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MINNESOTA DEPARTMENT OF PUBLIC WELFARE

April 13, 1967

TO: Medical Directors  
Administrators  
Superintendents  
  
State Hospitals and Facilities for the Mentally  
Ill and Mentally Retarded

Alcohol and Drug Unit, Willmar State Hospital  
Faribault State Hospital  
Minnesota Residential Treatment Center  
Minnesota Security Hospital  
Owatonna State School  
Rochester State Hospital  
Shakopee Home for Children

FROM: David J. Vail, M.D.  
Medical Director

SUBJECT: Southeast Regional Meeting  
May 3, 1967 9:30 - 3:30  
Olmsted County Courthouse  
515 Second Street S.W.  
(Between Second Street SW and Fifth Avenue)  
Rochester, Minnesota

The Medical Services Division of DPW, in collaboration with county welfare, mental health center and state mental institution personnel, has been developing a plan which clarifies the responsibilities of local, DPW-related agencies in the field of mental health and mental retardation. The purpose of the plan is to develop a more cohesive mental health-mental retardation program at the local level; that is, in each county and in each of the "areas" served by a mental health center. (In the case of the Mower County Mental Health Center the "area" is Mower County.)

In order to present this plan to all persons with policy-making and executive responsibility in agencies directly related to DPW, we will be convening meetings in each of the seven mental health-mental retardation regions of the state. The first such meeting will be held May 3 in Rochester for the 13 county Southeast Region.

We are inviting from these 13 counties, county welfare board members and directors, community mental health center board members and directors, daytime activity center board members and directors, and representatives from the several state mental hospitals and facilities serving the 13 counties, in addition to representatives from DPW.

Enclosed you will find a brief description of what will be presented at the morning meeting and then discussed in the afternoon in five smaller groups. Each group will be composed of persons serving those counties in a particular "area." There are five mental health center "areas" in the 13 county Southeast Region.

In order to keep the meeting focused and of manageable size, we have not invited the staff members of the above agencies (other than directors), nor have we invited representatives from non-DPW related agencies which will have a key role in a comprehensive program: schools, courts, nursing services, private agencies, etc.

The afternoon area meetings should provide the opportunity for discussion that will:

- 1) clarify what is meant by a comprehensive program and distinguish between program development and service to specific cases or clients;
- 2) clarify the responsibilities of the mental health centers, the county welfare departments, the daytime activity centers for the retarded, the state institutions, and central office, and the relationships among these;
- 3) produce the first steps toward an organization in each area to facilitate the development of an area-wide comprehensive program.

The emphasis on area organization and planning should not in any way weaken or disturb the existing relationships that have been developed through the leadership of the institutions, the county welfare departments, or other agencies. Rochester State Hospital, for instance, currently employs a nurse full time to coordinate hospital-community relationships in the region. We believe that the value of the service that such a person provides can be further enhanced through area programming and organization.

I hope as many of you as possible will be able to attend what we feel will be a very important meeting.

DJV:vw  
enc.  
4/13/67

## MINNESOTA'S COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH-MENTAL RETARDATION PROGRAM

### Medical Services Division Minnesota Department of Public Welfare

The Minnesota Department of Public Welfare supports, operates and supervises three major systems in the fields of mental health and mental retardation:

- \* State hospitals and facilities for the mentally ill and mentally retarded
- \* Mental health and mental retardation services of the County Welfare Boards
- \* Community mental health and mental retardation programs

To develop truly comprehensive community-based programs, the three systems must be integrated on an "area" basis, composed of one or more counties served by mental health centers. It is the dual responsibility of the Medical Services Division and the local grantee (mental health center board or county commissioner board) to 1) oversee the development of a comprehensive community-based program, cooperatively with other agencies; 2) provide certain services.

#### WHAT IS A COMPREHENSIVE MENTAL HEALTH-MENTAL RETARDATION PROGRAM?

A comprehensive program aimed at reducing mental disabilities must concern itself with the biological, psychological and social factors involved. Since no single agency is equipped to deal with this broad and complex field, the coordinated efforts of a wide range of resources is required. The development of needed programs, the coordination of existing resources and the availability of services to persons who need them, comprise a comprehensive program.

#### WHAT IS THE GOAL?

The broad goal of the state and local mental health-mental retardation program is to reduce the incidence and prevalence of mental disabilities by 1) directly modifying individual functioning or behavior (see Appendix I); 2) modifying the ways that communities deal with problems, which may mean changing attitudes and values, changing certain practices and expanding services.

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## HOW TO ACHIEVE THIS GOAL

In order to accomplish the above stated goal and achieve the desired results, it is necessary to develop a method or operation which will define or clarify at the county, area, and state levels, the responsibilities and relationships of the three systems (state hospitals, county welfare boards, community mental health-mental retardation programs.)

### County Level

#### County Welfare Boards

The county welfare boards are responsible for mental health-mental retardation programs at the county level. These programs relate to persons with serious mental disabilities as defined by statute.

These programs are referred to as public mental health-mental retardation programs. (See Appendix I.)

In addition to developing and coordinating a program to deal with these problems, the county welfare boards are also responsible for providing specific services, including, but not limited to, pre-commitment social evaluation for proposed patients; participation in case planning for patients during and after their period of residential care; the provision of resources and services for them, such as making arrangements for specialized medical, psychiatric, nursing and other treatment; and supervision of mentally deficient and epileptic wards under the guardianship of the Commissioner of Public Welfare.

### Area Level

#### Community Mental Health Board (Community Mental Health Center Board)

The community mental health board normally is the agency responsible for the development and coordination of a comprehensive program at the area level.

It is suggested that an executive director be employed by the local board, full time, to carry out the comprehensive program in their behalf. The public programs in each of the counties in the area would be parts of the comprehensive program. A major emphasis in developing a comprehensive program would be to bring about greater and more systematic cohesiveness among the county welfare departments, the various community programs, and the state hospitals for the mentally ill and mentally retarded serving the area.

In addition to developing and coordinating the comprehensive program the board would normally also operate a community mental health center whose professional staff would conduct its various programs and services, treat clients, and serve as a specialized resource to county welfare departments and other groups.

State Level

State hospitals and facilities for the mentally ill and mentally retarded

The county welfare boards and the community mental health boards each have both community organization and direct service responsibilities. The state hospitals and facilities for the mentally ill and mentally retarded, on the other hand, are primarily direct service agencies which would continue to serve as in-patient resources for persons with serious mental disabilities as defined by statute. (See Appendix I.)

The staff of the state hospitals and facilities for the mentally ill and mentally retarded would work in cooperation with the area program director and county welfare department director in assessing the needs of the area and county, and in developing ways to meet these needs effectively. In addition the state hospitals and facilities would offer their facilities and technical assistance in furthering the community-based mental health-mental retardation program.

Medical Services Division

The Medical Services Division is the agency with the responsibility for developing and coordinating a comprehensive mental health-mental retardation program at the state level.

In addition it directly supervises the operation of the state hospitals and facilities for the mentally ill and mentally retarded.

Regional Offices

The Medical Services Division is planning to establish seven regional offices which would serve as a liaison between state and local units, and provide assistance to area executive directors and boards in developing and coordinating comprehensive community-based mental health-mental retardation programs.

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APPENDIX 1 - Mental disabilities or problems of concern to a comprehensive, community-based mental health-mental retardation program.

STATE DEPARTMENT OF PUBLIC WELFARE

Field Services Division

Commissioner

Medical Services Division

\*\* County Welfare Departments

\*\* State Hospitals and Facilities for the Mentally Ill and Mentally Retarded  
\* Community Mental Health and Mental Retardation Programs

Problems of concern to a  
Comprehensive Community-Based Program

(The responsibility of the medical services  
division and community mental health boards)

I. Part of the comprehensive program referred to as 'public'      II. Other parts of the comprehensive program

Statutory:

Those defined by law: mental illness (voluntary and committed patients), mental deficiency, inebriacy, sex offender, psychopathic personality, epilepsy, senility.  
(The specific responsibility of the Medical Services Division and county welfare boards)

Emotional and mental aspects of other problems defined by statutes: e.g., crime, delinquency, child neglect, medically indigent, separated child, divorce, school dropout, illegitimate parenthood, educational handicapped, truancy, financial dependency, etc.  
(Not the specific responsibility of the Medical Services Division)

Cultural: (Non-statutory)

Culturally defined (by custom, pressure groups, professional organizations) problems usually referred to mental health specialists or agencies, e.g., impulsive irrational behavior; suicide attempt, marital disharmony, underachievement, etc.

Individual: (Non-statutory)

Problems which a person recognizes and voluntarily might turn to a mental health service for assistance (e.g., anxiety, irrational fears, feelings of inadequacy, sexual impotency, physical symptoms, work dissatisfaction).

The public mental health-mental retardation program is that part of the comprehensive program which deals with problems clearly defined by statute, and which are carried out by the county welfare departments and state hospitals and facilities for the mentally ill and retarded. In contrast, that part of the comprehensive mental illness-mental retardation program dealing with non-statutory problems, as carried out at the area level by the community mental health center boards is less rigidly and legally defined and, dependent upon the assessment of local boards for assessing problems and developing, providing and coordinating resources.

\* Overall general responsibility for the comprehensive program including the public part of it.

\*\* Specific responsibility for the public program.

Adults (16 and over) Children Total

	4	5A	5B	6	TOTAL		
Dodge	0	3	10	4	17	5	22
Rice	3	7	31	10	51	16	67
Steele	2	9	12	1	24	3	27
Waseca	3	4	9	7	23	2	25
Total	8	23	62	22	115	26	141
Fairbault	2	8	17	3	30	10	40
Freeborn	2	10	18	3	33	9	40
Total	4	18	35	6	63	19	82
Jackson	1	7	26	8	42	10	52
Orsted	5	16	29	8	58	15	73
Total	6	23	55	16	100	25	125
Houston	2	4	5	0	11	6	17
Wabasha	0	4	16	3	23	5	28
Winona	3	8	14	20	45	6	51
Total	5	16	35	23	79	17	96
Maumee	5	9	18	8	40	13	53
Pellston	1	10	17	3	31	4	35
Region Total	29	99	222	78	428	104	532
					M 250 F 178	M 66 F 38	M 316 F 216

69-70A-100  
State Inst. No.  
MINNESOTA DEPARTMENT OF PUBLIC WELFARE

April 26, 1967

TO: Participants in Southeast Regional Meeting, May 3, 1967.

FROM: David J. Vail, M.D.,  
Medical Director

SUBJECT: Regional Meeting May 3.

This is to give you additional information about the regional meeting and your part in it.

The morning session will start with a presentation by myself of the overall plan for comprehensive mental health-mental retardation programming in each of the community mental health center areas of the state. This will be followed by a round table discussion by representatives of the key agencies involved:

county welfare department -- Les Stiles, Director,  
Olmsted County Welfare Department  
community mental health center -- Miller Friesen,  
Director, Hiawatha Valley Mental Health  
Center  
state hospital for the mentally ill -- Dick Frisch,  
Director of Social Service, Rochester  
State Hospital  
state hospital for the mentally retarded -- Dean Nelson,  
Social Service Department, Faribault State  
Hospital

The purpose of the round table is to encourage questions, comments and other "feedback" from the points of view of the key agencies. Hopefully, this will lead to a general discussion. Every effort will be made to keep the discussion focused on the implications of the plan. This meeting is not intended to address current specific problems among the agencies. It is hoped that as a result of the meeting better ways to deal with such problems and implement the plan will be developed.

Every effort will be made to break for lunch at 11:30 in order to allow sufficient time for lunch.

We will reconvene at 1pm in five groups, each consisting of persons serving a particular mental health center area. These groups will be chaired by the program directors of the centers. Each group will also have a resource person and a recorder from my staff.

5-3-67. ✓ [Signature]

	<u>Chairman</u>	<u>Resource Person</u>	<u>Recorder</u>
Zumbro Valley Area	Robert Zabel, Program Director	John Moede, Director, Community Programs	Carol Griffith, Mental Health Educator
Hiawatha Valley Area	Miller Friesen, Program Director	Terry Sarazin, Assistant Director, Community Programs	Jo Ann Haas, Informational Writer
South Central Area	Cliff Schroeder, Program Director	Miriam Karlins, Dir., Public Information, Mental Health Educa- tion, and Volunteer Services	Eleanor Steel- smith, Research Analyst
Mower Area	Benton Barringer, Program Director	Kent Hawkins, Assistant Director, Medical Services	John Scherber, Informational Writer
Southern Minn. Area	Bob Muschler, Psychiatric Social Worker	Joseph Lucero, Research Coordina- tor	Jeanne Sulem, Research Analyst

In addition to county welfare board members and directors, representatives from Rochester State Hospital and Faribault State Hospital, daytime activity center board members and directors, community mental health center board members, these groups will include persons from central office of DFW, welfare field representatives, persons representing mental health associations, associations for retarded children and other groups.

The purpose of these afternoon group meetings is to take the first steps in developing the machinery in each area needed to implement the plan for comprehensive area-wide programs. Such machinery might take the form of an area committee with representatives not only from the groups at this meeting but also from such key resources as schools, courts and law enforcement agencies, nursing services, private and voluntary agencies, professionals in private practice, etc. Such an area committee would differ considerably from the regional coordinating committees. The area committee would be involved in decision making related to program design, development and coordination. The regional committees were not intended to function in this manner.

The Department of Public Welfare will look to the community mental health center boards through their program directors to take the leadership in establishing machinery in each area leading to the development of a comprehensive area-wide program. It is for this reason that I have asked the mental health center program directors to chair the afternoon group meetings.

In order to arrive at the point in the afternoon group meetings at which it will be possible to take the first steps in

establishing machinery to implement the plan there will no doubt need to be discussion of the plan, the responsibilities of each of the key agencies, the specific implications of the plan for each area, and possible problems. However, sufficient time should be allowed before 2:30pm to make decisions about the machinery for follow through on ongoing planning and program development in each area. The final hour will consist of a round table made up of the group chairmen, resource persons, Dr. Funke, Director of Study and Planning, and myself. The round table will discuss next steps in implementing the plan based on recommendations from the group.

DJV:vw



MINNESOTA'S  
MENTAL HEALTH - MENTAL RETARDATION REGIONS

MAY 1967

