REPORT TO THE LEGISLATURE:
MINNESOTA'S MENTAL HEALTH SYSTEM

February 11, 1987

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

February 11, 1987

The Honorable Jerome Hughes
President of the Senate
Room 328 State Capitol
St. Paul, MN 55155

The Honorable Fred Norton
Speaker of the House
Room 463 State Office Building
St. Paul, MN 55155

Dear Senator Hughes and Representative Norton:

As required by M.S. 245.69 this is the first of a series of annual reports to the Legislature regarding the Department of Human Services recommendations and steps to achieve a comprehensive, unified, and accountable mental health service system for Minnesota by 1990.

The report focuses on a series of steps necessary to accomplish our task. Included as a first step is limited reference to the mental health legislative initiative which will be introduced in February. The mental health initiative along with the proposed budget will serve as the basic plan to accomplish a greatly improved mental health system by 1990. In addition to the legislative package, however, there are other ongoing and planned activities which will also be necessary and are addressed in this report.

I am greatly pleased with our activities to date and will look forward to working with you to achieve a comprehensive, unified, and accountable mental health system for Minnesota citizens.

Sincerely,

for SANDRA S. GARDEBRING
Commissioner

HISTORICAL OVERVIEW

On June 14, 1985, Governor Perpich announced the formation of a Governor's Mental Health Commission. The Governor's Commission was charged with examining and making recommendation regarding:

1. the needs of the people;
2. state planning functions;
3. appropriate way to deliver mental health services;
4. the structure of the existing delivery system;
5. the level of funding and how funding is directed;
6. the provision of community support programs across the state;
7. a consolidated funding approach; and
8. minimum statewide service standards for all counties and all providers of service.

The Commission was broadly representative of consumers, advocates, mental health providers, professional groups, county government, county social services, businesses and the Legislature.

On February 3, 1986, the Governor's Commission released its report entitled "Mandate for Action". The Commission concluded that **"the system of mental healt services in Minnesota can only be described as a nonsystem".** The Commission further found that **"to the extent that a system exists, it is not well understood by those within it or those intended to be served by it".** Other findings were

"1. There are inconsistencies among the three sectors and levels of government in terms of regulations, uniformity and flexibility."

"2. Responsibility is not well identified or fixed within either the sector or levels of government."

"3. Leadership is often cited as a problem. As with responsibility, it must exist in all sectors and within all levels of government."

"4. There is no unified philosophy, sets of goals, or policy driving the mental health system."

"5. An array of services does exist within the state, but not in all parts or in all types of service."

"6. There is no ongoing, integrated method of ensuring accountability in all sectors and levels of government."

"7. Funding remains a problem in terms of stability and level of funding, and incentives and disincentives for certain programs and services."

In conclusion, the Governor's Commission found that **"the system is, to a significant extent, divided, inconsistent, uncoordinated, undirected, unaccountable and without a unified direction."**

In addition to the Governor's Commission findings, four other significant events regarding Minnesota's mental health system occurred during the early part of 1986.

First, in February the Program Evaluation Division of the Legislative Auditor's Office released a report regarding the coordination of care for people discharged from the state's regional treatment centers to the community. The Legislative Auditor's Office found that significant numbers of persons were released from the regional treatment centers without adequate discharge plans and community follow-up. The report highlighted the problem of excessive client to case manager staffing ratios which result in inadequate follow up for persons with serious mental illness within the community.

Second, in March a national consumer research group released a report which compared and ranked state programs for the care and treatment of persons with serious and persistent mental illness. This report ranked Minnesota's system as 37th in the nation. While one could argue the exact ratings, it was clear that Minnesota had lost considerable ground in its mental health system and was no longer considered a leader.

Third, in response to the findings of the Governor's Mental Health Commission, the Legislative Auditor's Office, and the national consumer research group, the 1986 Legislature took action. Legislation was introduced and enacted (M.S. 245.69) to establish a mission statement for Minnesota's mental health system. Specifically, the mental health mission statement is as follows:

"The Commissioner of Human Services shall create and ensure a unified, accountable, comprehensive system of mental health services that:

(a) recognizes the right of people with mental illness to control their own lives as fully as possible;

(b) promotes the independence and safety of people with mental illness;

(c) reduces chronicity of mental illness;

(d) reduces abuse of people with mental illness;

(e) provides services designed to:

(1) increase the level of functioning of people with mental illness or restore them to a previously held higher level of functioning,

(2) stabilize individuals with mental illness,

(3) prevent the development and deepening of mental illness,

(4) support and assist individuals in resolving emotional problems that impede their functioning,

(5) promote higher and more satisfying levels of emotional functioning, and

(6) promote sound mental health; and

(f) provide a quality of services that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.

The Commissioner shall implement the goals and objectives of this subdivision by February 15, 1990. By February 15, 1987, and annually after that until February 15, 1990, the Commissioner shall report to the Legislature on all steps taken and recommendations for full implementation and additional resources to further implement this subdivision."

Finally, in the summer of 1986, ten statewide hearings were held with the Governor and the Commissioner of Human Services for the purpose of giving the public an opportunity to come forward with their concerns regarding Minnesota's mental health system. These hearings produced an overwhelming outpouring of concern from clients and their families about the gaps in services and lack of coordination within the system. It was at this point that Allyson Ashley was named Assistant Commissioner of Mental Health and was charged with reshaping Minnesota's mental health system and reestablishing Minnesota as a leader in the nation.

RECOMMENDATIONS FOR LEGISLATIVE CONSIDERATION

In order to create and ensure a unified, accountable, comprehensive system of mental health services for Minnesota, a major mental health legislative initiative must be undertaken. Current statutes regarding mental health do <u>not</u>:

1. specify the duties of the Commissioner of Human Services vis a vis mental health;
2. define a specific mental health authority within the state similar to the Chemical Dependency Division for chemical dependency and the Mental Retardation Division for mental retardation;
3. clearly describe the role and responsibilities of the state and of the counties;
4. describe an array of services to be provided or made available by each county that are designed to meet the range of needs of persons with mental illness together with quality standards of care consistent with contemporary standards in the field of mental health;
5. provide a funding system that allows dollars to follow clients to needed services instead of clients obtaining certain services due solely to the type of funding they qualify for;
6. establish system management activities which encourage cost effective and efficient utilization of services at a level no more intensive, costly and restrictive than necessary to meet client needs; and
7. require coordination of the various treatment components.

With these gaps in current mental health statutes, the first step taken by the Assistant Commissioner of Mental Health and the Mental Health Division has been to draft a Mental Health System Act for consideration by the 1987 Legislature along with budget recommendations to implement a unified, accountable, comprehensive mental health system for the state of Minnesota.

The Mental Health System Act which will be introduced in both the House and the Senate later this month will specifically address the issues outlined above.

The legislation will require an array of treatment components to be made available by 1989 which will meet the needs of persons with mental illness. Specifically, the treatment components are: (1) prevention and education, (2) twenty-four hour emergency services, (3) outpatient services, (4) community support program services, (5) residential treatment services, (6) acute care hospital inpatient services, and (7) regional treatment center inpatient services. In addition, the legislation will call for: (1) case management of persons with serious and persistent mental illness, (2) screening for residential treatment and inpatient services, and (3) assistance in applying for federal benefits for persons with serious and persistent mental illness. The legislation will also create a consolidated funding approach which will increase the flexibility of the mental health system to treat clients in the least restrictive, most cost effective way, appropriate to individual client need.

Recommendations for New Funds:

The Governor's budget proposes $13.9 million in new money to implement the mental health initiative. These new funds include (all figures are in millions):

	F.Y. '88	F.Y. '89	Total
Service Expansion			
Grants to Counties	$2.2	$5.0	$7.2
State Share MA	-	3.1	3.1
Shift GAMC and CSSA to Current Payments	-	2.5	2.5
Administration	.5	.6	1.1
Total:	$2.7	$11.2	$13.9

A major focus will be placed on development of community support services programs in every county. Initially, this will be funded through Rule 14 grants in F.Y. '88, and continued through the Mental Health Fund in F.Y. '89. Another major focus is improved case management as part of the community support program for persons with serious and persistent mental illness. Case management will be funded mostly through increased expenditures under Medical Assistance.

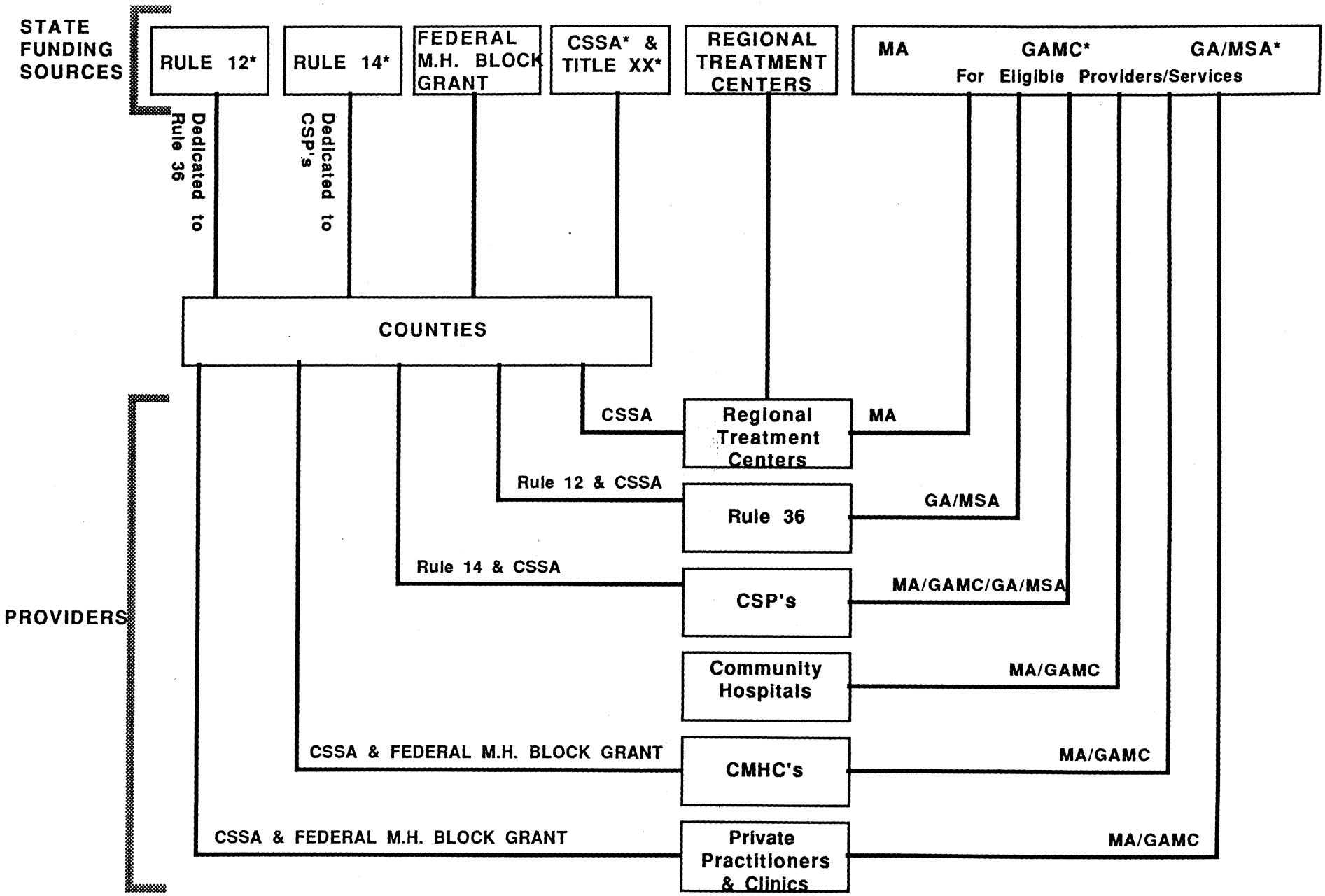
Integration of Funding for Mental Health Services:

Table 1 describes the current complicated system of funding for mental health services. The Department of Human Services pays for mental health services through 10 different funding sources. Each funding source has different restrictions. Oftentimes, clients receive services based not on need, but on the availability of funding sources.

As clients move toward self-sufficiency, it is essential that funds not be restricted to particular services. The Governor is proposing to move to a funding system where the dollars will follow the client. For F.Y. 89, the second year of the biennium, the Governor proposes that seven existing funding sources for mental health services be integrated into a Mental Health Fund. Table 2 describes how the complicated system in Table 1 will be simplified to a more integrated system. Table 3 presents a pie chart describing the components of the Mental Health Fund in dollar terms. The amounts to be included from each funding source are based on current utilization.

Only three funding sources are proposed to continue separately from the Mental Health Fund for the following reasons:

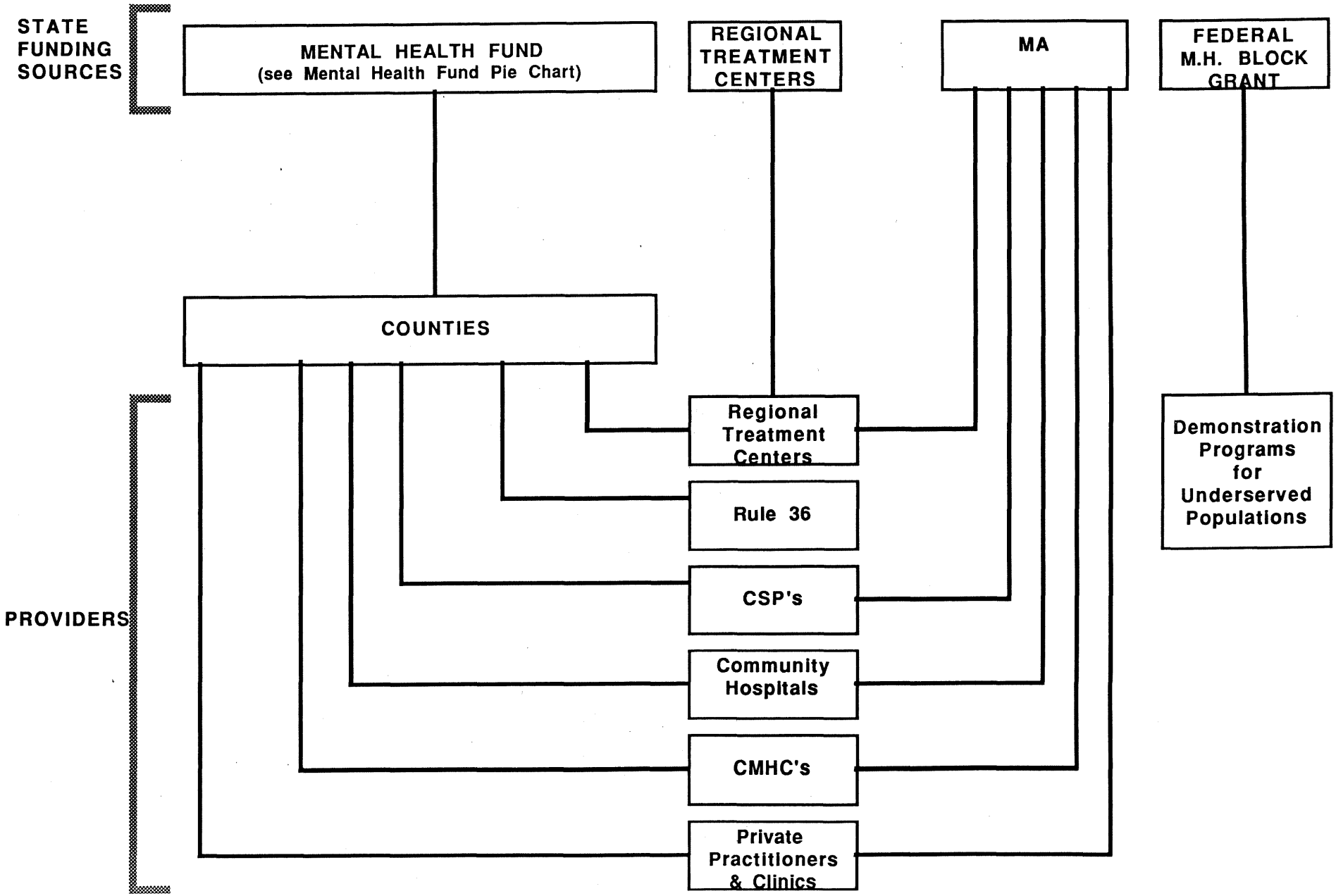
CURRENT STATE MENTAL HEALTH FUNDING



* Funds proposed to be included in Mental Health Fund

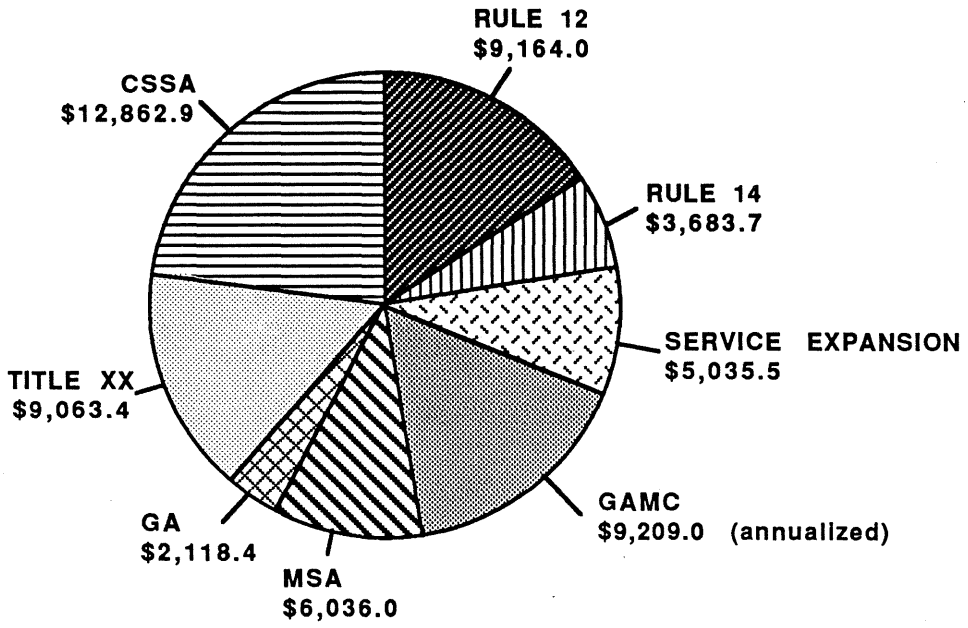
PROPOSED STATE MENTAL HEALTH FUNDING (F.Y. 1989)

Chart 2
2/87



MENTAL HEALTH FUND
GOVERNOR'S RECOMMENDATION FOR F.Y. '89

($ in thousands)



TOTAL FUND - $57,172.9

In addition, the Governor recommends expansion of case management and other mental health services under Medical Assistance, including increases of $3,068.6 in state funds and $3,940.3 in federal funds.

The Federal Mental Health Block Grant funds, totaling $1.1 million per year, include a number of federal restrictions. Currently, about half of these funds are used for special mental health services for Indians, for demonstration projects for other underserved populations, and for state level planning and administration. Because of the federal restrictions and because of special needs which will not be covered by the Mental Health Fund, the Governor proposes that major focus of these funds should be for special projects for underserved populations.

State hospital and Medical Assistance funding are excluded from the proposed Mental Health Fund until the Department has an opportunity to evaluate its experience under the Chemical Dependency Fund.

In considering this legislative initiative, it is important to keep in mind the fact that Minnesota's fragmented mental health system cannot be improved on a piecemeal basis. Rather, major system reform is necessary to appropriately meet the needs of those experiencing mental illness and to produce overall cost savings for mental health care in the future.

OTHER ONGOING ACTIVITIES TO CREATE A UNIFIED, ACCOUNTABLE, COMPREHENSIVE STATEWIDE MENTAL HEALTH SYSTEM

Currently there are in progress a number of activities in addition to the mental health legislative initiative to bring about improvement in Minnesota's mental health system. These activities include the following:

1. Establishing linkages and cooperative agreements between the Department of Human Services Mental Health Division and other state agencies with responsibilities to persons with mental illness.

2. Improving the quality of residential treatment programs currently funded by the state.
3. Improving the coordination of necessary service elements in the current forty-three community support programs funded by the state.
4. Improving the coordination of care between treatment settings; e.g., regional treatment centers and community based services, residential treatment programs and community support programs, etc.
5. Working with the Medicaid office regarding mental health care for eligible recipients.

Interdepartmental Relationships:

Persons with mental illness have a variety of needs in addition to treatment. These needs include such things as vocational rehabilitation, housing and other health care. In addition, some individuals with mental illness are incarcerated in correctional facilities. Our youth with mental health needs often have these needs met or not met within the educational system. Finally, many of our elderly with mental health needs reside in long term care facilities. Because of the overlapping involvement of many state agencies in the lives of persons with mental illness, there is an urgent need to coordinate and cooperate with these state agencies so that services and programs are not duplicative, so that all needs are well met, and so that services are unified.

Currently, the Mental Health Division has a formal working agreement with the Department of Jobs and Training, Division of Rehabilitative Services. As the federal government becomes increasingly concerned about the vocational needs of persons with mental illness and provides funding specifically for this purpose,

these two Departments and Divisions must coordinate their efforts in order that scarce resources may be well used.

Housing is a major need of persons with serious and persistent mental illness. It is important to note that housing needs and residential treatment needs are not synonymous. Residential treatment should be relatively short term (up to 18 months). When residential treatment is complete, many persons with serious mental illness will continue to have long term housing needs. These can range from adult foster care, to supervised congregate living arrangements, to independent living with adequate community support services. Although there are a variety of funding mechanisms available to persons with serious mental illness to obtain housing, much work needs to be done to make sure an adequate variety of affordable, sanitary housing options are available. Work with local housing authorities, social service agencies, landlords, etc., will be necessary to ensure that adequate housing is available on a local level. Without this effort, persons with serious and persistent mental illness will continue to overuse state regional treatment centers, residential treatment programs, or simply go without housing and join or rejoin the ranks of the homeless.

There is a growing concern that persons with serious mental health problems incarcerated in correctional facilities do not have adequate services. Likewise, there is a concern that persons with serious personality disorders in need of correctional intervention are committed to one of our regional treatment centers where they prey on a vulnerable, often psychotic population. This is a complex problem which needs the full attention of the Department of Corrections, the Department of Human Services Mental Health Division, and the legal establishment.

It is important that the state take leadership with this problem to improve the current situation. Adequate mental health services need to be made available to those with mental illness in jails and prisons and those needing correctional intervention must not be placed in our state facilities which are improperly equipped to provide this type of intervention.

Nationally, there exists an epidemic of teenage suicide. Suicide is the third leading cause of death for Minnesota teens and is on the increase. Despite this alarming fact, there is not yet a statewide plan for dealing with this problem in our schools. Research is quite clear that peer support/peer counseling approaches are effective in reducing the incidence of teen suicide, yet many schools are fearful that attention to the issue will only make the problem worse. The Department of Human Services Mental Health Division should take a lead role in working with the Department of Education to develop a planful, thoughtful approach to this growing problem. One contact has been made with the Department of Education to begin exploring this concern. Ongoing effort is necessary.

It is estimated that over 15,000 persons with mental illness in Minnesota resided in nursing homes during 1985. In many of these facilities, mental health services are inadequate or unavailable. Adequate mental health services for our elderly residing in nursing homes is an issue that must be addressed within the Department of Human Services. The Division of Mental Health is now implementing a new demonstration project for the elderly, funded by the National Institute of Mental Health. It is intended that improvements in care developed at the demonstration site can be implemented on a statewide basis in the future.

Residential Treatment Quality of Care*

Currently, there are eighty licensed Rule 36 adult mental illness facilities within the state. These licensed facilities serve approximately 1,700 persons at any one time. In examining a number of these facilities, it has become readily apparent that quality care and treatment is sometimes lacking. Serious efforts need to be made to improve this situation so that persons placed in Rule 36 facilities receive the care and treatment they require. This effort will involve increased guidance from the Division of Mental Health regarding program requirements, more stringent licensure review processes, and the licensure of those facilities required to be licensed by statue but currently unlicensed. This effort will take the combined efforts of the Mental Health, Licensing, and Rulemaking Divisions of the Department of Human Services.

A second issue regarding residential treatment is the dispersal of this service outside the seven county metro area. Currently, 68% of the Rule 36 beds are concentrated in the metro area. As new programs are developed or old programs closed, this service needs to be made available in the many unserved areas of greater Minnesota.

Community Support Program Quality of Care*

Currently, there are 43 community support programs (Rule 14) in 45 counties, funded at 90% by the state. While these programs represent substantial progress in community based care for persons with serious and persistent mental illness over the past few years, they are not yet well coordinated, nor comprehensive enough in their scope to fully accomplish the goal of assisting these persons to remain in their communities. All community support programs need to develop coordinated

* Refer to Report to the Legislature Rules 36, 12, and 14, dated January 15, 1987.

programming to provide outreach, medication management, case management, crisis intervention, psychosocial rehabilitation and employability services to this population. Without a coordinated, comprehensive approach, consumers and their families lack adequate support to reduce the "revolving door syndrome" and persons will often "fall through the cracks" only to turn up later in a hospital setting.

Reorganizing and expanding community support programs, including case management, to every county within the state is a major part of the mental health legislative initiative. It is this state of the art type of mental health programming for persons with serious and persistent mental illness which offers the greatest hope for clients, their families and those interested in appropriately and humanely conserving fiscal resources. Much can be gained by vigorous joint efforts of the Mental Health Division and counties to develop this type of community based mental health care.

Coordination of Care Among Treatment Settings

One of the greatest problems within the state's current mental health system is the lack of coordination and communication between the six treatment settings (emergency, outpatient, community support, residential treatment, acute care hospitals and regional treatment centers). The previously cited report of the Legislative Auditor's Office focused on the lack of adequate discharge planning for persons ready to leave the regional treatment centers. This is not the only lack of communication and coordination of care evident in the system, however. Currently, many of the state's 80 licensed Rule 36 programs do not adequately coordinate and plan for discharge to community support programs or outpatient settings. Acute care hospitals are not adequately aware of follow-up programs for their clients discharged after an acute episode of mental illness. Outpatient clinics

and providers are often unaware of community support programs to assist clients with serious and persistent mental illness gain access to needed supportive services. Emergency service providers do not often coordinate their crisis intervention activities with other treatment component providers. While the mental health legislative initiative will formally address this critical problem, the Mental Health Division is now beginning to provide the necessary leadership to assure that ongoing mental health care is well coordinated in the interest of clients. Without this type of ongoing coordination between provider settings, placement bottlenecks will develop and in fact are already occurring, resulting in longer than necessary lengths of stay in regional treatment centers and residential treatment programs. This result is neither client appropriate nor cost effective.

Working with the Medicaid Office

Currently, one of the major payors for mental health services is Title XIX or Medicaid. Medicaid operates on a fee for service basis as an uncapped entitlement for eligible recipients. Because of federal and state rules and regulations, Medicaid does not currently pay for certain types of services demonstrated to be most beneficial to persons with serious and persistent mental illness. These rules and regulations, to the extent they originate within the state, should be modified in order to achieve the best possible outcomes in the least intensive, costly and restrictive settings possible and appropriate for clients. These changes will require the joint efforts of the Mental Health and Health Care Program Divisions within the Department of Human Services. Effort in this regard is currently underway.

A second area of joint work will be to evaluate the appropriateness of the prepaid demonstration projects as well as additional managed mental health care

models for their effectiveness in meeting the needs of persons with mental illness. Mental health needs have not traditionally been well handled by HMO's, particularly for persons with serious and persistent mental illness. Because there is an economic need to contain costs in the overall health care arena, new methods need to be carefully examined which will meet client mental health care needs while at the same time conserving resources. This issue is under current discussion between the two Divisions for future recommendations.

PLANNED FUTURE ACTIVITIES TO CONTINUE PROGRESS TOWARD A UNIFIED, COMPREHENSIVE, AND ACCOUNTABLE STATEWIDE MENTAL HEALTH SYSTEM

In addition to the previously described mental health legislative initiative and other ongoing activities, there are a number of planned future steps necessary to achieve a comprehensive, unified and accountable mental health system for Minnesota by 1990. These planned activities include:

1. Increased staffing and reorganization of the Mental Health Division.
2. Development of a mental health data base and information system.
3. Revision of current Rule 36 (residential facility license for adult persons with mental illness).
4. Projects for special target populations.
5. Development of a specialized children/adolescent outpatient continuum of mental health care.
6. Research into effective and efficient programming for persons with serious and persistent mental illness.

Increased staffing and reorganization of Mental Health Division

The Mental Health Division of the Department of Human Services currently operates with eight professional/policy staff in addition to the Assistant Commissioner.

Division staff are currently responsible to provide oversight for 87 county mental health systems, 80 Rule 36 licensed residential facilities, 43 community support programs, seven Indian Mental Health Projects, an elderly mental health demonstration grant, administration of the federal mental health block grant, staffing several advisory committees, and numerous additional special projects and interdepartmental relationships. In addition, the Office of Refugee Mental Health, under a special time limited federal grant, has three staff to conduct a needs assessment of Southeast Asian refugee mental health needs and plan for appropriate provision of services. In all, staff resources are simply inadequate to oversee and guide a comprehensive, unified and accountable statewide mental health system.

The Department's mental health initiative and Governor's budget proposes the addition of seven new staff and permanent funding for three current staff (not in the Office of Refugee Mental Health). This would bring the staff complement to a total of 22. This level of staffing is not out of order given the nature of the work effort which will be required to achieve the current legislative mandate. The proposed level of staffing would be comparable with the existing Mental Retardation Division (21 staff) and the Chemical Dependency Division (22.5 staff). Both of these divisions deal with fewer citizens at risk and in need of services and less treatment options or program types needed. In addition, change in the current system will require intensive technical assistance to both counties and providers, all of which require appropriate staff resources. Should the mental health initiative be approved, staff will be organized in a fashion to accomplish both the specialized program activities and also the more general oversight activities.

Development of a Mental Health Data Base/Information System

In order to assure accountability, a mental health data base needs to be developed which provides accurate information in a timely fashion. In addition, persons with serious and persistent mental illness need to be "tracked" through the mental health service system so that clients will no get "lost". this was a recommendation of the Governor's Commission. Within current departmental funding for data systems as well as additional requests, planning is underway to develop an appropriate mental health data base and client tracking system for persons with serious and persistent mental illness.

Revision of Rule 36 (Adult Mental Illness Residential Facilities License)

Rule 36 is currently in need of revision to address the treatment of needs of persons with serious mental illness in a more program specific fashion. As part of that rule revision, treatment issues need to be separated from housing issues. In addition, rulemaking must address the housing and supervision issues for persons with mental illness currently residing in board and lodging and supervised living residences. The rule is scheduled for revision starting this summer (July 1987).

Projects for Special Target Populations

It is estimated that approximately one-third of the homeless are mentally ill and in need of a variety of services. There are a number of significant causes of homelessness according to the latest Federal Government Accounting Office report. Among the most important are:

1. unemployment,
2. dislocation due to urban revitalization and the consequent lack of low cost housing, and
3. deinstitutionalization of the seriously mentally ill without adequate community based mental health services.

In order to address the issue of the homeless mnetally ill, all three factors need to be addressed concurrently. There are several models in use throughout the country for successful intervention into the lives of the homeless mentally ill which address the major causes of homelessness. In addition, there are several National Institute of Mental Health and foundation grants available to fund projects designed to assist this population. This is an activity that the Mental Health Division must become more involved with. Current activities and limited resources prevent this from occurring until the summer and fall of 1987.

Poor economic conditions in certain regions of the state, due to the decline of the agricultural industry and the iron ore industry for example, are resulting in sharply increased demand for mental health services. According to a 1982 Johns Hopkins University study, for each 1% increase in unemployment there is a corresponding increase in the following:

a. suicide	4.1%
b. homicide	5.7%
c. state hospital admissions	3.4%
d. state prison admissions	4.0%

Currently, the National Institute of Mental Health and the National Association of Counties has recognized one Minnesota rural crisis program at Southwestern Mental Health Center as a model for the country in responding to rural economic decline. Due to national concern regarding the increased mental health needs of certain economically affected rural communities, the National Institute of Mental Health is selecting five states for demonstration grant monies. Minnesota will apply for these demonstration monies.

Child/Adolescent Outpatient Mental Health Initiative

Perhaps to an even greater degree than with adults, children and adolescents with serious mental health problems have a lack of appropriate services available. Minnesota on the whole, appears to be very reluctant to identify children or adolescents as having serious mental health problems. Few outpatient providers have established programming of any sort to intervene early in the lives of our children. Instead, we tend to identify problems as "emotional disturbance" and assign the task of meeting these children's needs to the educational system. The educational system does a noteworthy job to attempt to educate children so identified within the mainstream. However, the educational system is not often capable of meeting the treatment needs of these youngsters. When problems become too great to handle within the educational system, children are sent to inpatient or residential facilities for long term care and treatment. The failure of these out of home placements to reintegrate, unite and strengthen families to adequately care for their children over the long term has been well demonstrated and documented. Specialized outpatient services must be made available and interventions must occur early, before out of home placement is needed, in order for children and adolescent needs to be met.

In reviewing county social service data and medical assistance data, it is evident that children's residential and hospital placements and the costs of those placements are increasing. Outpatient children's services are not increasing. Over the next two years, efforts will be made to address these concerns and focus some service development efforts on children. Any legislative activity necessary will be developed by the 1989 Legislative Session.

Research

During the upcoming years, resources must be obtained or diverted by the Mental Health Division or the University of Minnesota into research of effective community based mental health care. The outcome of this activity offers promise in upgrading current mental health services in directions demonstrated to produce significant results for clients in need. Most of this activity will be accomplished by working in cooperation with our state institutions of higher learning where research skills are readily available.

SUMMARY

The Department of Human Services has undertaken a major mental health legislative initiative for presentation to the Legislature in the near future. This initiative will create in statute service requirements and a funding mechanism to implement a high quality statewide mental health services system. In addition, a departmental mental health budget has been presented which would adequately fund the development of such a comprehensive, unified and accountable system of care. Along with this basic restructuring of the state's mental health system, there are a number of non-legislative activities necessary to gain system-wide improvement. All will be necessary, along with new strategies to address emerging needs as they arise over the next three years in order to meet the statutory mandates that serve as the context of this report: **"The Commissioner of Human Services shall create and ensure a unified, accountable, comprehensive system of mental health services"** and **"The Commissioner shall implement the goals and objectives of this subdivision by February 15, 1990".** The citizens of Minnesota should expect no less.

APPENDIX A

STEPS NECESSARY TO CREATE A COMPREHENSIVE, UNIFIED AND ACCOUNTABLE MENTAL HEALTH SYSTEM

Activity	Time Frame
Step 1	
Mental health legislative initiative	February 1987 - May 1987
Step 2	
Implementation of mental health legislation enacted	June 1987
Step 3	
Interdepartmental Relationships	Current and ongoing
a. Department of Jobs and Training	Current and ongoing
b. Local housing authorities	Summer of 1987 ongoing
c. Department of Education	Summer of 1987 ongoing
d. Long Term Care Division (DHS)	Current and ongoing
Step 4	
Residential Treatment Quality of Care	Current and ongoing
a. Upgrading care	Current and ongoing
b. Dispersal of service	Fall of 1987
Step 5	
Community Support Program Quality of Care	Current and ongoing
Step 6	
Coordination of Care Among Treatment Settings	Current and ongoing
Step 7	
Working with the Medicaid Office	Current and ongoing
Step 8	
Increased Staffing and Reorganization of Mental Health Division	Summer of 1987

Step 9

Development of a Mental Health Data Base/ Information System	Current - 1989

Step 10

Revision of Rule 36 (Adult Mental Illness Residential Facilities License)	Fall of 1987

Step 11

Projects for Special Target Populations	Fall 1987 ongoing
a. Homelessness	Fall 1987 ongoing
b. Rural Crisis	Fall 1987 ongoing

Step 12

Child/Adolescent Mental Health Initiative	Fall 1987 - Spring 1989

Step 13

Research	1988 ongoing