REPORT TO THE 1987 LEGISLATURE ON THE ADMINISTRATIVE LOCATION OF MENTAL HEALTH PROGRAMS

MINNESOTA STATE PLANNING AGENCY

Introduction

In 1986 the Minnesota State Legislature directed the State Planning Agency to examine the "need for a central point in state government to administer a system of mental health services." The Legislature required the Agency to report back on the current administrative placement of mental health services and to present options for reorganization.

This report provides a history of the administrative placement of mental health programs in Minnesota, provides information on the ways other states address this issue and examines the strengths and weaknesses of: 1) leaving the mental health programs in the Department of Human Services; 2) moving the programs to the Department of Health and 3) creating a new and separate department to administer the programs.

HISTORY OF MENTAL HEALTH SERVICES IN MINNESOTA

Early in Minnnesota history, the Board of Control and Charities had responsibility for the delivery of services to the mentally ill; the Board controlled state hospitals. The Board also had responsibility for state correctional facilities and financial control over state colleges and teacher training programs. In 1949 the administration of Governor Luther Youngdahl reorganized the Board of Control into the Department of Social Security. One of the department's three divisions--the Division of Public Institutions--had responsibility for the state hospitals and for mentally ill persons in general. The reorganization into the Department of Social Security indicated a change in state policy toward mental illness and how mental illness was defined. The first lines of the revised statute stated that, "Whereas, mental illness is a sickness with respect to which there should be not stigma or shame....".

During the early 1950's all mental health services fell under the jurisdiction of a "commissioner" of mental health and mental hospitals within the Department of Social Security. Law required the commissioner to be a medical doctor with at least five years experience in psychiatry. Later changes in the department lowered the status of the mental health commissioner's position to that of division director, eliminating the requirement of medical training.

The present department structure took shape in 1953 when the correctional institutions were split off of the Department of Social Security. This established two new departments, Corrections and Public Welfare.

As programs and services for the mentally ill have changed and expanded since the early 1950's, so has the administration of related programs in the department. At the present time, the Department of Human Services (formerly the Department of Public Welfare) administers state hospital services for the mentally ill in a division separate from community mental health programs. Another division handles quality assurance and licensing for mental health services.

Sanitation and health standards for programs for the mentally ill are administered by the Department of Health. The Department of Health began originally as the Board of Health and has remained a separate entity to the present time.

A strong historical precedent exists in Minnesota for a central authority for mental health -- the present Department of Human Services. A weaker precedent also exists for a separate department of mental health. Over a long time span in the history of the Department of Human Services and it predecessors, there is a pattern of splitting off activities and creating seperate departments.

STATE COMPARISONS

The experiences of other states can provide insight as to how Minnesota ought to structure departments and services. The following section briefly outlines how other states have chosen to administer services for the mentally ill. Washington, Oregon, Colorado, Wisconsin and Maryland were chosen for comparison because of their similar size to Minnesota and their reasonably good mental health systems. The analysis suggests that: (1) other states have not found it necessary to set up separate departments for mental health; (2) mental health services can be provided in either a department that is "health-oriented" or "welfare-oriented" or one that encompasses both health and welfare; (3) some states have more consolidation of mental health responsibilites than Minnesota. More importantly, the analysis suggests that legislative direction has a greater impact on the success of mental health services than does the administrative structure for providing services..

WASHINGTON

In Washington, mental health administration is the Department of Social and Health Services. The department administers state institutions for mentally ill persons and community mental health

programs; health, income maintenance and juvenile corrections programs, residential programs for the deaf and blind; and other similar programs. Washington's department is very broad in scope, somewhat analogous to the federal Department of Health and Human Services.

In setting up mental health programs in Washington, the statute sets forth a priority system for the care of the mentally ill. Highest priority for services and state funding is for the care of acutely mentally ill, principally those persons likely to cause harm to themselves and others. Next in priority are persons who are chronically mentally ill, and next those who are seriously disturbed. Each group is carefully defined in state law. Washington also has a tracking system to record the participation of mentally ill persons in programs. (Minnesota law does not currently contain priority categories for service and no system-wide tracking system is in place.)

OREGON

Mental health is a separate division in the Department of Human Resources, an agency that includes corrections and health programs. Oregon has a statutory definiton of mental illness that guides the allocation of resources.

COLORADO

In Colorado mental health is under the Department of Institutions. Other programs in the Department include services to chemically

dependent and developmentally disabled persons. The Department also administers programs for community services purchased by the state from local providers.

WISCONSIN

Mental health is the responsibility of Wisconsin's Department of Health and Human Services. This department is an example of a large umbrella agency that includes corrections, services to the the blind, deaf and developmentally disabled and other target populations, as well as public health.

MARYLAND

In Maryland mental health is located in the Department of Health and Hygiene. The department also provides services for persons who are chemically dependent or developmentally disabled. Public health programs are also under the jurisdiction of this department. The mental health programs also include the state hospitals. The programs are required to be directed by a psychiatrist or neurologist with experience in mental health. Maryland also has a psychiatric research center.

Similarities between mental health services in other states lie not in the administrative structure, but in the sense of direction for mental health services provided in law. From this, one might

conclude that the specific administrative structure is not nearly as important as how clearly the legislature spells out what the administration ought to do.

STRENGTHS AND WEAKNESSES OF VARIOUS ADMINISTRATIVE STRUCTURES

CENTRALIZE MENTAL HEALTH SERVICES IN THE DEPARTMENT OF HUMAN SERVICES

Strengths

- Maintains historical location
- Maintains connection to funding sources such as General Assistance, Medical Assistance and Community Social Services
- Department has strong relationships built with county social service agencies to deliver services
- Mental Health programs are currently receiving a lot of attention in the department
- State hospital services, which include services to the mentally ill, are in this department

Weaknesses

- May not always receive needed attention from department head due to multiple activities in department
- May be in competition with other programs within department for allocation of resources (i.e., entitlement programs such as Medical Assistance or AFDC where cost is difficult to contain)
- Placement of services under the Department of Human Services may create a stigma if the location appears to suggest that mental illness is a welfare or social problem

CENTRALIZE MENTAL HEALTH SERVICES IN THE DEPARTMENT OF HEALTH

Strengths

- Mental health programs would be of large enough size to command major attention from the organization
- Affiliation with a more health-oriented department might ensure

prompt application of latest research in physical origins of mental illness

- Location in a health oriented agency, rather than one more known for welfare or social problems, might help to remove the stigma from mental illness

Weaknesses

- Department would either need to establish relationships with the county social services agencies (who have traditionally been the agencies dealing with mentally ill persons) or, if the Department planned to use the community health services personnel in counties, it would need to provide training to coordinate them with county financial workers

- Would remove programs from agency that has control over funding sources needed by the mentally ill individuals being served, such as General Assistance, General Assistance Medical Care and Medical Assistance

- Unless the state hospital system was moved all or in part from the Department of Human Services, mental health programs would be separated from that component of the service system

- The size of the mental health program could overshadow other activities in the agency

- In the short-run, the scale of reorganization required by such a move could be disruptive to the delivery of services

MOVE SERVICES INTO A SEPARATE DEPARTMENT OF MENTAL HEALTH

Strengths

- Department would have clear mission, would not have to share focus with other programs

- Commissioner of the new department would have direct access to the Governor

- Budget setting within department and by the Legislature might be easier as there would be less internal competition for scarce resources

- Could increase public awareness and generate public discussion of mental health

Weaknesses

- Costs would need to increase for administrative personnel as it is unlikely all needed services could be transferred

- Establishment of new agency would initially take time away from service provision as issues such as space, personnel and management would demand immediate attention of agency head
- Depending on decisions, such as transfer of all or a portion of the state hospitals, the department would not have control over all parts of the mental health system
- Could add to stigma if public perceives mental illness is so different from other state programs that it demands a separate department
- Department not likely to have control over funding from Medical Assistance, General Assistance Medical Care and others monies which provide financial assistance to persons with mental illness

CONCLUSIONS

The review and analysis of the provision of mental health services in Minnesota and of the approach to providing these services in other states leads to the conclusion that there is no optimal solution for the placement of mental health programs within state government. The analysis suggests that legislative direction has a greater impact on success than does the administrative structure employed.

In 1986 when the legislature requested that the State Planning Agency examine the issue of adminstrative placement of mental health services, frustration over problems in the system were great. Since that time much has happened which has an impact on the issues. The Department of Human Services has appointed an Assistant Commissioner for Mental Health. The department has

drafted a bill for legislative approval which would create a "system" of mental health services, including standards for services and increased funding. In addition, a separate bill has been prepared to establish a Mental Health Division in the Department of Human Services. Enactment of these bills may resolve many of the problems with mental health services which seemed to be identified with the Department of Human Services. If this is true, there may be less concern in the future with the administrative placement of the Mental Health program and more attention devoted to the implementation of the improvements in services to persons who are mentally ill.

The issues of quality mental health programs and the creation of a mental health "system" for the state have been vigorously brought to the attention of the Legislature by the Governor's Commission on Mental Health. This process has been healthy for the administrative and legislative systems which must deal with the complex issues involved. Debate and effort continue with the goal of establishing a mental health system which serves the needs of the mentally ill at a reasonable cost and in a straightforward manner. We conclude that this goal can be accomplished under various administrative approaches with adequate legislative direction.

Regardless of the placement of mental health programs, either in the Department of Human Services, in the Department of Health or in

a separate agency, organizational issues remain which will need to be addressed. These issues include: the relationship and control of state hospital services for mentally ill persons; and the relationship among funding mechanisms available to mentally ill persons such as General Assistance and General Assistance Medical Care and programs such as Community Social Services that fund some mental health programs. Aside from the organizational issue, a need exists to more clearly define service priorities for the mental health system in statute.