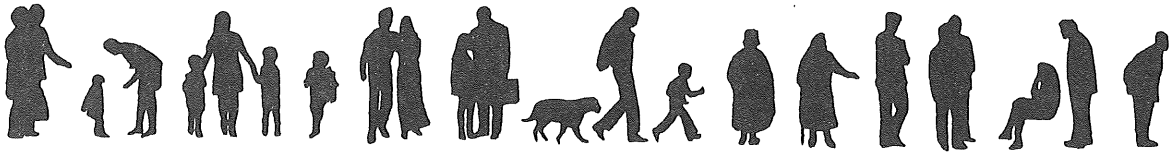
FINAL REPORT

STUDY OF SERVICES TO MENTALLY ILL PEOPLE



MN DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH DIVISION

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FINAL REPORT

STUDY OF SERVICES TO MENTALLY ILL PEOPLE

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MENTAL ILLNESS SURVEY FINAL REPORT

INTRODUCTION

The purpose of this report is to detail the procedures and findings of the study "Study of Services for Mentally Ill Persons" conducted by the Program Evaluation Resource Center (a part of the Minneapolis Medical Research Foundation) under contract with the State of Minnesota Department of Human Services.

This study was comprised of three components: (1) a review of relevant state and federal legislation and Department of Human Services rules pertaining to this population as well as pertinent statistical information that reflected utilization of mental health services within counties; (2) conduct of a mailed survey to all counties which assessed the availability, accessibility and quality of services to mentally ill persons; and (3) completion of detailed onsite interviews in a selected array of 6 to 10 Minnesota counties. Throughout the conduct of this study, the Program Evaluation Resource Center staff worked closely with and reported to the Services for People with Mental Illness Study Committee and representatives from the State of Minnesota Department of Human Services, Mental Health Bureau and Social Services Bureau.

This report consists of four principle sections: (1) a description of the literature reviewed by the investigators; (2) a description of the mail survey; (3) a description of onsite interviews and (4) general conclusions.

DESCRIPTION OF LITERATURE REVIEWED

In order to familiarize ourselves more fully with the intent of the study, the terminology employed by the State of Minnesota in the mental health field, and the types of services currently being offered to mentally ill persons in the state, all materials provided by the State of Minnesota Department of Human Services were reviewed. A total of 40 articles, charts, graphs, reports and maps were studied. A complete listing of the materials studied prior to questionnaire construction as pursuant to the details in our contract may be found in Appendix A.

DESCRIPTION OF THE MAIL SURVEY

The second phase of the study was the design and conduct of a mailed survey of mental health professionals in county welfare/human services departments to assess the availability, accessibility, and quality of services to mentally ill persons. The following set of definitions were developed and used in questionnaire construction to operationalize the concepts of "mentally ill persons," "adequacy of services," "accessibility of services," and "quality of services.

MENTALLY ILL PERSON: means any adult or child who has a diagnosed condition that: (1) impairs functioning in the primary aspects of daily living; and (2) is listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition (1980), or the corresponding code in the clinical manual of the International Classification of Disease, Ninth Revision (1980) code range 290.0-302.0 and 306.0-316.0, or in any subsequent revision of these publications.

ACCESSIBILITY OF SERVICES: the extent to which barriers to service utilization by mentally ill clients do or do not exist relative to:

1. elgibility requirements (intake procedures, requirements)
2. community and/or client awareness of available services
3. proximity - transportation issues
4. distribution of available resource
5. cultural and linguistic barriers

QUALITY OF SERVICES: the degree to which a service effectively meets the required needs of clients relative to:

1. clients' acceptance of service offered
2. client's status improvement
3. client's attainment of goals
4. client satisfaction
5. appropriate client referrals
6. good case management

ADEQUACY OF SERVICES: the degree to which a service is sufficient to address identified needs for the service relative to:

1. program(s) exist to address this need
2. duration of waiting time for program entry

Utilizing these definitions, information gathered in the phase 1 literature review, and input from the Services for People with Mental Illness Study Committee and the State of Minnesota Department of Human Services Mental Health Bureau and Social Services Bureau a detailed mail survey was developed.

Construction of the Survey

The final version of the survey (see Appendix B) consisted of three parts. Part I of the survey gathered information on the availability of services for mentally ill persons in each county. The intent of this section was to elaborate on information already gathered from CSSA reports for each county, as well as collecting information of services not currently reflected in this system. In order to ease completion of the questionnaire for respondents, service areas already reported as provided on the last years CSSA report were checked off by a PERC staff member. In this way, the respondent only had to verify information as correct, or make the corrections in those instances where the situation had changed since the last report.

Thirty-one services which may potentially be provided to mentally ill

persons were organized on a grid-shaped form. While there were many other services which could have been listed, this group of thirty-one was selected in order to keep the questionnaire length at a reasonable completion time, and to reflect a broad spectrum of services. Respondents were asked to indicate for each of these services the level of availability and need, the method of provisions (whether purchased, provided or something else), and whether the service was provided within or outside of county boundaries. In order that respondents work from a common understanding of service categories, a definition sheet was provided in order to help ensure consistency of response.

Part II of the questionnaire consisted of an assessment of services in each county. The intent of this section was to gather information for assessing needs regarding quality, adequacy and accessibility of services in each county. Since the use of an extended list of services would have been too unwieldly for respondents to answer, services identified by the Services for People with Mental Illness Study Committee as comprising the comprehensive array of services to mentally ill persons were grouped into five general service types: (1) Preventive/Education, (2) Protective, (3) Diagnostic/Evaluation, (4) Supportive/Rehabilitative and (5) Administrative. Specific services comprising each of these areas as given to respondents are as follows.

Preventive/Education Services

Preventive/Education Services are those intended to provide information about the symptoms and characteristics of specific problems of mental illness to (a) help alleviate fears of seeking help, (b) increase understanding and acceptance by the general public, and (c) provide information about access to appropriate services.

Examples of this service type include: (1) public information programs; (2) case location; (3) prevention programs; (4) needs assessments; (5) liaison relationships with nursing homes, boarding homes, community hospitals, emergency rooms, police departments, jails,, etc.; (6) outreach services; and (7) using natural support systems (e.g., families, churches, neighborhood networks, etc.) to increase opportunities for mentally ill persons.

Protective Services

Protective services are those aimed at alleviating urgent needs of the mentally ill population. These include (a) determination of urgent need; (b) shielding mentally ill persons in hazardous conditions when individuals are unable to care for themselves; and (c) provision of urgently needed services.

Examples of this service type include: (1) Emergency services; (2) 24 hour a day emergency care services; (3) adult and child protection; (4) crisis homes; and (5) emergency counseling.

Diagnostic/Evaluation Services

Diagnostic/Evaluation services are those activities which provide an appraisal of the mentally ill person's condition with regard to (a) illness; (b) screening for placement; (c) diagnosis; (d) evaluation of functioning; and (e) determination of what services are needed.

Examples of this service type include: (1) assessment; (2) screening for individuals for state hospital admission; (3) pre-petition screening services; and (4) diagnosis, assessment and evaluation.

Supportive/Rehabilitative Services

Supportive/Rehabilitative services are those whose purpose is to assist mentally ill persons to function at the highest possible level. These services include both (a) those aimed at increasing client level of functioning and (b) maintaining current levels of functioning.

Examples of this service type include:

(1) TREATMENT: aftercare, chemotherapy, counseling, day treatment;

(2) COMMUNITY RESIDENTIAL SERVICES: facilities for emotionally disturbed children, extended care, group home, halfway house, semi-independent living, supportive living, other residential facilities, state hospitals, other hospitals, nursing home rehabilitation;

(3) EMPLOYABILITY: pre-vocational rehabilitation, vocational counseling, supported employment, transitional employment, adult education and training, sheltered workshop, work activity, job development/employer outreach, job placement.

(4) ASSISTANCE IN INDEPENDENT LIVING: health care, housing, information and referral, legal, money management, social and recreational, and transportation;

(5) OTHER PARTIAL HOSPITALIZATIONS

(6) FACILITATION OF PLACEMENT IN HOSPITALS

(7) OUTPATIENT SERVICES: psychotherapy, aftercare, community support services, counseling, medication management.

(8) ASSISTANCE IN MEETING BASIC HUMAN NEEDS: procedures for assessment of needs and eligibility for benefits and entitlements for income maintenance, medical and dental care, housing, transportation, etc.; referral to community resources; assistance in applying for benefits and/or services.

Administrative Services

Administrative services are those whose purpose is to coordinate and facilitate the effective use of formal and informal helping systems in order to best address client needs and goals. This includes assistance in

making informed decisions about opportunities and services, assuring timely access to needed assistance, providing opportunities and encouragement for self-help activities, and coordinating all services to meet the client's needs and goals.

Examples of this service type include: (1) case management; and (2) consultation.

Part III of the survey was designed to elicit the priorities of counties for a minimum capability recommendation. For each of the service categories listed in Part II, respondents were asked to rate services as essential, desirable or not a priority for mentally ill persons. In addition, space was provided for any additional comments or recommendations that respondents wished to make.

Development of Supporting Documents

In order to provide complete and useful information to respondents, a number of supporting documents were developed. First, a general instruction sheet [see Appendix C] was devised to provide general overall information regarding how to complete the questionnaire. Additionally, detailed instructions were provided detailing how to complete each section of the questionnaire [see survey instructions within questionnaire in Appendix B]. A transmittal letter was devised in order to inform respondents of the purposes of the study [see Appendix D]. Finally, a set of service definitions was provided in order to ensure consistency of understanding of how each service was defined [see Appendix E]. All of the above supporting documents were reviewed and accepted by the Services for People with Mental Illness Study Committee before they were sent to respondents. These documents will be discussed in greater detail in the following section.

Mail Survey Procedures

Description of the Mailing

Mail surveys were sent to collect information on 87 counties. However, once the counties were grouped on the basis of multi-county human service arrangements, 82 sets of questionnaire information were sent. Surveys were addressed to the Social Service Director in each county or county group. A listing of the Social Service Directors to whom the questionnaires were sent may be found in Appendix F.

In addition to the mail survey itself, each Social Service Director received the following materials: (1) a transmittal letter which explained the purpose of the "Services to Mentally Ill Persons Survey" and requested the participation of the director in the survey [Appendix D]; (2) a copy of the legislative mandate for the study of mentally ill persons [Appendix G]; (3) a list of the members of the Services for People with Mental Illness Study Committee [see Appendix H] ; and (4) a set of instructions and definitions [Appendices C and E] were enclosed in the set of questionnaire information to aid in the completion of the mail survey.

The instructions reviewed the procedures for completing the forms, the abbreviations and concepts employed in the questionnaire and the procedures for requesting assistance and submitting completed questionnaires. The definitions included operationally defined concepts, which were fully detailed in the instructions, (e.g., mentally ill persons, accessibility of services, quality of services, and adequacy of services) and selected service definitions either from the 1985-1986 Service Definitions for CSSA or developed specifically for the survey. An addressed, stamped return envelope was also enclosed in the set of materials in order to facilitate the return of completed questionnaires to the Program Evaluation Resource Center (PERC).

The 82 sets of questionnaire information were mailed to the Social Service Directors on Friday, October 5, 1984 by certified registered mail. Certified, registered mail was utilized in order to: (1) verify receipt of the packet of materials; and (2) the receipt date. Within approximately one week, all 82 registered mail receipts had been returned to the Program Evaluation Resource Center.

Follow-up Procedures

Approximately two days following the distribution of the mail surveys, the project team at PERC began telephone follow-up procedures. Follow-up consisted of a PERC project member contacting the Social Service Director of each county or multi-county group. The purpose of follow-up was to: (1) establish personal contact with each Social Service Director; (2) ensure that the questionnaire packet was received by the correct individual; (3) briefly familiarize each director with the study; (4) answer any questions regarding the survey or its completion; (5) reemphasize the availability of the PERC staff for assistance in completing the questionnaire; (6) secure the name(s) and contact information for the respondent(s) who would actually be completing the questionnaire; and (7) emphasize the October 22, 1984 deadline. If the Social Service Director delegated the responsibility of questionnaire completion to other Social Service staff members (e.g., Social Service Supervisor or Social Worker), these individuals were contacted by telephone as well.

Availability for Technical Assistance

PERC project team members were available to handle incoming calls requesting assistance in questionnaire completion. In order to ensure consistency in the responses given to those calling for assistance, a list of questions and the appropriate answers were created and made available to the PERC staff handling these calls.The most frequently asked questions received by the PERC staff regarding the mail survey dealt with assistance in defining individual items. For example, according to a tally kept by PERC staff members, the most frequently asked questions were: (A) Part I - (1) "Why were some boxes previously checked?" and (2) "Does question number one include both services within and outside county boundaries?"; (B) Part II - (1) "What is meant by special mental health populations?"; and (C) Part III -(1) "What is meant by minimum capability?"

Quality Control Procedures

Once the completed survey forms were received, two quality control procedures were employed by the PERC project staff in order to ensure both the quality and completeness of the data received. First, each of the incoming questionnaires was carefully reviewed separately by two project members at PERC. Each reviewer checked for clarity of both open- and closed-ended responses and for any missing items. Following this two-stage review, follow-up telephone calls were initiated whenever the reviewers identified any problems with the completed survey. All counties but two (or 80 counties) required telephone follow-up. The respondents identified on the contact sheet attached to the questionnaire as responsible for actually completing the questionnaire were contacted in order to clarify or to obtain the necessary information. The most frequent problem was that of missing data; particularly for the open-ended questions regarding recommended minimum capabilities. Follow-up telephone calls proved to be very successful in securing missing data and clarifying possible misunderstandings.

Analysis of Mail Survey Data

Response rate on the mail survey was excellent. Only two counties, Sibley and Kittson failed to respond. This yields an overall response rate of 97.6%. The reason given by these counties for not responding was that they were too pressed by other business to take the time to complete the survey.

Analysis of the data received was conducted in two stages. First, general frequencies and percentages were reported for statewide totals. This codebook report may be found in Appendix I. These data were presented to the Services for People with Mental Illness Study Committee at their meeting on November 28, 1984. At this time, the Committee requested that additional analyses be conducted in order to examine differences between (1) state hospital catchment areas, (2) economic development regions and (3) size of county as measured by population. The results of these analyses [which can be found in Appendix J] were presented to the committee on December 10, 1984.

Initial Statewide Analysis

The initial statewide analysis revealed the following trends:

(1) For the most part, needed services were available to mentally ill persons residing in Minnesota - while individual counties expressed concern regarding gaps in their current service system, of the thirty-one services examined in Part I of the survey, only five services were indicated by fifteen percent of counties or more as being not currently available to them, but needed. These needed services were:

CRISIS HOME - MI	23 (29%)
HOUSING SERVICE	18 (23%)
SOCIAL & RECREATIONAL SERVICES	17 (21%)
DAY TREATMENT - MI	15 (29%)
ADULT FOSTER CARE	14 (18%)

(2) In Part II of the survey, the one area that was identified by respondents as lacking in service programming was Preventive/Education Services. Many respondents felt that a statewide media campaign was needed that would both emphasize the availability of services and help to reduce the stigma attached to mental illness. Other service areas were seen as effectively meeting client needs.

(3) When queried regarding possible barriers to service, hours of service availability, eligibility requirements, cultural and linguistic factors, and level of client/community awareness of programs were not seen as major problems. However, except in the areas of Protective and Administrative Services, transportation to and from services was rated by the majority of counties as being either "somewhat inadequate," or "inadequate."

(4) In Part III of the survey, the following services were endorsed by seventy-five percent of counties or more as constituting "essential" services for mentally ill persons:

ADULT & CHILD PROTECTION	98%
CASE MANAGEMENT	95%
ASSESSMENT	95%
TREATMENT	93%
24-HOUR EMERGENCY SERVICES	88%
EMERGENCY SERVICES	88%
PRE-PETITION SCREENING SERVICES	88%
ASSISTANCE IN MEETING BASIC HUMAN NEEDS	88%
OUTPATIENT SERVICES	87%
COMMUNITY RESIDENTIAL SERVICES	80%
DIAGNOSIS	77%
INPATIENT PSYCHIATRIC SERVICES	76%

(5) Open-ended comments reflected the following themes regarding minimum capability recommendations:

-There should be no state mandates without accompanying state funds to implement these mandates.

-Mandates, if any, should be general, not specific and prescriptive, allowing counties to implement mandated services in the way that best fits the counties.

-If there are to be state service mandates for any CSSA target groups, these standards should apply to all target groups.

-There should be no more state hospital closings.

-Committment procedures need to be re-examined. There is a difficulty getting people committed when they need it.

Second Analysis

For the second analysis of data, three breakdowns were used: (1) economic development regions, (2) population size of counties, and (3) state hospital catchment area. The groupings for economic development regions and hospital catchment areas may be examined using the maps on the next two pages. Population groupings were made by the following breakdowns: 0-10,000; 10,001-20,000; 20,001-30,000; 30,001-40,000; 40,001-50,000; and 50,001 +. For this analysis, data from Part I of the survey was collapsed to reflect whether services were available and adequate or whether a need existed in each of the 31 service areas.

The following themes emerged from this second analysis of the data:

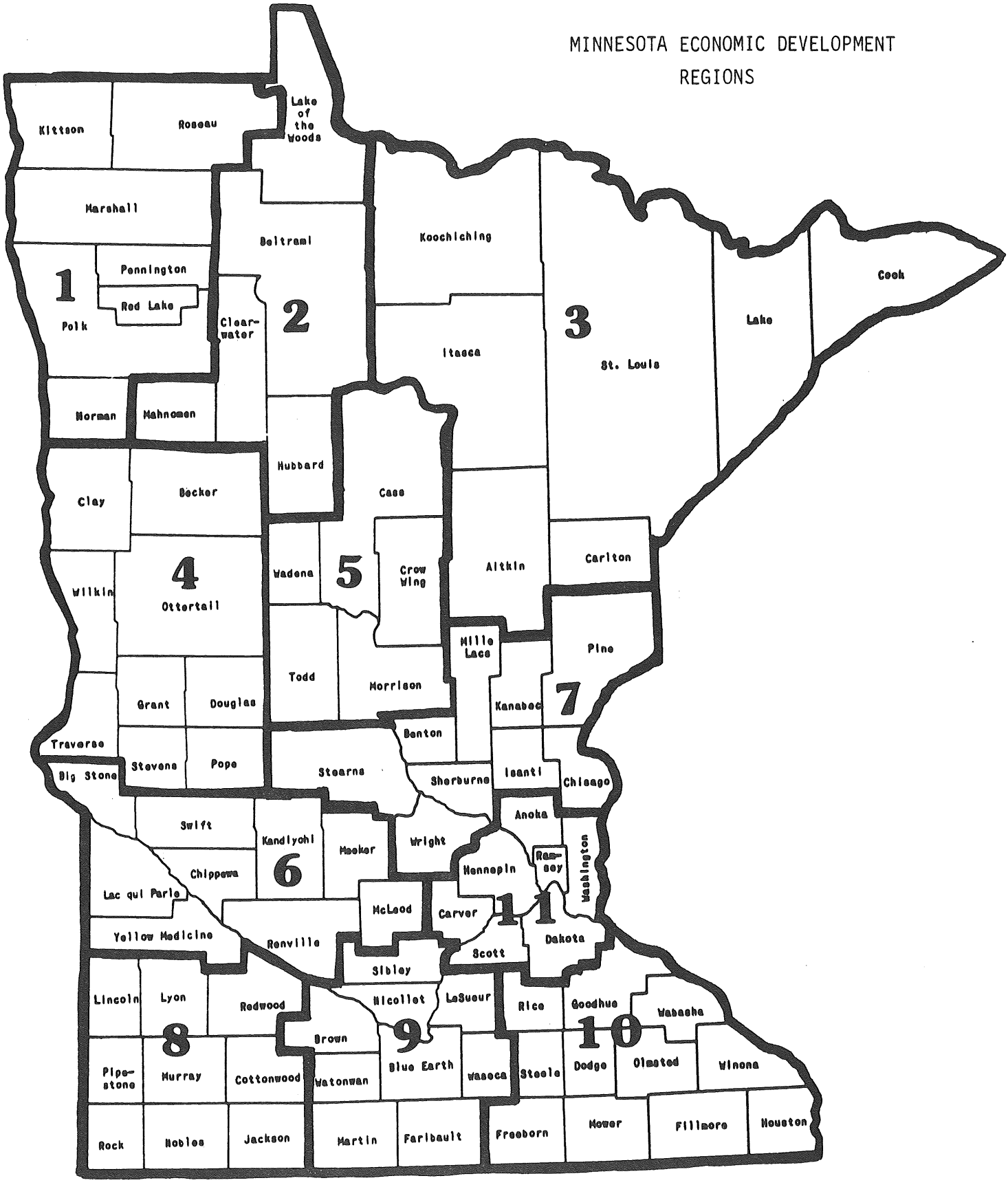
(1) A greater number of needs for additional services were expressed in Economic Development Regions which covered southern or metropolitan counties. Possible explanations may include: availability of services may attract clients previously unserved or served in some alternate way, or higher expectations may accompany greater availability of services.

(2) Few differences in expressed need were noted among state hospital catchment areas, with the exception of the Anoka State Hospital catchment area, which had the most expressed needs. This may be due to the greater population density in the area served by this state hospital.

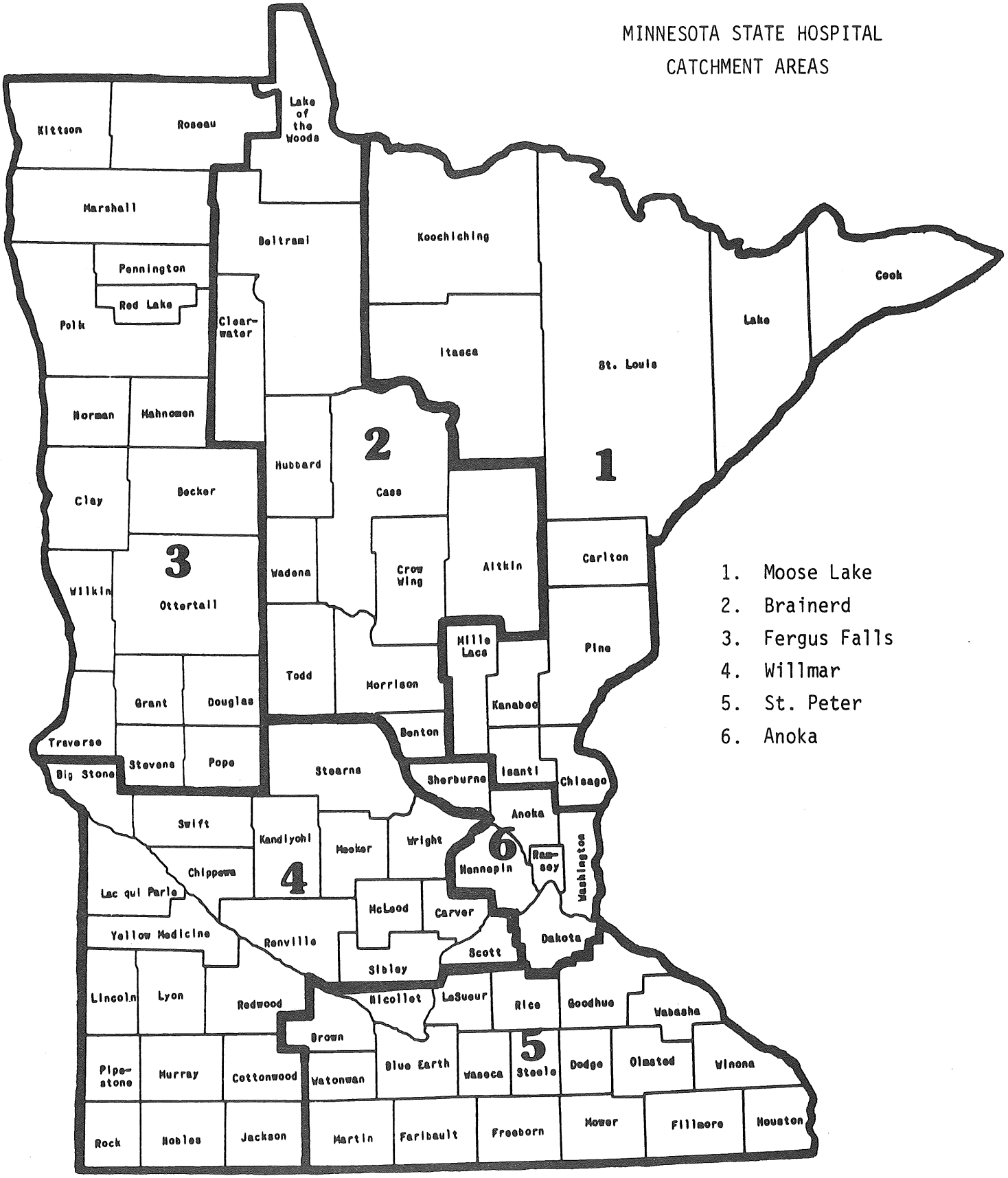
(3) As county population size increases, the number of expressed needs also increase. A possible explanation may be that greater numbers of people lead to greater use and/or need for services.

(4) Regardless of type of breakdown, the greatest gap seen in service was in the area of preventive/education.

MINNESOTA ECONOMIC DEVELOPMENT REGIONS



MINNESOTA STATE HOSPITAL CATCHMENT AREAS



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

DESCRIPTION OF ONSITE INTERVIEWS

The final stage of this study was the conduct of in-person interviews within selected counties. Based on the number of variables of interest, it was not possible to either randomly select or to draw a true stratified random sample. Therefore, counties were selected purposively based on a number of criteria identified by PERC staff and members of the committee. The following section details the selection of the ten counties for onsite interviews:

Selection of Counties for Onsite Interviews

The following counties were selected for inclusion in the onsite interview portion of the Study of Services for Mentally Ill Persons:

1. Anoka County
2. Freeborn County
3. Kandiyohi County
4. Lake of the Woods County
5. Lyon County
6. Mahnomen County
7. Morrison County
8. St. Louis County
9. Winona County
10. Hennepin County

The following selection criteria were considered in specifying these counties:

A. Metropolitan Counties: Large - St. Louis (6,092 SQ.MI.)
Hennepin County
Midsize - Winona (620 SQ. MI.)
Small - Anoka (424 SQ. MI.)

B. Rural Counties: Large - Lake of the Woods (1,311 SQ. MI.)
Morrison (1,127 SQ. MI.)
Small - Freeborn (701 SQ. MI.)
Kandiyohi (783 SQ. MI.)
Lyon (709 SQ. MI.)
Mahnomen (563 SQ. MI.)

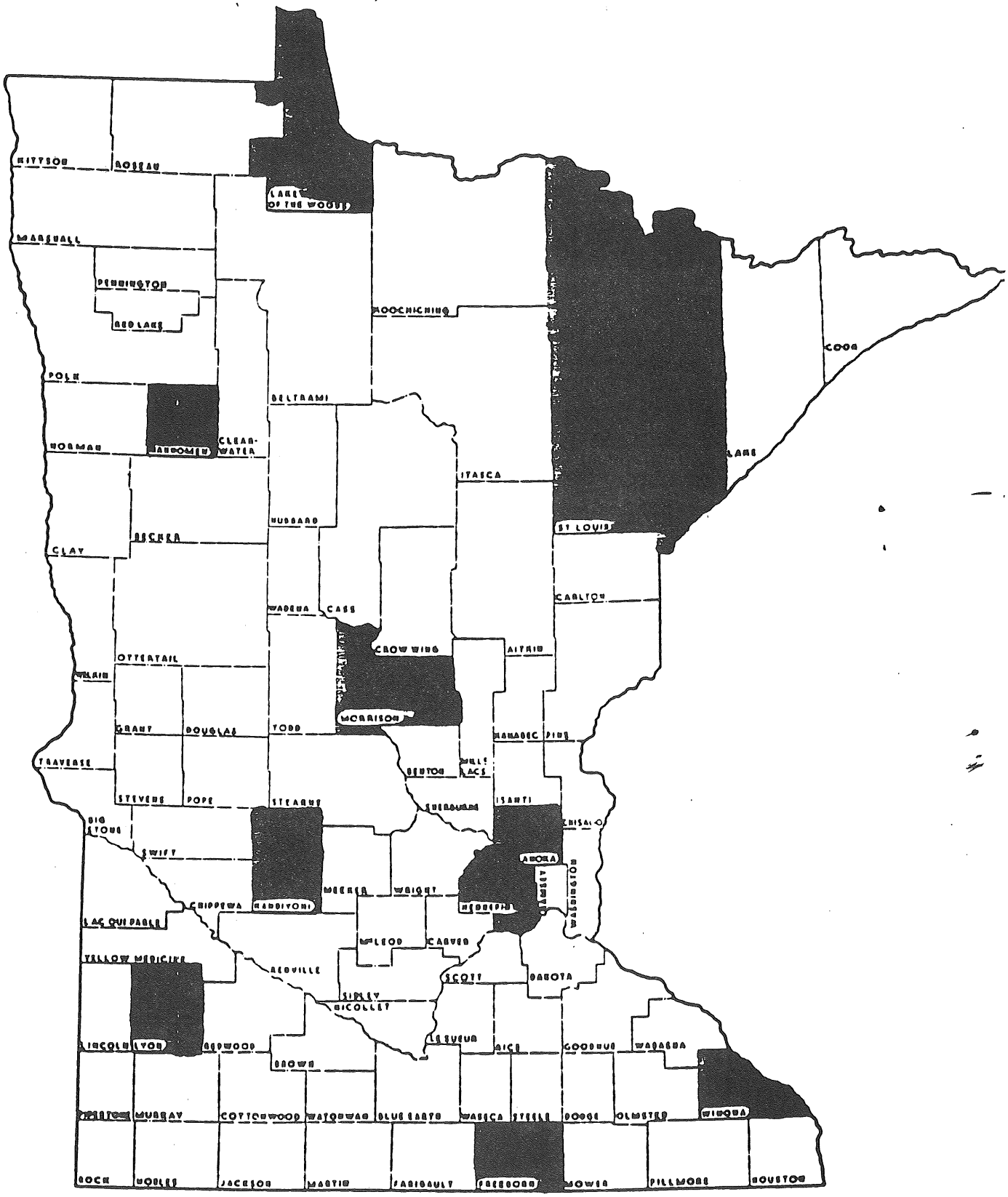
C. High Unemployment (8.5% or greater): St. Louis
Mahnomen
Morrison

D. High Ethnic Population: Lake of the Woods
Mahnomen

E. State Hospital Within County Boundaries: Anoka
Kandiyohi

F. Geographic Dispersion: See map.

COUNTIES SELECTED FOR ONSITE INTERVIEWS



G. A county which does not participate in the Community Services Information System (CSIS): Anoka
Lake of the Woods
Mahnomen
St. Louis County
Hennepin

H. A county where a mental health coalition is functioning:

St. Louis County
Anoka County
Winona County
Hennepin County

I. Representation of each State Hospital Receiving District:

Brainerd State Hospital Receiving District: Lake of the Woods
Morrison

Fergus Falls State Hospital Receiving District: Mahnomen

Moose Lake State Hospital Receiving District: St. Louis

Anoka State Hospital Receiving District: Anoka
Hennepin

Willmar State Hospital Receiving District: Kandiyohi
Lyon

St. Peter State Hospital Receiving District: Winona
Freeborn

J. A county which provides CMHC services through its own employees:

Freeborn
Hennepin

K. A county without Rule 36 facilities: Anoka
Lyon

L. A county participating in a multi-county CMHC: Lyon
Winona

M. A county which has withdrawn its support from a CMHC: Freeborn

N. A county with specialized MH grants: only Lake of the Woods does not have either a CSP or Federal Block Grant.

O. A county with a purchase of service contract with a CMHC:

Lake of the Woods
Mahnomen
St. Louis
Morrison
Kandiyohi

Lyon
Winona

P. A county where a Community Support Project exists: St. Louis
Morrison
Anoka
Kandiyohi
Winona
Hennepin

Selection of Key Informants

Once county selection had been accomplished, the next task was to identify key informants to be interviewed in each county. Initially, a list of potential types of key informants for the onsite visits was developed by the PERC project staff. This list was then reviewed by the Services to People with Mental Illness Study Committee, and several additional types of key informants were identified. The potential types of key informants identified by this process included:

(1) County Board Chairs or Members;
(2) County Directors of Social Service;
(3) Social Service Supervisors;
(4) Social Workers;
(5) Mental Health Center Directors;
(6) State Hospital Directors;
(7) Public Health Nursing Directors;
(8) CSP Representatives;
(9) Mental Health Advocates and Consumers;
(10) Service Providers for Rule 36 Facilities;
(11) Private Service Providers (e.g., Psychologists and Psychiatrists);
(12) Judicial and Law Enforcement Personnel (e.g., Probate Judges and Sheriffs); and
(13) County Fiscal Personnel.

A PERC staff member telephoned the Director of Social Service in each of the ten counties chosen in order to obtain appropriate nominees for the onsite interviews. The Social Service Directors were asked to nominate key informants based on the suggested types of potential key informants listed above and who were felt to (1) have knowledge of the county's mental health delivery system and (2) represent viewpoints inclusive of the spectrum of services provided.

Nominations of appropriate key informants for the onsite interviews were also obtained through the assistance of the State Mental Illness Division, the Minnesota Mental Health Association, and the Mental Health Advocates Coalition.

Snowball sampling (a procedure whereby identified informants can nominate others that they feel would be particularly knowledgeable about the subject matter) was also utilized in the field in some counties for the purpose of securing appropriate nominees. This procedure was most often employed where previously nominated key informants were either not available during

the course of the study or who felt they were not prime candidates for this particular study.

Finally, financial informants were identified by a representative of the State of Minnesota Department of Human Services, Mental Health Bureau and Social Services Bureau in order to collect information on costs for services. A list of all key informants who participated in the onsite interviews may be found in Appendix K.

Construction of the Interview Schedules

The purpose of the onsite interviews was to supplement information about service availability, accessibility and quality acquired from the mailed survey. This procedure enabled us to explore the themes identified through the mail survey in greater detail.

The following procedures were followed in constructing the interviews that were used for these field interviews. First, mail survey data for each county selected was reviewed in order to identify themes for further exploration. Secondly, the specific topics for inclusion in the interview schedule were selected. The interview schedule itself was semi-structured, allowing for elaboration and probing by the interviewers, and containing both open and closed ended questions.Topic areas that were chosen for inclusion were:

AVAILABILITY OF SERVICES: For those services indicated as being available on the mailed questionnaire, interviewers gathered information regarding the use of such services, with special attention to the existence of any problems which exist in the provision of such services, and need for any services not being offered currently. Special attention was accorded to the identification of "gaps" in the existing service delivery system.

ACCESSIBILITY OF SERVICES: Of particular emphasis in this area was information pertaining to barriers which inhibit the use of services by mentally ill persons. Specific questions were developed to assess the level of difficulty that was presented by each of ten possible service barriers.

QUALITY OF SERVICES: Subjective ratings of the quality of the service delivery system were gathered from all persons interviewed.

SITE VISITS: Whenever possible, interviews took place at the sites where services were delivered. Interviewers gathered information regarding the physical facility itself, its accessibility to mentally ill clients in the county, and information regarding whether or not the facility is used to capacity.

SPECIAL MENTAL HEALTH POPULATIONS: This topic area, which relates to both accessibility and availability issues was one of concern to committee members. A special set of questions was developed in order to determine if special subpopulations of mentally ill individuals were either unserved or underserved due to the existence of confounding factors for their treatment (e.g., dualdisability, age, etc.)

SERVICE DELIVERY ENVIRONMENT: To the extent possible, the interviewers created a picture of the service delivery system in each county. Questions such as: from whom and to whom are referrals made? are referrals appropriate? what community or other environmental factors inhibit or facilitate the provision of services to mentally ill persons in the county? were asked to address this issue.

Since our selected key informant group was so varied, it was decided that a single interview schedule would not be appropriate for all respondents. Thus, a set of interview schedules was developed. A core set of questions was developed, and additional questions for each specific type of respondent group were identified for inclusion. The final set of interviews included specialized interview schedules for (1) service providers, (2) directors of county social service agencies, (3) members of county boards, (4) consumers, (5) judges, (6) financial informants, and (7) law enforcement personnel. These schedules may be found in Appendix L.

Interviewers

Ten interviewers were employed to conduct the onsite interviews in the ten counties selected. A listing of interviewing staff may be found in Appendix M. Through special arrangements with the Minnesota Institute in Anoka, Minnesota, several of their consultants who reside in or near selected counties were made available to us for purposes of conducting these interviews.

Interviewers attended a training session on November 23, 1984. During this training session, interviewers were acquainted with the purpose of the study, were familiarized with the various interview schedules, and were provided with the opportunity to practice these schedules and ask any questions regarding the study or the interview schedules.

Onsite Interview Procedures

Each interviewer was provided with a list of key informants for his/her county, and was required to schedule their own appointments. Interviewing took place between November 26 and December 7, 1984. In those cases where a respondent was for some reason unavailable during the time that the interviewer was conducting in-person interviews, attempts were made to reach respondents by telephone in order to complete the interviews.

Analysis of Onsite Interviews

We experienced an extremely high completion rate in conducting these interviews. Our original list of nominees consisted of 149 individuals. Of the original list, 138 (93%) completed an interview. Of those who did not complete the interview, only two potential interviewees refused, the remainder were simply not accessible during the interview period. An additional ten individuals were identified during the interviews themselves, resulting in a total of 148 individuals who were interviewed during the specified two week period. This total includes 125 respondents who answered the core questions identified above (consumers, providers, directors of social services, and county board members); 7 law enforcement representatives who provided information on their role in the emergency

service system for the mentally ill; 6 judges who discussed pre-petition screening procedures with us; and 10 financial informants who helped to detail service costs for use in making cost estimates.

Data were examined in several ways, first, financial information was turned over to those who would be making cost recommendations. Secondly, a special report was generated to examine the viewpoint of judges regarding the pre-petition screening process [see Appendix N]. Third, law enforcement interviews were examined for common themes in the provision of emergency services. Fourth, each county's data was aggregated, and individual county reports were generated [see Appendix O]. Finally, cross-county comparisons were made [see Appendix P].

Results of the cross-county comparisons showed that for the most part counties could identify gaps within their service systems. The needs of these individual counties, however, varied considerably. The one area mentioned as a need by all counties however was the need for supportive living arrangements to fill the gaps in the spectrum of housing alternatives (this may include halfway houses, 3/4 way houses, board and care, board and lodging, Rule 36, SILS programs for the mentally ill, or apartment living.) Other areas mentioned by more than half of the counties were: (1) employment programs for the mentally ill, training, placement and sheltered work alternatives, (2) affordable, decent housing for those on fixed incomes, (3) patient follow-up and aftercare (linked to the need for smaller caseloads), (4) crisis critical care capability/crisis homes, (5) need for more county social workers to deal with the mentally ill, and (6) transportation services.

The largest barriers to service provision were identified as: the distance to available services (80%), lack of transportation to available services (70%), lack of community/client awareness of services (70%), and unavailability of needed services (60%).

Discussion surrounding the needs of the various special mental health populations showed that the majority of counties reported that there were problems in dealing with the mental health problems of these groups. The table below indicates each county and aggregate responses to this question.

Are there any special problems in your county in dealing with the mental health problems of the following groups?

PERCENTAGE OF RESPONDENTS SAYING "YES"

CATEGORIES	LYON	KANDIYOHI	LAKE OF THE WOODS	HENNEPIN	WINONA	ANOKA	MORRISON	FREEBORN	ST. LOUIS	MAHNOMEN	TOTAL
I. THE ELDERLY IN NURSING HOMES	45%	42%	20%	69%	50%	38%	40%	45%	33%	25%	55 (44%)
II. THE DUALLY DISABLED	45%	50%	20%	93%	55%	77%	70%	27%	76%	37%	77 (62%)
III. THE HOMELESS MENTALLY ILL	9%	8%	---	100%	28%	38%	40%	---	52%	37%	46 (37%)
IV. ETHNIC POPULATIONS	9%	---	---	56%	5%	15%	---	18%	29%	37%	24 (19%)
V. CHILDREN AND ADOLESCENTS	36%	25%	---	93%	50%	61%	60%	54%	57%	25%	65 (52%)
VI. MIGRANT WORKERS	---	---	---	6%	5%	---	---	18%	---	---	4 (3%)

The particular problems in dealing with these groups were as follows:

I. THE ELDERLY IN NURSING HOMES - Medication problems, overmedication, lack of awareness of mental health problems by nursing home staff, no psych nurses on nursing home staffs, lack of behavioral management, no psychologist or psychiatrist to monitor these patients.

II. THE DUALLY DISABLED - Lack of programming in general for dual disability groups, most programs treat only one disability, program eligibility requirements often block needed services.

MI/PHYSICALLY HANDICAPPED - lack of accessible buildings, lack of staff with special knowledge to deal with this group, lack of interpreters for the hearing impaired.

MI/MR - Problems with eligibility requirements for admittance into programs for either the MI or MR part of the problem.

MI/CD - (This was the most frequently mentioned problem group, and often mentioned in connection with the treatment of young adults.) Lack of programming for both problems, lack of community support networks after return from CD treatment - go back to using friends, the treatments for MI and CD conflict, i.e., the MI treatment tries to encourage the individual to make responsible choices while the AA model

of CD treatment stresses the inability to make responsible choices regarding the chemical, lack of halfway facilities.

III. THE HOMELESS MENTALLY ILL - Inability to make contact with these people to bring them into the system, lack of housing facilities for this group.

IV. ETHNIC POPULATIONS - Some linguistic barriers, attitude that it's not "all right" to seek treatment (should be self-sufficient)

V. CHILDREN AND ADOLESCENTS - Lack of enough specialized programming for children, lack of examination of what children actually need, lack of school involvement, lack of child psychologist and child psychiatrist availability in rural regions.

VI. MIGRANT WORKERS - don't utilize services, and are difficult to identify.

CONCLUSIONS

Throughout both the mail survey and onsite interview portion of the study, it became apparent that counties could identify the gaps in their own service systems. The viewpoints of the individuals queried in 10 counties showed a high degree of consistency with results obtained by mail. The gaps identified within service systems however varied among counties.

Generally, the key to the success of the service systems tended to be the availability of dedicated, caring and high quality personnel. It was often noted that these individuals were in high demand, and often carried extremely high caseloads.

In order to accommodate the diversity of needs and concerns voiced by counties, it was often mentioned that any mandates must not be so prescriptive as to thwart local innovation and adaptations in implementation. Most critically, more funding is needed in order to provide high quality care for mentally ill persons.

LISTING OF APPENDICES