From Deinstitutionalization to Today:

The History of the Modern Mental Health Crisis

Katie Moret

University of Minnesota Duluth

Abstract

Treatment for those with mental health conditions has been influenced by many factors and changes in the field. One such change which shifted mental health treatment drastically was the deinstitutionalization movement in the United States during the 1950s. This movement advocated for the closing of state mental hospitals in favor of community-based resources to help those with mental illnesses. While hospitals were seen as restricting, community resources were seen as more conducive to recovery. This was a well-intentioned but failed initiative which led to negative outcomes for the area of mental health treatment throughout the country. This paper outlines the history of deinstitutionalization in the U.S. and its repercussions, and examines how this movement has led to the mental health crisis seen across the country. The state of mental health in St. Louis County, Minnesota is the focus, and the various services available and future improvements to be made are described.

Keywords: mental health, deinstitutionalization, Minnesota, St. Louis County

From Deinstitutionalization to Today:

The History of the Modern Mental Health Crisis

The treatment of those with mental health conditions has a sordid history, one riddled with mistreatment and misunderstanding since the beginning. Over the years, we have let go of many poor treatment options and inaccurate ideas, but there are some we stubbornly refuse to abandon. The purpose of this paper, though, is not to detail the entire history of mental health treatment. Rather, this paper will focus on mental health treatment in Minnesota and throughout the country, specifically focusing on the change in treatment since the beginning of the deinstitutionalization movement. Deinstitutionalization radically changed the face of mental health care, and its effects continue to be seen today. This movement fundamentally shifted the base of mental health care in the United States, and contributed to the poor mental health care currently seen in this country. Focusing on mental health treatment in the St. Louis County area in northern Minnesota, this paper will investigate the repercussions of the deinstitutionalization movement and how leaders in the field today are working to improve the conditions of mental health treatment.

The History of the Deinstitutionalization of Mental Health Treatment

Prior to the beginning of deinstitutionalization, mental health treatment was drastically different throughout the country. This movement, motivated by several developments and concerns relating to mental health, led to various negative outcomes which have worsened the condition of mental health in the United States.

The Basics of Deinstitutionalization

Deinstitutionalization was a movement in the mental health field that began in the 1950s. This movement impacted the entire country, leading to a major overhaul of the mental health

care system that affected every facet of mental health treatment and all those involved. The fundamental purpose of deinstitutionalization was to close state mental health hospitals in favor of more local, community-based treatment options.

Mental Health Treatment Prior to Deinstitutionalization

To understand the deinstitutionalization movement fully, it is first necessary to know what came before it. In the years leading up to the 1950s, mental health treatment was primarily focused in state mental health hospitals. The first mental health hospital in Minnesota was established in 1866 in St. Peter (Program Evaluation Division, 1986). In the years following, many more hospitals were established throughout the state, and at the time of deinstitutionalization there were 11 hospitals in the state of Minnesota. The state's population of patients hospitalized as mentally ill, mentally retarded, or chemically dependent reached its height of over 16,000 in the 1960s before beginning a sharp decline corresponding with deinstitutionalization (Minnesota State Planning Agency, 1985). By 1984, the state hospital population experienced a 75% decline to just over 4,000 patients.

Factors Leading to Deinstitutionalization

Several factors contributed to the beginning of the deinstitutionalization movement. Advancements in antipsychotic medications, changes in the health care system (Medicare and Medicaid), human rights concerns, and budgetary concerns were the major components that drove the movement.

Development of new antipsychotic drugs. In 1955, the first medication considered to be capable of effectively treating psychotic disorders, Thorazine, entered the market (Torrey, 1997). While it was originally used for sedation following operations or with psychiatric patients in extreme distress, Thorazine soon became the first antipsychotic medication used to treat

schizophrenia, a severe mental disorder that was responsible for placing the majority of patients in mental health hospitals at the time. It also was used in the management of manic periods in bipolar disorder as well as several other health conditions. Because of its use in the treatment of several serious mental health conditions, Thorazine's entrance into the mental health world drastically impacted how patients received care and allowed many patients to live more normal lives outside of a hospital setting.

Enactment of Medicare and Medicaid. The progress of deinstitutionalization increased following the enactment of Medicaid and Medicare (known as Medical Assistance) in the 1970s (Minnesota Department of Human Services, 2014). After this, many large state treatment centers were classified as Institutes for Mental Diseases (IMDs), making them ineligible to receive federal reimbursements for patients between the ages of 22 and 64. This lack of federal funding for state mental hospitals gave states an incentive to close them in favor of other services which could be covered. The Medical Assistance (MA) program also created a system in which hospitals could not be reimbursed for care given to patients after it was no longer determined to be medically necessary, based on certain criteria. These criteria required that a patient be in a crisis that presented danger to self or others, or be incapable of self-care (Minnesota Department of Human Services, 2014). The MA program and the criteria for medical necessity changed the goals of hospitals to focus on stabilizing patients, rather than encouraging long-term recovery. Following being discharged, patients were expected to continue their long-term recovery in the community-based services deinstitutionalization advocates favored, further encouraging the movement from state facilities to community services.

Concern for human rights. The concern for human rights was another major contributing factor involved in the desire to close mental health hospitals. Many people

supported deinstitutionalization as a way to secure more humane treatment of those with mental health conditions. Hospitals were seen as restrictive settings that limited a person's freedom and hindered treatment and recovery (Torrey, 1997). Many referred to the advancements made by mental health advocate Dorothea Dix in the mid-1800s in arguments supporting deinstitutionalization. Dix was a major figure involved in improving the poor living conditions and treatment options for those with mental illnesses during a time when being diagnosed with a mental illness often meant living in jails and prisons or facing inhumane treatment in a mental health hospital (Treatment Advocacy Center, 2010). The public was shocked and appalled at the conditions of mental health hospitals and the high numbers of incarceration for those with mental illnesses, leading to a movement to improve conditions and move those diagnosed with mental illnesses out of jails and prisons.

This attitude during the mid-1900s was a factor in deinstitutionalization's beginning. Many of those who believed in deinstitutionalization thought patients in mental health hospitals should be liberated from the hospitals that had become overcrowded and were deteriorating (Treatment Advocacy Center, 2010). These social reformers were advocating for "normalization," saying that those with mental illnesses should be removed from hospitals they perceived as restrictive and placed where they would be able to live more normal lives (Program Evaluation Division, 1986). This meant the creation of community resources and services that would promote recovery, independence, and normalcy.

Monetary concerns. Other deinstitutionalization advocates were less concerned with human rights than monetary factors. These advocates favored closing state mental health hospitals because they believed it would be of monetary benefit. Fiscal conservatives believed closing these hospitals would save money at the federal, state, and local levels, therefore

allowing this funding to be allocated elsewhere in areas considered more essential (Treatment Advocacy Center, 2010).

Facets of Deinstitutionalization

As previously mentioned, the main components of the deinstitutionalization movement involved the closing of state mental health hospitals across the country and placing patients in community-based facilities instead.

Closing state hospitals. Moving patients out of state mental health hospitals and closing those hospitals was the first goal of deinstitutionalization. Of the eleven state mental hospitals running in Minnesota at the time of deinstitutionalization, the only remaining hospital today is the Anoka Metro Regional Treatment Center. Minnesota has established seven "subacute hospitals" across the state, each with 16 beds (Leys, 2015). These hospitals are intended to feel more comfortable and less like being in an institution, and they qualify for federal money under Medicaid, a type of assistance not usually available for larger mental health hospitals. Apart from these resources, Minnesota does still have a facility in St. Peter for those who have mental illnesses that have led to criminal activity. As will be discussed later, those with mental illnesses who also commit crimes related to their illnesses have caused several problems for the mental health system.

Developing community-based resources. The proposed alternative for mental health hospitals was developing resources to keep patients in their communities. Patients discharged from hospitals were supposed to be moved to Intermediate Care Facilities for Mentally Retarded people, or ICFs-MR, funded by the Medical Assistance Program (Program Evaluation Division, 1986). The state of Minnesota placed a moratorium on the establishment of new ICFs-MR in 1983 after determining the state had enough facilities.

One of the problems with this change was that there were few guidelines established to determine what would make an appropriate service or resource (Program Evaluation Division, 1986). This lack of planning, oversight, and support meant many patients were placed in inadequate situations or were not placed at all.

While some argue the increase in private beds allowed for an adequate amount of facilities for those in need of treatment, many of these private facilities would only accept certain patients. Any without the right health care or any seen as potentially disruptive or violent were not allowed (Treatment Advocacy Center, 2008). Additionally, there simply are not enough community-based facilities to accommodate all those in need of them. Nation-wide, there was a 95% reduction in available beds from 1955 to 2005, and the establishment of community services has not been rapid enough to offset this drastic decrease in psychiatric beds.

Outcomes of Deinstitutionalization

The poor planning, organization, and attention paid to mental health care following deinstitutionalization has helped lead us to the mental health crisis our country is in today. Many problems we are currently facing can be traced back to the beginning of deinstitutionalization, including the rise of trans-institutionalization and homelessness, the increased stress on the health care system and law enforcement, and the transfer (instead of removal) of the monetary burden associated with mental health care.

Trans-institutionalization. Discharging patients from state hospitals to move them to community-based facilities caused a problem when there was not an adequate amount of services. This lack of services caused a phenomenon known as trans-institutionalization, which is moving patients out of hospitals only to have them taken to jails and prisons instead (Minnesota Department of Human Services, 2014). This was not an immediate outcome of

deinstitutionalization; from 1950 to 1980, there was almost no trans-institutionalization, but from 1980 to 2000, the rate of this phenomenon increased dramatically. During this time period of rapid trans-institutionalization, 4-7% of the incarcerated population was attributed to the deinstitutionalization, or approximately 40,000 to 72,000 people. Of these people incarcerated during this time, many were put behind bars due to crimes they committed related to their illnesses (Torrey, 1997).

A study done by the U.S. Department of Justice in 1998 found that over 16% of jail and prison inmates had serious mental illnesses, a number which increased to 20% in 2000 and is showing no signs of lowering (Treatment Advocacy Center, 2010). In Minnesota's Hennepin County Jail, which is the state's largest jail at 40,000 inmates, 25-30% of inmates in 2014 had mental illnesses (Bierschbach, 2014). Between the years of 2000 and 2014, 35 county jail inmates and 27 state prison inmates in Minnesota known to have mental illnesses committed suicide. When those with mental illnesses are kept behind bars, the form of treatment they receive for their illnesses is often nothing more than medication. Without actual treatment, these individuals do not recover, and unfortunately, that means a large amount of those with mental illnesses will show little to no improvement. The populations of those with mental illnesses in jails and prisons throughout the country are far greater than those in mental health facilities. In fact, as of 2008, the 3 largest facilities in the United States caring for those with mental illnesses were the Los Angeles County Jail, Chicago's Cook County Jail, and New York's Rikers Island Jail (Treatment Advocacy Center, 2008).

Rise in homelessness. While some patients were trans-institutionalized from state hospitals to jails, others were discharged into homelessness. For many, mental illness impairs the ability to perform essential aspects of everyday life, including holding a job, maintaining

relationships, and caring for oneself. These and other factors make a person with a mental illness more likely to be homeless than those without mental illnesses. While 20-25% of those who were homeless in 2009 were also experiencing mental illness, only 6% of the general population had mental illnesses (National Coalition for the Homeless, 2009). This trend is particularly evident for those with schizophrenia or bipolar disorder, severe mental illnesses which, if untreated, significantly impact a person's ability to maintain stable functioning. The relationship between mental illness and homelessness has been verified by many studies and seen in areas throughout the country. A study of 81 cities in the United States showed an inverse relationship between the number of beds available for psychiatric care and the number of homeless individuals (Treatment Advocacy Center, 2010). Outside of this correlation with homelessness, this study also showed a relationship between available beds and violent crimes, which included murder, assault, rape, and robbery.

Stress on the health care system. When those with mental illnesses who are in crisis and require immediate care do not have access to mental health services, responders to the situation are left with few options when there are no psychiatric beds available. Frequently, patients who are in need of mental health care are temporary held in emergency rooms while waiting for a psychiatric bed to open up to accommodate them (Treatment Advocacy Center, 2008). These temporary holds can last anywhere from hours to days, depending on how long it takes to find a bed. When no beds can be found in the area, patients can be transferred hours away to the nearest available facility which can house them. During temporary emergency holds, ER staff are put in the position to be offering intermediate care to stabilize mental health patients when there is nowhere else for them to go. Emergency room staff are not intended to or trained to provide the in-depth mental health treatment those in crisis need, so both the patient and the facility are being

negatively impacted by this circumstance. This service interferes with the ability of ER staff to treat other emergency patients and increases the waiting time for individuals who go to the ER in need of emergency medical care.

Stress on law enforcement. Often, the first responders bringing those in need of mental health treatment to emergency rooms are police officers. Police officers are put in the position to ensure the safety of those in mental health crises by placing them in some sort of facility, mental health or otherwise. While some cities have begun programs to train police officers and other first responders on how to determine if an individual may be in mental distress and how to deal with such situations, there are many more cities where officers do not receive the proper training to handle these situations. This has ended with many fatalities across the country, as officers respond with weapons or force as trained instead of the calm and patience required to take control of a mental illness-related situation. In some situations in which officers correctly detect signs of mental illness and act to care for the individual, they arrest the individual to offer them protection as there are no facilities open elsewhere. In a 1992 study, it was found that 29% of jails would incarcerate individuals waiting for psychiatric treatment even when they had no charges against them (Torrey, 1997).

Transfer of monetary burden. One reason many supported deinstitutionalization was to reduce the costs that were then associated with maintaining state mental health hospitals. As a result of deinstitutionalization, however, this cost has not declined, but rather has merely been shifted from mental health to corrections and hospitals (Treatment Advocacy Center, 2008). The rise in arrests, incarcerations, emergency room care, and crisis intervention has led to increased stress and spending in the criminal justice and health care systems. Taxpayers continue to pay for

those with mental illnesses, it is just in the way of imprisonment, emergency care, and chronic short-term care instead of long-term care focused on recovery.

Needs and Gaps in Mental Health Care

The deinstitutionalization movement and its resulting outcomes have led us to the mental health crisis we are facing today. Nationwide, the United States is experiencing a mental health care system which cannot meet the demand and care for those in need of treatment. There are very few counties and states throughout the country which are meeting the requirements for a minimal level of mental health care. In St. Louis County and Minnesota, there are many areas in which there are significant gaps in the available mental health care.

Requirements for Minimum Care

The proposed minimum number of public psychiatric beds required to provide minimal mental health care is 50 beds per 100,000 people, but 42 out of 50 states have less than half that number (Treatment Advocacy Center, 2008). In 2005, 17 public beds per 100,000 was the average across the country. This puts the country at a total public bed shortfall of 95,820. Many beds are reserved for short term stays, meaning those in need of long-term care are discharged without anywhere else to go or are placed in residential facilities like nursing homes. Additionally, the majority of beds are filled by forensic cases in which a patient was court-ordered to receive mental health treatment (Treatment Advocacy Center, 2010). In 2008, an analysis of Minnesota's coverage identified the state as having a serious bed shortage at only 20-34 beds per 100,000. In the same analysis, Mississippi was the only state in the country which met the minimal standard of care with 49.7 beds per 100,000 (Treatment Advocacy Center, 2008).

Rates of Mental Illness in St. Louis County

In the recently released 2015 Bridge to Health Survey done to analyze the health condition in northeastern Minnesota and northwestern Wisconsin, data was collected regarding several facets of mental health (Kjos, Kinney, Finch, Peterson, & Bridge to Health Collaborative, 2015). In the past 15 years, the rates of anxiety and panic attacks, depression, and other mental health issues have all increased steadily. From a sample size of nearly 6,000 people in the area, 22.9% of respondents reported having anxiety or panic attacks, 25.2% reported having depression, and 8.1% reported having other mental health problems. The rates of all these disorders were higher for those in poverty, being almost or more than doubled. Of those surveyed, 16.5% reported wanting mental health help but either not going or delaying going, and of that group, 14.5% said it was due to services costing too much. Another combined 20.6% reported not knowing where to go or not being able to get an appointment, and a combined 27.2% reported some other monetary or insurance-related factor as the reason for not seeking or delaying treatment.

Primary Gaps in Mental Health Care

In a 2013-2014 analysis of the gaps in mental health care in the state of Minnesota, very few services for children and adults with mental illnesses were determined to be meeting demand (Minnesota Department of Human Services, 2015). The three primary gaps in care for children were in inpatient psychiatric hospitalizations, psychiatric prescribing, and residential treatment. Similar results were seen for adults, with the main gaps were in inpatient psychiatric hospitalization, psychiatric prescribing, permanent supportive housing, and medication management for psychotropic drugs.

Growing Demand for Mental Health Care

The services available to treat those with mental illnesses is currently insufficient, and the need for such services is only going to increase over the next 5-10 years (Sg2 Health Care Intelligence, 2015). A projected 8% increase in the need of clinical mental health centers and residential facilities is expected by 2020. In the same time period, there is a projected 11% increase in the need of outpatient programs and 7% increase in inpatient programs. The mental illnesses projected to grow the most in combined inpatient and outpatient demand by 2020 are, in order, dementia and cognitive disorders, mood disorders, anxiety and personality disorders, and psychosis.

Current Mental Health Services and Resources in St. Louis County

While there certainly is an inadequate amount of mental health services available in St. Louis County and throughout the country, there are several resources in the county and state that help to support those with mental illnesses. The following is a list of some of the major providers of mental health care in the area.

Anoka Metro Regional Treatment Center

Anoka Metro Regional Treatment Center (AMRTC) is not a St. Louis-county based service, but it is resource that serves the entire state of Minnesota. AMRTC is the second largest mental hospital in Minnesota, containing 175 beds (Serres, 2016). These beds are open to all those in need of psychiatric care, but a large portion of AMRTC's patient population has been committed by a judge following criminal activity. Increasingly, AMRTC is treating patients who come from jails who are in need of mental health care. Each year, AMRTC receives about $3.5 million in federal funding to maintain its services, which serve as an important piece of Minnesota's safety net for those with serious mental illness in the state.

The 48-hour rule. In 2013, a law was passed that required state facilities to place patients committed by a judge in beds within 48 hours. Following the enactment of this law, AMRTC saw an influx in patients coming from the criminal justice system. With this came an increase in violent patients, leading to a rise in assaults at the facility toward hospital workers and patients (Olson, 2015). Prior to this rule, hospitals transferred 253 patients to AMRTC in 2012. After the rule's enactment, less than 70 patients were transferred in 2015.

Problems with the care at AMRTC. In January of 2016, AMRTC put its federal funding at risk when it was found to be violating mental care procedures that ensure individualized treatment and quality medical care (U.S. Department of Education, Centers for Medicare & Medicaid Services [CMS], 2016). The hospital was using generic treatment options that did not account for the unique needs of each patient, thereby putting many of them at risk. This included violations such as not addressing suicidal ideation in the treatment of patients who had attempted suicide, and using antipsychotic drugs with patients even when ordered not to. Prior to these findings, AMRTC was already receiving attention for its problems controlling the violence within its walls, violence due to the large number of patients coming from the state's jails.

Delay in patient discharge. In January of 2016, almost 50 of the patients (half of the total population at the time) no longer met the criteria for care at the hospital, but continued to be kept there because there was nowhere in the community to place them. This is a common problem at AMRTC, leading patients to spend an unnecessary number of days at the hospital, preventing the treatment of other patients.

Accend Services

Accend is a for-profit resource serving in Duluth which services St. Louis County as well as surrounding counties. Accend provides various mental health services, including Adult Rehabilitative Mental Health Services (ARMHS), targeted case management, assistance with MNsure navigation, diagnostic assessment and clinical consultation, school-based mental health services, referrals, and therapy for individuals and groups. Clients at Accend can pay for their treatment via public health care programs, like Medical Assistance, MinnesotaCare, and General Assistance Medical Care (Accend Services, 2016). Additionally, Accend offers Sliding Fee Scale Services for those who are under-insured or low-income. Sliding Fee Scale Services allow patients to be treated at a discounted rate, based on their ability to pay for treatment.

Adult Rehabilitative Mental Health Services. ARMHS is a comprehensive set of services intended to bring recovery-oriented treatment to those in need, whether that be in their homes, at their workplace, or anywhere else in the community (Minnesota Department of Human Services, 2016). There are several components of ARMHS, including basic living and social skills, medication education, community intervention, and transitioning to community living. ARMHS helps clients with achieving and maintaining psychiatric stability, emotional adjustment, and independent living when the client's mental illness(es) impair these abilities. Accend provides ARMHS to eligible residents in Anoka, Dakota, Hennepin, Lake, Ramsey, and St. Louis counties (Accend Services, 2016).

Human Development Center

The Human Development Center (HDC) in Duluth, MN is an example of the type of community resource human rights activists had in mind when they pushed for deinstitutionalization. HDC provides a wide array of programs and services, including case management, ARMHS, chemical dependency treatment, psychotherapy, psychological testing

and assessment, eating disorders treatment, community support programs, and support for those who are homeless (Human Development Center, 2016).

Homeless Project. HDC's Homeless Project serves individuals in the Duluth area who are experiencing homelessness and a mental illness. This project involves community outreach to locate those who are homeless and help them find and keep permanent housing. The Homeless Project also helps with case management, transportation, benefits assistance, employment assistance, and crisis intervention.

Community Support Programs. Community Support Programs (CSP) help adults who qualify as having a serious and persistent mental illness (SPMI). CSP services include vocational support, promoting independent living skills, monitoring of medications and symptoms, housing assistance, psychosocial rehabilitation, and crisis assistance. Individuals can be referred to CSP by a therapist, physician, or mental health case manager.

Birch Tree Center

Birch Tree provides medical assessment, crisis assessment and intervention, 24-hour nursing care, psychiatric medical assessment, medication administration and management, symptom management and relapse prevention, and the mobile crisis intervention team (Birch Tree Center, 2016).

Mobile Crisis Intervention Team. The MCIT acts as an alternative emergency option to the police. The team consists of mental health professionals who report to an individual's location when they are in need of mental health-related attention. The team provides stabilization and intervention services to individuals and can refer them to other professionals as needed. The team is available to respond to situations 24 hours a day, seven days a week.

Center for Alcohol and Drug Treatment

The Center for Alcohol and Drug Treatment (CADT) offers detoxification, intensive outpatient treatment, individual counseling, residential treatment, adolescent treatment, mental health recovery program, housing assistance, health care assistance, and more (Center for Alcohol & Drug Treatment, 2016).

Mental Health Recovery Program. The MHRP is a dual disorder treatment program that provides diagnostic assessment, medication management, substance abuse/mental health integrated treatment, psychosocial support, and service coordination services. This is a flexible treatment program which can be specialized to the patient.

Essentia Health

The Essentia Health system serves patients in St. Louis County and beyond, offering a variety of services. Essentia's services include inpatient programs for adults, adolescents, and children; electroconvulsive therapy; medication evaluation; stabilization services; social service consultations; and more.

Adult Partial Hospitalization Program. Essentia offers an Adult Partial Hospitalization Program, which is an outpatient treatment program for individuals 18 years of age and older who are experiencing an acute mental illness. The program is six hours a day, four days a week. Clients in the program typically participate for 2-3 weeks, although the amount differs based on need.

Intensive Outpatient Program for Young Adults. This program is designed to specifically address the needs of young adults ages 18-25 with mental illnesses. It is specialized to offer individualized care and skilled assessment to help young adults build on their strengths to help them recover and succeed. Individuals in this program could be hospitalized or have recently been hospitalized.

Adolescent Partial Hospitalization Program. The Adolescent Partial Hospitalization Program works with teenagers from 12-18 to help them overcome emotional problems interfering with their everyday lives. This is an outpatient program which lasts 2-3 weeks.

Adolescent Chemical Dependency Outpatient Program. This program is for adolescents between the ages of 12 and 18 which offers education and therapy for the adolescent and family. Individuals can participate in the program if they show evidence of pathological chemical use despite knowledge and experience of the consequences related to that chemical use.

St. Luke's Hospital

St. Luke's Hospital in Duluth officers several services for individuals facing a variety of issues, both mental and behavioral (St. Luke's, 2016). This includes mental disorders as well as issues related to grief and bereavement, parenting, work/life balance, and stress management. St. Luke's offers inpatient, outpatient, and short-term programs to accommodate the individual needs of each patient.

Outpatient services. St. Luke's outpatient services include therapy for individuals, groups, couples, and families. St. Luke's also provides medication management and psychiatric evaluation for children, adolescents, and adults.

Older Adult Behavioral Health Unit. This inpatient program treats adults aged 60 and over who are facing new or long-standing mental illnesses. Patients receive medical and psychosocial treatment, and are monitored 24 hours a day. The goal of this program is to assist patients in returning to the best level of health possible so they may return to a stable outside life.

Adult inpatient services. Adults in need of a structured, 24 hour a day unit can be placed at St. Luke's. A team of mental health professionals helps to create individualized treatment plans and educate the patients and their families on how to return to their communities.

Mental Health Intensive Outpatient Program. St. Luke's offers outpatient day programs for individuals 18 years of age or older. These programs can be 5 hours per day for 3 or 5 days a week. Services provided within the program include group psychotherapy, occupational therapy, music therapy, dual diagnosis groups, and medical education.

Community Intervention Group

The Community Intervention Group (CIG) is a collaborative project between CHUM, the Duluth Police Department, and several other organizations in the community (including HDC, CADT, St. Luke's, and Essentia). This group is aimed at assisting individuals who are chronically homeless with mental illnesses and/or addictions who frequently come in contact with the police (Stuart, 2014). Monthly, CIG reviews the list of 30-50 people who are coming in contact with police the most (4 or more police contacts a month) to determine which individuals to reach out to and ask to join the program. This program involves helping individuals to meet basic needs, go to detox, obtain mental health screenings, and find housing support.

CHUM Human Services Agency. While not explicitly for helping those with mental illnesses, CHUM's services frequently help this population. In addition to the Community Intervention Group, CHUM offers housing support in the form of emergency shelters, transitional housing, permanent supportive housing, and housing advocacy. They also operate a nurse clinic in which a nurse is available 20 hours per week to assist individuals with basic health needs. CHUM also helps individuals with employment services, income advocacy, and the provision of basic necessities like food and clothing.

Crisis Intervention Training

Crisis Intervention Training (CIT) is a training for law enforcement officials intended to teach proper mental health crisis response. This system originate in Memphis, Tennessee in

1988, and has since spread throughout the country. This program focuses on the de-escalation model of responding to mental health crises. Training includes exercises involving actors portraying related mental health crisis response scenarios so police officers can apply their knowledge and skills. The training also involves presentations and discussions from area professionals to provide a comprehensive experience.

Mental Health Courts

Mental health courts allow those who have committed crimes driven by their mental illnesses to receive court-supervised treatment rather than go to jail. The mental health court in Duluth is one of three in the state of Minnesota, the other two being in Hennepin County and Ramsey County (National Alliance on Mental Illness, 2016). The mental health court receives individuals who have been civilly committed (by a criminal court) due to signs of mental illness, chemical dependency, psychopathy, and developmental disability. Individuals can also be directed to the mental health courts by petition of a family member, hospital, or other source.

The Future of Mental Health Care in St. Louis County

With the mental health services currently available not being sufficient in meeting the need and with that need projected to grow in the coming years, making changes to the current system is vital in order to offer quality mental health care to the residents in St. Louis County and surrounding areas. In recent years, leaders in the community have begun identifying changes that can be made to the mental health care in the area.

Improvements to Be Made

The mental health treatment system in St. Louis County is deeply fragmented. There is a variety of different organizations and providers of care, but the communication and collaboration between these groups has been minimal. Erin Metzger, Clinic Manager at St. Luke's Outpatient

Mental Health Center, states that while community leaders have recently begun to work more collaboratively to improve mental health in St. Louis County and beyond, more collaboration and teamwork is needed to repair the damage that has been done (personal communication, April 8, 2016). Mental health care should be a community-based effort and concern, and resources in the area should reflect the desire of all community leaders for improvement. The way we currently think of mental health treatment also needs to shift, switching from defensive to offensive. This means focusing on preventative and long-term care rather than responding to those in need after their conditions have worsened to the point of needing emergency care. With the need for mental health projected to grow in the area, system-wide changes are needed to provide adequate mental health care.

The Mental Health Triage Center: A Potential Solution

The Mental Health Triage Center is a program currently developing in Duluth (E. Metzger, personal communication, April 8, 2016). This program began as a response to the fragmented mental health care that the community was providing to those in need. A group of state legislators, local government officials, and community agencies banded together to begin developing a mental health triage center to serve the region. This proposed 24 hours a day, 7 days a week center would provide a hub of mental health care acting as the first point of contact for those in need of mental health help. The triage center would provide assessments to determine the services an individual needed and where they could be sent for further attention. It would be the piece connecting all the mental health services throughout the community and acting as an open community spot where anyone could go when in need. It would also take the burden off of emergency rooms which are currently acting as the catchall for individuals in need of mental health assistance. It would be a way of supporting the police officers in the area as well

by giving them a place where they could send individuals in mental health crisis. Currently triage center organizers are seeking legislative support and funding to establish the center.

Conclusion

Mental health care and the perception of mental illness has shifted radically over time, and not always for the better. The deinstitutionalization movement was one such change which, while mostly well-intentioned, ended in a failure that prevented the proper treatment many of those with mental illnesses for years to come. The outcomes of deinstitutionalization can still be seen across the country, with Minnesota and the St. Louis County area being no exception. The services of the current providers and organizations are not adequate to provide care to all of those in need, and the need for these services is projected to grow in the coming years. To provide essential mental health care, system-wide improvements need to be made that will allow for an overall better level of mental health in the area and throughout the country.

References

Accend Services. (2016). *Our Services.* Retrieved from http://accendservices.com/

Bierschbach, B. (2014, June 19). Minnesota's jails turn into storehouses for people with mental illness. *MinnPost.* Retrieved from: https://www.minnpost.com/politics-policy/2014/06/minnesota-s-jails-turn-storehouses-people-mental-illness

Birch Tree Center. (2016). *Services.* Retrieved from http://www.birchtreeduluth.com/

Center for Alcohol & Drug Treatment. (2016). *Services and Treatment.* Retrieved from http://cadt.org/

Human Development Center. (2016). *Programs.* Retrieved from https://www.humandevelopmentcenter.org/programs/

Kjos, S.A., Kinney, A.M., Finch, M.D., Peterson, J.M.; Bridge to Health Collaborative (2015). *Bridge to Health Survey 2015: Northeastern Minnesota and Northwestern Wisconsin Regional Health Status Survey.* April 2016 (Available from Generations Health Care Initiatives, Inc., Duluth MN)

Leys, T. (2015, February 14). Minnesota has closed 10 of 11 state mental hospitals. *The Des Moines Register.* Retrieved from: http://www.desmoinesregister.com/story/news/2015/02/14/minnesota-iowa-mental-hospitals/23430427/

Minnesota Department of Human Services. (2014). Plan for the Anoka Metro Regional Treatment Center [PDF Document]. Retrieved from: http://www.mentalhealthmn.org/pdfs/AMRTCLegislativeReport2-18-14.pdf

Minnesota Department of Human Services. (2015). Status of Long-Term Services and Supports (DHS-6812A). Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6812A-ENG

Minnesota Department of Human Services. (2016). *Adult Rehabilitative Mental Health Services.* Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058153

Minnesota State Planning Agency. (1985). Minnesota's state hospitals [PDF Document]. Retrieved from: http://mn.gov/mnddc/learning/document/GT033.PDF

National Alliance on Mental Illness. (2016). *Criminal Justice Project.* Retrieved from http://www.namihelps.org/advocacy/criminal-justice-project.html

National Coalition for the Homeless. (2009). *Mental Illness and Homelessness.* Washington, DC.

Olson, J. (2015, November 2). Shortage of state psychiatric beds leaves local hospitals jammed. *The Star Tribune.* Retrieved from: http://www.startribune.com/shortage-of-state-psychiatric-beds-jams-twin-cities-hospitals/339185701/

Program Evaluation Division: Office of the Legislative Auditor. (1986). Deinstitutionalization of mentally retarded people [PDF Document]. Retrieved from http://www.auditor.leg.state.mn.us/ped/1986/86-05.pdf

Serres, C. (2016, January 16). Anoka state mental hospital violated basic rules for patient care, feds say. *The Star Tribune.* Retrieved from: http://www.startribune.com/anoka-state-mental-hospital-violated-basic-rules-for-patient-care-feds-say/365551291/

Sg2 Health Care Intelligence. (2015). *St. Luke's Sg2 Analytics Overview.* Skokie, IL.

St. Luke's. (2016). *Treating Behavioral Conditions at St. Luke's.* Retrieved from http://www.slhn.org/Conditions-Services/Behavioral-Health

Stuart, L. (2014, April). *What is the Community Intervention Group?.* Retrieved from http://archive.constantcontact.com/fs163/1102455632464/archive/1117061525669.html

Torrey, E. F. (1997). Out of the shadows: Confronting America's mental illness crisis.

Treatment Advocacy Center. (2008). *The shortage of public hospital beds for mentally ill persons.* Arlington, VA: Torrey, Entsminger, Geller, Stanley, & Jaffe.

Treatment Advocacy Center. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states.* Arlington, VA: Torrey, Kennard, Eslinger, Lamb, & Pavle.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2016). Statement of Deficiencies and Plan of Correction for Anoka Metro Regional Treatment Center (Form CMS-2567(02-99)). Retrieved from http://files.ctctcdn.com/09ab5193401/270c6943-1c54-42ca-aa13-116ab1d848db.pdf