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DEPARTMENT OF PUBLIC WELFARE

To: Mr. Morris Hursh, Commissioner — February 23, 1968

DPW Cabinet

Mental Health Medical Policy Committee

Medical Services Division Institutions
Attention: Medical Directors
Administrators

Community Mental Health Programs
Attention: Board Chairmen
Program Directors

Daytime Activity Centers
Attention: Board Chairmen
Program Directors

Medical Services Division Staff

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

SUBJECT: Minnesota's Ten-Year Community Mental Health Program

I attach for your information the manuscript of the paper I will be delivering at the American Psychiatric Association meeting in Boston this coming May. I will be interested in your comments. I may, of course, make some changes in the paper prior to the actual delivery.

Please remember that this paper is technically the property of the American Psychiatric Association, and therefore it must not be reproduced or printed in whole or in part without their permission or until released subsequent to the May meeting. I think that distribution within the official family in this manner is permissible, but it should go no further.

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MINNESOTA'S TEN YEAR COMMUNITY MENTAL HEALTH PROGRAM

by David J. Vail, M. D.#

Because of time limitations, I must abbreviate this presentation. I have chosen mainly to stick with interpretations based on the experience rather than recite the experience itself.

This program was inaugurated in 1957 with the enactment of the Community Mental Health Services Act by the Minnesota legislature. At the time of its passage, only three other states, New York, New Jersey, and California, had enacted similar legislation.

A. Financing

A summary of the state appropriations gives a quick picture of the progress of legislative support of the program.

1957-59 biennium:	$342,000 (of which $100,000 was earmarked for the grant-in-aid program and the remainder allocated for state mental hygiene clinics, phased out in 1960)
1959-61 biennium:	$770,000
1961-63 biennium:	$1,400,000
1963-65 biennium:	$1,900,000
1965-67 biennium:	$2,580,000
1967-69 biennium:	$3,270,000

As the state funds are matched equally by local funds, mainly in taxes, this means that by 1968 the total of state and local expenditures is better than $3 million per year, or almost $1 per capita of the state population.*

*Meanwhile state appropriations for grants-in-aid to dyatime activity centers for the mentally retarded, under parallel legislation in a program administered under the same auspices, have risen to a level of over a half million dollars per year, again matched by local funds.

Medical Director, Minnesota Department of Public Welfare

The state financing has expanded from $342,000 to over $3 million in 10 years, a growth rate of 1,000%.

Virtually the entire state is now covered, there being only four out of 87 counties not being served by the program. These 83 counties are sorted into 23 organized areas.*

B. Legislation

The basic 1957 legislation opens as follows:

> An Act relating to the establishment of community mental health services programs, providing for state grants-in-aid to assist local communities and non-profit corporations in establishing and operating such programs.

245.61 COMMISSIONER OF PUBLIC WELFARE MAY MAKE GRANTS FOR LOCAL MENTAL HEALTH PROGRAMS. The commissioner of public welfare is hereby authorized 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 to provide the following services: (a) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, and other psychiatric disabilities; (b) informational and educational services to the general public, and lay and professional groups; (c) consultative services to schools, courts and health and welfare agencies, both public and private; (d) out-patient diagnostic and treatment services; (e) rehabilitative services for patients suffering from mental or emotional disorders, mental retardation and other psychiatric conditions particularly those who have received prior treatment in an in-patient facility.

Note three points here:

*The total number of areas when the remaining four counties are organized may be 26. For the description of "area" see p. 6

(1) The subtitle of the act, the section title, and the opening sentence all refer to local mental health programs.

(2) The statute identifies three main problems to be solved in the form of "mental illness"/"mental or emotional disorders"; "mental retardation"; and "other psychiatric disabilities"/"conditions."

(3) The law allows matching only for out-patient services. By interpretation this has been extended to include everything that might occur up to but not including overnight occupancy of a regular hospital bed.

We have had occasion to return again and again to the language of the enabling statute, especially since starting around 1964 we became frustrated with the services-purveyance model and sought clarification of a model of problem-solving on a sound programmatic base. To our gratification we found it had been in the statute the whole time.

The law also calls for establishment of a board which may be administrative or advisory; appointed by the executives of the political subdivision or constituted as directors of a nonprofit corporation. The board is intended to be broadly representative of the community. Duties of the board are stated in law and have been recently expanded by interpretation, especially in regard to program planning.

The statute has been amended over the years. Amendments have had mainly to do with internal administrative matters. Two amendments of major importance have allowed state matching for amortization costs and in 1967 removal of a per capita limitation on the amount of state money that could be granted to the locality. The per capita limitation, seemingly a sensible precaution in 1957, became increasingly restrictive and obsolete. The fact that a conservative legislature was willing to remove it speaks well for the acceptance of the program.

With a sound conceptual framework of program development and removal of an arbitrary limit on financing we believe ourselves to be now in a very advantageous position.

In 1967 the legislature enacted a new hospitalization and commitment act. It has two main impacts on the community mental health - mental retardation program: (1) It requires that centers "cooperate" in establishing "a continuing plan of aftercare services" for patients leaving hospitals. (2) It includes the community mental health center in the legal definition of "hospital" under the act, as "equipped to provide care and treatment for mentally ill, mentally deficient, or inebriate persons." This means that under certain conditions such persons could be committed to a community mental health center for "care and treatment"; obviously this fact has pronounced implications for future program development.

C. Program

1. Administrative models

The emphasis of the program for the first several years, based on what we now see as a limited reading of the enabling law, was on the establishment and operation of mental health centers, that is a professional staff operation quartered in some building or part of a building. Under this model the board has seen itself as being responsible mainly for the operation of the center itself, with very limited responsibilities outside of this. The "program director" has been a member of the professional staff trained and often highly oriented as a clinician, who takes on extra administrative responsibilities on a part time and so to speak "after hours" basis, for which he receives extra pay over and above his regular salary as a psychiatrist, psychologist, or social worker.*

Since 1965 the state has been working with the boards and staffs to reshape the administrative model in a way that would bring about a pronounced change in several directions:

(1) With the emphasis on program rather than simply operating a center, the board -- now we are using the style of area mental health-mental retardation board -- is expected to expand its purview to the

*In appointing the program director the boards have gone by criteria in the person's interest and ability in administration generally, fiscal management, public relations and especially community organization, regardless of his other professional background. We call this the "best man" approach. While the psychiatrist has had supremacy in case management or treatment matters we have seen no reason why he should also have to be the program administrator if he has not the interest nor ability to carry out this function.

entire community and its problems and take responsibility for designing and developing a total program, including various program elements or services, that will attack the problems. The board may choose to add on service operations, e.g., aftercare social clubs, under its direct operation. More often it will see to the development of program-elements by indirect means such as subgrants or subcontracts to other agencies, making expert staff consultation available, and more intangible efforts under the general heading of "providing leadership." The state looks to the board as the mental health-mental retardation planning agency for the area, which is defined as the county, group of counties, or part of a county served by the board.

(2) For the board to be able to carry out such responsibilities requires strong staff assistance. We have promoted the idea of a full-time program director serving as an executive officer to the board. Such a function would remove him entirely from the clinician role and put a premium on his community organization skills.

Thanks to careful pacing and widespread discussion over a 2-3 year period involving those who would be affected by such changes, we find that the general plan is being well accepted.

2. Substance

In analyzing what is meant by "comprehensive" we have sorted out the general field of "mental and emotional disorders" into three main groups.

(1) Statutorily-defined mental problems and mental and emotional components of other statutorily-defined problems.

(2) Culturally-defined problems.

(3) Individually-defined problems.

The comprehensive program takes in all three problems. Under our plan it is the responsibility locally of the area mental health-mental retardation board to develop programs aimed at all three, though of course their actual involvement in or management of service operations need not be this broad and in practice may be quite appropriately aimed primarily at culturally and individually defined problems. This sector of culturally and individually defined problems, which we define as "non-public," will take in the great majority of persons with "mental health problems" or "emotional disorders" (in William Ryan's usage), our friends and neighbors and just plain folks leading lives of quiet and sometimes not-so-quiet desperation.

The public mental health-mental retardation program is included in the comprehensive program; it is aimed at the statutorily-defined problems, in particular mental problems. These are disorders defined in law, for which the law assigns specific and inescapable responsibility under mandate to public agencies. In Minnesota the problems are mentally ill person (plus subgroups of mentally ill and dangerous to the public, psychopathic personality, and sexual offender), mentally deficient person, and inebriate person (which includes drug addiction in the definition).

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2. Substance

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In regard to problems, the local programs have concentrated mainly on "mental illness" and "mental and emotional disorders" especially among children and young adults. Attention to mental retardation and "other psychiatric disabilities" such as alcoholism, problems of aging, suicide, etc., have been relatively modest. Program expansion in these areas is expected to occur in the next few years.

As to method, controversy has run high in the past over direct vs. indirect service techniques. We have historically always stressed consultation to other agencies as the law intends. With program goals and strategies now clear, we regard the question of method, which is a tactical issue, as relatively secondary in importance and in any event derivative.

D. Evaluation

Program evaluation is still elusive, though we have learned a great deal since we entered this field in 1962.

We have learned that evaluation and planning are inseparable from each other and that they are an integral part of program administration. We have learned also that the evaluation-planning effort derives in the first instance from clear goal definitions. In practice we have found it most useful to state the goals in terms of problems to be overcome.

Goals divide into internal and external goals. For example, if we are in St. Paul and want to get to Boston, the external goal is "reach

Boston."* Internal goals then involve getting the necessary funds, devising or obtaining the means of transportation, etc. An internal goal may become absorbing and may even replace the external goal. Thus in the above example the traveler may become so preoccupied about getting his car in shape that he forgets about the trip.

In operation, we have seen historically in Minnesota three phases of goals: priming, activities, and impact.

Of these, priming and activities are essentially internal goals. Priming means "getting services going" (or "getting centers started"). This was our great emphasis in the early years, and the evaluation was in terms of how many centers established, how much staff on hand, how much money being spent, etc. Activities is consequent to priming and refers to services being purveyed, evaluated in terms of number of cases opened and closed, man-hours of performance in different activities, etc. In our view there is widespread non-recognition of priming and activities goals as being essentially internal in nature: This is

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*In purist usage, we would postulate this as a problem. The problem is being in St. Paul rather than Boston and the goal is then to overcome the problem, i.e., to get to Boston from St. Paul. The usage is similar to the null hypothesis in research methodology and further lends itself well to computer technology.

especially true of services or service which is seen all too often not in its true light as a means but falsely as an end in itself.*

Though we have outgrown the priming and activities phases in Minnesota and we want to enter the impact phase we are frustrated and unsure of ourselves as to how to go about it. Measures of impact are uncertain in our business. In Minnesota we have observed in the last several months, for example, a 10% drop in first admissions of mentally ill persons to state hospitals; how this finding connects as an outcome of the above described program and what value to place on it are obscure.**

We are now giving some thought to going beyond and possibly well beyond the immediate field of "mental illness, mental retardation and other psychiatric disabilities" to seek a broader and more generic impact

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*The so-called "national mental health program" of the NIMH is aimed at an activities goal but is still as of 1968 essentially in the priming phase. Priming is represented by the effort to get comprehensive centers established and activities by the emphasis on "quality services." Though the federal model is more inclusive and sophisticated than that in Minnesota prior to 1963, the historical process is identical.

Hindsight would now suggest that for both Minnesota and the nation the last step should have come first. That is, we should have clearly defined desired impact, i.e., goals, and then designed the methods accordingly. Sad to say, it often happens in public life that Doing Things Backward is the name of the game.

**We do know that unfortunately measures may become distorted into goals; for example, the rapid and continuing decline of population in state hospitals for the mentally ill and mentally retarded is a valid measure of overall program progress but it should not be seen as an end in itself.

model.* The "time down" concept used in health planning, i.e., time lost from normal duties or satisfying activities, might be useful. Cost measures may be possible if we are clever: computations of non-productiveness in work, cost of direct services or care, the loss of revenue in taxes not being paid, etc.

In the search for a generic model we may approximate measures that go to make up the "quality of life," to use the current phrase.** This may not be as elusive as it seems, if we remember to state the goals as

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*It is of some interest and possibly a portent for the future that our most recent operation, started in Anoka County on a pilot basis in 1966, is called not "mental health center" like the earlier ones but "Human Resources Office."

** In a 1967 survey by Midwest Research Institute Minnesota was rated among the top five states in "the good life" (in order: California, Minnesota, Connecticut, Massachusetts, Washington). The overall rating was based on a composite of nine items: status of the individual, individual equality, democratic process, education, economic growth, technological change, living conditions, health and welfare, and agriculture. Savants might find a more fundamental cause of Minnesota's high quality of life in her myriad lakes. W. H. Auden, for example, points out:

> A lake allows an average father, walking slowly,
> To circumvent it in an afternoon,
> And any healthy mother to halloo the children
> Back to her bedtime from their games across:
> (Anything bigger than that, like Michigan, or Baikal,
> Though potable, is an 'estranging sea').
>
> Lake-folks require no fiend to keep them on their toes;
> They leave aggression to ill-bred romantics
> Who duel with their shadows over blasted heaths:
> A month is a lacustrine atmosphere
> Would find the fluvial rivals waltzing not exchanging
> The rhyming insults of their great-great-uncles.

problems and break them down into measurable objectives. For example, personal and property damage suffered in civil disturbances might turn out to be a good problem-oriented measure of the "mental health" of a community, or damage from auto accidents.

Public documents, old and new, give us some guidance. "Life, Liberty, and the pursuit of happiness" may be measurable in impact terms, as may "domestic tranquility . . . the general welfare, and . . . the blessings of peace." The opening passage of P.L. 89-749 ("The Comprehensive Health Planning and Public Health Services Amendments of 1966") gives another suggestion when it speaks of "assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living."

It is up to those involved in community-based mental health-mental retardation programs at all levels to see to it that the programs will not just be an adornment of that environment but will in fact forcefully and measurably contribute to it.