALLY ILL MINORS OR IN FACILITIES PROVIDING SERVICES FOR EMOTIONALLY DISTURBED MINORS ON A 24-HOUR BASIS:

ISOLATION AND RESTRAINTS

A minor patient who has been admitted to a residential program as defined in section 7 has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed consulting psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

TREATMENT PLAN

A minor patient who has been admitted to a residential program as defined in section 7 has the right to a written treatment plan that describes in behaviorial terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor patient and his or her parents or guardian shall be involved in the development of the treatment and discharge plan.

Inquiries or complaints regarding medical treatment or the Patients Bill of Rights may be directed to:

Board of Medical Examiners
2700 University Ave. West
Room 106
St. Paul, MN 55114
(612) 642-0538

Or

Office of Health Facility Complaints
717 S.E. Delaware St., Room 232
Minneapolis, MN 55440
(612) 623-5562

PATIENTS BILL OF RIGHTS

LEGISLATIVE INTENT

It is the intent of the legislature and the purpose of this statement to promote the interests and well-being of the patients of health care facilities. No health care facility may require a patient to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient. An interested person may also seek enforcement of these rights on behalf of a patient who has a guardian or conservator through administrative agencies or in probate court or county court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

DEFINITIONS

For the purposes of this statement, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. "Patient" also means a minor who is admitted to a residential program as defined in section 7, Laws of Minnesota 1986, Chapter 326. For purposes of this statement, "patient" also means any person who is receiving mental health treatment on an out-patient basis or in a community support program or other community-based program.

PUBLIC POLICY DECLARATION

It is declared to be the public policy of this state that the interests of each patient be protected by a declaration of a patient's bill of rights which shall include but not be limited to the rights specified in this statement.

INFORMATION ABOUT RIGHTS

Patients shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 7, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the data practices act, and section 626.557, relating to vulnerable adults.

COURTEOUS TREATMENT

Patients have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

APPROPRIATE HEALTH CARE

Patients shall have the right to appropriate medical and personal care based on individual needs. This right is limited where the service is not reimbursable by public or private resources.

PHYSICIAN'S IDENTITY

Patients shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative.

RELATIONSHIP WITH OTHER HEALTH SERVICES

Patients who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Informaton shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative.

INFORMATION ABOUT TREATMENT

Patients shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients can reasonably be expected to understand. Patients may be accompanied by a family member or other chosen representative. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's medical record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative. Individuals have the right to refuse this information.

Every patient suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

PARTICIPATION IN PLANNING TREATMENT

Patients shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative. In the event that the patient cannot be present, a family member or other representative chosen by the patient may be included in such conferences.

CONTINUITY OF CARE

Patients shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

RIGHT TO REFUSE CARE

Competent patients shall have the right to refuse treatment based on the information required in Right No. 6. In cases where a patient is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's medical record.

EXPERIMENTAL RESEARCH

Written, informed consent must be obtained prior to a patient's participation in experimental research. Patients have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

FREEDOM FROM ABUSE

Patients shall be free from mental and physical abuse as defined in the Vulnerable Adults Protection Act. "Abuse" means any act which constitutes assault, sexual exploitation, or criminal sexual conduct as described in section 626.557, subdivision 2d, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's physician for a specified and limited period of time, and only when necessary to protect the patient from self-injury or injury to others.

TREATMENT PRIVACY

Patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance.

CONFIDENTIALITY OF RECORDS

Patients shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the department of health, where required by third party payment contracts, or where otherwise provided by law.

DISCLOSURE OF SERVICES AVAILABLE

Patients shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients in obtaining information regarding whether the Medicare or Medical Assistance program will pay for any or all of the aforementioned services.

RESPONSIVE SERVICE

Patients shall have the right to a prompt and reasonable response to their questions and requests.

PERSONAL PRIVACY

Patients shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being.

GRIEVANCES

Patients shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients and citizens. Patients may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care in patient facility, every residential program as defined in section 7, and every facility employing more than two people that provides out patient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision-maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 7 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

COMMUNICATION PRIVACY

Patients may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without

Needed: A System of Community Care

Supportive Housing - A range of housing is needed with various levels of support to meet the diversity of needs of mentally ill persons.

Day Programs - Ranging from day treatment (outpatient) to psychosocial and vocational rehabilitation, these programs help persons recover lost skills and become as independent as possible.

Client Management - Trained persons are needed to help mentally ill persons access community services.

The Basic Necessities of Life - Like everyone, these people need money, food, recreation, friends, housing, and jobs.

How Can the Community Help?

There are so many ways that caring people can help that we can only list a few. We suggest you contact your local Alliance for the Mentally Ill and see what you, your church, your club, or your neighborhood can do. Some suggestions:

- **Help combat stigma** by objecting to negative stereotyping of mentally ill persons. Tactfully correct misunderstandings about mental illness held by friends and relatives.
- **If you are an employer**, hire these persons for low stress jobs. For private employers there can be tax advantages.
- **As a taxpayer**, support funds for a good community-based support system and research to further understanding of cause and treatment.
- **If you are a homeowner**, welcome a group home in your neighborhood. People with mental illness can be good neighbors.
- **Groups can help finance** a house or apartment for mentally ill persons or help furnish existing ones. Employment projects and social clubs are also badly needed.
- **If you are a family with an afflicted member**, join your local Alliance for the Mentally Ill. If you know of families with this problem, tell them about NAMI. Even if you don't have a mentally ill relative, you are invited to become a member of NAMI and/or to make donations to our work.

The National Alliance for the Mentally Ill

The National Alliance for the Mentally Ill is a self-help organization of families of mentally ill persons, of mentally ill persons themselves, and of friends. Composed of several hundred local and state alliance groups all across the country, its goals are mutual support, education and advocacy for the victims of severe mental illness, especially schizophrenia and manic and other disabling depressions.

Recommended Reading

The following publications, and many others, are available through NAMI. Orders must be prepaid.

NAMI ADVOCATE, published bi-monthly, $25 per year. Write NAMI 2101 Wilson Boulevard, Suite 302, Arlington, VA 22201. Single copy free.

THE BROKEN BRAIN: THE BIOLOGICAL REVOLUTION IN PSYCHIATRY, by Nancy C. Andreasen, M.D., Ph.D. Harper and Row, 1984. $7.60 paper

SCHIZOPHRENIA, STRAIGHT TALK FOR FAMILIES AND FRIENDS, by Maryellen Walsh, Warner Books, 1986

SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL, by E. Fuller Torrey, M.D., Revised Edition, Harper and Row, 1988. $8.50 paperback

MOOD DISORDERS: DEPRESSION AND MANIC DEPRESSION, by Demitri Papolos, M.D., Dept. of Psychiatry, Albert Einstein College of Medicine Montefiore Medical Center. 25¢ pamphlet

OVERCOMING DEPRESSION, by Demitri and Janice Papolos, Harper and Row, 1987. $7.70 paper

National Alliance for the Mentally Ill
2101 Wilson Boulevard
Suite 302
Arlington, VA 22201
(703) 524-7600

NAMI

National Alliance
for the
Mentally Ill

MENTAL ILLNESS IS EVERYBODY'S BUSINESS

Alliance for the Mentally Ill of Minnesota

1595 Selby Avenue #103
St. Paul, MN 55104
(Phone: 612/645-2948)

What is Mental Illness?

Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating. They result in substantially diminished capacity for coping with the ordinary demands of life. Mental illnesses can affect persons of any age — children, adolescents, adults, and the elderly — and they can occur in any family. Several million people in this country suffer from a serious, long term mental illness. The cost to society is high due to lost productivity and treatment expense. Patients with mental illness occupy more hospital beds than do persons with any other illness.

Mental illness is not the same as mental retardation. The mentally retarded have a diminshed intellectual capacity usually present since birth. Those with mental illnesses are usually of normal intelligence although they may have difficulty performing at a normal level due to their illness.

Schizophrenia is one of the most serious and disabling of the mental illnesses. It affects approximately one person in a hundred. The disease affects men and women about equally. Its onset is usually in the late teens or early twenties. People with schizophrenia usually have several of the following symptoms:

- disconnected and confusing language
- poor reasoning, memory and judgment
- high levels of anxiety
- eating and sleeping disorders
- hallucinations - hearing and seeing things that exist only in the mind of the patient
- delusions - persistent false beliefs about something, e.g., that others are controlling their thoughts
- deterioration of appearance and personal hygiene
- loss of motivation and poor concentration
- tendencies to withdraw from others

Unfortunately there are many myths about schizophrenia. Persons with schizophrenia do not have a "split personality" and are not prone to criminal violence. Their illness is not caused by bad parenting and it is not evidence of weakness of character. Their illness is due to a biochemical disturbance of the brain.

Affective Disorder

The affective disorders are the most common of psychiatric disorders. They are generally less persistently disabling than schizophrenia. The primary disturbance in these disorders is that of affect or mood. These mood disorders may be manic depressive illness (bi-polar) in which the person swings between extreme high and low moods, or they may be uni-polar in which the persons suffers from persistent severe depression. About six per cent of the population suffers from an affective disorder - a major cause of suicide.

Persons diagnosed as having bi-polar illness usually have several of the following characteristics:

- boundless energy, enthusiasm, and need for activity
- decreased need for sleep
- grandiose ideas and poor judgment
- rapid, loud, disorganized speech
- short temper and argumentativeness
- impulsive and erratic behavior
- possible delusional thinking
- rapid switch to severe depression

Persons having severe depression (or the depressive phase of a bi-polar disorder) may have several of the following characteristics:

- difficulty in sleeping
- loss of interest in daily activities
- loss of appetite
- feelings of worthlessness, guilt and hopelessness
- feelings of despondence or sadness
- inability to concentrate
- possible psychotic symptoms
- suicidal thoughts and even actions

Other Disabling Mental Illness - Anxiety disorders, when severe, may also be considered a mental illness. Other conditions such as personality disorders, behavioral disorders, and the abuse of alcohol and drugs may be so disabling as to be labeled a mental illness.

Causes of Mental Illness

The causes of mental illnesses are not well understood, although it is believed that the functioning of the brain's neurotransmitters is involved. Many factors may contribute to this disturbed functioning. Heredity may be a factor in mental illness as it is in diabetes and cancer. Stress may contribute to the onset of mental illness in a vulnerable person. Recreational drugs may also contribute to onset but are unlikely to be the single cause. Family interaction and early child training were once a dominant theory of causation; however, research does not support that theory any longer.

Can Mental Illness be Prevented? Cured?

Since the causes of long term mental illnesses are not known, there is no effective prevention at this time. More research is needed to determine causes and to plan strategies of prevention. Likewise, there are no cures for mental illnesses. However, there are treatments available which can substantially improve the functioning of persons with these disorders.

What are the Treatments for Mental Illness?

An expanding range of medications is available at this time. While they do not cure these illness, they reduce symptoms markedly for most people. In addition, most persons can profit from a community program to help them build self-confidence and learn independent living skills. With well-developed programs some patients recover substantially, hold a job, and achieve a satisfactory life.

Others may need some support for all or most of their lives. The goal is to help them achieve the highest degree of independence and productivity possible.

Once active symptoms are under control, how well the person can function depends upon what his community provides for his rehabilitation.

Commonly Asked Questions. . .

What is mental illness?

Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating. They result in substantially diminished capacity for coping with the ordinary demands of life. Mental illnesses can affect persons of any age—children, adolescents, adults, and the elderly—and they can occur in any family.

How prevalent is mental illness?

15% of all adults seek mental health treatment. About 6% suffer from the most severe forms of mental illness—schizophrenia, severe depression and manic depression. All told, one in four families has a family member with mental illness.

Do people recover from mental illness?

With the right treatment and services, recovery can and does happen. 33% of those who have schizophrenia will fully recover and another 33% will be able to function in the community with minimal support. More than 80% of people with depression can also be successfully treated.

How can people help?

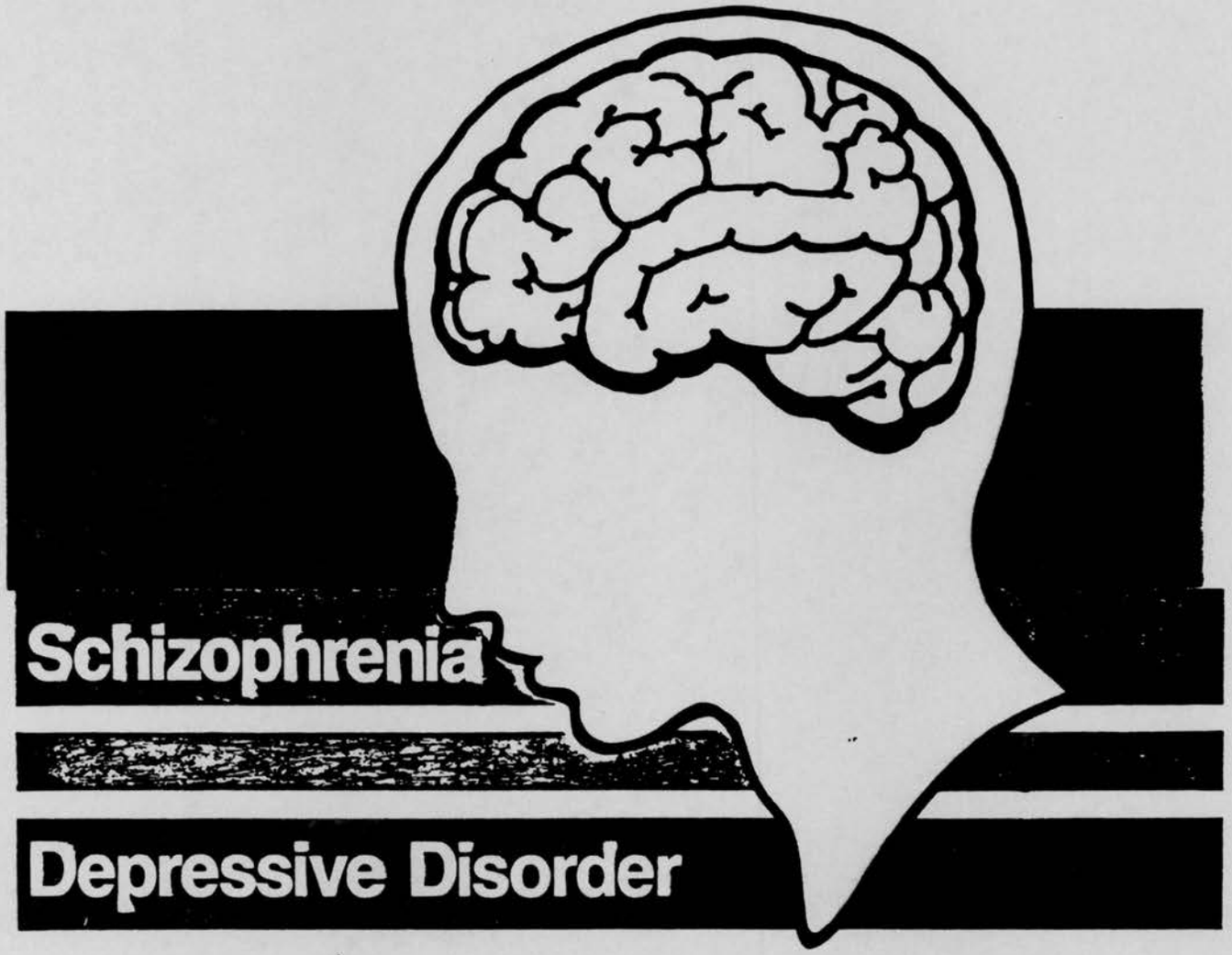
- Speak out—educate others about the needs of mentally ill people.
- If you are an employer, hire mentally ill people.
- As a taxpayer, support funds for a good community-based support system.
- If you are a homeowner, welcome a group home in your neighborhood.
- If you are a family with an afflicted member, join your local Alliance for the Mentally Ill (AMI).

There was a time when the general public had little interest in mental illness and knew little about it. This is no longer true. The words "mental illness" come up frequently in the media. People now are increasingly aware that mental illness is a severe and disabling disorder. We believe that society has a responsibility toward those who suffer from it.

Alliance for the Mentally Ill of Minnesota

1595 Selby Avenue #163
St. Paul, MN 55104
(612) 645-2948

The brain is part of the body. It, TOO, can become ill.



Schizophrenia

Depressive Disorder

are *no fault* brain illnesses.

AMI

Alliance for the Mentally Ill of Minnesota

National Institute of Mental Health

The 14 Worst Myths About Recovered Mental Patients

MYTH No. 1

FALSE "A person who has been mentally ill can never be normal."

FACT

Mental illness is often temporary in nature. A previously well-adjusted individual may have an episode of illness lasting weeks or months, and then may go for years – even a lifetime – without further difficulty. To label such a recovered patient "abnormal" is both unfair and unrealistic.

Many other patients are subject to bouts of disturbance. Between episodes though, they may be perfectly well, and at these times they understandably resent being treated as other than normal.

Like the rest of us, former mental patients deserve to be judged on their own merits. Too often, they are thought of only in terms that unfairly label them.

MYTH No. 2

FALSE "Even if some mentally ill persons return to normal, chronically mentally ill people remain different – in fact, crazy."

FACT

Individuals who have been disturbed for a long time and continue to have symptoms are called chronically mentally ill. Usually, these people have spent long years in hospitals and, even after discharge, must continue to take medication. The combination of illness, years of hospitalization, and side effects of medication often causes them to look or act in strange ways. But the longer they are in the community and able to interact with other people, the more nearly normal their behavior is likely to become.

In any case, among those who have recovered enough to live outside a hospital, any strange behavior is likely to be relatively limited and harmless. Some of them, for example, mutter to themselves to an abnormal degree. But many of these individuals will stop talking to themselves when spoken to and then can carry on a pleasant conversation. Many also are able to work productively and live at least semi-independently, if the community will support their efforts.

MYTH No. 3

FALSE "If people with other handicaps can cope on their own, recovered mental patients should be able to do so, too."

FACT

Most people who have been through a disabling illness need help, or *rehabilitation*, to return to normal functioning. Physical therapy often fills this role after physical illness. Similarly, following mental illness, social rehabilitation is usually needed.

There are many reasons why this is so. In the case of persons with chronic mental illness, the "differentness" we have mentioned makes it difficult for many of them to get back into society without help. Also, they often first become mentally ill in their teens or early twenties. Their education is interrupted, making it that much more difficult for them to earn a living later. In addition, "fitting in" is particularly important during these early years. Since mentally disturbed young people have difficulty fitting in, their social connections may be disrupted and their self-esteem seriously, and often permanently, damaged. For all these reasons, recovered mental patients typically need substantial support to reenter their communities successfully.

MYTH No. 4

FALSE "Persons with mental illness are unpredictable."

FACT

Some *are* impulsive and their actions unpredictable when they are actively ill. But once they have recovered, most of them are consistent in their behavior and are likely to present few surprises to those who know them.

MYTH No. 5

FALSE "Yes, but those with 'split personalities' must remain unpredictable."

FACT

"Split personality" is a popular but misleading description of schizophrenia, one of the major mental illnesses. Persons with *schizophrenia* do not really have split personalities. Rather, when they are ill, their thinking becomes confused. They may also suffer from delusions (false beliefs) or hallucinations. Appropriate medication will often control or eliminate these symptoms and any accompanying unpredictability.

On the other hand, those with *multiple personalities* (such as Eve in the motion picture, "The Three Faces of Eve") may be extremely unpredictable. But individuals with this condition are so rare that few of us will ever encounter one of them. And though they may be unpredictable, they are generally not violent.

MYTH No. 6

FALSE "Mentally ill persons are dangerous."

FACT

Patients who have come through mental illness and have returned to the community are apt, if anything, to be anxious, timid, and passive. They rarely present a danger to the public.

Of a sample of some 20,000 former mental patients monitored for 18 months after their release from hospitals, only 33 were arrested for crimes involving violence. It is true that even this low ratio is somewhat higher than would be expected in the general population. But a closer look shows that the excess comes from those who had arrest records prior to their hospitalizations. A former patient without such a record is *less* likely to be arrested than the average citizen.

In the great majority of cases, the image of the former mental patient as a homicidal maniac in need of restraint is far from the truth.

MYTH No. 7

FALSE "But recovered mental patients are surely potentially dangerous. They could go berserk at any time."

FACT

Most people who have been mentally ill never went "berserk" in the first place. Mental patients are more likely to be depressed and withdrawn than wild and aggressive. Also, according to experts, most relapses develop gradually, and if physicians, friends, families, or the persons themselves are alert and knowledgeable enough to recognize early symptoms, recurrences can usually be detected and dealt with before they become too severe.

Fear that a recovered patient may "go wild" rarely has any basis in fact. It is almost never a valid reason for denying a former patient employment, housing, or friendship.

FALSE

MYTH No. 8

"Anyone who has had shock treatment must *really* be in a bad way."

FACT

Shock treatment (electroshock or electroconvulsive therapy) is an effective way of dealing with certain cases of serious depression that are resistant to drugs and "talk" therapy. Some patients make dramatic recovery following shock treatment and remain well for years. There is no reason to assume that someone who receives this kind of therapy must be sicker than other patients, or to view such persons with added suspicion once they have recovered.

FALSE

MYTH No. 9

"When you learn a person has been mentally ill, you have learned the most important thing about his or her personality."

may suffer from certain delusions or act disturbed at times, but in their calmer moments they will probably be able to discuss many things reasonably and sensibly.

FALSE

MYTH No. 11

"If a former mental patient has a really bad history there isn't much hope."

FACT

That person's history is important in predicting his or her chances for recovery. But some may be ill for many years before they finally receive effective treatment or their condition improves for other reasons. Once the turnaround occurs, these individuals may remain well for the rest of their lives.

FALSE

MYTH No. 12

"A former mental patient is bound to make a second-rate employee."

FACT

Many recovered mental patients make excellent employees. In fact, employers frequently report that former patients outperform other workers in such areas as attendance and punctuality, and are about equal in motivation, quality of work, and job tenure.

However, some are subject to relapses which may cause them to lose time from their jobs.

These individuals should work in flexible situations that can accommodate such interruptions. When they are working, they may perform extremely well.

FALSE

MYTH No. 13

"Perhaps recovered mental patients can work successfully at low-level jobs. But they aren't suited for really important or responsible positions."

FACT

Recovered mental patients are individuals. As such, their career potentials depend on their particular talents, abilities, experience, and motivation, as well as their current state of physical and mental health.

As mentioned earlier, a number of political leaders, artists, and others have achieved greatness despite the handicap of mental illness. Few of us can hope to match the accomplishments of these outstanding men and women. But, with modern treatment, former mental patients can reasonably expect to work at responsible jobs and continue to contribute to society, if society does not arbitrarily bar their way.

FALSE

MYTH No. 14

"Recovered mental patients have a tough row to hoe. But there's not much that can be done about it."

FACT

The way we act toward former mental patients can make all the difference in their lives. Effective treatment, hard work, and good motivation are of limited value when functioning, hard-working, well-motivated former patients are refused employment, housing, or other opportunities because of false beliefs and stereotypes. Everyone's help is needed. Here are some things *you* can do:

- Respond to recovered mental patients as individuals. Learn about the person and deal with him or her on the basis of your knowledge.
- Do what you can to help former mental patients reenter society. Support their efforts to *obtain* housing and jobs.
- Don't let false statements about mental illness or mentally ill persons go unchallenged. Many people have wrong and damaging ideas on the subject but honestly believe their notions to be true. Correct information *may* help change their minds.
- Spread the word. Tell others what you have learned and urge that recovered mental patients be treated fairly. Help give them what they need most – a chance.

Learning the Facts...

One in four American families is affected by mental illness, a fact that makes it everbody's business. No segment of our society is immune.

The picture is not a bleak one, however, since people can and do recover from mental illness. There are some famous examples, including President Abraham Lincoln, philosopher William James, novelist Virginia Woolf, U.S. Senator Thomas Eagleton, popular singer Rosemary Clooney, and professional golfer Bert Yancy.

Lincoln was a victim of depression. Before his illness, he was little more than an average lawyer – honest but undistinguished. It was *after* he overcame that illness that he attained the presidency and became one of America's – and the world's – outstanding leaders.

Lincoln is not alone in having achieved great things despite an intense struggle with mental illness. The accomplishments of these other remarkable men and women who have suffered and recovered from mental illness also make a strong case for encouraging recovered mental patients to strive to the limits of their capacity.

Concerned citizens and mental health professionals are working to improve community resources for former mental patients, and they welcome the help of others in the effort. At the same time, if recovered patients are to become a part of the larger community, it is essential that the public learn more of the facts about mental illness and former mental patients.

how can family and friends help?

The very nature of depressive illness often keeps the depressed person from seeking treatment. It also destroys self-esteem and confidence. Family and friends can encourage the depressed person to get appropriate treatment and can provide much needed love and support. The following simple actions can make the difference:

- Help lead the depressed person to appropriate treatment
- Maintain as normal a relationship as possible
- Point out distorted negative thinking without being critical or disapproving
- Acknowledge that the person is suffering and in pain
- Offer encouragement and pay compliments
- Show that you respect and value the depressed person
- Demonstrate that you know that the person is suffering from an illness, not a personal weakness.

The National Alliance for the Mentally Ill

The National Alliance for the Mentally Ill (NAMI) is a grassroots, self-help support and advocacy organization of families and friends of people with serious mental illnesses. NAMI's mission is to eradicate mental illness and to improve the quality of life for those who suffer from these no-fault brain diseases.

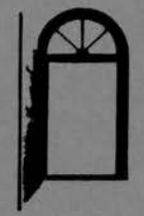
To learn more about the Depressive Illness Project or to join NAMI, contact us at: The National Alliance for the Mentally Ill, 200 Wilson Blvd., Suite 302, Arlington, VA 22201 [(703) 524-7600]

depressive illness could also be called Lincoln's Disease because ***Abraham Lincoln*** *knew it well. "I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on earth. Whether I shall ever be better, I cannot tell; I awfully forebode I shall not. To remain as I am is impossible. I must die or be better, it appears to me." There was no professional help for President Lincoln, but there is now for you or someone you love.*

the depressive illness project

BRINGING THE FACTS TO LIGHT

The National Alliance for the Mentally Ill
200 Wilson Blvd., Suite 302, Arlington, VA 22201 (703) 524-7600



WHAT DO ABRAHAM LINCOLN, WINSTON CHURCHILL AND SOME OF YOUR FRIENDS HAVE IN COMMON?

depressive illness

NOW YOU CAN LEARN HOW TO HELP...

THE facts

- Clinical depression is a biological illness which affects the brain's chemistry, just as diabetes is a biological illness which affects the kidneys.
- Willpower will not alleviate the intense pain and debilitating despair of depression. Medical treatment will in 80% to 90% of cases.
- At least one in five Americans will suffer a major depressive episode over the course of a lifetime.
- Fifteen percent of those who feel the physical and mental pain of depression will commit suicide.

THE symptoms

Persistent sad, anxious, or "empty" mood

- Feelings of hopelessness, pessimism, guilt, or worthlessness
- Loss of interest or pleasure in ordinary activities, including sex
- Sleep disturbances (insomnia, early morning waking, or oversleeping)
- Eating disturbances (either loss or gain of appetite or weight)
- Decreased energy, fatigue, being "slowed down"
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Difficulty concentrating, remembering, making decisions

If some or all of the symptoms of depression persist for more than two weeks, or are causing impairment in ordinary functioning, treatment is needed.

THE resources

National Alliance for the Mentally Ill
200 Wilson Blvd., Suite 302
Arlington, VA 22201 [(703) 524-7600]

National Depressive and Manic Depressive Association
Merchandise Mart
Box 3395
Chicago, IL 60654 [(312) 939-2442]

Depression Awareness, Recognition, and Treatment (D/ART) Program
National Institute of Mental Health
Rockville, MD 20857

For a list of suggested books about depressive illness and its treatment, write NAMI at the above address.

the depressive illness project

BRINGING THE FACTS TO LIGHT

THE DEPRESSIVE ILLNESS PROJECT

The Depressive Illness Project of the National Alliance for the Mentally Ill (NAMI) is an effort to bring light to the facts about depression and its treatments. After twenty years of research, scientists have clearly established that depressive illness has deep genetic and biological roots. Yet over half of all Americans view depressive illness as a personal weakness and only one-third of the estimated 10 million people who suffer from clinical depression each year receive any help.

Established by a seed grant from the Dana Memorial Fund, the Depressive Illness Project educates the public on scientific facts, research discoveries and effective treatment options through symposia on college campuses and in corporate settings. The Depressive Illness Project also receives technical and financial support from the National Institute of Mental Health's D/ART campaign.

ON CAMPUSES

One of the cruel ironies of this disease is that it manifests itself in early adulthood. A time of great hope and new beginnings is turned to one of great hopelessness and despair.

The Depressive Illness Project presents scientific symposia to help young people draw the distinction between the depression one feels after failing an exam, for example, and the depression that is life-threatening illness. Students, faculty and staff meet distinguished research scientists, people who have experienced the real pain of this illness relieved through treatment, and local health professionals who acquaint them with services available in their own community.

IN THE WORKPLACE

The economic toll of untreated depressive illness compels us to bring the facts about this disease to America's corporate community. The National Institute of Mental Health estimates that more than 150 million workdays are lost each year due to depressive illness.

Through a series of science symposia, the Depressive Illness Project brings together outstanding scientists and business leaders to present facts of this illness' devastation in the workplace. Materials detailing the symptoms and treatments of depression available at local medical centers are provided. Family and patient self-help support groups are highlighted as an ongoing community resource.

THROUGH THE MEDIA

Finally, each year the Depressive Illness Project presents the Dana Memorial Fund News Public Service Award to a newspaper, wire service, or magazine journalist for an article or series of articles which makes an exceptional contribution to the advancement of public understanding and treatment of clinical and manic depression.

THE WAYSTATION

by

Kitty Van Evera Reichert

Partially Scanned Material

Version 3
March 18, 2019

Care Providers
Of Minnesota

Patients'/Residents' Rights
STATEMENT OF POLICIES AND RIGHTS

It is the intent of the State of Minnesota in enacting Minnesota Statutes Sections 144.651 and 144.652 and of the Federal Government in promulgating the regulations found in Volume 42, **Code of Federal Regulations**, Sections 405.1121 (k), 442.311 and 442.404, to promote the interests and well-being of patients/residents of health care facilities. It is the further intent of the State of Minnesota to assure that every patient's/resident's civil and religious liberties, including the right to independent decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in probate court or county court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding, the health care facility may, in good faith, comply with the instructions of a guardian or conservator.

The interests of the patient/resident and, where appropriate, guardians, next of kin, sponsoring agencies, representative payees or the public shall be protected by, but not limited to, the following policies and procedures:

PATIENTS' AND RESIDENTS' BILL OF RIGHTS

(1) **INFORMATION ABOUT RIGHTS.** Patients and residents shall be told at admission that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of their rights and responsibilities. In the case of patients admitted to residential programs as defined in Laws of MN 1986, Chapter 326, Section 7, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Upon receipt of this statement and a full explanation, the resident must acknowledge the receipt in writing. Patients and residents already in the facility must be provided with amended statements if these provisions are changed. The receipt of the changes must also be acknowledged in writing. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with Chapter 13, the data practices act, and section 626.557, relating to vulnerable adults.

(2) **COURTEOUS TREATMENT.** Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

(3) **APPROPRIATE HEALTH CARE.** Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.

(4) **PHYSICIAN'S IDENTITY.** Patients and residents shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as his or her representative.

(5) **RELATIONSHIP WITH OTHER HEALTH SERVICES.** Patients and residents who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Residents shall be informed, in writing, of any health care services which are provided to those residents by individuals, corporations, or organizations other than their facility. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as his or her representative.

(6) **INFORMATION ABOUT TREATMENT.** Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients or residents can reasonably be expected to understand. Patients and residents may be accompanied by a family member or other

Revised 9/87

chosen representative. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's medical record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as his or her representative. Individuals have the right to refuse this information.

Every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

(7) **PARTICIPATION IN PLANNING TREATMENT.** Patients and residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative. In the event that the patient or resident cannot be present, a family member or other representative chosen by the patient or resident may be included in such conferences.

(8) **CONTINUITY OF CARE.** Patients and residents shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

(9) **RIGHT TO REFUSE CARE.** Competent patients and residents shall have the right to refuse treatment based on the information required in 6 (above). Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a patient or resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's or resident's medical record.

(10) **EXPERIMENTAL RESEARCH.** Written, informed consent must be obtained prior to a patient's or resident's participation in experimental research. Patients and residents have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

(11) **FREEDOM FROM ABUSE.** Patients and residents shall be free from mental and physical abuse as defined in the Vulnerable Adults Protection Act [§626.557 subd. 2d]. "Abuse" means any act which constitutes assault, sexual exploitation, or criminal sexual conduct as referenced in the Vulnerable Adults Act or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

(12) **TREATMENT PRIVACY.** Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

(13) **CONFIDENTIALITY OF RECORDS.** Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and the Minnesota statutes governing access to health records [144.335]. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law.

(14) **DISCLOSURE OF SERVICES AVAILABLE.** Patients and residents shall be fully informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charge. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or Medical Assistance program will pay for any or all of the aforementioned services.

(15) **RESPONSIVE SERVICE.** Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.

(16) **PERSONAL PRIVACY.** Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

(17) **GRIEVANCES.** Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program as well as address and telephone numbers of the Office of Health Facility Complaints and the Area Nursing Home Ombudsman pursuant to the Older Americans Act [section 307 (a) (12)] shall be posted in a conspicuous place.

Every acute care in-patient facility, every residential program as defined in Laws of Minnesota, Chapter 326, Section 7, every nonacute care facility, and every facility employing more than two people that provides out-patient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in Laws of Minnesota, Chapter 326, Section 7, which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

(18) **COMMUNICATION PRIVACY.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' and residents' calls. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, clause 2, this right shall also be limited accordingly.

(19) **PERSONAL PROPERTY.** Patients and residents may retain and use their personal clothing and possessions as space permits, unless doing so would infringe upon rights of other patients or residents, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility must either maintain a central locked depository or provide individual locked storage areas in which residents may store their valuables for safekeeping. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

(20) **SERVICES FOR THE FACILITY.** Patients and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

(21) **CHOICE OF SUPPLIER.** A resident may purchase or rent goods or services not included in the per diem rate from a supplier of his or her choice unless otherwise provided by law. The supplier shall ensure that these purchases are sufficient to meet the medical or treatment needs of the resident.

(22) **FINANCIAL AFFAIRS.** Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

(23) **RIGHT TO ASSOCIATE.** Residents may meet with visitors and participate in activities of commercial, religious, political, as defined by the Minnesota statutes regarding voting while residing in a health care facility [203B.11] and community groups without interference at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes the right to join with other individuals within and outside the facility to work for improvements in long-term care.

(24) **ADVISORY COUNCILS.** Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

(25) **MARRIED RESIDENTS.** Residents, if married, shall be assured privacy for visits by their spouses and, if both spouses are residents of the facility, they shall be permitted to share a room, unless medically contraindicated and documented by their physicians in the medical records.

(26) **TRANSFERS AND DISCHARGES.** Residents shall not be arbitrarily transferred or discharged but may be transferred or discharged only for medical reasons, for his or other patients' or residents' welfare, or for nonpayment of stay unless prohibited by the welfare programs paying for the care as documented in the medical record. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the Area Nursing Home Ombudsman pursuant to the Older Americans Act [§307 (a) (12)]. The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accomodate new residents without disrupting room assignments.

(27) **PROTECTION AND ADVOCACY SERVICES.** Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

(28) Additional policies and procedures pertaining to residents of ICF/MR facilities:

(A) **INFORMATION ABOUT RIGHTS.** A mentally retarded individual's written acknowledgment of information regarding their rights or any amendments to their rights, must be witnessed by a third party.

(B) **FREEDOM FROM ABUSE.** Notwithstanding the rights of Freedom From Abuse conferred in number (11), in the case of a mentally retarded resident chemical or physical restraints may be used during a behavior modification session upon the conditions listed in (C) below.

(C) **BEHAVIOR MODIFICATION.** Chemical or physical restraints may be used during a behavior modification session for a mentally retarded resident if the use is authorized in writing by the physician or a qualified mental retardation professional and the parent or legal guardian of the mentally retarded resident has given informed consent to the use of restraints or aversive stimuli.

(D) **RIGHT TO ASSOCIATE.** The right of an ICF/MR resident to participate in social, religious, and community group activities may be restricted if a qualified mental retardation professional determines that these activities are contraindicated for a mentally retarded person and documents that determination in the resident's record.

A complaint regarding violations of any patient's/resident's rights enumerated herein, or any statute or regulation, may be filed by contacting the Office of Health Facility Complaints. This office may be contacted at:

Minnesota Department of Health
717 Delaware Street S.E.
Minneapolis, Minnesota 55440
Phone 612/623-5562

Inquiries about the medical care received by patients/residents may be directed to the State Board of Medical Examiners, Room 106, 2700 University Avenue West, St. Paul, MN 55114-1080, 612/642-0538 or to:

_____

(Name and phone number of person in the facility to whom inquiries can be addressed)

Regional Long Term Care Ombudsman or call Toll Free 1-800-652-9747 ext. 0380

I hereby acknowledge receipt of a copy of this Statement of Policies and Rights and have been fully informed of such policies and rights.

DATE: _____

_____
Signature of Patient/Resident

_____
Signature of Guardian or Conservator
(if appropriate)

Care Providers
Of Minnesota
2850 METRO DRIVE, SUITE 200
BLOOMINGTON, MN 55420

Written permission granted
12/7/87 until 5/31/90.
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ORIGINAL RESIDENT'S COPY

LEAGUE OF WOMEN VOTERS OF MINNESOTA

and

DEPARTMENT OF SOCIAL WORK
MANKATO STATE UNIVERSITY

Monitor Evaluation Project

This project wishes to gather information about the reaction of participants to their work with the Mental Health Monitoring Project. We are asking your help in assessing the attitudes of participants so that we may learn how to improve this project. We also wish to uncover more about the processes by which citizens become empowered to take on important public issues.

The questions that you will be asked are not personal or intrusive. They relate to your anticipation of participation and to what you have actually experienced. There are two parts to the project, this pre-monitoring questionnaire and a followup questionnaire after you have completed your work. A few persons will also be selected at random for an additional telephone interview. If you wish, you may freely decline to be interviewed but still complete the questionnaires.

If you choose to participate we ask that you do the following things:

1. Sign the Consent to Participate Statement

2. Complete the general information section of this form

3. Return this form with your completed first questionnaire

Thank you very much for considering this request. We hope that you will agree to participate.

Dr. Richard T. Wintersteen
Department of Social Work
MSU Box 185
Mankato State University
Mankato MN 56001

Phone: 507 / 389-5078 (O)
507 / 387-3936 (H)

CONSENT TO PARTICIPATE IN RESEARCH

The Monitor Evaluation Project has been explained to me. I understand that the questions relate only to my participation in the Mental Health Monitoring Project and do not include questions of a personal nature.

By agreeing to participate I agree to complete both the pre-monitoring and the post-monitoring questionnaires. Project staff also understand that other factors may make it impossible to complete the second questionnaire.

I understand that I am free to withdraw my participation at any point and that project staff will not solicit my further participation should I decide not to continue.

I agree to participate in this project.

_____ _____

Signature Date

I am willing to be contacted for a telephone interview.

_____ _____

Signature Date

* * *

_____

Address

_____

_____

Telephone (Only if you have agree to be called.)

LWV-1

LEAGUE OF WOMEN VOTERS OF MINNESOTA

and

DEPARTMENT OF SOCIAL WORK
MANKATO STATE UNIVERSITY

Monitor Evaluation Project

SECTION A - ORIENTATION TO THE PROJECT

Instructions: Answer each question as fully as necessary to share your ideas.

1. Why did you decide to volunteer for this project?

2. Background with mental health service delivery (check all that apply)

_____ Consumer
_____ Family member
_____ Pre-professional student
_____ Other (specify)
_____ Provider of services
_____ Interested citizen

3. How familiar do you FEEL with Minnesota Mental Health Services?

_____ Very Familiar
_____ Moderately familiar
_____ Slightly familiar
_____ Unfamiliar

Comments:

4. How well informed do you feel about severe and persistent mental health problems?

_____ Very informed
_____ Moderately informed
_____ Slightly informed
_____ Uninformed

Comments:

5. What personal qualities or skills do you bring to the project?

6. From what you now know, why do you think that this project is needed (if at all)?

7. From what you now know, what are the major needs of the mental health system?

8. In which areas do you have some concerns about participating in this project (check all that apply)?

_____ About my own abilities
_____ About questioning professionals/providers
_____ About meeting consumers
_____ About working with a team
_____ About the use that LWV will make of the data
_____ No concerns

Comments:

9. What response do you anticipate from professionals/providers?

10. What response do you expect from consumers?

11. How do you expect to be changed as a result of participating in this project?

SECTION B. KNOWLEDGE INVENTORY ABOUT MENTAL ILLNESSES

INSTRUCTIONS: (1) Please circle as many of the lettered answers as you think are correct.

(2) Note that some questions are about mental illness in general, while others are about specific conditions such as schizophrenia or bipolar disorder.

(3) Some of these questions are derived from a knowledge inventory developed and reported by the following authors:

McGill, C.W., Falloon, I.R.H., Boyd, J.L., & Wood-Silvero, C. (1983). Family educational intervention in the treatment of schizophrenia. Hospital & Community Psychiatry, 34, 934-938.

1. Which of the following are symptoms of schizophrenia?

A. Delusions or unrealistic thoughts
B. Hallucinations such as hearing voices
C. Fear of heights
D. Fainting attacks
E. Laughing or crying for no reason

2. Which of the following are associated with bipolar (manic depressive) disorder?

A. Periods of intense activity or energy
B. Delusions or unrealistic thoughts
C. Compulsive behavior
D. Serious suicide risks
E. Self-mutilating behavior

3. Which of the following are associated with mental illness?

A. Parents or brothers or sisters who have been mentally ill
B. Problems with peers
C. Unhappy childhood
D. Headaches
E. Disordered brain chemistry

4. Which areas of a patient's life does schizophrenia affect?

A. Thinking
B. Moods or feelings
C. Working
D. Caring for self
E. Making relationships and socializing

5. Which of the following makes schizophrenia worse?

A. Stressful life problems
B. Angry nagging by family members
C. Having nothing to do with time
D. Taking street drugs (cocaine, LSD, amphetamines, etc.)
E. Stopping medications

6. A person with schizophrenia nearly always has:

A. Two or more personalities
B. Mood swings from elation to depression
C. Difficulty coping with changes in life
D. Tendency to behave violently
E. Difficulty in deciding what is real and what isn't

7. A person with schizophrenia may believe that they:

A. Have been persecuted unjustly
B. Hear voices when nobody is around
C. Thoughts are being put into (or taken out of) their mind
D. Comments on TV or in newspapers are directed toward them
E. Their toughts are controlled by another person

8. Relapse of symptoms occurs in _____% of patients with schizophrenia in one year if medication is stopped.

A. 10%
B. 30%
C. 50%
D. 70 %
E. 100%

9. This can be reduced to _____% if medication is continued at low doses.

A. 10%
B. 30%
C. 50%
D. 70 %
E. 100%

10. In addition to medication, the following are important standard treatments for schizophrenia:

A. Primal screaming
B. Hypnosis
C. Family counseling
D. Resocialization
E. ECT/ Shock treatment

11. Which of the following medications is/are frequently used for the treatment of Schizophrenia?

A. Sinequan
B. Haldol
C. Elavil
D. Mellaril
E. Lithium

12. Which of the following are standard drugs to control the side effects of antipsychotic medications?

A. Artane
B. Amphetamine
C. Cogentin
D. Benedryl
E. Thorazine

13. Common side-effects of drugs used in the treatment of schizophrenia are:

A. Drowsiness
B. Weight gain
C. Restless legs or shakiness
D. Abdominal pains
E. Memory loss

14. Ways of coping and reducing side-effects are:

A. Waiting a few weeks/months
B. Reducing the dosage with doctor's advice
C. Changing to another drug without the annoying side-effect
D. Using an additional drug such as Benadryl, Artane or Cogentin
E. Using a combination of medications such as Thorazine, Mellaril, and Prolixin

15. Which of the following medications is/are commonly used for bipolar disorder?

A. Sinequan
B. Haldol
C. Elavil
D. Mellaril
E. Lithium

16. Which of the following medications is/are commonly used for unipolar depression?

A. Sinequan
B. Haldol
C. Dilantin
D. Mellaril
E. Lithium

17. Approximately _____% of persons having a single schizophrenic episode never experience another one?

A. 25%
B. 48%
C. 62%
D. 75%
E. 90%

18. When a person with schizophrenia is under pressure, they should:

A. Take an extra dose of medication without checking with their doctor
B. Spend several days in bed
C. Ask family members or friends for advice
D. Discuss their difficulties with their doctor or social worker
E. Try to find ways to cope with the stress and continue their activities

19. Fountain House is:

A. A San Francisco night club
B. A patient run hotel in Ft. Worth
C. A community residential program in Milwaukee
D. A psychosocial clubhouse in New York
E. A long term halfway house in Los Angeles

20. Which of the following is/are not part of a good community support program?

A. Crisis intervention
B. Meals of Wheels
C. Vocational training
D. Case management
E. Shock treatment

21. When families have a mentally ill member, family counseling or therapy can sometimes help to:

A. Clarify communication problems
B. Establish reasonable "house rules"
C. Cure the illness
D. Foster the coping abilities of family members
E. Decide who or what caused the illness

22. The best family environment for a person with a mental illness is one where:

A. The person can do whatever he/she wants
B. The person spends most of the time with another family member
C. The person is forced to go out and get a job
D. The person is encouraged to gradually regain former skills
E. The family takes over and protects the patient from any stress

23. Parents are able to cope better if they:

A. Take care of their own emotional needs
B. Concentrate mostly on the needs of their relative
C. Make their expectations clear
D. Give the ill relative constant attention
E. Cut off all contact and let someone else deal with things

THANK YOU VERY MUCH FOR YOUR PARTICIPATION

SERVICE PROVIDER AGREEMENT

The League of Women Voters of_____
and_____, a service provider in Minnesota, hereby agree to cooperate in a Mental Health Monitoring Project, the purpose of which is to continue to educate citizens and League Members through involving them in an examination of the mental health system in Minnesota with particular emphasis on the availability and quality of community services. The objective of this project is to enhance community services for persons with mental illness by fostering cooperation with county officials and service providers, and recognizing areas of strengths and creativity, as well as deficiencies.

The following procedures of monitoring are understood by both parties:

1. An appointment will be scheduled with the service provider to be monitored to explain the objectives of the project.

2. Monitoring groups will consist of at least two people, but no more than three.

3. No surprise visits will be made.

4. Volunteers will not attempt to look at any client files or medication records.

5. Ordinarily two monitoring visits will be scheduled for each facility.

6. All findings will be shared first with service providers. Input from staff members will be encouraged.

7. Except in cases of outstanding program features, project reporting will not name specific facilities.

8. A final report on information obtained through the monitoring project will be prepared in May 1991 by the League of Women Voters of Minnesota Education Fund.

This agreement will be in effect until June 1, 1991 or until either party elects to withdraw from the project.

_____ _____
League of Women Voters Date

_____ _____
Service Provider Date

JOINT AGREEMENT

The League of Women Voters of_____, hereby agrees to complete a Mental Health Monitoring Project, the purpose of which is to continue to educate citizens and League Members through involving them in an examination of the mental health system in Minnesota with particular emphasis on the availability and quality of community services. The objective of this project is to enhance community services for persons with mental illness by fostering cooperation with county officials and service providers, and recognizing areas of strengths and creativity, as well as deficiencies.

The local league agrees to:

1. Foster cooperation among monitors, care providers, agencies and citizen groups.

2. Refrain from political lobbying using monitoring results until June 1, 1991. (Reporting of objective findings is permitted.)

3. Comply with volunteer guidelines.

4. Have each volunteer monitor sign a Volunteer Agreement stating understanding of and agreement with the volunteer guidelines.

5. Respect the confidentiality of all consumers.

6. Report findings locally. (Stress outstanding programs. Negative findings about providers or agencies will be reported generally. Do not report names of individual staff members of facilities with whom there are perceived problems.)

7. Complete progess reports.

8. Send copies of all completed checklists to the state project.

9. Complete expense vouchers if requested to do so.

10. Complete evaluation forms for checklists.

11. Send final report to state league.

State Mental Health Monitoring Project agrees to provide the following to participating leagues:

1. Technical assistance.
2. Volunteer training and support.
3. A variety of forms. (Including, but not limited to, sample press releases, Volunteer Agreement, Service Provider Agreement, revised checklists, evaluation forms, sample letters to agencies and programs to be monitored, etc.)

This agreement will be in effect until June 1, 1991.

_____ _____

League of Women Voters of Minnesota Date

_____ _____

Local League Date

VOLUNTEER AGREEMENT

The League of Women Voters of_____
and_____, a Volunteer Monitor, hereby agree to complete a Mental Health Monitoring Project, the purpose of which is to continue to educate citizens and League Members through involving them in an examination of the mental health system in Minnesota with particular emphasis on the availability and quality of community services. The objective of this project is to enhance community services for persons with mental illness by fostering cooperation with county officials and service providers, and recognizing areas of strengths and creativity, as well as deficiencies.

I understand that if I or a member of my immediate family have been a consumer of a mental health service, program or facility within the last two years, I may not monitor that service, program or facility. I also understand that if I am a board member of, or am employed by a mental health service, program or facility, I may not monitor that service, program or facility.

As a Volunteer Monitor, I agree to the following volunteer guidelines. Volunteer Monitors should:

1. Participate in training when offered.

2. Thoroughly familiarize themselves with the checklists before monitoring visits.

3. Approach officials, service providers and consumers with an open mind.

4. Make every effort to respect the good will of those interviewed.

5. Monitor in teams of three or two; never in groups of more than three in areas where consumers live or work.

6. Treat all visits and reports with confidentiality.

7. Arrive promptly for monitoring appointments.

8. Make monitoring visits and prepare written reports only as a member of a monitoring team.

9. Respect consumer's (client's) right to refuse access to personal space or to decline to talk with monitors.

10. Visit with individual consumers (clients) only when staff or another monitor are present.

11. Notify the team leader if unable to be present for a scheduled visit. This should be done as early as possible to permit rescheduling of the visit if necessary.

This agreement will be in effect until June 1, 1991 or until either party elects to withdraw from the project.

_____ _____
League of Women Voters Date

_____ _____
Volunteer Monitor Date

Commitment procedures

How to get someone into a hospital:

Criteria vary from state to state; the procedures are used when the person is dangerous to self or others.

How to get someone out of the hospital:

Various national organizations address the procedures which are based on the rights of mental patients, increased exercise of the patient's right to counsel, and other civil liberties.

The Family and the Schizophrenic

Blame and shame

"People do not cause schizophrenia; they merely blame each other for doing so."(p. 156) This blame can come from both patient and family. Family education, including brothers and sisters, which encourages the expression of beliefs, fears, and feelings helps reduce the blame-and-shame syndrome. As a result, schizophrenia becomes easier to live with.

Anger and depression

Families of schizophrenics often feel anger toward the schizophrenic member for being ill, then with fate, the universe, or God, for allowing this illness. Unexpressed anger turns inward to emerge as depression.

Brothers and sisters

Siblings, often forgotten, share the guilt and fear experienced by the parents. They also worry that they, too, may become ill, or perhaps are jealous that their problems have been given secondary consideration. One must remember to include them in family education since "it is they, after all, who are likely to have long-term responsibility for their schizophrenic brother or sister after the mother and father have died...".(p.179)

Where should he/she live?

The majority of people with schizophrenia do better living away from home — as do most adults who are not schizophrenic — and coming home only for visits. Living at home creates an atmosphere of unpredictability and tension. The family fears imminent relapse, perhaps through their fault. The patient fears that everything he/she says or does may be misconstrued as a symptom. Consequently, minor frictions and incidents can easily grow out of proportion.

How to behave

The way to behave toward a schizophrenic person is naturally, simply, and with the respect due another human being, adult or child. Intense emotion can be overwhelming and should be avoided, as should arguing about delusions. Humor, especially sarcasm, is difficult for the schizophrenic to understand. Two-way communication, expression of emotion, and interpersonal relations can be difficult for the schizophrenic, especially in group social events. Schizophrenics like to be around people, but they also need time and space to be alone quietly. An atmosphere of calm confidence is important to them. Predictable, simple routine helps to counteract hallucinations, delusions and sensory overload.

Violence, suicide, homicide

The schizophrenic is rarely violent or homicidal, and, moreover, these acts are invariably preceded by threats or delusional statements. This allows the family time to consult with the treating psychiatrist to assess the seriousness of the situation. The estimated suicide rate varies from 2 per 100 to 10 per 100 schizophrenic persons —and many of these suicides are the accidental result of delusional thinking.

Expectations for the future

Keep expectations realistic and within realization, even if this means lowering them. The resulting positive benefit enables the family and its schizophrenic member to share and to enjoy the activities and accomplishments that are within his/her capacity.

Family support groups

These have proliferated since the mid-70's. All of them include mutual support and education on the subject of psychiatrists, problems of living, housing, patient finances, and patient advocacy. Their most important function is to provide a forum for sharing common experiences and problems.

AMI

What Is Schizophrenia ?

Alliance for the Mentally Ill of Minnesota

1595 Selby Avenue #103
St. Paul, MN 55104
(Phone: 612/645-2948)

The National Alliance For The Mentally Ill

There are as many schizophrenics in America as there are people in Oregon, Mississippi, and Kansas; or in Wyoming, Vermont, Delaware, and Hawaii combined."
President's Commission on Mental Health, 1978

What Schizophrenia Is

"Schizophrenia is a brain disease, now definitely known to be such. It is a real scientific and biological entity as clearly as diabetes, multiple sclerosis, and cancer are scientific and biological entities. It exhibits symptoms of a brain disease, symptoms which include impairment in thinking, delusions, hallucinations, changes in emotions, and changes in behavior. And, like cancer, it probably has more than one cause. Thus, though we speak of schizophrenia and cancer in the singular, we really understand them as being in the plural; there are probably several different kinds of schizophrenia of the brain just as there are several different kinds of cancer of the brain." (p. 2)*

Schizophrenia is not a split personality, nor is it an idiosyncratic way of thinking, correctible through psychoanalysis. It is no one's fault.

As a disease, schizophrenia is not uncommon, therefore it need not be a stigma. Its symptoms are predictable - and fortunately, it is enormously treatable.

Onset by age

- Three-quarters of persons with schizophrenia develop the disease between 16 and 25 years of age.
- Occurrence after age 30 is uncommon.
- Occurrence after age 40 is rare.

Onset by sex

- In the 16-to-25-year-old age group, schizophrenia affects more men than women.
- In the 25-to-30-year-old age group, the incidence is higher in women than in men.

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*All the quotations are taken from *Surviving Schizophrenia: A Family Manual*. Copyright 1983 by E. Fuller Torrey. Reprinted by permission of Harper & Row Publishers, Inc.

Early warning signs

- Thought patterns become illogical.
- The sense of body boundaries deteriorates.
- The person experiences auditory hallucinations.
- Emotions become grossly inappropriate or flattened.
- The person feels that his/her thoughts are controlled by others, are not his own at all, or that he can control the thoughts of others.

Schizophrenia in the United States

- The average prevalence rate is 3.4 per 1,000 people.
- Each year 100,000 people are newly diagnosed as schizophrenic.
- On any given day, 600,000 people are in active treatment for schizophrenia.
- The estimated cost to society is $10-20 billion annually for hospitalization, social security disability benefits, welfare payments, and lost wages.

Schizophrenia worldwide

- The schizophrenia rate is high for Sweden, Norway, western Ireland, northern Yugoslavia; lower in southern European countries and in most developing nations.
- Countries with approximately the same rate as the United States are Japan, England, Germany, and Denmark.

What Schizophrenia Is Not

Bipolar illness

Formerly called manic-depressive illness — a periodic, recurrent mood disorder with intervening periods of complete normalcy.

Schizoaffective disorder

An intermediate disease category on a spectrum between bipolar disorder and schizophrenia, which may respond to lithium.

Brief reactive psychosis

May mimic schizophrenia; it is thought to be precipitated by severe stress and lasts less than two weeks.

Schizophrenic-like symptoms

Due to other diseases, e.g., brain tumors, temporal lobe epilepsy, viral infections of the brain, or following childbirth, three to seven days postpartum.

Schizoid personalities

Are emotionally cold and aloof, unable to form close relationships; indifferent to praise, criticism, or the feelings of others; these people are usually loners who hold loner jobs.

The creative person

Shares common cognitive traits with the schizophrenic — unusual thought processes and use of language, unusual views of reality. However, the creative person is in control of his thought processes; the schizophrenic is not.

Treatment of Schizophrenia

A good doctor

Find one who is recommended by other doctors or by families with a schizophrenic member; a doctor who combines "technical competence with an interest in the disease and empathy with its sufferers." (p.101)

Hospitalization

When acutely ill, the schizophrenic person should be hospitalized in an accredited hospital where the doctor of choice either is affiliated or has privileges. This provides the clinical setting needed for observation, testing, differential diagnosis, and initiation of medication under supervision of trained staff. It also protects the patient from injury to self or to others — and gives family members an often-needed respite after the crisis.

Alternatives to hospitalization

Treatment for a relapse can sometimes be given in the emergency room, clinic, or the patient's home with the use of injectable drugs. A skilled physician can dramatically reduce the psychotic symptoms in approximately half of schizophrenic patients within 6 to 8 hours. Partial hospitalization is also a good alternative where available.