



**MENTAL HEALTH
MENTAL RETARDATION
PLANNING
FOR HENNEPIN COUNTY**

NOVEMBER, 1967

Community HEALTH AND WELFARE *Council*

404 SOUTH 8TH STREET

MINNEAPOLIS, MINNESOTA / 55404

MENTAL HEALTH
MENTAL RETARDATION
PLANNING

For Hennepin County

An Analysis of the Findings and Recommendations of the
Study Committee for a Mental Health-Mental Retardation Plan
as requested by the Hennepin County Mental Health Board

November, 1967

Community Health Committee

COMMUNITY HEALTH AND WELFARE COUNCIL
404 South 8th Street, Minneapolis, Minnesota 55404

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INTRODUCTION

This report entitled "Mental Health-Mental Retardation Planning in Hennepin County" is the result of serious study by a special committee of the Community Health and Welfare Council of Hennepin County, Inc. The findings and recommendations have been prepared in response to a request from the Hennepin County Mental Health Board for assistance in planning a comprehensive mental health plan.

The report represents the combined efforts of a dedicated and knowledgeable committee of lay and professional citizens over a period of eighteen months. In addition to conducting numerous meetings, the committee reviewed plans which have been developed in other parts of the country, reviewed the literature in the field, studied legislation and guidelines, and talked with professionals representing organizations, both public and private, at the local, metropolitan, state and national levels.

The report is intended to assist Hennepin County in reducing its problems in the areas of mental illness and mental retardation.

PART I

HISTORICAL DEVELOPMENT OF MENTAL HEALTH CENTER PROGRAMMING IN HENNEPIN COUNTY

A. Initial Impetus for a Mental Health Center

In 1955 a conference series on mental health needs and resources, attended by representatives of fifteen Hennepin County agencies, was held under the joint sponsorship of the Health and Medical Care Division of the Community Welfare Council (now the Community Health and Welfare Council) and the Citizens' Mental Health Association (now the Minnesota Association for Mental Health). The major recommendation of this conference was that an all-purpose mental hygiene clinic should be developed in the community to provide outpatient clinical services, to make consultation services available to community agencies, and to conduct research. A committee appointed by the Community Welfare Council set out to plan a course of action designed to establish a mental health clinic at General Hospital.

In 1957 the Minnesota legislature passed the Minnesota Community Mental Health Services Act which enabled the state to match local funds on a 50-50 basis for the "establishment and operation of local mental health programs."¹

As a result of deliberations with city and county officials, agencies, and citizens the first Minneapolis and Hennepin County Mental Health Board was established under the chairmanship of State Senator Daniel Feidt.

The board's first meeting was held April 10, 1958. It immediately began to make plans for an expansion of General Hospital's

¹Minnesota Community Mental Health Services Act, Minnesota Statutes of 1957, Section 245.61 to 245.69.

psychiatric outpatient department which could then become eligible for matching state funds. On August 1, 1960 the Minneapolis and Hennepin County Mental Health Clinic opened its doors to outpatients on a county-wide basis.² In 1962 the Hennepin County Board of Commissioners entered into a joint funding arrangement with the State of Minnesota, and the clinic was expanded and became known as the Hennepin County Mental Health Center. Since 1962 the program has been expanded to include: outpatient services, inpatient services, partial hospitalization services, emergency services, consultation and education services, aftercare services, social rehabilitation services, research, and training.

B. Focus of Early Planning and Programming

From this brief historic resume' of the growth and development of the Hennepin County Mental Health Center, it is apparent that there has long been a recognition of the need for a full array of treatment resources for dealing with the mentally disturbed in this community. This concern was translated into specific action which led to development of a Mental Health Center which in a number of significant ways has become a model of its type throughout the country.

Although the major focus of programming has been on the operation and administration of the Mental Health Center itself, from the beginning there was recognition of the wider program implications articulated in the Community Mental Health Services Act which required the board to:

1. review and evaluate community mental health services and report to the commissioners of public welfare, the parties

²Based on a paper prepared in 1962 by Mrs. Louise McCannel, present chairman of the Hennepin County Mental Health Board.

supporting the program, and when appropriate, to the public, together with recommendations for additional services and facilities;

2. when so determined by the authority establishing the program, act as administrator of the program;
3. recruit and promote local financial support for the program from private sources such as Community Chests, business, industrial and private foundations, voluntary agencies, and other lawful sources and promote public support from municipal and county appropriations;
4. promote, arrange, and implement working agreements with social service agencies, both public and private, and with other health and educational and judicial agencies;
5. promote the adoption and implementation of policies to stimulate community relations;
6. review the annual plan and budget and make recommendations.³

Recognition of the wider responsibilities implied in the legislation can be identified in the continued expansion of the center operation which has resulted in informal agreements with a variety of public and private agencies in the community.

Nevertheless, the primary focus of the operation has been on administering and "running the center", and program expansion has consisted primarily of broadening the number and scope of programs offered by the center. Such a concept of programming was in evidence throughout the United States, and the particular facility here in Hennepin County has come to be recognized as an exemplary model of such an operation.

C. New Concepts of Planning and Programming

During the decade since the passage of the Minnesota Community Mental Health Services Act of 1957, new concepts and philosophies of

³Minnesota Community Mental Health Services Act, op. cit.

1. the reduction of the number of patients in state hospitals;
2. the provision of services to persons in their own communities;
3. the provision of continuity of care;
4. the reduction of the disabilities of those suffering from mental disorders.⁸

It is important to note that these trends, which were finding expression in national legislation, had been to some extent anticipated both locally and at the state level. The creation of the Mental Health Board in Hennepin County and the Minnesota Community Mental Health Services Act predated both the findings of the Joint Commission and the ensuing legislation.

As we shall see, however, there are significant differences in the concept of programming expressed and called for both in the new federal legislation and in the changing requirements the state is expecting from local mental health boards. No longer is it possible to equate a "comprehensive mental health program" with the operation of a center or clinic.

E. Local Impetus for Comprehensive Mental Health Planning

The impact of this new legislation became more evident when two local voluntary hospitals submitted plans to expand their facilities to include a joint rehabilitative and inpatient psychiatric facility. The plans were submitted through the usual channels to qualify for federal funding under the Hill-Burton Hospital Construction Act. Because of the fact that psychiatric facilities were part of the plan, the request for Hill-Burton funds was denied and these hospitals were advised to seek funding under Public Law 88-164. This was done and

⁸Ibid

the plan was subsequently reviewed for approval by the Hennepin County Mental Health Board, as required by the Minnesota Department of Public Welfare.

Key requirements of Public Law 88-164 include the necessity of fitting the construction of new facilities into an over-all "comprehensive mental health plan."

The meaning of the term "comprehensive mental health plan" was not made explicit in the legislation, but there were a number of requirements which did indicate the need for a total look at the entire community. Included in these were the requirements that any new facilities constructed under these PL 88-164 funds had to serve "catchment areas" of not less than 75,000 nor more than 200,000 persons. Further, they each had to provide at least five basic or essential services to the residents of these areas: inpatient services, outpatient services, partial hospitalization services, emergency services, and consultation and education services. There were a number of other requirements which will be discussed in detail in Part III, but it is sufficient to indicate here that a new concept of planning was being called for, both by this legislation, and by the Minnesota Comprehensive Mental Health Plan, which was beginning to call for a wider role by local mental health boards in community mental health planning.

F. The Request to the Community Health and Welfare Council

The Hennepin County Mental Health Board recognized its expanding responsibilities in community mental health planning, and realized the need to prepare a comprehensive mental health plan for the community.

The Mental Health Board passed a resolution in April, 1966

requesting the Community Health and Welfare Council to prepare such a plan. (See Appendix). The Board of Directors of the Council accepted the request in the same month, and assigned the task to its Health Committee. A special committee under the chairmanship of Robert Henson, was formed to meet this request.

G. Approach to Planning Taken by the Committee

It became apparent early in the deliberations of this committee that among the first steps it had to undertake would be the clarification of the meaning of the term "comprehensive mental health planning" and the determination of the role of this committee in relationship to such planning. It further became evident that an operational or working definition of the problems with which such planning should be concerned would need to be developed.

The committee also realized that there had to be some clarification as to what must be included in the concept of "planning". It was recognized that there are many types of planning, and it became important to consider the implications of these for the work of this committee. There was discussion of the concept of "blueprint" planning, which was seen as the development of a specific plan designed to serve as a guide for the geographic location of new and additional facilities and resources. There was also discussion of the concept of planning as a "process", which means an on-going operation, concerned with assessing needs, setting goals, selecting courses of action, implementing the programs needed to achieve these goals, evaluating progress being made toward the goals, reformulation of goals and objectives, etc.

Deliberations on these and other concepts of planning led the committee to assess its own role in the planning process. It did not

seem feasible for this committee to develop a long-range "blueprint" for the geographic location of new and additional resources in Hennepin County.

It seemed to this committee that it could make its greatest contribution by looking at recent trends in mental health programming; by examining the legislation which reflects these trends; and in light of this to assess the role and function of the present Mental Health Board, which has on-going responsibility for both "process" and "blueprint" planning in mental health in this community. More specifically, this committee elected to examine the following major questions:

1. What will this committee adopt as its operational definition of mental illness-mental retardation?
2. Based on current concepts and goals in mental health programming, and on the laws, rules and guidelines promulgated at the federal, state and local level, what are the essential components which should be included in a comprehensive program based on local needs?
3. Given these major components, what would it take in terms of structure, staff, time, and manpower to develop a mental health program with the elements which the committee feels should be included?
4. In the light of these major components what do we now have in Hennepin County by way of structure and organization for planning and programming, and what modifications seem indicated?

PART II

OPERATIONAL DEFINITION OF MENTAL ILLNESS-MENTAL RETARDATION

The committee felt that it was of great importance to develop an operational or working definition of mental illness-mental retardation and to define the kinds of problems with which the program should be concerned. Representatives from the Minnesota Department of Public Welfare were invited to committee meetings and the committee accepted the broad definition of mental disorder which is included in the state's mental health-mental retardation plan.

For purposes of comprehensive mental health-mental retardation programming, the state's definition of mental disorder falls into three broad categories:

A. Statutorily Defined Problems - Existing and Potential

Statutorily defined problems refers to conditions or behaviors that are defined by the body politic through its legislative machinery. While the "definitions" in law are usually general, there is provision for courts or other agents to apply these general definitions to specific cases.

- Statutorily Defined Mental Problems

1. mental illness
2. mental deficiency
3. mentally ill and dangerous
4. inebriacy - alcoholism and drug addiction
5. psychopathic personality
6. sex offender

- Mental and Emotional Aspects of other Statutorily Defined Problems

1. crime
2. juvenile delinquency
3. educational handicap
4. school dropout
5. truancy
6. illegitimate birth
7. child neglect

8. separated child
9. financial dependency
10. indigent disability
11. medical indigency
12. divorce
13. legal separation
14. desertion
15. public health menace

B. Non-Statutorily Defined Problems

1. Culturally Defined Problems - Existing and Potential

Included in this category are those behaviors or conditions other than legally defined problems that are of community concern and generally disvalued, or are considered by a particular group or subculture (e.g., ethnic, religious, professional, etc.) to be a problem.

- Culturally Defined Mental Problems, for example:

1. suicide attempts
2. mental retardation
3. suspected and diagnosed psychiatric disorders
4. impulsive, hostile behavior
5. peculiar, irrational behavior, etc.

- Mental and Emotional Aspects of other Culturally Defined Problems, for example:

1. marital disharmony
2. unemployment
3. under achievement
4. physical disease or disability
5. excessive drinking, etc. alcoholism

2. Individually Defined Problems - Existing and Potential

This category refers to problems, other than those that would be included above, that are defined as problems by the person exhibiting the behavior or condition.

- Individually Defined Mental Problems, for example:

1. anxiety
2. irrational fears, etc.
3. feeling of inadequacy
4. disturbance of mood
5. compulsions, etc.

3. Mental and Emotional Aspects of other Individually Defined Problems, for example:

1. sexual impotency
2. physical symptoms
3. work dissatisfaction
4. child rearing problems, etc.
5. marital problems, etc.

The Minnesota Department of Public Welfare has been making explicit its expectations and responsibilities at the local level for dealing with these problems by differentiating between a "Comprehensive Mental Health-Mental Retardation Program" and a "Public Mental Health-Mental Retardation Program"

A "Comprehensive Mental Health-Mental Retardation Program" as defined by the Minnesota Department of Public Welfare must address itself to both statutorily defined and non-statutorily defined problems - existing and potential. A "Public Mental Health-Mental Retardation Program" as defined by the state is that part of a "Comprehensive Program" which focuses on existing and potential statutorily defined mental disorders and the mental and emotional aspects of other statutorily defined problems.

Responsibility for developing the overall "Comprehensive Program" at the state level rests with the Commissioner of Public Welfare and at the local level with the local administrator of grant-in-aid funds (usually a community mental health board). Responsibility for developing a "Public Program" at the state level also rests with the Commissioner of Public Welfare, but at the local level the county welfare board has legal responsibility for program development for statutorily defined mental illness and mental retardation. As interpreted by the state, the local administrator (mental health board) has responsibility to assist the county welfare board in developing its "Public Program". This does not mean that the local mental health board has authority over the welfare board, but rather is expected to assist it in developing the "Public Program" as an integral part of the overall comprehensive program.

As will be discussed in a later part of this report, the Minnesota Department of Public Welfare has been translating these expectations of the local administrator into specific requirements by modifying the application requirements for grant-in-aid funds which must be submitted annually by the local administrator.

PART III

FEDERAL AND STATE CONCEPTS OF PROGRAMMING IN MENTAL HEALTH AND MENTAL RETARDATION

A number of factors at the local, state and federal level have been operating which make necessary a reappraisal of the respective role and function of the County Commissioners and the Mental Health Board in the area of comprehensive mental health-mental retardation programming and planning. Chief among these factors have been:

- a. The movement away from treatment in large institutions toward the goal of community care and the additional planning and programming responsibilities which this places on local mental health boards.
- b. Recent federal legislation which makes additional funds available to local communities, but which also makes additional demands for an analysis of the total community.
- c. Changing requirements by the Minnesota Department of Public Welfare which are resulting in an enlargement of the responsibility the local mental health board or other program administrators for developing comprehensive mental health-mental retardation programs.
- d. A growing awareness by the local mental health board of its responsibility for developing a comprehensive mental health program.

Each of these key factors will be discussed in some detail below. Their combined impact makes it clear that the magnitude of the programming responsibilities of the local mental health boards or other administrators has been greatly expanded.

A. Care in the Local Community

There has been a definite movement in the last few years away from the practice of isolating mental patients in large remote state institutions. The goal now is to keep the person in the community, providing the treatment he needs with the least disruption to his own family and community involvement. It is one thing to set forth such objective as a desirable goal - it is another to actually implement it in a specific community. Setting up a mental health center is one key step in achieving this goal. It is, however, only one in a series of steps which must be taken. In addition to mental health centers, a full array of treatment and other resources must be developed and coordinated in a community. Continuity of care and responsibility must be achieved if this goal of community care is to be realized. The operation of a direct service agency, such as a mental health center, is only one aspect of total programming. A much broader view of planning and programming must be assumed by the local Mental Health Board to meet this urgent need to plan for the effective utilization of all the major mental health, mental retardation and related systems in the total community.

B. Federal Legislation and Mental Health-Mental Retardation Programming

As indicated in Part I of this report, these trends in mental health programming have found expression at the federal level in specific legislation. There is recent legislation which has major implications for the development of local programs. For purposes of discussion here, two key federal acts will be examined to illustrate the basic approach the federal government has taken toward programming, and to determine what implications this has for local efforts here in Hennepin County.

1. Public Law 88-164

The most significant recent legislation at the federal level is Public Law 88-164, known as the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

This legislation provides funds for the construction of mental health centers. A major focus of this act is on locating such centers geographically and ensuring that they provide certain specified types of services to the residents of the "catchment area" which they serve. "Catchment area" is defined as an area of not less than 75,000 nor more than 200,000 persons. Any such center constructed with federal funds must provide the following essential services:

- inpatient services
- outpatient services
- partial hospitalization, i.e., day care, night care
- emergency services 24 hours a day
- consultation and education services to the community

Such facilities must be integrated into a comprehensive plan for the total community. Planning must be related to other community planning efforts, such as city and regional planning and poverty planning, and multiple funding sources must be coordinated for the operation of mental health programs.

The construction plan submitted by the Minnesota Department of Public Welfare to the federal government under Public Law 88-164 specifies that the local body with planning responsibility in Minnesota is the local mental health board or other program administrator.

Federal requirements emphasize the necessity of identifying precisely the nature of the population to be served in each of the "catchment areas". Extensive data must be obtained about the population characteristics, socio-economic characteristics, mental health facilities already in the area, and social problem indicators

of high risk groups. The task of gathering the kinds of information required by the federal act, both statistical data and information about the planning efforts of other mental health related agencies and efforts, implies major new demands on the local mental health board. In addition to requiring substantial amounts of data about the total community and about each specific proposed "catchment area", the federal guidelines, paraphrased below, include the following key components:

- a. The plan should give a narrative description of the major problems in each of the areas considered. This description should include consideration of conspicuous minority group problems, regional economic problems, or any conspicuous skewing of the distribution of the population at different age levels.
- b. The area descriptions should also highlight the implications of the special characteristics of each area for the development of mental health programming. For example, does the area require special attention to services to children, to the aged, to addicts, or to alcoholics?
- c. The inventory of facilities should also include data on Army and VA hospitals in the state, and the significance of these facilities for the provision of total care in the state.
- d. The area description should give some consideration to relevant voluntary health, educational, correctional, social work agencies (e.g., child care and family services, rehabilitation services, housing, economic opportunity programs, and employment or re-employment programs). This description would make a major contribution to an understanding of the total resources available for mental health care in a given area.

- e. The plan should include a description of the decision-making consequences of the coordination of the various planning efforts. It should show specific awareness of how other state and federal programs have been integrated with the development of community mental health centers. In particular, the discussion should describe any coordinated arrangements with such agencies in a state as education, welfare, office of economic opportunity, urban renewal and the state's agency for economic planning and development.
- f. The plan should also describe how the center's program has been able to share data, develop joint decisions and marshal resources of multiple financing through other programs that would contribute to the over-all effectiveness of the community mental health centers plan. It should be stressed here that it is not sufficient to merely list which committee members are representatives of other agencies. This section is intended to provide some substantive description as to how specific coordination is being achieved with relevant agencies. The plan should also provide some meaningful discussion of how the development of categorical areas in the plan, such as programs for drug addiction, alcoholism, consultation to the schools, and consultation to the churches, is being furthered through a conscientious integration of local level programs with the community mental health center's program.

Additional requests for federal funds may be forthcoming from local agencies. Federal and state requirements make necessary a new and different interpretation of the role of the Mental Health Board in integrating such additional centers into a comprehensive community program.

2. Public Law 89-105

Another federal act, Public Law 89-105, provides funds for the staffing of mental health centers during the first 51 months of operation of new centers and for new programs in existing centers. This potential source of financing must be examined for its implications in Hennepin County by such questions as: What is the relationship between staff and services matchable for funding under federal law and those which would be eligible under Minnesota law? Can these services, initially supported under federal funds, be eligible for state funds on a permanent basis, or would centers, by utilizing PL 89-105 funds, be adding staff which would ultimately have to be financed totally by local funds? The whole question of constructing and financing these centers under both Public Law 88-164 and Public Law 89-105 must be examined for its long range implications for this community.

C. A Comparison of State and Federal Programming Guides

The federal approach to mental health programming has broad implications for the functioning of the local mental health board. Federal requirements greatly expand the size of the job which must be done by those local communities wishing to capitalize on the funding possibilities made available by such laws as the Mental Retardation Facilities and Community Mental Health Centers Construction Act (PL 88-164).

The Minnesota Department of Public Welfare is making a major effort to clarify and to broaden the role and responsibility of local mental health boards throughout the state. The Minnesota Department of Public Welfare is now making specific plans to integrate the twenty-three mental health centers in the state into a unified program for attacking

major problems of mental illness and mental retardation.

The Minnesota approach to mental health-mental retardation programming compliments that of the federal government; both have been interested in the establishment of mental health centers. In addition to adding those new and additional resources which appear to be necessary, the Minnesota Department of Public Welfare is attempting to integrate the several key systems now under its jurisdiction. Key systems which the state operates or supervises and is attempting to integrate are:

1. State hospitals and facilities for the mentally ill and mentally retarded.
2. Mental health and mental retardation services of the county welfare board.
3. Community mental health and mental retardation programs.

In attempting to integrate these several systems, the Minnesota Department of Public Welfare is making explicit its expectations, and clarifying the roles and responsibilities with which each system has been charged.

Under the 1957 Minnesota Community Mental Health Services Act the local mental health board has responsibility for a comprehensive program serving a designated area. This includes responsibility for programming for statutorily defined problems, and also for programming for non-statutorily defined problems (See Part II). As interpreted by the Minnesota Department of Public Welfare, this does not mean that the mental health board has authority over the county welfare board's public mental health-mental retardation program, nor is the mental health board under the county welfare board's authority. What it does mean is that the mental health board is expected to help the county welfare board to develop an effective public mental health-

mental retardation program which will be coordinated with the other parts of the comprehensive mental health-mental retardation program for the county. It also means that the local mental health board has the responsibility for leadership in programming for non-statutory problems of the community and for coordinating public with voluntary and private resources which are concerned with such problems.

In Hennepin County, the administrator of the mental health program is the Board of County Commissioners. In line with the state definition of a comprehensive mental health-mental retardation program, the Board of County Commissioners and its Mental Health Board have responsibility for the programming, which includes, but which goes far beyond, the operation and administration of the Hennepin County Mental Health Center.

1. The Program as Defined by Law

The Minnesota Community Mental Health Services Act of 1957 delineates what is expected of the administrator of local mental health programs. The 1957 act authorizes the Commissioner of Public Welfare to "make grants to assist cities, counties, towns, villages, or any combination thereof, or non-profit corporations in the establishment and operation of local mental health programs..."⁹

The underlined terms are then defined as follows:

"Establishment and operation" refers to the responsibilities of the local administrator and is construed to mean that the board which is responsible for the program should:

- a. Provide the leadership for:
 - a comprehensive assessment of need;

⁹ Minnesota Community Mental Health Services Act, op. cit.

- the development of needed new resources;
- the appropriate modification, utilization and coordination of existing resources; and

b. Administer certain aspects of the program itself. Generally this will include the administration of a mental health center as one part of a comprehensive area-wide program.

"Program" refers to a coordinated system of activities and services referred to in (a) and (b) above (need assessment, resource development, utilization and coordination, and the administration of specialized services) directed toward helping to reduce "mental and emotional disorders, mental retardation, and other psychiatric conditions."¹⁰ The disorders and conditions referred to by the state are those indicated earlier: statutory disorders, culturally defined problems, and individually defined problems.

2. Revised Guidelines of Application for Community Mental Health Grant-In-Aid Funds

The State Department of Public Welfare is translating its changed expectations into specific requirements by modifying the guidelines which are required as part of the application for community mental health grant-in-aid funds. The purposes of these guidelines as articulated by the Minnesota Department of Public Welfare are to:

1. Facilitate understanding between the Minnesota Department of Public Welfare and local mental health boards.
2. Emphasize the mutuality of program planning.
3. Enable mental health boards or other administrators to develop programs suitable to local conditions and to continually improve program effectiveness.

¹⁰Ibid

Substantial changes are being made in the state guidelines relating to grant-in-aid applications for matching funds. In addition to spelling out the usual budgetary needs of the mental health center, the state is requiring that the annual application must include a description of the relationships with key agencies and institutions in the area, including mental health programs of the county welfare department and the appropriate state institutions. In addition to requiring the mental health board to assist those public agencies which have responsibility for statutorily defined mental problems, the state is further requiring the local program administrator to be concerned with non-statutory problems which generally fall within the province of voluntary and private mental health systems in the community. The responsibility of the mental health board in the voluntary and private sector pertains to the on-going assessment of needs and assistance in developing and utilizing new and additional resources.

D. Recognition by the Local Board of its Responsibility

There has been a growing recognition by the local Mental Health Board of these changing requirements, and the implications they have for mental health-mental retardation programming in Hennepin County. In line with the interpretation now being put on the Community Mental Health Services Act by the Minnesota Department of Public Welfare, the board has begun to recognize its broader responsibility for planning and programming for mental health services beyond operation of the Mental Health Center.

It was this recognition of changing responsibilities

which led the Mental Health Board to see the need for a reassessment of its own role in mental health and mental retardation programming in Hennepin County. Accordingly, the Mental Health Board requested the assistance of the Community Health and Welfare Council in developing a comprehensive mental health plan.

PART IV

KEY COMPONENTS OF A MENTAL HEALTH-MENTAL RETARDATION PROGRAM

Responsibility for designing, developing, coordinating and evaluating comprehensive mental health-mental retardation programming in Hennepin County is lodged with the Board of County Commissioners and its Mental Health Board. Analysis of recent federal legislation indicates that funds are available for the construction and staffing of mental health services, but that such services must be integrated into an area-wide program.

The committee, having examined the federal and state requirements, undertook, as a next step, an analysis of what is required in Hennepin County to develop the kind of program needed. It felt that such a program must be related to the local needs of Hennepin County and at the same time make maximum use of the funding opportunities at the federal, state and local levels.

The committee's analysis of local needs, federal and state requirements, and mental health plans and programs from other parts of the country led the committee to the conclusion that there are certain essential components which must be included in a comprehensive program. At least the following major components are considered essential to such a program:

- A responsible board or agency to act as administrator of the program, with responsibility for designing, developing, coordinating, and evaluating a comprehensive program.
- Methods to ensure continuity of care and continuity of responsibility.
- A data collection and evaluation system.
- The coordination of a full array of community resources, both psychiatric and non-psychiatric.

- The development of long range plans for the addition of new resources and the modification of existing resources.
- Integrated and coordinated planning with other key planning groups at the local, state and federal level.

A. Responsible Agency or Board

A responsible agency or board is defined as a specific organization with clear responsibility to provide on-going leadership in designing, developing, implementing, coordinating and evaluating a community-wide, comprehensive mental health-mental retardation program. Such agency or board provides a clearly recognized and accepted focal point of responsibility for mobilizing all of the relevant agencies and professions in the county in working toward the goal of reducing mental health-mental retardation problems.

In Hennepin County the Board of County Commissioners has accepted this responsibility by applying for and accepting state community mental health grant-in-aid funds. The Board of County Commissioners has chosen to utilize a Mental Health Board in carrying out this responsibility. As previously indicated, the Mental Health Board has requested the Community Health and Welfare Council to assist it in assessing the best way of carrying out this responsibility in light of broadened program demands.

B. Continuity of Care and Responsibility

Continuity of care to patients has been well spelled out as a concept and delineated as a desirable goal in almost all recent state and federal legislation as well as in the literature and thinking of professionals in the field of mental health. The basic question appears to be: in the field of services to the emotionally

disturbed and the mentally retarded, who is responsible for what? How is this goal of continuity of care to be achieved if there has been no determination of the responsibility and accountability for persons with such problems. Dr. Ryan, in the Boston Mental Health Study, poses a number of questions which are pertinent: "when a person knocks on the door of, let's say, a mental health clinic, who is responsible for him? Who is accountable for him? If he is not accepted for treatment, whose case is he? What is the responsibility of the agency? What is the responsibility of the referring agency? Who is going to keep track of this patient and try to make sure that he gets some help for his problems? The answer, and this is the answer that is applicable to most people with social problems, is that no one really takes case responsibility. No one is fully accountable for this patient!"¹¹

Problems of continuity of care and continuity of responsibility must be dealt with both at the case level and at the agency or community level. There is need for machinery to ensure continuity, both within agencies and between agencies. That is, regardless of whether a person or family is active with one agency or several agencies, there must be a specific plan developed for the family and a method of seeing to it that this plan is implemented and the results evaluated.

Currently, the only procedure which exists is the so-called "referral process" which has been shown in studies to be not only inadequate, but very often inappropriate. It has been shown to be

¹¹"Facts to be Faced in Planning Urban Mental Health Services", lecture by William Ryan, Ph.D., part of a series sponsored by Tufts Medical School, Department of Psychiatry, September 30, 1964.

term planning as well as for program and case coordination. The development and maintenance of a register is a difficult procedure. Of primary importance is the need for an adequate supporting staff to make possible the collection, coding, processing and analysis of the data and an adequate budget to provide for the maintenance of such an operation, as well as the safeguard needed for establishing confidentiality.*

D. Development and Coordination of a Full Array of Community Services

One of the key components of a community program must be the development and coordination of a wide array of services and programs for dealing with mental disorders and with other social problems which have mental or "emotional" elements.

There is increasing recognition that not all mental and emotional problems must be dealt with exclusively by "mental health specialists." Isolating the "mental" aspects from the complex problems presented by individuals and families and attempting to deal with them as medical or mental problems has often had two negative effects: first, it immediately makes hopeless any attempt to find enough specialist staff and manpower to cope with all such problems, and second, and more basic, it is often inappropriate and can be identified as one of the key factors leading to a breakdown in the referral process which often results in a lack of any treatment for the afflicted individual or family.

There is growing recognition of the necessity for developing

*The committee recognizes the potential threat to the individual's right to privacy inherent in such a register. Accordingly, it makes no recommendation with respect to such an effort in this community beyond further study.

and utilizing a broad array of resources to deal with problems of mental and social dysfunctioning. This includes the use of non-medical as well as medical resources; it involves the coordination of the existing resource base as well as the development of new resources. When "program" is perceived of as something broader than the operation of a clinic or center it is possible to consider the full range of services which are available in urban areas such as Hennepin County.

For purposes of discussion this wide array of resources can be viewed from two aspects--the public, tax-supported systems, and the private and voluntary systems.

1. The Public Tax-Supported Mental Health System

In addition to the Mental Health Center, which is primarily concerned with problems of mental dysfunctioning, there are several other systems within the public sphere which have some responsibility for dealing with mental problems or with other social problems which have a mental component to them.

Hennepin County government is significantly involved in providing mental health-mental retardation services in the community. These services include the Hennepin County Welfare Department, the Department of Court Services under the District Court, and the Hennepin County Court Commissioner's Office within the structure of the Probate Court of Hennepin County.

Forty-four positions support the Hennepin County Welfare Department's mental health-mental retardation program. These represent a total estimated annual cost of \$391,500.

Six positions support the Court Commissioner's office for a total estimated annual cost of \$50,000. An additional \$50,000 is budgeted to pay for mental examinations provided by that office.

Four positions support the clinical services, both psychiatric and psychological, of the Department of Court Services. These represent a total estimated annual cost of \$26,000.

These tax-supported services are available on a county-wide basis. An examination of these several agencies, supported by county funds, indicates that there are currently existing major public mental health-mental retardation operations in Hennepin County in addition to the Mental Health Center itself. More than \$500,000 is being spent by county government alone to support these services.

There is a potential for more effectively coordinating the funding sources represented by these several services. Also, these local mental health-mental retardation expenditures should be examined for their potential use as local matching funds for additional state grant-in-aid monies under the Community Mental Health Services Act of 1957. With the Minnesota Department of Public Welfare emphasizing the movement away from the focus on centers and toward the broad concept of program, it is appropriate that these services be examined in the light of this broader concept.

Amendments of the Community Mental Health Services Act passed by the 1967 legislature should also be examined. The amendments removed the per-capita ceiling that the state would match. The legislature also increased the maximum which communities may levy for mental health programming from one mill to two mills. (The 1967 value of a mill in Hennepin County is \$720,000.) On this basis Hennepin County has a potential for raising \$1,440,000 in local funds to be theoretically matched by equal state funds under the 1967 amendment to the Mental Health Services Act.

2. The Private and Voluntary Mental Health System in Hennepin County

Hennepin County has a well-developed private and voluntary network of mental health and social agencies which provides a major resource to this community. With the need for additional mental health specialists, it becomes imperative that there be a more effective use of all the resources which are available in the community.

In the past there have been many barriers to the effective cooperation between the public and private sectors. Such barriers include the kinds of intake policies, and case and problem criteria set by many of the private and voluntary agencies, as well as various eligibility rules, etc., set by the public agencies.

In the past two decades tax funds have become increasingly available to voluntary agencies for the purchase of direct services to clients for whom there is a public responsibility. "Purchase of service refers to direct payments by a governmental agency to a voluntary agency as a reimbursement for care or service given to an individual for whom there is a public responsibility."¹⁷

The general rationale for purchase of service, a concept which has been well developed in the field of child care, is that the voluntary or private agency can often provide the service more appropriately, efficiently, and economically, and also because they have the manpower to do it.

There are certain safeguards which can and must be designed into any such system which might be developed in this community, and these are summarized by Ralph Kramer as follows:

1. Provision should be made for full coverage of all persons

¹⁷Ralph M. Kramer, "Voluntary Agencies and the Use of Public Funds; Some Policy Issues" Social Service Review, April, 1966, pp. 15-20.

for whom there is public responsibility whether the service is provided directly by government or through a voluntary agency.

2. The service should be clearly defined; the clientele for whom there is public responsibility should be designated, together with the duration of the program.
3. Standards acceptable to both governmental and voluntary agencies should be set regarding intake policy, personnel, and services.
4. There should be adequate provision for joint planning on behalf of clients; for reporting, review, and audit; and for evaluation in order to assure accountability for public funds.
5. Fair payment should be made by government up to the full cost of the service, as determined by a cost analysis. Reimbursement rate should take qualitative factors into account and provide incentives for improvement.
6. A contract embodying these considerations should be jointly developed.¹⁸

It is apparent that if such a set of guides and safeguards can be developed by the purchasing agency in Hennepin County, additional community resources could be utilized in an attack on serious problems of community concern.

In addition to serving as guides for working out contracts with the voluntary and private system, many of these principles should be applied to any new facilities which might be constructed under Public Law 88-164; - The Mental Retardation Facilities and Community Mental Health Center Construction Act of 1963.

Safeguards which protect the autonomy and independent operation of voluntary and private agencies and at the same time ensure accountability to the public interest can and should be developed in contractual arrangements.

¹⁸ Ibid

Many of these same principles also apply to relationships and contracts which might be developed between the Mental Health Board and other public agencies if the purchase of service principle is developed in the fashion indicated earlier. For example, there are instances in Minnesota where a county welfare board, under Section 245-65, Subdivision I, of the Minnesota Community Mental Health Services Act, has entered into a contractual arrangement with the mental health board for funds to assist it in carrying out that part of the mental health-mental retardation program for which the county welfare board is responsible. Any such contractual arrangements entered into either with the welfare board or other agencies, such as the school system, should include the kind of safeguards and guides spelled out above.

E. The Development of Long Range Plans for the Addition of New Resources and Modification of Existing Resources

Another major component of programming must be the development of new resources in the community as well as a systematic method for modifying existing systems. Essential to such long range planning is the development of epidemiologic data about the incidence and prevalence of mental disorder. This would indicate the need for use of demographic analyses, population projections, and knowledge of factors affecting growth patterns of the county and metropolitan area. Much of this data may be available from other agencies in the community. Combined with such data must be information on trends and patterns of usage of state hospitals and outpatient psychiatric clinics, as well as the changing role of general hospitals and nursing homes in the care of the mentally ill.

Nationwide data concerning the use of state mental hospitals indicates that the over-all population of these hospitals has been decreasing at the rate of one percent per year. The decrease, however, has not been uniform for all age groups.

TABLE I

CHANGE IN RATES OF STATE AND COUNTY
MENTAL HOSPITALS, UNITED STATES, 1950-63
BY AGE GROUPS¹⁹

<u>Age Group</u>	<u>Rate of Increase or Decrease in Usage</u>
10-14 years	+12%
15-24 years	+ 7%
25-34 years	+ 1%
35-44 years	- 4%
45-54 years	- 2%
55-64 years	+ .2%
65 and over	- 2%

The increase in the number of adolescents and young adults in the population, and the rapid increase of these age groupings as patients in state hospitals, has important implications for the location and type of mental health services required. On the other hand, although the number of patients 65 and over is decreasing, they still constitute almost one-third of the patient population of the state hospitals. Morton Kramer points out that there is an imbalance in the provision of psychiatric services to the elderly in community psychiatric settings. For example, persons 65 years and over constitute only about two percent of the admissions to outpatient psychiatric clinics on a nationwide basis. It is suggested that the new Medicare program should provide additional impetus for communities to develop much needed programs of comprehensive health services for the aged.

¹⁹Kramer, Morton, op. cit.

There is also data available which indicates that population of the state hospitals is heavily weighted with never-marrieds, separated, divorced, and widowed persons. "Thus, in the planning of community placements, particular attention must be given to the living arrangements required by such persons, as well as the types of community-based services most suited to meet the medical, psychiatric, and personal needs of patients living in families as well as of patients living by themselves, or non-family settings."²⁰

In addition to developing new resources in the community, methods should be developed for evaluating the impact of such programs on the community. Programming for mental disorders is usually based on the premise that certain mental disorders can be prevented; others, although not preventable, can be treated successfully; and others, although not curable, can be treated in such a way as to minimize their disabling effects and to maximize the potential for rehabilitation of persons with the problem. The local mental health authority must have data on the extent to which each of these kinds of problems are occurring.

In summary, the local mental health authority will need to make certain that on-going studies of the epidemiology of mental disorders and the effectiveness of comprehensive mental health-mental retardation programs are carried out. Only on such a foundation of research can long range programming for the reduction of mental illness and mental retardation be effectively carried out.

²⁰ Ibid

E. Development of Relationships with Key Community Groups

Relationships with key agencies in the community must be developed by the board and its staff to assist them in developing a comprehensive community mental health-mental retardation program. The scope of the job to be done is broad and the tasks are many. Hence, no single agency can be expected to undertake all of the responsibilities outlined in previous sections of this report.

It is the board's function to provide the continuity and the relationships that are required to develop a comprehensive program out of a group of discrete services.

The board that serves as administrator of the program should therefore have time to be active in promoting this continuity through each member's participation in one or more of the key types of the agencies described below:

- those whose primary responsibility is limited to planning;
- those which are primarily responsible for administering certain services;
- voluntary associations and other community groups and organizations.

1. The Local Program Administrator's Relationships with Planning Agencies

Mental health and mental retardation programs are but a part of the community's efforts to reduce human problems. Mental health and mental retardation planning and programming must also be considered within the broad area of health care and within the area of comprehensive health care planning.

Organizations exist within Hennepin County, the metropolitan area and the State of Minnesota whose purposes and functions are

limited to planning. Such agencies include the Community Health and Welfare Council of Hennepin County, Inc., the Minneapolis City Planning Department, the City Coordinator's office, and other organizations which are currently planning and administering programs in the poverty areas, including Pilot Centers and Model Neighborhoods. All of these organizations are concerned with problems which partially fall within the program area of the Hennepin County Mental Health Board.

Within the metropolitan area similar agencies exist in the City of St. Paul. Still others are concerned with planning for the metropolitan area as a whole and include such agencies as the Joint Staff for the Metropolitan St. Paul and Minneapolis Hospital Planning Councils, and the Metropolitan Planning Council, which was recently created by the 1967 legislature.

The State of Minnesota has created a State Planning Agency which will address itself in the broad area of state-wide planning, and will include planning for comprehensive mental health care.

The agency with responsibility for problems in the area of mental health and mental retardation must contribute to and be guided by planning in the broader areas of human and community problems.

Relationships must be established with these key agencies. Communication with them is essential for both the current and future planning and programming responsibilities which are being placed with the local mental health-mental retardation program.

2. The Local Program Administrator's Relationship with Agencies which are Primarily Concerned with the Provision of Services

Within the broad framework of mental health-mental retardation programming which would be but one aspect of even broader community planning, specific agreements or understandings would need to be developed with each relevant service agency regarding its participation in the comprehensive mental health-mental retardation program. Such arrangements may or may not involve financial agreements.

Such agencies include the state hospitals, the county welfare agency, the University of Minnesota, daycare services, the schools, the courts, law enforcement and correction agencies, hospitals and other residential facilities, social agencies, nursing services, and professionals in private practice. To develop and implement a community-based comprehensive program will require establishing specific agreements between these service agencies. The local board and its planning staff must find new ways to involve these agencies to undertake some of the responsibilities and carry out some of the tasks outlined above. Many of the existing facilities and organizations in this community are providing effective services, yet they are not significantly related to each other in a comprehensive community program.

Partnerships must be formed between the Mental Health Board responsible for the program and the governing bodies of these facilities. Written agreements must ensure that the clients or families that are referred for services will receive them at the time of need, and in the amount and kind indicated.

Agreements must also ensure that these facilities will be reimbursed for the costs involved in those instances where the client is unable to pay for the services or where they are able to pay for only part of the cost. These agreements should clearly establish responsibility for all persons for whom the program is accountable.

Included in such agreements would be provisions for exchange of records of individuals and families between the various facilities and services related to the community's program. Agreements with the governing boards of these care-giving agencies must include case reporting as part of the community information system to be developed. These provisions will assist the program board and its staff to carry out some of their responsibilities directly and enable them to engage other relevant facilities and services.

These agreements should serve to facilitate understanding between the program and the relevant care-giving agencies and services in the community. They should also serve to emphasize the mutuality of planning and programming, and should assist in clarifying the roles and responsibilities of the many related agencies which will be called upon to carry out the responsibilities of the program.

3. The Local Administrator's Relationship with Voluntary Associations and the Community Groups

Again no one agency can assume responsibility for all aspects of the community's program. It is necessary that the responsible board and its staff develop relationships with key groups in the

community that can assist it in measuring the extent of the need, the effectiveness of the program, and the results of the efforts.

Key citizens groups, such as voluntary associations, church groups, service organizations, and business and labor groups, representing all segments of the community, can provide invaluable information on the impact of the mental health and mental retardation problems in the community.

These groups can also provide effective leaders who can assist the program board and its staff and the many facilities and service agencies to develop community awareness and understanding, to assist in identifying the extent of the problems in this community, and to stimulate support of the general public to plan and program for these problems.

PART V

THE SITUATION IN HENNEPIN COUNTY

At the present time, the Hennepin County Board of Commissioners, as the administrator of the state community mental health grant-in-aid funds, is the responsible local body for program development. These Commissioners also make up the County Welfare Board, which has major statutory responsibilities in the area of mental health and mental retardation. Since it is impossible for the Commissioners to spend the time necessary to administer the mental health program and the county welfare program they have delegated program responsibilities to the Hennepin County Mental Health Board and the County Welfare Director respectively.

The Mental Health Board members, in turn, also serve as the Advisory Board for the Hennepin County General Hospital, and the press of matters relating to General Hospital has left little of their time for attention to mental health planning.

The focus of mental health center staff activity has been upon the services provided at the General Hospital. The staff of the respective disciplines, psychiatry, psychology, social work, nursing, and others, have responsibilities in several areas. These involve provision of direct clinical service, supervision, consultation and educational services, after-care services, social rehabilitation services, training, and research. While these services are nationally recognized as outstanding examples of their type, they do not constitute a comprehensive program. The staff has concentrated its efforts on developing the program within General Hospital and in providing limited consultation services to key agencies in the community. Because of the pressing demands being placed on the staff to provide these clinical and teaching services, there is little time left for staff to undertake the kind of community planning

and programming indicated in this report.

Efforts have been made to provide consultation to key groups in the community which are planning mental health facilities and services, but these consultation services have necessarily been on a limited basis.

Although many agencies, daytime activity centers, residential facilities, the County Welfare Department, state hospitals, and other private, voluntary and public agencies and organizations provide services to the mentally retarded and their families, there has not been sufficient sustained leadership for developing a coordinated, community-wide program in mental retardation. The administrator of the community mental health grant-in-aid funds has this responsibility and in Hennepin County this is the Board of County Commissioners and its Mental Health Board.

In this report the committee has attempted to outline its awareness of the many complex tasks remaining in the field of mental health and mental retardation. In addition to the numerous suggestions contained in the text of this report, the committee has a number of specific recommendations which are set forth in the following section.

R E C O M M E N D A T I O N S

The membership of the present Mental Health Board is eminently qualified and suited as a mental health advisory board, but because of the need to devote the bulk of its time and attention to the large issues involving General Hospital as a whole there is a need for a separate board. Therefore:

- I. It is recommended that the Board of County Commissioners consider establishing a separate and distinct Community Mental Health-Mental Retardation Board. (See Organizational Chart, page 50)
- II. It is recommended that the proposed Mental Health-Mental Retardation Board have one or possibly two members who are also members of the General Hospital Advisory Board.
- III. The proposed Mental Health-Mental Retardation Board would be responsible for functioning in the following areas:
 - A. To advise and assist the Board of County Commissioners in carrying out its statutory obligations and responsibilities imposed by county, state, and federal directives as conditions to Hennepin County's participation in funding for mental health-mental retardation programs.
 - B. The operation and administration of the existing Hennepin County Mental Health Center presently located at General Hospital.
 1. This center would continue under the direction of the Center Director and the Hospital Administrator.
 2. The Mental Health Center should continue to operate

as an integral service of the Hennepin County General Hospital and within the existing organizational and administrative structure of the hospital.

3. The Mental Health-Mental Retardation Board should consider establishing satellite centers in other locations as an extension of the existing Mental Health Center.
4. The programmatic relationships which currently exist between the Mental Health Center and the General Hospital complex should be maintained. This would also maintain the relationships which the Mental Health Center has developed as a clinical, teaching research facility affiliated with the University of Minnesota and with national accrediting bodies.
5. The Mental Health Center services offered at General Hospital and at other locations should be considered as one of the elements of the county's mental health-mental retardation program.

C. The Mental Health-Mental Retardation Board would have responsibility for comprehensive county mental health-mental retardation planning and programming. This would include designing, developing, and evaluating such a program for the total county.

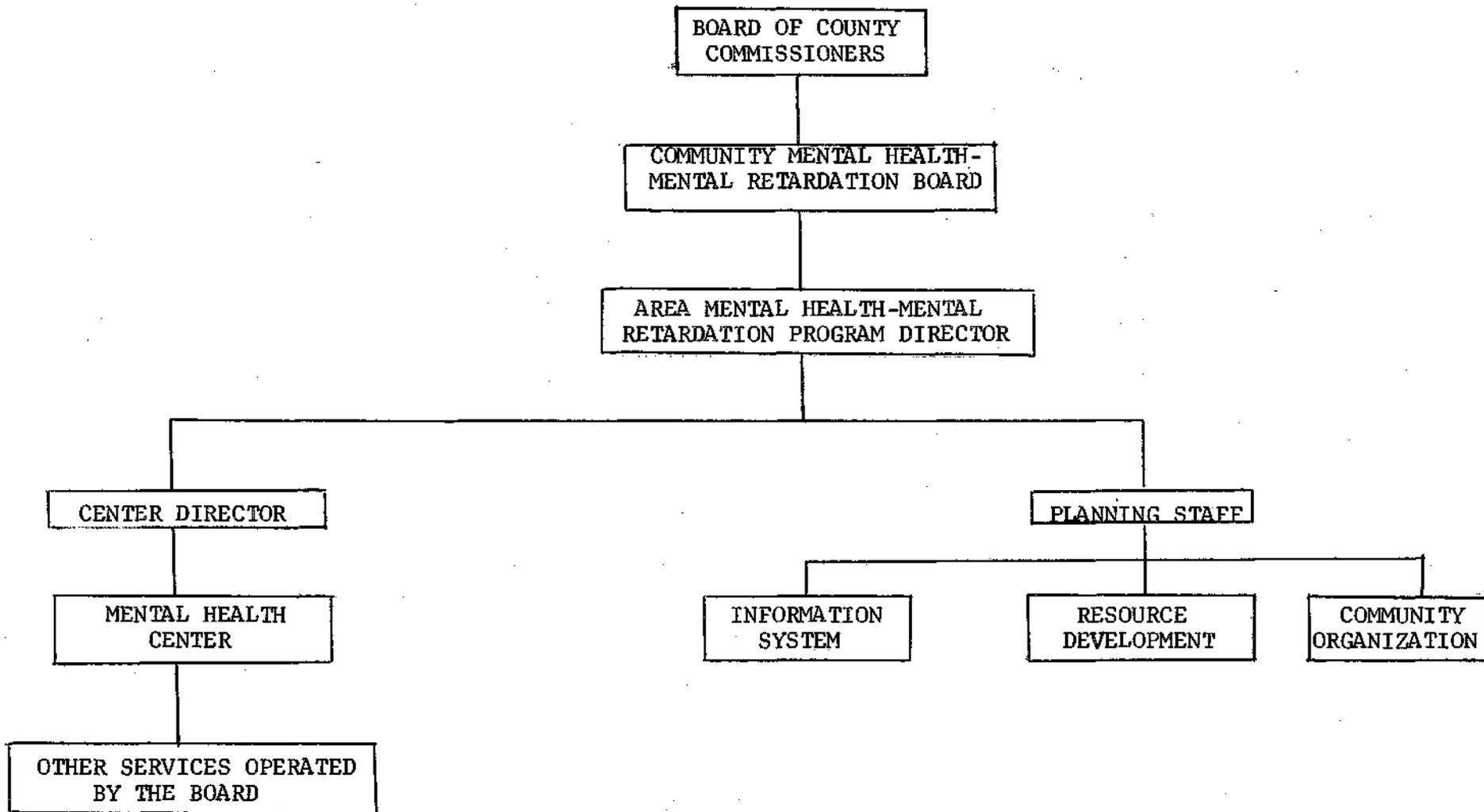
IV. In order to implement the foregoing recommendations it is further suggested that the Board of County Commissioners establish a position of Area Mental Health-Mental Retardation Program Director. The primary functions of

this position would be to:

- A. Serve as overall director of operations within the jurisdiction of the Mental Health-Mental Retardation Board;
- B. Develop program plans and assist the County Commissioners and the Mental Health-Mental Retardation Board in meeting their respective statutory and advisory responsibilities;
- C. Execute the planning functions directed by the Board;
- D. Develop and monitor necessary agreements with community resources both public and private;
- E. Carry out the activities required to encourage the development of new resources, public and private, and the modification of existing resources.

It is recommended that the staff necessary to perform these functions be hired as part of the Office of Area Program Director and that the Area Program Director and supporting Staff be free from all direct service responsibility.

The Area Program Director and staff should be qualified in community organization, administration, program planning, program evaluation, and social research. The position of Area Program Director may be filled by a professional mental health person (psychiatrist, psychologist, or social worker) but could also be recruited from other fields such as administration, public health, biometry, etc. Legal, accounting, research, and administrative service should be available to the Area Program Director's office.



Note:

The above oversimplified chart suggests possible organizational relationships between board and staff. Of necessity the Mental Health Center and staff will also be related to the Hennepin County General Hospital Administrator.

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Mrs. Malcolm A. McCannel - 58 Groveland Terrace - Minneapolis 3, Minnesota

15 April 1966

Mr. Marvin Borman, President
Community Health and Welfare Council
404 South 8th Street
Minneapolis, Minnesota 55404

Dear Mr. Borman,

Enclosed, a resolution passed at the last meeting of the Hennepin County Mental Health Board and which I am forwarding to you with the hopes of favorable action by your board.

The Mental Health Board members recognize that the Community Health and Welfare Council would be performing a great service for Hennepin County and for the cause of mental health in Minnesota by undertaking this project. We particularly appreciate the fact of your having such well-qualified staff for this purpose, and the possibility of their being able to start work almost immediately should the project be approved.

It is only within the past year that we have been given greatly extended responsibility for evaluating new mental health projects throughout the county, and we have found that we cannot do so without a comprehensive, long-range plan (which we first needed acutely several months ago).

Most sincerely,

(Sgd.) Louise W. McCannel

Louise W. McCannel, Chairman
Hennepin County Mental Health Board

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WHEREAS, the Hennepin County Mental Health Board has immediate need for, and has voted to prepare a comprehensive, long-range, community mental health plan for Hennepin County, and

WHEREAS, it appears that the Community Health and Welfare Council would be an ideal agency for undertaking such a plan both because its point of view would be objective and because it has at present the time and an exceptionally well qualified staff for the purpose,

NOW, THEREFORE, BE IT RESOLVED that the Hennepin County Mental Health Board requests the Health and Welfare Council to prepare a comprehensive, long-range, Hennepin County mental health plan in cooperation and consultation with the Hennepin County Board of Commissioners and the Hennepin County Mental Health Board and staff, and that work on it be started as soon as possible.

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