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TO: Participants, Mental Health Planning Retreat

May 12, 1965

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

SUBJECT: Working Paper, Mental Health Planning Retreat

INTRODUCTION

The following document is intended to serve several purposes. It is a tentative order of business for the Planning Retreat on May 26-27, 1965. It is a discussion guide. It is also a working paper to aid the group in arriving at the recommendations to be made on the second day of the meeting.

Initial plans were more ambitious. We had thought we could draw up a final report of the Minnesota Mental Health Planning Council prior to the Retreat, with a view to discussion of the proposals in preparation for a final plenary session of the Mental Health Planning Council in June. The document that would emerge would have been the Comprehensive Mental Health Plan, presented on or before June 30, 1965, by the Planning Council to Governor Karl F. Rolvaag.

Further consideration has led to the conclusion that this approach is not feasible. Factors such as time are against it. This approach, further, would have the effect of presenting the Retreat Participants and the Planning Council with a fait accompli, previously digested and packaged by the staff; this would be unfair and unwise.

More importantly, we question the June 30, 1965, deadline, and the idea of a "final" Comprehensive Plan in a complex field in which no plan is ever final. We want whatever emerges from the Planning Council not to suffer the fate of countless survey groups and task forces in the past, with their dust-gathering reports and recommendations that are not acted upon.

One of the duties of the Retreat is to help lay down a plan for some form of continuity in these deliberations. Our thought is to hold a plenary session of the Planning Council in June as originally scheduled. But we feel that we should take more time over the Comprehensive Mental Health Plan. We also want to explore ways of developing the Comprehensive Plan as a process, writing and revising it in stages, with some built-in feed-back or dialogue system which would allow us to check back 2-3 times each year with an advisory group. The nature of the advisory group then becomes important. Should this be the Mental Health Planning Council or some other group? The existing Executive Committee of the Mental Health Planning Council might serve the purpose. Or possibly a new, different, and smaller body chaired from the Governor's Office. A related concern is tying together the chronology and coordination of the federal grant-in-aid Plan; the Comprehensive Community Mental Health Centers construction plan; the allocation of state research, training, and mental health center funds each spring; the preparation of biennial budget requests; and the intercurrent work with the Legislative Building Commission.

The document that follows is divided into four sections, as follows:

Section One: Report of the Medical Services Division

In the total context of the Mental Health Planning Council this report has the status roughly of a committee report. It is divided into two subsections: basic concepts and the Anoka study report.

Section Two: Critical Issues

This section takes up a variety of important topics or problem areas which are of concern to the mental health "industry."

Section Three: Reports of the Mental Health Planning Council Committees

Also includes a summary of the report of the Governor's Coordinating Council on Alcoholism and some points concerning mental retardation. Important: the items here are extracts not summaries or abstracts, of the Committee reports.

Section Four: Recommendations

This section consists solely of headings. Participants will be furnished similar blanks and asked to write in their specific recommendations on the second day.

We will bring to the meeting the full text of the Committee reports as available at this writing. We will also bring copies of the Construction Plan (viewed as the report of the Facilities Committee), the MAMI Hospitalization and Commitment Bill (viewed as the report of the Forensics Committee), the Final Report of the Governor's Coordinating Council on Alcoholism, the Anoka Study Report and other documents.

The proceedings of the meeting will be taped.

A final word as to the general orientation of this Working Paper. It is inevitably a personal document colored by my own views, concerns, and experience as Medical Director. Thus, bias is inescapable, and the considerations are incomplete. I do propose that the Retreat should concentrate first and foremost on the public endeavors of mental health in Minnesota: the best future investment of tax dollars and tax-supported energies for the good of the people of this state. I believe the emphasis should be not on "getting more money" to expand services (when the question of how much "more money" will be available is very serious and very problematical), but on how to get the best use out of presently available money and what the priorities should be.

SECTION ONEREPORT OF THE MEDICAL SERVICES DIVISIONA. Basic concepts:

This section summarizes hundreds of man-hours of deliberation in the Medical Services Division of the Department of Public Welfare, especially in the group of program supervisors known as Section Heads. It is presented here in its most simplified skeletal form for purposes of discussion.

The aim of the deliberations has been to develop a rational concept of a mental health program for the Medical Services Division. More precisely -- and this simple yet powerful elaboration has evolved out of the Section Heads discussions -- the aim has been to develop the concept of a public* mental health program for the Medical Services Division.

From this we can derive deductively and implement administratively a public mental health program through the levels of organization subsidiary to the Medical Services Division. An elusive and unsolved problem by way of exception is the community mental health centers program: because of their nature, it is a matter of interpretation whether a statewide, public template can be applied to this diverse group, whose primary accountability appears to be local rather than statewide in origin. For public purposes it appears that centers are a specialized resource rather than line agencies.

From the Medical Services Division model of the public mental health program we can derive inductively and recommend, with decreasing accuracy and power of influence, the public mental health duties of other divisions of the Department of Public Welfare, the Department of Public Welfare as a department, other state departments, and the executive branch of the state government as government. Even more remotely, we can comment on the functions of nonpublic areas such as private agencies, church enterprises, the private practice of professions, citizens' groups, etc. The important function of the Planning Council and whatever continuing advisory group carries on will be to clarify the responsibilities of the operations other than Medical Services Division in a broad-gauged mental health program and to relate the endeavors with each other.

Our concept is built on these assumptions:

1. The goal of the public mental health program is to reduce the problem of major mental disorder.
2. In a society based on Western individualism the free-enterprise system is seen as the desirable means of making the services available that will reduce dysfunctioning. But there are thresholds beyond which public intervention can and must occur under due process of law if the dysfunctioning is to be coped with.
3. The public intervention system, which has the most critical and necessary duties to perform, needs urgently to have its status clarified and raised in the public estimation and its resources strengthened. The free-enterprise sector of mental health, in contrast, is doing relatively well.

* Public in our usage refers to the responsibilities of government; government in turn is viewed as one of the instruments available to society for its regulation and for the distribution of goods and services among its members.

Some tentative conclusions from Section Heads discussions are:

1. The urgent problem before us as a public agency is not how to add or expand services in the free enterprise system but how to provide continuity of responsibility in the public intervention system- (cf. Anoka study report).
2. The community mental health center in its present "image" and mode of operation appears to function in the free-enterprise system. Its role in public intervention is very unclear; the MAMH Hospitalization and Commitment Bill sharpens the public intervention role of the community mental health center to some extent. The question of comprehensiveness arises: can any element of the free-enterprise system, no matter how many "services" it provides, carry out the function of the public intervention system?
3. If we accept the goal of reducing the problem of major mental disorder as measured by the reduction of hospitalization, several possible methods of reaching the goal emerge:
 - 3.1 By reducing the need of individuals to be admitted to mental hospitals.
 - 3.2 By intervening at earlier points.
 - 3.3 By intervening more appropriately.
 - 3.4 By providing better alternatives (e.g., nursing homes, foster homes, assisting corrections, etc.)
 - 3.5 By shortening institutional stay.
 - 3.6 By improving programs within hospitals (reducing dehumanization; implementing unit systems).
 - 3.7 By reducing the need for re-hospitalization (improving aftercare programs).
4. The mental health industry has a significant responsibility to collaborate with corrections in preventing criminal careers.
5. The function of the public intervention system can be improved by strengthening and interrelating public operations such as schools, county welfare departments, law enforcement agencies and courts. This could be done through increased manpower. Short of this, however, much could be done by more effective training, improved methods of operation, and even by ordinary clarification of roles. "Training" here refers not only to what will occur on the job (e.g., the work of community mental health centers as a training resource) but to basic training in public concepts that could or should be taking place in secondary and higher education.
6. Predicting future mental patient and criminal careers early in life is difficult. However, we have not made adequate use of the instruments

that exist in the subsystem birth-medical-school-public welfare.
To wit:

- 6.1 Genetics counseling.
 - 6.2 Family planning, including the prevention of premature, inappropriate marriages.
 - 6.3 Follow-up of battered-child cases.
 - 6.4 Improved child welfare programs (adoption, illegitimacy, dependency, neglect, placement) including training of foster parents.
 - 6.5 Improved school counseling and school management of problem cases, with systematic tie-in with county welfare operations (see 7).
7. The public mental health functions of the county welfare department can be clarified and elaborated according to the following model (See also Sec. 16, Subd. 9-13 of the MAMH Hospitalization and Commitment Bill):
- 7.1 The county welfare board represents the hub of local public mental health responsibility.
 - 7.2 Other community services, e.g., community mental health centers and daytime activity centers, are primarily specialized resources which complement, not substitute for, the county welfare board's functions in the field of mental health.
 - 7.3 Programs can be developed which better implement the county welfare board's responsibilities in mental health and which make maximum use of existing community resources.
8. The financing of the systems and subsystems needs much further study: e.g., the role of private and government insurance programs; the gradients of public cost differentials, etc.

B. Anoka Study

This will be summarized at the meeting. Important outcomes are:

1. The feasibility of the family rather than the individual as the focus of problem-solving at the case level.
2. The elaboration of the following functions of a well-organized local mental health program:
 - 2.1 Early detection of mental disorder.
 - 2.2 Diagnostic assessment.
 - 2.3 Locating and organizing resources to carry out treatment.

- 2.4 Carrying out treatment.
- 2.5 Social restoration.
3. The urgency of implementing the public mental health responsibility of the county welfare department.
4. The dual need of the community for both the public mental health program (in the Public Intervention System sense) and other mental resources, such as the community mental health center (in the Free Enterprise System sense).
 - 4.1 Priorities for the local dollar are not clear, but it appears increasingly that the public program is more basic.
 - 4.2 The state dollars and the design of the Minnesota Community Mental Health Centers Act of 1957 appear to be exclusive for the community mental health centers as they now operate.

SECTION TWO:

CRITICAL ISSUES

Here we simply list areas of concern as a discussion guideline. The breakdown is along three lines: agency structures, biopsychosocial dysfunction groups, and other.

A. Agency Structures

- I. Government departments
 - Medical Services Division
 - Department of Public Welfare
 - Department of Corrections
 - Department of Education
 - Vocational Rehabilitation
 - Special Education
 - Department of Health
 - Genetics Counseling
 - Hospitals and Nursing Homes
 - Public Health Nursing

- Higher Education
 - University of Minnesota
 - State Colleges
 - State Junior Colleges
- Department of Administration
- Department of Civil Service
- Other state departments
- Governor's Office

2. Non-government

- General hospitals
- Mental health centers
- Daytime activity centers for the mentally retarded
- Professions
- Private agencies
- Health and welfare councils
- Citizen groups
- Other

B. Biopsychosocial dysfunction groups:

Mentally Ill

Mentally Retarded

Antisocial

Sexual Offenders ("psychopathic personality")

Alcoholic-addictive

Dangerous

Chronically dependent (hard core "welfare" families)

(Note: To complicate matters further, special concerns arise in the above with regard to age categories, especially in children, adolescents, and the aged. Special events such as poisoning and accidents may produce emergency intervention -- may also occur in the above groups.)

C. Other

1. Impact of financing and other changes.
 - Insurance and related programs, including Medicare
 - Economic Opportunity Act
 - Comprehensive mental health centers staffing
 - Other programs (e.g., Manpower Development and Training Act; replenishment of personal funds prior to discharge, etc.)
2. The need for improved attention to the public philosophy in secondary and higher education.
3. The future of regional organization.
4. The future use for mental hospital space and resources.
5. The future impact of automation, the national economy, tax structures, state and federal relationships, and improved transportation and communication.
6. Manpower developments, especially GP training, psychotherapists, indigenous non-professionals, volunteers, second careerists, the "time rich," etc.
7. The possibility of more effective use of training and research funds.
8. The future use of a planning-advisory group.
9. The future of the staff Planning Operation (e.g., further elaboration of the county welfare board responsibility for public mental health programs. Cf. Section One, Subsection 7, p. 5)

SECTION THREE:COMMITTEE REPORTSI. Non-medical Problems

- A. Marital incompatibility (includes report of DFW Public Assistance Division)

Problem:Recommendation:

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| <p>1. Marital counseling resources inadequate (lawyers and clergy need some guidance on availability and referral mechanism).</p> | <p>1.1 Include clergy on staff of mental health center.</p> <p>1.2 Educate MD's.</p> |
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- 1.3 MD's make better use of medical social workers.
- 1.4 Premarital counseling.
- 1.5 Walk-in agency (plus "call up")
- 1.6 Encourage development of adult recreational patterns.
- 1.7 Day-care baby sitting service and other aids to harrassed young mothers.
- 1.8 Sex education, family planning.
- 1.9 Adult education.
- 2. Need for assistance in money planning and buying.
- 2. Educational program on family living (junior and senior high schools).
- 3. Need for aid for the indigent to obtain legal counsel.
- 3. Concern for legal indigence.
- 4. Early diagnosis.
- 4. Information and training for clergy.

B. Child Neglect (includes report of Education Subcommittee)

Problem:

Recommendation:

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| <ul style="list-style-type: none"> 1. Lawyers and welfare operate a different value systems. 2. School roles unclear: school is undervalued: | <ul style="list-style-type: none"> 1. Legal changes to allow for quicker intervention. 2.1 Special funds for special education through the state education department. 2.2 Interdisciplinary and interagency resources organized and coordinated. 2.3 Service programs, early diagnosis, <u>clinical services introduced directly into school without interruption of academic education</u> (including broader role of school psychologist and social worker). 2.4 In-service training for school personnel. 2.5 Over-riding responsibility as between school, agency, institutions, etc. 2.6 Additional foster homes and short-term facilities. |
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3. Faulty home conditions. 3. Increased homemaker services.

C. Delinquency and Anti-Social Behavior

<u>Problem:</u>	<u>Recommendation:</u>
1. Acting-out cases: confusion over diagnosis and disposition.	1.1 Psychiatric and other consultations to courts, sheriffs, etc. 1.2 Improved remedial services in schools.
2. Staff shortages.	2. More and better training for public service at the University.
3. Family suspicion of the agencies.	3.1 Continuing exploration and coordination in health-mental health-welfare-correctional fields. 3.2 Foster homes for children leaving correctional facilities. 3.3 More work with family while child is institutionalized. 3.4 Regional centers for "acting-out" disturbed child.

II. Committee on Institutions

<u>Problem:</u>	<u>Recommendation:</u>
1. Dehumanization	1.1 Explore one-to-one relationships outside hospital. 1.2 Improve admissions procedures.
2. Educational deprivation.	2. Provide educational programs for children and adults.
3. Oversize.	3.1 Develop unit system. 3.2 Improved design of new buildings.
4. Less than ideal location.	4. Locations closer to population centers.
5. Mental illness - mental retardation split.	5. Treat mentally ill and mentally retarded in the same facility.
Other retardation problems:	See full report: Recommendation X
— inadequate diagnosis	
— delinquent cases committed as MR	

-- inadequate treatment for cases on MR waiting list

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| 6. | Need for expanded volunteer services | 6.1 | Research on increased utilization of volunteers. |
| | | 6.2 | Develop areas such as: commitment hearings, follow-up programs, one-to-one, indigenous non-professional, providing transportation. |
| | | 6.3 | Restructure volunteer programs in relation to unit system in institution. |
| | | 6.4 | Volunteers on regional coordinating committees. |

III. Committee on Aftercare

Problem:

1. Multiagency responsibility for post-hospital patient.
2. Institutions limited in ability to influence post-hospital adjustment.
3. Post hospital cases such as routine or dull.
4. Need for clearer responsibility among community agencies, especially county welfare department.
5. Need for clear communications between hospital and community teams.

Recommendation:

1. Mental health centers and other agencies besides county welfare departments should be included.
2. Involvement of community agencies in pre-discharge work.
3. Eliminate distinctions concerning different classes of patients among professional persons.
- 4.1 Increased manpower in county welfare departments so they can do their assigned jobs more effectively.
- 4.2 Coordinators of aftercare services employed in county welfare department.
- 4.3 Vocational rehabilitation included in aftercare planning.
- 4.4 Community mental health centers should assist in aftercare.
- 4.5 Clergy should be entitled to help improve community attitudes.
- 5.1 Complete equality of status as between teams.

- 5.2 Discussion to include pre-admission and pre-discharge cases.
- 5.3 Assigned to subcommittee of regional mental health coordinating committees.
- 6. Inadequate preparation of patient.
 - 6.1 Regional Coordinating Committee should promote continuity.
 - 6.2 Standardization of patterns of services.
 - 6.3 Money to leave the hospital with.
- 7. Discontinuity of programs.
 - 7.1 Training in better use of leisure time.
 - 7.2 Pay for work done in institutions.
 - 7.3 Sheltered workshops in communities and institutions.

IV. Committee on Economics

No report for this Committee, which disbanded early.

Aftercare Committee states:

- Provisions should be made with regard to sharing in the cost of drugs for patients after discharge and insuring that patients not only get them but take them as prescribed.
- Mental illness should be covered by hospitalization insurance.

One problem is the sharp difference in cost for counties between community and institutional care. This relates in turn to the overall problem of financing of welfare costs. Some form of continuing study should be given to the cost problem, possibly through the use of state research funds.

V. Committee on Forensics

No report from this Committee as such. However, the Hospitalization and Commitment law revision submitted by the Minnesota Association for Mental Health could be construed as a report.

VI. Committee on Facilities

The Construction Plan is construed as the report for this Committee.

VII. Committee on Professional Practices

Summary of the Report is as follows:

The Committee agreed to study the manpower situation related to the medical profession, nursing, psychology, and social work. Members of the Committee prepared individual reports related to these professions including the following items:

1. Quantity of profession available.
 - (a) Level of training.
2. Location by area and/or setting.
3. Professional organizations represented.
4. Training facilities within Minnesota.
 - (a) Undergraduate.
 - (b) Post-graduate.
5. In-service training programs.
6. Recruitment methods and problems.
7. Services of public and private practitioners.

The question of emergency psychiatric care was considered. Problems of definition were encountered. Types of programs found in other parts of the country were briefly discussed. Seriousness of the problem in Minnesota was not ascertained. General feeling was that this is being handled fairly well in Minnesota with a variety of methods adopted by Community Mental Health Centers, private practitioners, and general hospitals.

A. Nursing Sub-committee

Problems:

1. Shortages of basic RN's in Minnesota to care for the mentally ill.

Recommendations:

- 1.1 More staff nursing and other levels of professional nursing positions should be allocated at each institution.
- 1.2 Better recruitment measures instituted such as directories at state institutions of available active and inactive nurses in the area.
- 1.3 Publication in newspaper articles, professional organizations and workshops on values of state service.
- 1.4 Employment of teenagers in volunteer services to acquaint them with mental health work and follow through by the nurses at the hospitals on values of professional nursing education.

- 1.5 Increase the present budget allocations for stipends available to the nursing personnel by the professional and non-professional at our state institutions.
- 1.6 Closer alliance between RN's in their area with community resources, agencies and organizations whereby they can interpret the needs of the institution for more RN's.
2. Shortages of RN's in the Minnesota public program who possess higher qualifications.
 - 2.1 Encouragement at the University of Minnesota to expand and explore additional facilities so that RN's and non-professional nursing personnel could pursue courses on a part-time basis as well as full time.
 - 2.2 Expansion of the Department of Public Welfare stipend program.
 - 2.3 Encourage graduate nurses to expand professional preparation prior to advancement in position.
 - 2.4 Modification of Civil Service standards whereby more recognition can be given for advance preparation financially.
 - 2.5 Committee of prepared psychiatric nurses work with Civil Service to study the problems of advancement in educational preparation.
 - 2.6 Employing institutions should develop a system by which staff nurses can advance financially but not be limited by a particular classification.
3. The relative failure to provide nursing instructors an educational experience for affiliating nursing students. The lack of well prepared RN's to function as instructors.
 - 3.1 Refer to recruitment measures under item 1 above.
 - 3.2 Encouragement to the schools of nursing to provide their own instructors for nursing students.
 - 3.3 Workshops be offered on a regular basis to improve the curriculum based on creativity, flexibility and problem-solving skills.
 - 3.4 Nursing curriculum be strengthened in community based activities.

4. Inadequate continuity of nursing care for mentally ill patients.
 - 4.1 Nursing expand to contribute in meeting the needs of discharge and pre-admission patients.
 - 4.2 Nursing provide interdisciplinary planning in this area.
 - 4.3 Nursing attempt to strengthen community participation in treatment centers and community agencies in nurse curriculum (especially baccalaureate and masters) program for strengthening and providing more clinical experience in the community with individuals who are mentally ill.
 - 4.4 Inservice education on a joint basis be established for public health nurses and institutional nurses.
 - 4.5 Recruitment efforts be stepped up and more positions be established for nurses in public health practice.
5. A need to secure the contribution of nursing at community mental health centers.
 - 5.1 Nursing be an integral discipline of the center.
 - 5.2 Nursing groups explore and define more clearly the role of nurses in the setting through research such as pilot projects.
 - 5.3 Studies be done to define the nursing role and the use of psychiatric and public health nurses in a mental health setting.
 - 5.4 When a nurse is employed in a mental health center, joint planning be done with other nursing groups in the community so that better service is given through cooperation of nursing efforts. Duplication of service can then be avoided.
 - 5.5 Qualifications for the nurse employed at the center be designated by the function she will perform and qualifications of other center personnel.
6. Need for higher standards of patient care in state facilities.
 - 6.1 More awareness, encouragement and policy direction both on a state-wide basis and an institutional basis by administrative personnel.

- 6.2 Civil Service classification for Licensed Practical Nurses be established.
- 6.3 Strong inservice education programs be developed on all levels of nursing personnel with focus upon patient care, not procedures, etc.
- 6.4 Extensive study on the utilization of all levels of nursing personnel with the purpose of providing auxiliary positions, such as ward secretaries, to free the nurse to carry out direct patient care activities.
7. Need for higher standards of patient care among the mentally retarded patients.
 - 7.1 Research be done by nurses in the area of mental retardation nursing.
 - 7.2 Encouragement of nurses to work with the mentally retarded and their families.
 - 7.3 Opportunity be given for nurses, without loss of salary, to take courses in other parts of the country in the field of mental retardation with financial assistance.
 - 7.4 Establishment of graduate nursing programs on the masters level in Minnesota to prepare nurses in rehabilitation nursing and maternal and child health in mental retardation nursing.
 - 7.5 More emphasis be placed on mental retardation in the nursing curriculum of schools of nursing with provision for clinical experience within mental retardation institutions and community agencies.
 - 7.6 Clarification among nursing groups on the roles of nursing in care for the nursing needs of the mentally retarded and their families.
 - 7.7 A nucleus of nurses obtain special preparation in mental retardation so that they can give help to the nurses working with the mentally retarded.

B. Psychology Subcommittees

There are about 400 psychologists holding the M.A. or Ph.D. degrees living in Minnesota, exclusive of students still in training.

Psychologists involved in programs of service to persons with mental disorders are primarily in clinical, counseling, and school psychology; among these it is the clinical psychologist who has a primary focus of interest in work with persons having severe psychological dysfunction. About one-third of all psychologists are clinical psychologists.

Under state statute it is possible, on a voluntary basis, to apply for status as a Certified Psychologist. Certification requires holding the M.A. degree, one year of satisfactory employment as a psychologist, and passing of a written and oral examination conducted by the State Board of Examiners of Psychologists. Certification as a School Psychologist requires the status first of Certified Psychologist plus academic training beyond the M.A. to the equivalent of the University's diploma program as Specialist in School Psychological Services. A higher level of certification, Certified Consulting Psychologist, is provided for persons holding the Ph.D. degree who have three years of experience and who pass the Board's examination.

The University of Minnesota is the only educational institution in the state which grants the Doctor of Philosophy Degree in psychology. Its programs in all specialty areas are accredited by appropriate professional and academic groups. Currently there are about 70 students in the doctoral program in clinical psychology, about 50 in counseling psychology, and about 30 in school psychology. The total number of graduate students is about 250.

VIII. Alcoholism

The Minnesota Mental Health Planning Council did not consider alcoholism primarily or singly as one of its study topics. However, during the period of calendar years 1963 and 1964 another planning group was working to analyze the problems of alcoholism and what is done about it in Minnesota. This was the Governor's Coordinating Council on Alcoholism. Their final report, published early in 1965, is an important document. A summary of the findings and recommendations is as follows (from pages 19-21 of the Report, with minor editorial changes):

The following then are observations and recommendations relating to activities in all three categories, Education, Treatment, and Research. Of necessity, they are interrelated and overlapping. They cannot be entirely separated.

- (1) Research - It is obvious to the Council that there should be continued research in Minnesota. This should include research of a technical nature relating to causes of alcoholism in relation to mental, physiological, social, physical, etc., values. It should also include statistical research and recording with the purpose of evaluation and improvement of methods and administration in all categories. The latter type of research has been included in the reports and recommendations of every organization, commission, board or council, studied by the Council.

It is therefore obvious that some type of permanent body be appointed or created to perform this continuing appraisal. The Council recog-

nizes that the presently existing "Minnesota Advisory Board on Problems of Alcoholism" is presently performing this function. (See Section 2, Article 4, Minnesota Laws, Chapter 705, 1953.) It is recommended, however, that the Board be replaced by a "State Advisory Council on Alcoholism" which will be proposed in detail to follow in this report.

In relation to the technical research problems, it is recommended that increased budget allotments be made in some form to allow further participation in current technical research. The exact mode of allocation and amount will be proposed in detail to follow in this report.

- (2) Education - It will be seen from this report that there are four functioning organizations presently operating in the field of education in Minnesota. A review of the functions of these four organizations reveals the following pertinent facts:

There is a vast area to be covered in the field of alcoholism education. The four organizations are doing good work, but their lack of finances and resulting lack of sufficient personnel leaves much to be done. Accordingly, the Council recommends that methods be implemented to increase the finances of the state agencies to allow them to increase their staff; consideration should also be given to aiding the two volunteer agencies and to the creation of additional facilities to assist in implementing these suggestions. Further suggestions on these points will follow in this report. There is a great need for a central coordinating authority in the field of education to avoid overlapping by the functioning organizations.

- (3) Treatment - Again it was apparent to the Council that there is much activity in the treatment field of alcoholism. This activity is being carried on by a variety of both volunteer and governmental agencies or organizations at both the state and county level.

A. In relation to in-patient treatment, the great majority of in-patient treatment is being conducted by the state at its hospitals in Willmar and Moccasin Lake. These facilities are overcrowded and understaffed. It was also noted that, despite a trend to the contrary, there are still service hospitals that do not admit alcoholic patients for treatment, and there are doctors who do not treat alcoholics. The Council, therefore, recommends that the need for more in-patient treatment facilities be satisfied in the following ways:

1. Increase of staff at state hospitals.
2. Continued educational and public relations work with the service hospitals and physicians to accept for treatment those alcoholic patients who can afford private help.
3. Continued research and evaluation of existing facilities with implementation of newly discovered concepts and needs in the field of inpatient treatment and facilities and alcohol education.

F. Out-patient treatment consisting of counseling, referral and follow-up care. Along with the needs in the education field, out-patient treatment facilities for the alcoholic are in need of expansion and coordination of existing facilities. This is an area where there are several excellent organizations functioning, notably AA. There are three areas in out-patient treatment or care that are critical:

1. Post-treatment or follow-up care. It is essential that alcoholics who are discharged from hospitals or in-patient facilities be subjected to a regime of follow-up care. The Council recommends an expansion and development of facilities in this field. The utilization of the community mental health centers, as previously reported, is highly commended and recommended by the Council. In addition, continued efforts should be maintained to develop any additional follow-up treatment facilities.
2. Referral services for contacted alcoholics. It has been noted that there are many quarters where the alcoholic is contacted, but thru lack of information, he is not properly referred to a facility designed to help him (i. e., many industries, clergy, courts, the alcoholic's family, attorney, etc.). This is an area where more services are needed and, in addition, education is badly needed to inform the public in general what can be done and who can do it.
3. Care facilities for the chronic police-court or revolving-door alcoholic who can not be rehabilitated. This class of alcoholic has a history of almost infinite repetitious commitments to jails or hospitals. The cost to society to maintain him is immense. Presently, there are no facilities in Minnesota to care for this class of alcoholic. The Council recommends research on this problem with consideration of a facility much akin to the old CCC camps where the chronic police-court alcoholic could be committed for his own good and whatever beneficial services he can render to society.

(4) General Recommendations and Suggested Solutions.

In reading this report, the reader will be impressed by the many recommendations it encompasses. Some are general and others are specific. The Council did not intend that these should be mere criticism and idle suggestions. In order to implement the many recommendations, the Council spent much time and effort to determine how these recommendations should be carried out.

It was concluded that the administration and implementation of the many suggestions of the Council would require the creation of a new state agency. The question then arose as to whether it should be an independent autonomous agency or an agency integrated into some already existing agency. The pros and cons of each were discussed at length at many of the interim meetings.

One of the greatest considerations taken up by the Council was the matter of availing such an agency of federal funds which are to be

made available under Public Health Service Grants. It was observed that, at the federal level, the alcoholism interest is located within the National Institute of Mental Health which is one of the major subdivisions of the Public Health Service, itself a subdivision of the Department of Health, Education and Welfare. It was further observed that recently, when planning money was made available to states to develop community mental health plans, it was indicated that their total community mental health plans should also include planning for alcoholism. This planning money was made available to our Department of Public Welfare as our state's mental health authority. Thus, it seemed that the pattern of federal financial support made it advisable to place our alcoholism program within our mental health authority. This will place responsibility for alcoholism planning in the hands of the mental health authorities.

Having considered all things, the Council, therefore, recommends the creation of an integrated alcohol agency to be named the "Alcoholism Service". This service is to be directly under the Division of Medical Services which in turn is a subdivision of the Department of Public Welfare. Again, much deliberation was done on the structure, function, and administration of the proposed Alcoholism Service.

IX. Mental retardation

As the field of mental retardation in Minnesota is under study by the Minnesota Mental Retardation Planning Council, it would be inappropriate for the Minnesota Mental Health Planning Council to make definitive recommendations in regard to mental retardation. However, certain aspects of mental retardation and some questions and tentative suggestions emerging from the early work of the Mental Retardation Planning Council, together with ideas being worked on by the Department of Public Welfare, are highly relevant. It will be noted that the foregoing committee reports contain recommendations concerning mental retardation.

The following topics are simply listed here for purposes of orientation:

1. Regional diagnosis and evaluation centers for the mentally retarded.
2. Department and Medical Services Division plan to decentralize case-level decision-making authority to counties working directly with the institutions and agencies that serve them.
3. The duties of community mental health centers in regard to mental retardation (relates to both 1 and 2).
4. Future use of beds in mental illness hospitals: Is it feasible to allocate these for the mentally retarded? If so, should they be primarily nursing/custodial, which would tend to relieve overcrowding at existing mental retardation institutions and reduce the waiting list? Or should some more specialized use be found, that would assist indirectly to the foregoing aim but would not dilute existing mental illness hospital programs?
5. Definition of the mental retardation services "region" for administrative purposes. Coterminous with mental health regions, or not? Regional mental retardation planning: will the regional mental health coordinating committees be an adequate medium?

SECTION FOURRECOMMENDATIONS

When the Council was formed, it was asked to make recommendations in the following three areas:

Responsibilities of the Medical Services Division.

Responsibilities of Other Agencies.

Responsibilities of the Particular Agency which the Council member represented.

These three major headings have been expanded below into seven groupings.

Here we ask the Participants to list their own recommendations according to the scheme shown below. These will be reviewed in the final session of the Retreat. They will be incorporated into a draft Comprehensive Plan to be presented at the plenary session of the Planning Council in June.

Work Sheets will be furnished at the meeting for the Participants to use in writing their specific recommendations.

The scheme is as follows:

Recommendations TO:

For:

Groupings of Organizations

Priorities of emphasis within existine means and resources

Priorities for future

1. Welfare

Medical Services Div.

Department of Public Welfare

2. Corrections and Law Enforcement

Department of Corrections

Other law enforcement

3. Public Health

Department of Health

4. Education

Department of Education

University of Minnesota

State College Board

State Jr. College Board

Programs; Legislation, Financing

5. Executive Branch

Department of Administration

Department of Civil Service

Other state departments

Governor's office

6. Community resources

General hospitals

Mental health centers

Daytime activity centers for the mentally retarded

Professions

Private agencies

7. Voluntary associations

Health and Welfare Councils

Minnesota Assn. for Mental Health

Minnesota Assn. for Retarded Children

Other citizens groups and voluntary associations