

League of Women Voters of Minneapolis
Current Public Mental Health Policy in Minnesota
With an Emphasis on Hennepin County

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I. Introduction

This report is an update to the 1988 study by the League of Women Voters of Minnesota, *Serving Minnesota's Mentally Ill: An Introduction*. It focuses on adults with serious and persistent mental illness, (SPMI) under Minnesota Law. People with SPMI have a diagnosis of schizophrenia, bi-polar disorder, formerly known as manic depressive illness; severe clinical depression or borderline personality disorder and have been frequently hospitalized or are at risk of hospitalization if they do not receive services. People who are under civil commitment to the MN Department of Human Services are also categorized as SPMI. Many people with SPMI would once have spent much of their adult life in state hospitals.

The MN Department of Human Services (DHS) estimates that there are an estimated 22,274 adults with SPMI in Hennepin County, 24.5 per cent of the state's total. Seventy per cent of these people probably need public mental health services. Hennepin County estimates the number at 19,209, using the figures in the Surgeon General's report. The county reports that 12,245 different individuals received county or contracted services in 2006.

Serious mental illness is often cyclical, unpredictable and chronic. It may fluctuate, even if people stay on prescribed medications. People often need long-time services, though the intensity may vary. Some individuals may be on public medical and income programs at one time; at another time they may be employed and pay taxes.

Increasingly, people with serious mental illness are dual-diagnosed. As many as 50 percent of people with SPMI also have a diagnosis of chemical dependency (MI/CD).

Many people with SPMI are homeless and imprisoned. Some say prisons have become the new state hospitals. There is also a critical shortage of community hospital beds. Some suggest de-institutionalization has failed; we believe that effective, progressive de-institutionalization has never been implemented in Minnesota.

It would be very expensive to provide a full array of community services: medical treatment, social supports, housing, and employment opportunities. Stigma issues, lack of strong advocacy, popular misunderstanding of mental illness, competing demands for limited resources from other high needs groups, and opposition to growing government and raising taxes have all been obstacles to continued adequate funding.

There are many gaps in the public mental health system. Many services work well but there are too few of them to meet the needs of all people who need them. Others are time-limited. The efforts and compassion of many mental health professionals and the courage and persistence of people with SPMI demonstrate, however, that many clients can do well in the community with adequate services.

II. Historical Overview

State Hospitals

By the 1860s most states had assumed financial responsibility for people with SPMI by creating large state hospitals. From 1854 until the 1950s the federal government consistently refused to help fund these services. Minnesota opened its first hospital at St. Peter in 1866; by 1955 the population in Minnesota's eight RTCs (formerly state hospitals) peaked at 11,500. This number had decreased to 3,223 in 1970 and 1,200 in 1985. By February 2006 the statewide census had declined to 191. Anoka Metro Regional Treatment Center (AMRTC), serving the metro area, will remain open, but all the other RTCs are being replaced by ten 16-bed Community Behavioral Health Hospitals (CBHHs) in Greater Minnesota.

RTC Funding

The state originally assumed all state hospital costs. After World War II, the counties contributed \$10.00 per month per patient. The county share rose in 1981 to ten per cent of cost per resident per month. The county share rose again in 2004 to 20 percent to encourage counties to provide community services.

Dissatisfaction with State Hospitals

Stronger advocacy for people with SPMI developed after World War II. Middle class conscientious objectors worked in state hospitals highlighted problems in institutions offering only custodial care in financially strapped facilities.

The film *The Snake Pit* in 1948 helped increase public understanding of problems in state hospitals. Journalists documented deplorable conditions in some state hospitals.

Reforms to the System

Minnesota began to reform its state hospital system under Governor Luther Youngdahl 1947-1951. Reforms continued under Dr. David Vail, 1960-71.

Factors Leading to De-Institutionalization

A combination of factors led to the gradual transfer of many people with SPMI from state hospitals to the community—de-institutionalization—beginning in the 1950s and 1960s.

- The growing dissatisfaction among the public with state hospitals.
- The development of effective anti-psychotic drugs, e.g. Thorazine and Haldol, starting in the 1950s, reduced the worst symptoms of many people with schizophrenia. Lithium was often successful in treating bi-polar disorder.
- The development in the 1960s of new federal income plans and medical insurance for people with very low incomes and disabilities meant that the state could share the financial burden of supporting people with SPMI with the federal government. Federally funded income support programs, Supplemental Security Income (SSI), for disabled persons who had not worked, and Social Security Disability Income (SSDI), for people with disabilities who had worked for a sufficient number of quarters to be eligible, were created. Federal Medical Assistance (MA) funded by a federal/state match, 50 per cent each federal and state, paid medical costs for very low income people with SPMI. Federal Medicare funds covered the first 60 days of psychiatric inpatient care for people who

were eligible. The new federal programs permitted the discharge of many people who would not earn competitive wages at ordinary jobs.

- The MN Hospitalization and Commitment Act of 1967 required lawyers and judges to consider community alternatives to RTC care.

III. De-Institutionalization from the Regional Treatment Centers (RTCs)

A variety of initiatives were designed to provide community care alternatives for people with SPMI:

- In 1957 MN passed the Community Health Centers Act (the federal law was passed in 1963) to create multi-disciplinary teams (psychiatrists, psychologists, social workers, nurses) to offer outpatient services to people with SPMI.
- In 1971, the MN Legislature authorized the establishment of residential treatment services for people with SPMI. Licensed by DHS under Rule 36, residential treatment centers were established in the 1970s. County/state grants paid for treatment, SSI, SSDI or state General Assistance (GA) paid for room and board.
- In 1977 the National Institute of Mental Health launched Community Support Programs (CSPs). These provided flexible supports (life skills, vocational advocacy, assistance with benefits and socialization.) MN DHS Rule 14 passed in 1979 to provide standards and state grants for CSPs.
- By 1979 it was clear that dedicated funding for community mental health programs were needed. The MN Comprehensive Social Service Act (CSSA) block grants were allotted based on annually submitted county plans by DHS.
- Employment services specifically designed for people with SPMI started in the 1970s. One such program, the Fairweather Program, began at Anoka MRTC in collaboration with the Department of Vocational Rehabilitation (now part of the Department of Employment and Economic Development (DEED).) Now called Tasks Unlimited, the program continues to serve very disabled people who want to work. They work in groups and generally live in lodges.
- The closing of the RTC at Hastings, which served the metro area, and the RTC at Rochester in the 1980s accelerated de-institutionalization.

Challenges during Early De-Institutionalization

- Few of the state funds, which had maintained patients at Anoka MRTC, followed them to the community. The reliance on exclusively medical outpatient services proved insufficient. There was never adequate planning for the necessary range of housing and support services. The fine programs established were insufficient.
- The two relevant divisions of the MN Department of Human Services (DHS) the State Operated Services Division (SOS) and, 2) the Mental Health Division which supervised community services had different missions and visions.
- There were differences in approach between county mental health officials, DHS Mental Health, and State Operated Services Divisions on the best way to move services to the community.

Basic and Specialized Housing Needs

Finding and keeping community housing for people with SPMI was a major challenge. Most people with SPMI faced all the obstacles that other very low-income people encountered in finding decent, affordable housing. They could rarely afford market rate housing. They also

needed help finding housing and avoiding evictions. In addition they often needed ongoing supports.

Note: As services in the community improved, more people sought these services, increasing the number of referrals faster than service capacity could be increased. This has been an ongoing issue as new services are developed and demand exceeds capacity.

- Rule 36 residential treatment centers varied in quality. Staffing and funding levels were insufficient to deal with severe episodes of illness. There were insufficient “step down” options and lengths of stay became very long.
- More people with SPMI lived in board and lodge (hotel license only) facilities with no treatment services, often-unsafe conditions and locations.
- Many people were placed in nursing homes; where staff often had little experience with this population. Nursing homes began to add beds and locked units. Licensed nursing home beds rose from 11,308 in 1960 to 30,341 in 1970. County case management ended for people in nursing homes. Some people became stuck in nursing homes: 1) they had little help accessing information on alternatives, 2) they were left with little money, since most of their SSI or SSDI went to the facility, making it difficult to save for the deposit on an apartment.

Housing Needs “Clog” the Mental Health System

The scarcity of suitable and affordable housing, including housing with supports, clogged the mental health system:

- Available RTC beds began to decline in 1980.
- People already committed to AMRTC were on the Wait List; counties had to pay for uncompensated care in community hospitals where patients often got little treatment.
- When ready for discharge from AMRTC, patients often faced waiting lists for Rule 36 facilities or other appropriate housing.
- Residents in Rule 36 facilities could not be discharged because suitable housing was lacking.

Employment Issues

Studies show that many people with SPMI want to work, but job opportunities are limited. The fluctuating nature of mental illness means that people may lose jobs they already have.

Employment is desirable since it gives structure to people’s lives and can help maintain balance.

- Sheltered workshops began offering slots to persons with SPMI. They continued to work with people to obtain competitive employment, if appropriate, and hired some people on a long-term basis.
- Few programs existed to provide ongoing support for people with SPMI in the competitive workforce. This need was partially met by collaboration between the DHS Mental Health Division and Vocational Rehab Services (now in DEED) to create “supported employment programs.”
- Lack of an increase in federal funding for vocational rehabilitation funds in 2003 created long waiting lists for services.
- The strong belief in the value of work has led to many new initiatives for people with SPMI.

IV. The 1987 Comprehensive Mental Health Act: Improvements and Continuing Challenges

In 1987, as a result of the realization that programs for people with SPMI were inadequate, the Comprehensive Mental Health Act mandated that all counties provide an array of services; the system would be county-operated and state supervised. Increased funding accompanied the bill. Counties had to provide services “up to available resources;” priority was given to people with acute mental illness and SPMI. Each county had to submit an annual plan detailing planned services. The Act called for:

- Community hospital inpatient psychiatric care;
- RTC care;
- County and/or contracted case management services; and,
- Community Support Programs (CSPs).
- Establishment of local mental health advisory councils (LACs) composed of consumers of mental health services, family members, service providers and advocates. A State Mental Health Advisory Council was also established.

Other Changes to the System

- The Bridges program, started in the 1990s, provided rental subsidies to clients with SPMI waiting for federal Section 8 rental housing subsidies.
- RTCs, together with county mental health providers, and DHS Mental Health Division, began the Adult Mental Health Initiative in 1995. This program reallocated state staff resources—social workers, nurses, psychologists, vocational counselors and psychiatrists—to case management, CSPs and Mental Health Centers in the communities. The hope was that this program would reduce the need for admissions to RTCs.
- Mental Health and Drug Courts in Hennepin County have attempted to de-criminalize mental health symptoms and provide alternatives to incarceration.
- Care Alternatives for Disabled Persons (CADI), funded by Medical Assistance, became available to people with mental health disabilities. Small four-person corporate adult foster care residences for clients with very high needs were developed, as well as home-based services.
- Mental health providers and faith communities created new housing alternatives. CSP providers: Mental Health Resources, Spectrum Mental Health, Vail Place and People Incorporated developed supported apartments. The Plymouth Church Neighborhood Foundation, connected to Plymouth Congregational Church in central Minneapolis, and Mount Olivet Lutheran Church both developed housing with services. Some Rule 36 facilities also began renting apartments to which residents could move, with continuing service by staff they knew.
- Intentional Communities have been introduced as a viable housing option. See: www.kevinturnquist.org, and www.touchstonementalhealth.org. The premise is that people who live in these communities will be able to govern them, and decide on programming.

New Medical Assistance Funding for Evidence-based Programs

In 2002, the MN DHS Mental Health Division was granted an MA Rehabilitation Waiver; MA would now cover certain services previously deemed “non-medical” in nature but essential to mental health care. This Rehabilitation Waiver provides MA funding for skill-building services known as Adult Rehabilitation Mental Health Services (ARMHS). This allows case management, CSPs, vocational programs, and mental health centers to bill for services formerly dependent on state/county grants. While widely used as a source of revenue, some agencies

found that the programs were costly to administer. They do not cover many “maintenance” services. Often building the trust to deliver services involves frequent attempts to get face-to-face contact. These attempts are not covered by ARMHS. Nonetheless the program provides significant additional funding. State/county grants continue to cover some non-medical services provided by CSPs.

- Intensive Residential Services (IRTs) funded with MA dollars, replaced many of the former Rule 36 facilities. Some Rule 36s became IRTS providers, but the total number of available residential treatment beds has been reduced. In addition, the lengths of stay were limited to 90 days unless a medical necessity allowed for an exemption. The average length of stay at IRTS facilities is 48 days. The MA funding provides additional staffing and higher standards of care.
- Assertive Community Treatment (ACT) teams were developed in Dane County, Wisconsin to help address the complex needs of people discharged from state hospitals in the 1970s. “Wraparound services” were provided with a strong research component. A multidisciplinary team (including psychiatrists for the first time) provided flexible, 24/7 services. Mental Health Resources, through its SLIC program (Sharing Life in the Community) brought the program to Minnesota. SLIC was deemed successful but limited in the number of clients it could serve and in the time it could serve them. Beginning in 2002 ACT services were approved for MA reimbursement. There are now openings on Hennepin ACT teams; in part because the admission criteria exclude people with active chemical dependency problems and personality disorders leading to significant behavior problems.
- Assisted Living facilities – Previously thought of as providing care to those who are aged and/or physically disabled, the concept of apartment living with in-home services is gaining popularity as a housing option for people with SPMI.
- MA reimbursement for essential mental health services recognizes that mental illness is a real disease, needing the same continuum of care as cancer, diabetes, etc. There is hope that new federal dollars will be viewed as an addition to state and county funding.

Continuing Challenges

- The increase in dual-diagnosed persons (MI/CD) challenges providers to develop more effective treatment.
- The long-standing use of DRGs (Diagnostic Related Groups) by insurance company’s shortened average stays for people with SPMI in community hospital psychiatric units by several weeks. Many people are discharged without being completely stabilized—particularly if they are on new medications. After several short stays a number of people with SPMI are then committed to AMRTC or remain in certain community hospitals, which have contracted with State Operated Services at DHS for longer stays. Because of short stays and the lack of sufficient appropriate housing options, psychiatric unit social workers are sometimes forced to discharge people to homeless shelters or other less than ideal settings.
- Wilder Research found in its survey of homeless people in October 2006 that 52 per cent of homeless adults statewide have a serious mental illness. This compares to 20 per cent in 1994.
- There is shortage of inpatient community hospital beds. Psychiatric beds are now a financial drain on hospitals. The shortage of psychiatrists in Minnesota sometimes means beds are not available because of a shortage of psychiatrists to staff them; outpatient psychiatric care can be difficult to arrange.

- Perhaps the greatest challenge is the increasing number of people with SPMI needing services. This is called “case finding” and demonstrates the improvements in services. Keeping up with increased demand is an ongoing challenge.

The Hennepin County Mental Health Advisory Council (LAC) Identifies Priorities

In 2006 the Hennepin County LAC gave the highest priority to the following service needs:

- Housing options/housing supports;
- Employment opportunities; and,
- Coordination of services between the criminal justice and mental health system.

V. Far-Reaching Pending Legislation

The MN Legislature is now considering two major bills, both of which would substantially increase mental health funding. One bill, Governor Pawlenty’s Mental Health Initiative, would significantly change the present public mental health delivery system. Counties would no longer provide all public mental health services to their residents; they would share responsibility with health plans in *integrated healthcare networks*. The Mental Health Initiative has bipartisan backing; Senator Linda Berglin (DFL-Mpls) was the major Senate author in both 2006 and 2007. She chairs the Senate Health and Human Services Budget Division.

The Mental Health Initiative, first introduced in 2006, was developed with the Minnesota Mental Health Action Group (MMHAG), “a public/private partnership to design a more client-centered mental health delivery system in Minnesota.” The steering committee, chaired by Gary Cunningham of the Citizen’s League and Commissioner Kevin Goodno of the DHS Mental Health Division, included representatives of health plans, hospitals, counties, the MN Department of Health, the MN Department of Human Services, and representatives of major stakeholder groups.

Current System Broken

MMHAG judged that the current mental health system was broken. They focused particularly on the separation between physical and mental health services. People with SPMI live shorter lives than those without mental illness; suicide alone does not account for the difference. People with SPMI are often under-treated for physical illnesses.

Cost Shifting, Access Both Issues

MMHAG also wanted to address cost shifting by health plans to the public sector. The plan they devised was also designed to improve access to the system; early intervention in the illness was one of their goals.

Integrated Healthcare Networks

The new integrated healthcare networks, established in cooperation with counties, would be responsible for both physical and mental health care. Priority would be given to managed care plans. The networks would pay for IRTs, ARMHS and ACT teams; the organization of case management would be determined by individual contracts. Counties would have total responsibility for people with mental illness who were not insured or were underinsured. Clients on MA, MNCare and GMAC would be assigned to one of the integrated networks.

Extension of Mental Health Benefits

The second major provision of the Initiative was to extend the full set of mental health benefits under Medical Assistance to people covered by the state funded plans Minnesota Care and General Assistance Medical Care (GAMC.) Benefits would include:

- Assertive Community Treatment (ACT)
- Intensive Residential Treatment Services (IRTS)
- Adult Crisis Services, and
- Case management or care coordination.

The 2006 bill also provided increased funding to strengthen or develop: crisis intervention, support of best practices—evidence-based treatment, children’s school based services, monitoring and tracking the availability of psychiatric hospital beds and increased rates for psychiatrists and other mental health professionals to address workforce shortages.

Funding

The Initiative was to be partly funded by an increase in the percentage that counties would pay for residents in RTCs. For stays lasting 60 or more days the county share would rise from 20 percent to 50 per cent. Additional funds were to come from the MN Health Care Access Fund and the general fund.

Integrated Networks Proposal Generated Concerns

Most stakeholders strongly supported many features of the bill, especially increased investment in the system and the extension of mental health benefits. Several advocacy groups expressed concerns, though about the effects of the integrated networks. They had questions about how they would actually operate.

Some believed that the main problem with the system serving people with SPMI was the lack of commitment from all levels of government to fund essential programs adequately, not the fact that it was county-operated. They worried that the networks, with MA funding, might further “medicalize” mental health services. Other states had “carved out” people with SPMI when they transferred publicly insured groups to managed care. Particular concerns were:

- The priority for services designed for people with SPMI was not mentioned in the new Initiative.
- Most health plans, in the past, had not had extensive experience with the SPMI population.

Would the Networks Recognize the Crucial Need for Flexible Wraparound Services?

- The Initiative emphasized the *integration* of physical and mental health medical services, but only the *coordination* of medical services with social services.
- It was not clear that framers of the Initiative or the health plans realized the depth of service that many people with SPMI require to maintain themselves in the community. Basic support services provided by county case managers and CSP programs and other programs might lose funding if the criterion of “medical necessity” were rigorously enforced. Essential programs which offered help in applying for and reapplying for benefits, getting to appointments, understanding medication, looking for signs of worsening illness, in building social supports and in getting and keeping employment, and finding and keeping housing had proved their worth even without sufficient income to serve all who might have benefited.
- Would the networks impose unrealistic time limits on support services in the interest of cost saving which would not fit the cyclical nature of the illness?

- Many people with SPMI would not relate easily to traditional health plan procedures. Persuading people to seek help is often difficult. It may be necessary for staff to accompany people to appointments.

DHS Mental Health Division Assures Grants Will Continue

The Mental Health Division of the MN Department of Human Services, in 2007, stated that state grants to counties for CSPs would continue and that they were well aware of the need for the crucial services they provide. They also stressed the fact that counties would be very involved in creating the new integrated networks.

Other Concerns

Other problems cited with the proposal centered on 1) the difficulty of a person opting out of a network that did not meet her needs and 2) the possible loss of accountability since consumers could no longer appeal directly to elected decision-makers like the county board of commissioners.

Major Initiative Features Failed to Pass in 2006

Neither the transfer of most responsibility for mental health care to the integrated networks or the extension of benefits to people on MN Care and GAMC passed the 2006 Legislature.

Mental Health Improvements in 2006

However, the 2006 Legislature passed more than \$10 million in new mental health funding—more than any other session since 2001—for infrastructure improvements:

- Crisis services;
- A system to track psychiatric beds in community hospitals;
- A rate increase of 23.7 per cent for psychiatrists and other critical mental health professionals
- The development of a web-based statewide service for collecting and evaluating mental health outcomes for children and adults.

The Legislature also passed a provision for county “maintenance of effort.” Counties were required to provide at least the same amounts for mental health services as they had in 2004 and 2005.

Initiative Re-Introduced in 2007

The major features of the 2006 proposal, which failed to pass in 2007, were re-introduced in 2007. The bill was authored by Senator Berglin and in the House by Representative Thomas Huntley (DFL – Duluth), chair of the House Health Care and Human Services Finance Division.

Changes in the 2007 Bill

In response to stakeholders, the 2007 changed some features:

- Sponsors of the Initiative legislation agreed to make it easier for consumers of mental health services to “opt out” of the integrated networks. (The bill had already provided for a person in a satisfactory therapeutic relationship to keep his provider.) It is not clear whether the “opt out” provision will survive if the number of enrollees is not sufficient for the health plans.
- The original bill was amended so that counties would only have to pay 50 per cent of costs for residents in an RTC or a new 16-bed Community Behavioral Health Hospital. after 60 days and *after the patient was deemed ready for discharge*. They would pay nothing for the first 30 days then pay 20 per cent.

Funding

The 2007 proposal projected \$44.5 million in new investments over the next biennium and \$37 million per year thereafter. They projected an additional \$6.9 million in the next biennium and \$4.6 million per year from the increase in county share for commitments. Other funding would come from the Health Care Access Fund or the state general fund. In addition to the two main system changes described above the legislation would:

- Develop capacity to meet the mental health needs of specialty populations;
- Expand capacity for a range of housing options: expand the Bridges Housing program and expand the availability of housing options for people with mental illness;
- Develop and support evidence-based practices and best practices;
- Shore up school-based mental health services;
- Extend the rate increases approved in 2006; and,
- Develop intensive outpatient treatment coverage for certain disorders.

The Greiling-Marty “Mega” Bill

In 2007 Representative Mindy Greiling (DFL – Roseville) and Senator John Marty (DFL – Roseville) introduced legislation to address weaknesses in the public mental health system while keeping the current county-operating system. Representative Greiling described the bill as a “multi-session blueprint.” It was designed to establish a template against which existing services could be measured. It was constructed with the help of the 20 organizations in the Mental Health Legislative Network. The bill would:

- Expand mental health courts;
- Mandate mental health screening of offenders;
- Offer support for people with mental illness who have been incarcerated;
- Provide a protocol for timely release from solitary confinement;
- Improve release procedures for people with mental illness who have been imprisoned;
- Provide state health care to inmates upon release;
- Create a council to expand crisis intervention training for the police;
- Provide employment supports and incentives for providers to find good stable jobs;
- Allocate more funding for the Bridges housing subsidy program and for supported housing.
- Provide voluntary screening of children and teens for mental health issues only with parental consent;
- Strengthen services for ethnic minorities and people who are underserved and providers who serve them;
- Support the development of peer-to-peer support programs;
- Create a demonstration program for people who are dually diagnosed as mentally ill and chemically dependent; and,
- Fund suicide prevention, which lost funding in 2005; crisis services; and a tracking system for mental health outcomes.

Funding

Fully funding the Greiling bill would cost an estimated \$134 million by fiscal year 2011. Most funding would come from the Department of Human Services.

Similarities

Both bills increase funding for the Bridges housing program and additional supported housing, employment and extend mental health benefits to people on MNCare and GAMC. They both

increase support for services to special populations. Both provide large rate increases to mental health providers to attempt to attract more qualified personnel.

Progress of the Bills

At this time the outcome in the Legislature is still fluid. Both houses have allocated roughly \$45 million for mental health improvements. The Senate bill conforms generally to the Governor's Mental Health Initiative; it would draw revenues from the general fund. The House bill incorporates much of the Greiling Bill and would draw funds from the MN Health Care Access Fund as well as the general fund.

The conference committee, with representatives from both houses, will determine the final outcome in the Legislature. Because the final bill is considerably more costly than the governor's original Mental Health Initiative proposal, it appears likely that he will veto it. The final legislative outcome is very unclear at this time.

Hennepin County Planning with the Metropolitan Health Plan

Hennepin County is making arrangements to prepare for the possible transition to integrated care networks. It is exploring a future "integrated network" with the Metropolitan Health Plan.

VI. Conclusion

The mental health community welcomes the increased funding from the Legislature for public mental health services. Even with these increased funds, however, problems will persist. Housing needs, especially housing with supports, and the need for sufficient well-tailored employment programs are not fully addressed. Solving the shortage of psychiatrists will take time and increased funding.

Federal cuts to social programs, especially case management, are of concern.

If the proposal for integrated healthcare networks passes, it will take time to see if changes are necessary to meet the needs of people with SPMI. Any significant systems change will probably require at least minor adjustments. One hopes that the best programs now available can be enhanced and that the improvements of medical integration can be realized. It will be important to monitor carefully the effects of any changes on the lives of people with SPMI.

The heightened interest in public mental health services and the willingness to increase mental health funding can only be viewed as a welcome change. As we concluded at the end of the 1988 study, however, it remains to be seen whether there will be sustained political will to create and maintain an adequately funded, complete community mental health system.

APPENDIX

CASE STUDIES:

“JOHN” is a 32 y/o single male disabled by schizophrenia from age 17; lives on Social Security; has Medicare and Medical Assistance. He has rarely responded well to medications, and doesn’t take them due to side effects. He has “self-medicated” with alcohol and drugs. He hears voices, most often calling him derogatory names. He has met people on the street and in treatment centers, but has no organized social life. His family is very concerned about him, well educated about mental illness, and has cared for him sporadically. John’s most comfortable in shelters, but stays are limited and he must be outside from 7:00 AM – 7:00 PM. He is extremely vulnerable to thieves, despite his own poverty. He is also very suspicious that most people will hurt him or take advantage of him, or hospitalize him. He is currently committed as mentally ill to Anoka-Metro Regional Treatment Center when he was found on the street unable to provide for his basic needs (housing, food, medical care). He has had 12 inpatient psychiatric hospitalizations, and this is his third commitment. He has been assigned a worker at Anoka, and has a county mental health case manager. John is currently working with these social workers on discharge plans as he has been stabilized on medication. DISCHARGE PLANS INCLUDE:

Aftercare Resource needed	Reason	Plan	Outcome of Plan as Written
Psychiatric Aftercare	Medication and monitoring response	John has been a patient at HCMC Outpatient Psychiatry and will return there. Earliest app/t is 6 weeks after discharge; Anoka gives him a RX for four weeks.	Anoka isn’t comfortable with John continuing on RX without face-to-face with community psychiatrist.
Housing	John wants to return to “the streets”, treatment team wants him to go into a community-based residential treatment center to further stabilize. John won’t interview for group home; case manager and Anoka refer to nursing home where he will be safe.	Because of John’s vulnerability, he is referred to a community nursing home with a locked psychiatric unit.	In a NH, John will be seen by an MD before his prescriptions run out. This is often given as reason for NH referral.
Community Supports	County MH Case manager will continue to work with John until his commitment ends; at that time case management will end unless CM refers John for extension of commitment.	Case manager will refer John to Community Support Program (CSP) for socialization and skills training if he wishes to attend.	John is likely to have his commitment extended in order to keep him in locked NH due to limited “safe” housing options. He’ll be assessed for CADI, but options are limited if he refuses meds or uses drugs.

Mental Health providers strongly support people living in the housing of their choice. A problem for clients like John is that behavioral issues (past and present), funding problems, criminal history, and prior evictions/unlawful detainers limit choices severely. Landlords are understandably concerned about these issues. Fortunately there are growing programs providing independent housing with supports, which allow John to prove himself in a setting of his choice.

“JANE” lives in a subsidized apartment. When she experiences a mental health crisis, she might be committed to Anoka-Metro Regional Treatment Center (AMRTC). Because her illness has significantly worsened, she may not have cared for her apartment adequately and been evicted. After discharge from AMRTC, she might move to a residential treatment program such as an Intensive Residential Treatment Services (IRTS) program; often this is a different setting than she lived in during a previous down cycle. At the IRTS program her stay may be limited to three months unless there is an exemption stating she needs further care. Because of her prior eviction, she had no access to a new apartment. Like most private landlords, public housing officials refuse to rent to people with evictions. This bars access to subsidized (Housing and Urban Development) funding. Options for independent living are increasing as mental health vendors open apartment programs in which the vendors act as landlord, and can ignore her prior eviction. Hopefully she can be readmitted to the employment training and support program she was in, funded in part by the Department of Employment and Economic Development.

This one situation demonstrates how the varied funding sources (county/state grants, MA, Federal Income Programs, HUD and Department of Employment and Economic Development) can affect one person’s struggle with the mental health system.

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BIBLIOGRAPHICAL NOTE

“Breaking the barrier of silence, Systemic shift needed to deal with issues concerning mentally ill” *Session Weekly*, MN House of Representatives, March 30, 2007.

Geller, Jeffrey L., M.D., M.P.H., “Excluding Institutions for Mental Diseases from Federal Reimbursement for Services: Strategy or Tragedy” in *Psychiatric Services* 51:1397-1403, November 2000, American Psychiatric Association. (on the web)

Goffman, Erving, *Asylums*, Essays on the social situation of mental patients and other inmates, Aldine Publishing Company, Chicago, 1961.

“Highlights of what passed in 2006 Legislative Session,” *Mental Health forum*, Mental Health association of Minnesota, summer 2006.

Minnesota Department of Human Services documents, particularly, “Fast Facts: 2007 Legislative Session: Governor’s Mental Health Initiative: Improving health care for children and adults with mental illness,” and, “Governor’s Mental Health Initiative: Questions and Answers,” March 27, 2006.

Mental Health Initiative on the Department of Human Services website:
www.dhs.state.mn.us/MHInitiative.

Minnesota Law & Politics, April/May 2007, No. 163, articles: Joan Oliver Goldsmith, “Killer Defense;” Frank Jossi, “A Second Chance for the Mentally Ill;” Anna Befort, “The Criminalization of Mental Illness;” and Erin Gulden, “The Lame-Duck Defense.”

Park, Eunkyung Ph.D, “Minnesota Adults with Co-Occurring Substance Use and Mental Health Disorders,” Minnesota Department of Human Services, May 2006.

Turnquist, Kevin, M.D. “Model Community Programs for the Mentally Ill,” November 2003, on the web at KevinTurnquist.org. Dr. Turnquist is a psychiatrist who has worked extensively in Hennepin County.

Wilder Research, Amherst Wilder Foundation, “Overview of homelessness in Minnesota 2006,” March 2007. (on the web at www.wilderresearch.org)

**Hennepin County Adult Mental Health Advisory Council
May 18, 2006**

Unmet Needs

Preamble

To fully meet the needs of people with serious and persistent mental illness we must ensure that the county and state support a balanced mental health system. The system must address the needs for the majority of clients and not only provide very extensive services for the most acutely ill. It is also important that we not plan our whole system so that it can be funded through Medical Assistance. Effective mental health services are a blend of social and medical services. Efforts to cost shift to services to meet Medical Assistance funding requirements have the unintended consequence of diminishing essential services that may not be medically necessary. Such a system would slant heavily toward a medical model of treatment and undermine the funding of strong psychosocial services promoted by the 1987 Mental Health Act. Finally, we must ensure that our system recognizes and values cultural differences among the people we serve and works toward a culturally competent system.

Note: The following unmet needs are prioritized based on a “forced choice” of each individual council member’s top three unmet mental health service needs. It should be understood that the mental health system is in flux and proposed funding and other changes in service delivery may require frequent updates to this statement of unmet needs.

The Hennepin County Adult Mental Health Advisory Council identified four unmet needs as the highest priority.

A sufficient supply of decent, safe, affordable, permanent housing and a broad array of housing supports. There needs to be a broad array of housing options. In addition to housing, we need an array of supports to enable people to stay in the least restrictive environment possible and minimize mental health crises. [16 Votes]
Combined Housing/Housing Supports

A broad range of employment opportunities and ongoing support for clients who are employed. Many individuals with serious mental illness could benefit from work experiences; the stability that work provides often helps to reduce the worsening of mental illness. There should also be an increase in work opportunities for persons who can work and flourish in the regular workplace if they have appropriate supports. Persons who work benefit, as does the community. [10 Votes]

Better coordination with the criminal justice system in dealing with persons with mental illness. Barriers to accessing mental health services contribute to many persons with mental illness getting caught up in the criminal justice system. Once in the criminal system, treatment is limited and people are subsequently released without adequate treatment. Specific plans should be in place for treatment of this population in jail and for mental health and substance abuse services upon their release. [7 Votes]

The Advisory Council assigned a high priority to four identified needs:

Expanded outreach to hard-to-serve groups of mentally ill clients. There should be increased outreach to persons who are mentally ill and living on the streets or in shelters, including the overflow shelters. Outreach should also be implemented for people with untreated mental illness to intervene before the illness worsens. [6 Votes]

Availability of a strong range of case management services for more clients. This should include intensive case management services for clients with especially high needs, less intensive services to a larger number of clients and ongoing less frequent monitoring to assist others in maintaining stability. [5 Votes]

Improved Information and understanding of how Assertive Community Treatment is accessed and operates for consumers, family members and providers. [4 Votes]

More effective and more complete crisis services. We need a coordinated, seamless crisis service delivery system to provide geographical coverage, crisis stabilization, and 24-hour mobile outreach. This system must improve coordination with the police, hospital emergency rooms, and Hennepin County Medical Center's Acute Psychiatric Services. Current demand for evaluation at Hennepin County Medical Center's Acute Psychiatric Services outstrips the program's capacity. Stabilization services should ensure safe transition from crisis through hospitalization and discharge from the hospital. [4 Votes]

Lastly, the Advisory Council identified the need for expanded services in these areas:

Enhanced services for elderly persons with mental illness. Develop and maintain specific programs and appropriate staffing requirements for the increasing number of elderly people who will require mental health services as they age. [3 Votes]

Hospital Bed Capacity. We need sufficient psychiatric bed capacity to meet the demand for services. Clients whose symptoms warrant hospitalization are often in a holding pattern and/or are transferred to distant hospitals because of the current capacity of both acute and long term hospital beds is insufficient. [2 Votes]

Expanded and strengthened transition services are needed for young adults. Currently many young adults have difficulty transitioning from the children's to the adult mental health system. This is at a time when they are also losing the structure of high school for independence in the adult system. Other young adults have their first mental illness episode during this period and need appropriate treatment and support. Programs addressing the specific needs of this age group should be strengthened. [2 Votes]

Strengthen services specifically designed for clients who have a dual diagnosis of mental illness and chemical dependency. Give special emphasis to the integrated dual disorder treatment of Mental Health and Chemical Health to better serve this population.

Specific attention to the treatment and support of parents with mental illness. Treatment and provision of necessary family supports (even when hospitalization is necessary to stabilize the parent's mental illness). Too frequently children are removed from a parent who has mental illness. Promote better collaboration between mental health services and the child protection system.

Resolution

- That the Hennepin County Adult Mental Health Advisory Council seek current measures, based on existing data collected within Hennepin County Human Services and Public Health Department, for current top three unmet needs for persons with a mental illness:
 1. Housing options/Housing Supports
 2. Employment opportunities
 3. Coordination of services between criminal justice and the mental health systems.

- That we forward our existing unmet needs document to the commissioners under cover that notes that we applaud the commissioners for their resolution recognizing the potential downside to proposed systems reforms in the DHS/MHAG proposal. It should be noted that the proposed reforms do little to address the unmet needs that we have identified.

Mental Health

LWVMN Position:

Support of a comprehensive and coordinated system of programs and services for mentally ill adults and emotionally disturbed children and adolescents (hereafter referred to as "persons with mental illness"). Priority should be given to persons with serious and persistent mental illness and/or acute mental illness. Minnesota public policy and funding should sustain an array of community-based services, which are available and accessible to persons with mental illness. Administration of that policy should provide clients with appropriate and adequate services. (1989)

Details

Support of:

- Adequate and consistent funding for services for persons with mental illness. Public funding should be flexible, following the client's needs, yet accountable to the public.
- A range of appropriate housing options for persons with mental illness.
- A commitment process, which ensures prompt and appropriate treatment for persons with mental illness while protecting their civil rights. The commitment process should enable the commitment of persons so gravely disabled by mental illness that they cannot meet their basic human needs.
- A coordinated system of quality assurance (including standards, mechanisms to monitor and the ability to take corrective action) for programs and services for persons with mental illness with an emphasis on evaluating outcomes and consumer response.
- Continuing state financial responsibility for improved intensive treatment programs and adequate living conditions for persons currently served in regional treatment centers.
- Investment in long-term care targeted to ease chronic staffing problems in facilities and community service.
- Dedication of new funds to the wages and benefits of workers to improve the quality of care for the residents and their family members.
- Provision of Children's Health Insurance Program (CHIP) benefits to the children of all long-term care workers.
- Regulation of supplemental staffing pools and limits on what they can charge.
- Expansion of training and education opportunities for potential and current long-term care workers; and commitment to updating the Nursing Assistant and Home Health Aide curriculum.
- Assurance of public accountability and solid planning for the future with the following studies and reports: results of the rate increases for wages, benefits, and major expenditures, time studies of staffing needs and financial implications; report on the changes in supplemental staffing pool usage; improved reporting of Vulnerable Adult caseloads, backlogs, and issues.
- Equal rates protections ensuring equal access to care regardless of the ability to pay.

History of State Action

The LWVMN Mental Health position was adopted in early 1989.

1989

- During Legislative Session the League monitored refinements of the 1987 Comprehensive Mental Health Act. The Legislature approved a plan to shift care for mentally retarded Minnesotans from regional treatment centers (RTCs) to community-based group homes. LWVMN lobbied for community-based services for mentally ill persons as well. We supported the Legislature's

direction to the Commissioner of Human Services to develop plans for downsizing RTC facilities that will not adversely affect the proper care of residents. League lobbied for appropriations for employment counselors for the people with mental illness.

- During the September special session LWVMN supported the concept of state funding for the major portion of the cost of state-mandated mental health services.

1993

- LWVMN supported refinements of the Comprehensive Mental Health Act. LWVMN lobbied for community-based homes for persons with mental illness. League has consistently supported increased funding for community services. We also supported the Anoka Alternatives, a fund to find housing for difficult-to-place persons at Anoka Regional Treatment Center. We supported the closing of Moose Lake Regional Treatment Center and increased funding for community services for those clients. LWVMN also supported innovative employment programs in the community, which will be an ongoing concern.

1995

- LWVMN testified+ in support of a bill to create delivery system pilots, which would pool the resources of regional treatment, centers with community dollars.

1996

- In 1996 the League lobbied successfully for the continued funding for five Coordinated Employment Projects. The projects provide job counseling for persons with mental illness.

1997

- LWVMN lobbied for additional employability projects.
- Bridges, a temporary housing program for persons with mental illness, was expanded in the 1997 after strong lobbying from the League. Other mental health issues that arose during the 1997 session included a cost of living increase for mental health employees, and additional funding for the relocation of Regional Treatment Centers staff into community services.
- Legislation to implement the recommendations of the Supreme Court Civil Commitment Task Force was successful. Funding was made available for a civil commitment training and resource center.

1998-1999

- LWVMN again lobbied for expansion of the Bridges Program and the Employability Program.

2000

- LWVMN issued action alerts to members on a number of issues in 2000: employability projects, housing, prescription drug programs and adequate wages for community health workers. Advocacy efforts during 2001 for many bills included action alerts, letters to legislators and newspaper editors and committee testimony. Among successes were expansion of the civil commitment criteria, increased wages for mental health workers and \$1 million to save the supported employment projects.

2004 -2005

- LWVMN continued to lobby for permanent supportive housing for people with mental illness. We were not successful in getting increased funding for the Bridges housing program.
- Working with NAMI-MN and job counselors from RISE, INC. LWVMN did succeed in having \$600,000 added to Extended employment programs across the state that stood to lose federal matching funds.

2006

- LWVMN concentrated on the proposed Governor's Mental Health Initiative. Developed in conjunction with MNHAG (MN Mental Health Action Group) a group appointed by the governor which included representatives of major health plans as well as some mental health advocates, the Initiative would transform the public mental health system. (Currently counties provide most mental health services to persons eligible for Medical Assistance and General Assistance Medical Care. State and federal funds go to the counties to provide services, which include an array of supports in addition to strictly medical care. The Initiative would transfer funds for these clients, as well as those on Minnesota Care, to new integrated health networks—primarily managed care health plans—to provide all services.
- Although League supported some parts of the bill—including the extension of full mental health benefits to persons on General Assistance Medical Care and Minnesota Care, an increase in funding for mental health professionals--we testified in opposition to the bill as it was then drafted. The integrated care networks and the extension of benefits did not pass in 2006 though the proposal was re-introduced in 2007.

We were mainly concerned because of what seemed to be inadequate safeguards for that group of mental health consumers with v with serious and persistent mental illness (SPMI) under state law. There is little evidence that private health plans are experienced in dealing with this group who often require a broad array of services over an extended period to cope with their illness. It is not at all clear sufficient funding would be available to continue providing them. The Initiative would essentially end the county-operated system, except for clients were uninsured or were underinsured.

- League also supported the Family Involvement Bill, which would have allowed physicians to share some information about drugs prescribed for their mentally ill family member. Physicians would not have been required to provide this information if they believed it was not in the patient's best interests.

2007

In the 2007 session LWVMN met regularly with the Mental Health Legislative Network, 20 organizations committed to improving mental health services. We participated in Mental Health Day on the Hill in March. LWVMN also worked to help craft an amendment to ensure that Community Support Program Services (CSPs) would continue to receive more flexible county grants if the Governor's Initiative passed. Testimony was also given about continuing concerns about the Mental Health Initiative. At this time it is not clear what the final Legislative action will be.

How You Can Help

You can play a role in helping build public support for an improved public mental health system

You can help address stigma and calm people's fears

Educate yourself about mental illness—people with SPMI are no more dangerous than “normal” people when they take their medications. Many people with serious mental illness suffer from lack of affect and a lack of initiative, and are most often seen as vulnerable.

- **Get information and help educate family, friends and neighbors. If we all help fight stigma it will eventually lessen**
- **Join an advocacy group. Mental Health Association Minnesota has an informational newsletter. It also has an excellent e-mail service sharing information about what happens in Congress, new research, etc.**
- **National Association for Mental Illness (NAMI-MN) has a service telling about upcoming bills on which you can act. NAMI also offers support groups and educational services for families. There may also be LWVMN Action Alerts.**
- **Go to neighborhood meetings and calm fears about locating mental health facilities in your neighborhood.**
- **Volunteer at a center, which serves people with SPMI.**
- **Get your faith community involved in mental illness issues. Many churches have committees to address needs of their parishioners and others in the community. Several run drop-ins for consumers of mental health services.**