MENTAL HEALTH SERVICES

A Practice Handbook for Mental Health Workers in Social Service Agencies

Minnesota Department of Public Welfare
1976
19p

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INTRODUCTION

The idea for this handbook came about when Mrs. Arlene Swanson, M.S.W., who has worked in the field of mental health in both a professional and volunteer capacity, offered her time and talent to the Staff Development and Service Development Sections of the Department of Public Welfare. Because of Arlene's interest and experience in the mental health field, and because the Department had, as an objective, the development of practice guidelines for workers in the county social service agencies, it was decided to have Arlene develop a practice handbook dealing with the mental health services provided by the county social service agencies.

A series of regional meetings were held with social workers and other practitioners working in the mental health field to obtain material and ideas for the handbook. The original material was revised and condensed, again with the collaboration of practitioners, and emerged in its present form and content.

The principle audience for this handbook is the worker in the county social service agency who has responsibility for conducting pre-petition and pre-commitment screenings, participating in the development of treatment and discharge plans for clients in hospitals or treatment facilities, and for providing after-care services. It is meant to assist new workers by presenting, in a sequential order, the procedures that the worker follows in carrying out his/her responsibilities on behalf of the client. The handbook can also serve as review or refresher material for the experienced worker and can permit the worker to compare his/her present practice against those outlined in the handbook.

While the handbook attempts, whenever possible, to cite the statutory base for the practice and procedure offered, it is not meant to dictate practice or procedure except in those situations where the statute itself requires certain procedures.

One final note, a major portion of the content of the handbook deals with activities the worker engages in when assisting the client who is hospitalized on a voluntary or involuntary basis. However, the practices and procedures outlined, in most instances, would be applicable with the clients who are admitted to any mental health treatment program.

The Department of Public Welfare is indeed grateful to Mrs. Arlene Swanson for authorship of this handbook and to all those who assisted her on the project. We believe that she and her collaborators *will* consider themselves amply rewarded if this work assists the social worker in providing better service to those people experiencing mental or emotional problems.

MENTAL HEALTH SERVICES

A Practice and Procedural Handbook for
Mental Health Workers

The *purpose* of the mental health program is:

1. To support community institutions, activities, and attitudes that enhance human dignity and create opportunities for human well-being and personal growth.

2. To provide care, protection, and other services to persons with emotional or behavioral handicaps which:

   a. Meet the needs of the individual;

   b. Reduce inappropriate, unnecessary, or extended hospitalization by means of early case-findings, referrals, and crisis intervention, and by providing alternatives to hospital treatment;

   c. Effect timely and appropriate return to community living;

   d. Develop and provide a broad range of opoortunities for achieving the best level of functioning to those persons temporarily or permanently handicapped, and which encourage the responsible use of these opportunities; and

   e. Assure the adequate protection of the individual's legal and civil rights.

Under the Minnesota Hospitalization and Commitment Act, county welfare boards are responsible for seeing to it that services are provided to the person who is, or may be described as, mentally ill. Responsibility for coordinating and/or delivering these services has, in turn, been delegated to the county social service agency.

The purpose of this handbook is to assist the county service worker in arranging and/or providing these services to those persons wishing to receive them.

CHAPTER I

PREVENTION OF DISABILITIES

to "create the opportunities for human well-being"

Primary Prevention: Informational and Education Services (M.S. 246.013, 246.014, Sec. 10)

Mental health workers, and others working in the field of public welfare, have the charge to promote public well-being. It is the responsibility of the mental health worker to find means of enhancing community life to reduce the prevalence of dysfunctioning.

1. The worker develops and encourages the development of programs and cooperative endeavors, such as:
   - Mental Health workshops for agency workers, ministers, schools, law enforcement agencies, and others;
   - Family education;
   - Mental health information services to employers, and assistance to employers with handicapped employees;
   - Informational services to the general public through the media;
   - Efforts to reduce social and economic discrimination;
   - Programs supportive of minority groups and populations with a high incidence of mental dysfunction.

2. The worker alerts co-workers in their role in primary prevention. Income maintenance, family education, homemaker services and other services reduce stress and contribute to mental health.

3. The worker documents gaps in mental health services and calls these to the attention of the area board or other agencies responsible for developing a range of services. (It is helpful for the county welfare department to have representation on all active committees on mental health, such as those advisory to area boards.)

4. The worker cooperates with co-workers to develop a body of information and a network of relationships within the agency and between agencies for providing the most effective services to the clients. The establishment of a good working relationship with law enforcement agencies is essential.

5. In addition to working with individual clients, the worker endeavors to retain a broad view of mental illness so that his/her activities contribute to the reduction of dysfunction.

Crisis Intervention Services

The crisis intervention services of the county welfare department, although distinct from mental health services, function both in primary and secondary prevention of mental and emotional handicaps. The individual's immediate need may be financial, physical, social, or emotional, but in every case a stress exists which requires immediate attention.

1. Through consultation with co-workers, the mental health worker endeavors to assure the provision of crisis services that are fully accessible to the potential client.

2. The worker participates, as necessary, to develop procedures and provide staff training for effective crisis intervention.

3. The worker follows-up those calls to the crisis service which have been made by individuals previously in mental health treatment programs for emotional stress, in order to determine whether the help received was adequate and that the stress has been ameliorated.

4. The worker encourages the development of guidelines and procedures which enable the crisis intervention service to promptly and effectively refer persons who may need mental health services to those who can provide this service.

CHAPTER II

EARLY INTERVENTION

"to reduce inappropriate, unnecessary, or extended hospitalizations"

Early Casefinding (M.S. 246.014)

When a problem arises, it is most successfully treated in its early stages. An emphasis on early services is "pound wise." In providing these services, care is taken not to stigmatize the persons receiving service or provide an "illness" or "problem" label that might result in a self-fulfilling prophecy or the Rosenthal effect.* The crisis-intervention service (Chapter I) is one of the means of early case-finding. Local welfare board administrative policy should support and encourage time for the worker to devote to early case finding. The worker can assist such policy by providing documented feedback resulting from early case finding experience.

1. The worker maintains regular contacts with mental health organizations, schools, churches, law enforcement agencies and others in the community for the purpose of case finding and early referrals.
2. The worker provides referral information to the Minnesota Schizophrenia Association, Mental Health Association and others, to enable prompt referrals and early case finding.
3. The worker cooperates with the Public Health Nursing Service to assure the effectiveness of this early and periodic screening procedure.

Evaluation and Assessment with the Client (M.S. 253A.04, Subd. 3)

The worker helps persons in distress evaluate and assess their situations and obtain the services they require. A problem may be situational or social, rather than emotional or psychological. The distress may be alleviated by providing services which assist the individual to regain self-esteem and adequate functioning. (See page 6 and 7 for a list of some of the services that can be helpful.) This process may be all that is necessary in a given situation, or it may lead to precommitment screening.

1. The worker begins by listening sensitively to the concerns expressed. Such listening reduces stress, as well as providing a firm base for the assessment process.
2. The worker establishes a base for the consultation by stating the reason for the meeting in unambiguous, behavioral terms; i.e., "You are concerned because your son/daughter has not left his/her room for several days, is that correct?" or "You are concerned because you are afraid your husband may hurt you or one of the children?"
3. The worker understands that asking for help can be distressful. The worker helps the client to identify and manifest his/her feelings in such a way that these do not stand in the way of his/her being helped. The worker understands that feelings about coming to the welfare department for help are some of the feelings that may interfere with acceptance of needed help.
4. The worker obtains all the facts as seen by the client. If the worker feels there is additional information that could aid the solution, he/she asks the client's permission to obtain this information.
5. The worker uses the problem-solving process to *help the client* assess the problem.

*Rosenthal effect: The expectations of others are often fulfilled.

6. The worker suggests resources that can be used and helps the client to explore these resources and decide on a plan. A good plan includes: (a) statement of the problem, in simple behavioral terms; (b) method(s) to be used in solving the problem; (c) participation of others in the plan; and (d) date for assessment, renegotiation, or termination of the plan. It is often helpful to put the plan in writing in terms of a contract between participants.

7. When indicated, and with the cooperation of the client, the worker utilizes the diagnostic resources available in the community; such as, psychological testing, diagnostic evaluation for chemical imbalance, physical examinations, etc.

8. The worker explains to the client the role and function of the county welfare department in the plan. (i.e., In an informal hospitalization, the county welfare department has certain obligations under the law.)

9. The worker clarifies future steps and answers other questions the client may have.

Resources and Alternatives (M.S. 253A.07, Sec. 4, Subd. 17a)

Many resources are available to meet mental health needs even when the initial request of the family or others may be only for commitment. These services may assist the person in crisis to cope more adequately with his/her situation. These services may also enable a person who has recovered from mental illness to maintain his/her functioning.

In exploring for alternatives to commitment, the alternative of choice is always the least restrictive alternative that may effectively assist the person's efforts to restore his/her capacity for making socially responsible choices and maintain healthy behavior.

Choice of resource is dependent upon type of problem, degree of impairment, services that can be provided, and the client's willingness to participate in the plan.

Resources to assist temporarily or to provide an alternative to commitment have been included below:

- Structured involvement of family members, neighbors, friends, and pastor
- Homemaker services
- Involvement in groups such as Emotions Anonymous, Neurotics Anonymous, Alcoholics Anonymous, Schizophrenia Anonymous, Friendship Club, or similar groups
- Supportive assistance from the mental health center or county welfare department
- Assistance by public health nursing or local physicians
- Medication supervision
- Diagnostic evaluation for biochemical imbalance
- Community day activity program
- Activity as a volunteer in areas where the client can be useful
- Individual or group therapy, family therapy, marriage counseling
- Occupational therapy
- Vocational rehabilitation, other vocational training
- Vocational assistance
- Sheltered workshops
- Involvement in community groups, such as YMCA, YWCA, Senior Citizens
- Community day treatment program
- Use of volunteers to provide specialized services and friendship

- ★ Residence in a supportive environment; i.e., halfway house, foster home (see Chapter IV)
- ★ Residence in a primary treatment facility
- ★ Voluntary treatment at an area mental health center, day hospital, or with a private psychiatrist
- ★ Voluntary hospitalization in a community general hospital or private psychiatric hospital
- ★ Informal (voluntary) hospitalization in a state hospital
- ★ Guardianship or financial guardianship

NOTE: Postponement or continuation of the commitment hearing is not a legitimate alternative. The law requires a hearing within 14 days of filing of the petition, with an extension for 30 days under certain conditions.

Pre-Petition Screening (M.S. 253A.07, Subd. 1, 7, 13, 17(a), 21)

1. The worker meets with a concerned person, often a relative, to discuss the possible need for mental health treatment program, commitment, or the use of an alternative which may serve the needs of a person who may be described as emotionally disturbed.

2. The worker meets with the potential client unless a substantial attempt to do so fails. The worker does not assume that a potential client is unable to act in his/her own welfare. A telephone call asking the potential client to come in for an interview, or to make an appointment for a home visit, will usually be successful.

   Mental health workers have found that honest and open communications are usually accepted. The worker may telephone the potential client and say, for example, "This is Mary Brown. I am a social service worker at the Smith County Social Service Department. I have just met with a relative of yours who is concerned about you. He/she feels you have been very distressed lately and may need help to solve the problem. I would like to talk with you about this and see how we might be of help. Would you come to see me this afternoon at 2:00 p.m.?"

   In situations where the potential client refuses to meet for an interview, the worker attempts to explore the reasons for the refusal with the client. If the client sounds fearful or angry, or depressed to the point of immobilization, the worker will acknowledge those feelings by saying, for example, "I know this must be fearful for you" or "I know you must be angry about this, but refusing to see me won't prevent a petition from being signed, and I do want to hear what you have to say about the situation."

3. The worker discusses the problems and concerns with the potential subject of the petition and other persons involved and explores alternatives for the least restrictive means of achieving the goal.

4. The worker is concerned about what these negotiations mean to the potential subject of the petition. The worker endeavors to understand the feelings of the subject of the petition and helps him/her to express these, including the subject of the petition's feeling about the worker's part in this process.

5. The worker, whenever possible, assists the subject of the petition to more completely explore alternatives of choice through interviews, visits, etc.

6. The worker helps the subject of the petition to understand that he/she is responsible in planning for his/her emotional needs. The worker and others stand ready to provide assistance, but will not make these decisions for him/her.

7. The worker takes the necessary steps to utilize the chosen alternative, such as referrals and financial arrangements.

8. When an adequate alternative is agreed upon, the pre-petition screening process terminates. The worker assists, as necessary, to implement the plan.

CHAPTER III

THE COMMITMENT PROCESS

"to provide care, protection, and other services"

The Minnesota Hospital and Commitment Act is concerned with the protection of both the individual and society. The MHCA defines the behavior which may require commitment for treatment under the Act, designates the procedures that must be followed to protect the legal and civil rights of persons committed under the Act, and places the responsibility for carrying out the provisions of the Act with the Commissioner of Public Welfare, county welfare boards, state hospitals and/or other agencies. The Commissioner of Public Welfare has overall responsibility for "the proper and efficient administration . . . " of the Act, even though some of the agencies involved are not under her supervision. (253A.21) A county welfare board has continuing responsibility for all persons from its county who are covered under the Act. This responsibility may be carried out through the provision of direct services or by contracting certain services to other agencies. When responsibility is delegated to another agency, the county welfare department regularly reviews the service provided. The assumption is that hospitalization is not *required* unless the person's behavior is detrimental (dangerous) to himself/herself or others *and* there is no suitable alternative available.

Pre-Commitment Screening (M.S. 253A.07, Subd. 1, 7, 13, 17(a), 21)

Pre-commitment screening and a report to the court may be the responsibility of the county welfare department worker, a special mental health advisory unit, or other agency. Because after-care planning is the responsibility of the county welfare board, the worker should always be a part of the pre-commitment screening process. In distinction from the pre-petition screening, this process takes place after a commitment petition has been signed. The screening process may reveal alternatives more appropriate than commitment to hospital treatment and the petition may be dropped. Initial steps in this process may follow the procedure of pre-petition screening (page 7).

Parallel steps are followed when informal admission to a hospital is indicated.

1. If the commitment is indicated, the worker explains the commitment process, step-by-step, to the petitioner, the subject of the petition, and others concerned.
2. The worker helps the petitioner, the subject of the petition, and others involved to deal with the feelings involved in the commitment process. One of the ways the worker does this is by verbalizing the unspoken concerns; i.e., "People often feel afraid or angry that treatment is necessary."
3. If commitment is indicated, the worker follows the procedure accepted by his/her county to draw up the petition and the necessary accompanying forms and submits these to the county attorney or to the court.
4. The worker recognizes the pain associated with involuntary hospitalization. When a client is openly resistant and/or hostile, the worker deals with this openly. The worker does this by recognizing the hostility and accepting it. (Example: "I know how angry you feel about this. It is hard to accept. But I'm concerned about you and you need time or help to come to grips with what you are feeling.")

Report to the Probate Court (M.S. 253A.04, Subd. 3; 253A.07, Subd. 7)

The county welfare worker prepares a report to the probate court, unless this responsibility has been delegated to a special screening committee. This report includes:

1. A history of events leading to the petition.

2. A description of the specific behaviors for which hospitalization or placement in a treatment facility is requested.

3. A social history and background information as required.

4. The social financial resources available.

5. Recommendations as to the use of an alternative to hospitalization or advisability of informal (voluntary) admission.

6. A physician's report that he/she has examined the person not more than five (5) days previous and that, in his/her opinion, the person is, or is not, mentally ill. Also, the physician's opinion as to whether the person is dangerous to himself/herself or others. If a physician's report cannot be obtained, the reason for its omission is given and a hold order may be recommended.

Pre-Commitment Services to Subject of the Petition and Family (M.S. 253A.07)

The worker provides services to the subject of the petition and family during the pre-commitment period.

1. The worker helps the family and subject of the petition to understand the services offered by the county welfare department.

2. The worker discusses with the family and subject of the petition the rights of the subject of the petition in the commitment process.

3. The worker informs the family and subject of the petition of the various alternative dispositions available to the court when these meet the needs of the subject of the petition, as well as informs the family and client of the general format of the court procedures.

4. The worker helps the subject of the petition, petitioner, and other persons concerned to understand their feelings about the commitment process. (The commitment process arouses feelings of guilt and shame, anger and fear, as well as fear of outcome. The worker is sensitive to these feelings and assists the participants in recognizing them and dealing with them realistically.)

5. When detention is necessary, the worker sees that the family arranges for proper clothing and personal necessities to accompany the client to the holding facility. When these are not available, the county welfare department provides clothing and personal needs allowance.

NOTE: In some counties, the petitioner, at the request of the family or county attorney, is the county welfare department. This is ordinarily an inadvisable procedure because it may interfere with the therapeutic assistance offered by the county welfare department in aftercare and case management. It may also deny the family the opportunity to fulfill its responsibility to be appropriately involved. However, when the family is unable or unwilling to assume this responsibility, it may be necessary for the county welfare department to act as petitioner.

CHAPTER IV

SERVICES TO CLIENTS PLACED IN A MENTAL HEALTH TREATMENT FACILITY

"to effect timely and appropriate return to community"

The county welfare department has a continuing responsibility to all persons from that county who are hospitalized in a state hospital either on a commitment or voluntary basis. Also, the responsibility includes the person committed in the community in a private or public hospital or to a mental health center.

Team Planning with Treatment Facility Staff (M.S. 253A.17, Subd. 9: 253A.15, Subd. 13)

1. The worker secures open lines of communication with treatment facility staff, so that the county welfare department is promptly informed of placement in the treatment facility. Likewise, the worker informs the treatment facility of pending placement and of the outcome of commitment hearings.

2. The worker provides the treatment facility with all information needed for admission by means of a written referral which shall include the client's medical history and reasons for placement clearly stated in behavioral terms.

3. The worker sees that the client has clothing and personal needs brought to the hospital by a friend or relative. Where such are not adequate, the county welfare department provides such needs.

4. With the permission of the client, the worker meets with client, staff, and others concerned as soon as possible to formulate, with the client, a treatment plan which will lead to discharge. The following matters are addressed:

   a. Reason for placement, in simple behavioral terms;
   b. Goals for treatment;
   c. Methods to be used in achieving goals;
   d. Time limit for each goal;
   e. Designation of responsibility for each method used;
   f. Date for re-evaluation of the treatment plan and the method to be used for this re-evaluation;
   g. Agreements between those involved about responsibilities for each component of the program.

NOTE: In determining a treatment plan, the team looks for the client's strengths and builds on these. Even resistance is a strength and can be used to motivate progress if accepted as a sign of strength.

5. It is assumed that for most individuals, placement in a treatment facility will be very brief, perhaps a few weeks. In the event of longer placement, the worker meets with client and staff quarterly to affirm the validity of the client's program or to revise it so it is more helpful.

6. The worker, as needed, initiates contact with the Social Security Office so there will be no financial barriers to return to the community. (This may be best accomplished through joint efforts with other workers.)

Involvement with the Client Placed in a Treatment Facility and Client's Family (M.S. 253A.19, Subd. 1a, b.)

1. The worker eases the client's transition to the treatment facility by explaining to the client where he/she is going and why. The worker should document that this has been done.

2. The worker helps the client and family members understand, accept, and deal with their feelings about the treatment facility and the events that lead to it.

3. The worker arranges for transportation to the treatment facility as authorized by the court, in an unmarked car if at all possible. In situations where there is no court authorized transportation, the worker shall assist the client or family in securing transportation to the treatment facility.

4. The worker assures that the client is informed of his/her rights to a reviewal of the commitment and the right to be given an informal status and this should be documented.

5. The worker explains to the client the county welfare department services that are available to him/her in the treatment facility.

6. The worker shall make efforts to assure that the client's family is included in the treatment planning so they may understand the plan and assist in the client's progress.

7. The worker helps the family to plan for visits to the client as appropriate to the treatment plan.

8. The worker ensures that his/her client receives informational materials about the treatment facility, including the role of the client advocate, and that the client receives treatment as outlined in the written treatment plan. (Most treatment facilities provide clients with written statements of hospital rules, client rights, access to advocate.)

9. The worker helps the client to understand that he/she is responsible for determining his/her treatment plan with the assistance of treatment facility staff and others concerned. The worker helps reduce the blocks the client may have in participating in this treatment planning.

10. The worker of the county of residence is responsible for case management and the client's financial needs. Exceptions to this policy may be made upon agreement between the host county and county of residence.

The Discharge Plan (M.S. 253A.17, Subd. 9; 253A.15, Subd. 11-14)

Discharge planning begins with admission and is a part of all treatment planning. The following procedures refer to finalizing the discharge plan.

1. The worker plans early with client and treatment facility staff, family, and others concerned, to develop the best possible aftercare plan. Alternatives to hospitalization (pages 6 and 7) provide supportive services *after* return from the treatment facility. A good aftercare plan will reduce or eliminate return from the treatment facility.

2. Prior to discharge, the director of the treatment facility shall notify the family of the proposed discharge date. The notice shall also indicate the date, time, and place of the meeting of the staff to discuss discharge and discharge planning. The family may attend the designated staff meeting and present any information relevant to the discharge of the client.

3. If the client is chemically dependent, the worker sees that the community mental health center is notified of the impending discharge. (M.S. 253A.15, Subd. 11)

4. The worker assists the client, as needed, to implement the discharge plan, by one or more of the following:

   a. Assuring that the client's discharge plan is acceptable to him/her;
   b. Utilization of a discharge contract with the client;
   c. Seeing that all participants in the plan fully understand their roles and responsibilities;
   d. Arranging financial supports, if needed;
   e. Making referrals to other agencies, as necessary;
   f. Assisting the client in arranging for housing, job, socialization, etc., as necessary.

5. Case record documentation:

   a. The discharge plan is written in the county social service record and in hospital files, and the files of other agencies involved.
   b. The discharge plan shall specify precise goals, including the length of time projected for provisional discharge. The plan shall be provided to the client in writing.
   c. A quarterly review of the discharge plan is required when the client is on a provisional discharge.

The Provisional Discharge (M.S. 253A.15, Subd. 11-14; 253A.17, Subd. 9)

Direct discharge is considered the norm and extended visits, partial hospitalization, and provisional discharge are the exceptions and used only when the client has not achieved the prescribed goals as set forth in his/her written treatment plan *and* continues to need the supervision or assistance provided by a provisional discharge.

1. In developing a discharge plan, the worker and other members of the team consider the necessity for a continuation of commitment following the release from the treatment facility. This necessity must be justified in the written plan.

2. Prior to any provisional discharge, the worker discusses the possible provisional discharge on a face-to-face basis with the client.

3. The worker informs the client of the report recommending a provisional discharge and any conditions, duties, or restrictions on the client.

4. The worker considers objections to the provisional discharge or its conditions that may be offered by the client.

5. The worker, if after such consideration, still believes a provisional discharge to be necessary, submits his/her report to the director of the treatment facility, with a copy to the client.

6. The report shall be in writing and shall contain:

   a. Specific grounds for the request;
   b. Date of conference with the client and client's opinions and suggestions;
   c. The anniversary date of the provisional discharge and/or the termination date.

7. Final discharge should be recommended as early in the period of provisional discharge as possible.

Revocation of Provisional Discharge

1. Whenever possible, revocation of provisional discharge should be avoided by efforts of the persons involved.

2. When it appears necessary to initiate the revocation of a client's provisional discharge, the worker informs the client of his/her rights to object to the revocation, and of his/her rights to the assistance of a client's counsel to obtain a hearing and appeal.

CHAPTER V

SUPPORTIVE COMMUNITY SERVICES

"to see to the provision of care and protection"

Post-Hospital Services

1. It is expected that many persons will need initial help in the utilization of community resources and they may need assistance in arranging their affairs. It would be anticipated that the worker would reassess the need for direct supervision on a quarterly basis. The worker takes care to increase the independence of the client by encouraging him/her to do for himself/herself and giving him/her every opportunity to do so.

2. In the event of a provisional discharge, the worker shall, as required by the MHCA, supervise the discharge plan. If the client desires to alter the discharge plan, the worker consults with the treatment facility and others concerned before making a decision.

3. The worker provides or arranges for the provision of counseling and medical services to the client as part of the plan or at the client's request.

4. The worker helps the client to select and utilize community services by referral and other assistance.

5. The worker provides necessary assistance during periods of crisis in the client's life. A worker may be frequently contacted by the client who perceives himself/herself to be in a crisis situation. The emotionally disturbed person has fewer resources with which to cope, and a crisis for that person may have serious consequences. At the same time, strength is built by exercise and the worker should help the client gain experience in dealing with his/her own difficulties. He/she may do this by helping the client look at the need or the use he/she is making of calls for assistance.

6. When return to a treatment facility may be anticipated, the worker continues to keep the treatment facility informed of the discharged client's progress.

7. The worker consults with the treatment facility before a decision is made to seek readmission.

Use of Supportive Residences (DPW Rule 36)

Supportive residences are primary residential treatment centers, halfway houses, group homes, supervised board and lodging, specialized nursing homes, specialized schools, and foster homes. The worker facilitates the proper use of supportive residences through regular involvement and supervision.

1. The worker arranges a preplacement visit so that the client can consider how the placement can serve the client's needs. The worker helps the client with what this placement means to him/her.

2. The worker arranges for a physical examination prior to placement.

3. The worker assists with the financial plan, as necessary.

4. The worker informs the client what information the residence needs, and obtains the client's permission to release this information. A signed release is desirable even when information is given verbally.

5. The worker visits the client at the new residence within the first few days, in order to:
   a. Help the client to express any fears or concerns and deal with these;
   b. Help the client understand the residence rules and expectations;
   c. Assure that the residence is involving the client in planning for his/her own welfare.

6. The worker encourages the client's family to visit within the first week, and plans a regular visitation program with them to encourage their efforts to help the client.

7. The worker answers the family's questions about the placement and helps them to understand and resolve their feelings, including anger and guilt.

8. The worker plans initial goals with client, residence staff, and others concerned. Useful goals are those which:
   a. Are easily defined in objective terms;
   b. Are consistent with the client's future hopes;
   c. Are attainable in small steps (see also page 13, Section 4).

9. The worker continues his/her responsibility to the client after placement by:
   a. Continued involvement in goal planning;
   b. Quarterly assessment and reports, as required;
   c. Awareness of the physical and program aspects of the residence;
   d. Assistance to residence staff through consultation.

Return to the Family Residence or to an Independent Living Situation

There is need for the worker to give supportive assistance in some situations where the client has returned to a family residence or has taken up independent living. The worker shall assess the guidelines suggested for **Post-Hospital Services** and **Use of Supportive Residences** and use those most applicable to the siuation.

CHAPTER VI

COMMUNITY RESOURCES

"to develop and provide a broad range of opportunities"

Comprehensive social and rehabilitative services to the mentally and emotionally handicapped are based on the concept of a continuum of care. This concept assumes an array of services from which people may select, as needed. The concept further assumes that available services are broad enough to provide for the full range of need and are fully accessible to the individual, regardless of the degree of disability or conformation to a recognized pattern of behavior. The continuum of care should *not* be seen as the progression of a client from hospital care through certain community services to independent living. Services can be designed to fit an orderly pattern, people do not. The continuum of care can be visualized as that model of endeavor and cooperation between client and community agencies which maximizes the individual's functioning and minimizes the effects of the handicap.

Development of Opportunities

1. The worker informs the area board of area mental health needs, *as seen by the worker.* (The worker consults with his/her agency to determine the method of relaying this information.)

2. The worker attempts to inform the community of area mental health needs whenever such an opportunity presents itself.

3. The worker assists other resources in their provision of services, by means of consultation and assistance in staff development. It is desirable for the county social service worker to be involved in the community in encouraging the development of services through community organization and the improvement of services through training. (It is suggested that the county worker have a percentage of his/her time allotted to consultation with staff of residences serving the mentally ill.)

Provision of Opportunities

1. The worker, in his/her expectations and attitudes, encourages client self-determination and utilization of opportunities.

2. The worker consults, as necessary, with community institutions to maximize the client's adjustment to the community.

3. The worker capitalizes on opportunities to develop expertise in serving handicapped clients.

4. The worker consults with his/her supervisor to determine the caseload which can be adequately served. (The consensus of workers is that 30 to 40 *active* clients can be given service, with a 10% allowance for time spent in community activities, such as consultation with group homes. About five inactive clients can be given service in place of one active client. An inactive client is considered to be a case for which the worker has only administrative responsibility and minimum personal contact.)

CHAPTER VII

CLIENT ADVOCACY

"to assure the protection of rights"

A primary purpose of the Minnesota Hospital and Commitment Act is the protection of the legal and civil rights of individuals covered under the Act. Other sections of the practice guide have made reference to this. Under the Department of Public Welfare Advocacy Policy, it is not only the right, but the responsibility of employees in the public welfare system to act as advocates for their clients. As part of this policy, the worker is assured that his/her position shall not be jeopardized by assuming an advocate role.

The Worker Advocate (M.S. 253A.16, 253A.17, 253A.18, 253A.05)

1. The worker assumes responsibility for educating the community about mental illness and for encouraging a greater acceptance for those who are less able to meet the normative expectations of the community.

2. The worker has an ongoing responsibility to help the client protect his/her civil and legal rights. When indicated, the worker may assist the client with the appeal process, or see that he/she receives such assistance. The worker may also assist the client to receive his/her rights under the welfare laws.

3. The worker informs the client of his/her right to access to his/her records, as required by law.

4. The worker encourages the development of guidelines for protecting the confidentiality of files, including computerized files.

NOTE: Persons defined as mentally ill have *all* the powers and rights of any other citizen, except where these have been limited by the due process of law.

BE8/02

MICROGRAPHIC SERVICES UNIT
DEPARTMENT OF ADMINISTRATION

STATE OF MINNESOTA

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77-2353
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APR 4 1980
DATE PRODUCED

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RM-00062-01