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The Historical Development of the Far Northwest Counselling Center

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THE HISTORICAL DEVELOPMENT OF THE FAR NORTHWEST COUNSELLING CENTER

By

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VITA

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CHAPTER I

INTRODUCTION

This study proposes to examine the historical development of the Far Northwest Counselling Center which prior to its establishment in the community was the outpatient program at Chicago-Read Mental Health Center, Chicago, Illinois. The Center began operating as a community mental health center in June of 1976 as a result of the transfer of its operation from the Illinois Department of Mental Health to Lutheran Social Services of Illinois. No longer located on the grounds of a State Hospital but in its own free-standing building on a commercial street in a residential neighborhood, the Center has been operating as the mental health center of the community for a period of four years.

The purpose of this examination will be to review significant components in that historical development as a community mental health center. It is hoped that this investigation will provide insight into the problems facing a developing mental health center as well as some of the remedies to those problems. The thesis of this study may be stated in the following question: "What were the significant components of the historical development

of the Far Northwest Counselling Center as a community mental health center?"

This thesis suggests the following subtheses:

1. What preliminary factors led to the plan for establishment of a community mental health center for this particular community?

2. How was the plan for establishment of a community mental health center implemented?

3. Once the Center was established in the community, what was the experience of the Center in the following key areas:

a) client oriented factors;

b) program oriented factors;

c) community oriented factors.

4. What were the significant components of the historical development of the Far Northwest Counselling Center as a community mental health center?

Questions 1 and 2 deal with the years preceding the Center's establishment in the community in 1976, especially fiscal years 1975 and 1976. These questions will be dealt with in Chapter III. Question 3 deals with the years of the community operation of the Center, fiscal years 1977 through 1980. This question is the subject of Chapter IV. Chapter V deals with question 4.

As a result of the passage of Public Law 88-164, "The Mental Retardation Facilities and Community Mental

Health Centers Construction Act,"[1] the concept of community mental health in the United States began to be an operational reality. Since 1963, books, reports, task forces, and symposia have chronicled the gradual development of community mental health centers throughout America. A dramatic change in public attitudes toward mental illness has taken place in the past fourteen years since the passage of Public Law 88-164.[2] To fully appreciate its impact, one must first examine its historical antecedents as found in the literature.

Review of Literature

Within the general field of psychiatry, community psychiatry is a relatively new development.[3] As its name indicates, this branch of psychiatry is concerned with the relationship between the patient and his community. Further, it aims at the utilization of community resources in the identification, treatment, and rehabilitation of the mentally ill or mentally retarded. Specialists within community psychiatry belong to one of the psychiatric

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[1]Public Law 88-164. Title II - Regulations. Community Mental Health Centers Act of 1963. Federal Register, 1964.

[2]Ibid.

[3]Goldenson, Robert M. The Encyclopedia of Human Behavior (New York: Doubleday and Company, Inc. 1970), p. 237.

professions--psychiatry, clinical psychology, psychiatric social work, or psychiatric nursing.

Historically, community psychiatry has its origins in the Mental Hygiene Movement (1908) founded by Clifford Beers.[4] The Mental Hygiene Movement resulted in the establishment of the National Committee for Mental Hygiene (1909), later to evolve into the present-day National Association for Mental Health.[5] Collaborating with this movement, the National Mental Health Foundation and the Psychiatric Foundation brought the federal government into the area of mental health through the passage of the National Mental Health Act of 1946 and the creation of the National Institute of Mental Health.[6]

This general historical survey gives a picture of the national awakening concerning mental health issues. More importantly, for the purpose of the present study, it provides the background for understanding the significance of the community mental health as a movement and as a concept. As a result of the historical developments described above, the Joint Commission on Mental Illness and Health was created by Congress in 1955 to determine the mental health needs of America and to make

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[4]Goldenson, The Encyc. of Human Behavior, p. 147.

[5]Ibid., p. 859.

[6]Ibid., p. 858.

concrete recommendations to meet those needs.[7] The recommendations of this Commission formed the basis for President Kennedy's historic message to Congress of February 5, 1963, asking for "a bold new approach" to the problems of mental illness and mental retardation.[8]

This message of President Kennedy resulted in legislative action by the Congress in the passage of Community Mental Health Centers Act of 1963.[9] With the passage and implementation of this Act in succeeding years, the terms "community psychiatry" and "community mental health" have become increasingly synonymous in common usage in the United States. Before proceeding further with an assessment of the existing literature related to the present study, an amplification of this identity between the two terms will help focus the discussion.

In "A Psychiatric Glossary" edited by the American Psychiatric Association, community psychiatry is defined as follows:

> That branch of psychiatry concerned with the provision and delivery of a coordinated program of mental health care to a specified population (usually all residents of a designated geographical area termed the catchment area). Implicit in the concept of community psychiatry is acceptance of continuing responsibility for all the

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[7] Ibid., p. 650.

[8] U. S. President, Message "Mental Illness and Mental Retardation" H.R. Document No. 58, 1963.

[9] Public Law, Title II - Regulations, p. 1.

> mental health needs of the community--diagnosis, treatment, rehabilitation (tertiary prevention) and aftercare, and equally important, early case-finding (secondary prevention), and promoting mental health and preventing psychosocial disorders (primary prevention). The organizational nucleus for such services is typically the Community Mental Health Center. The body of knowledge and theory on which the methods and techniques of community psychiatry are based is often called social psychiatry.[10]

In analyzing this definition of community psychiatry, three elements stand out as significant: 1. Geographic delineated population to be served, 2. A range of services geared to increasingly acute problems, and 3. An organization for the delivery of services. Clearly, community psychiatry is a problem-oriented, pragmatic approach to mental illness utilizing community organizational theory in its implementation.

Contrasting this analysis with the field of community mental health, one finds virtual identity between the terms community psychiatry and community mental health. With the passage of Community Mental Health Centers Act of 1963 by Congress, this identity of terms was made operational in the wording of the Act itself.[11] The Act clearly shifted emphasis away from the providers of services to the type of services to be provided and the way

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[10] American Psychiatric Association, A Psychiatric Glossary (Washington, D.C.: Publications Office, 1969), p. 20.

[11] Public Law, Title II - Regulations, p. 1.

in which services were to be provided. This emphasis is very pronounced in the U.S. Department of Health, Education, and Welfare literature which explains the intent and requirements of the Act. In the Department's "Fact Sheet on Comprehensive Community Mental Health Centers Programs" it asks and answers the following questions which illustrate this accent on the type and locus of services.

1. What Is A Community Mental Health Center?

   A Center is not necessarily a new or a separate building. It may be a wing added to a general hospital or to a clinic, or to another mental health facility in the community.

   Basically, the Mental Health Center is a program of mental health services in the community, in one or more facilities, under a unified system of care.

2. What does a Community Mental Health Center do?

   The Center assembles a variety of services within a geographic area for treatment of the mentally ill and the prevention of mental illnesses.

3. What is the purpose of a Community Mental Health Center?

   The purpose of the Center program is to provide a range of coordinated mental health services in the community. Through the Center's program, a patient will find the type of care he needs when he needs it, as close to his home as possible. Through the Center's program, the community also strengthens its resources for prevention of mental illness.

4. What are the essential services?

   To qualify for federal funds, a Center must provide at least five essential services:

A. Inpatient Care. This unit offers treatment to patients needing 24-hour care.

B. Out-patient Care. This unit offers treatment programs for adults, children, and families.

C. Partial Hospitalization. This unit offers, at least, day care and treatment for patients able to return home evenings and weekends. Night care may also be provided for patients able to work, but in need of further care or without suitable home arrangements.

D. Emergency Care. Twenty-four hour emergency service is available in one of the three units named above.

E. Consultation and Education. The Center staff offers consultation and education to community agencies and professional personnel.[12]

From this examination of the early historical developments in the field of community psychiatry and community mental health, the following areas for investigation present themselves:

1. Community psychiatry
2. Community mental health movement
3. Community Mental Health Centers Act of 1963 and subsequent legislation
4. Organization and effectiveness of Community Mental Health Centers
5. Recent developments in community mental health.

The literature is extensive in each of these areas. In addressing community psychiatry and community mental health, one can trace the separate origins of each area

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[12] U.S. Department of Health, Education, and Welfare, Fact Sheet: The Comprehensive Community Mental Health Centers Program (1968), pp. 1-2.

while at the same time noting their eventual meshing due mainly to public policy in the field of mental health legislation. With the publication of Perspectives in Community Mental Health edited by Arthur J. Bindman and Allen D. Spiegel in 1969, a certain coming of age of community mental health was marked.[13] This volume assesses the far-reaching effect of the community mental health legislation of 1963. The importance of this legislation cannot be overlooked if one is to get a comprehensive perspective on the field of mental health in the United States today.

The organization of community mental health centers varies widely depending on the state of development of the concept of community mental health in a given part of the United States. Also, a community mental health center should be designed to meet the dynamic factors in a given place that, taken in their constellation, may produce particular kinds of disorders. This type of planning demands scientific study of demographic and cultural characteristics of a given geographic area.[14]

In response to Public Law 88-164,[15] the individual

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[13]Bindman, A.J., and Speigel, A.D. Perspectives in Community Mental Health (New York: Aldine, 1969).

[14]Zax, Melvin, and Specter, Gerald A. An Introduction to Community Psychology (New York: John Wiley and Sons, Inc., 1974), pp. 1-27.

[15]Public Law, Title II - Regulations, p. 1.

states have established statewide mental health plans, similar to the Illinois Mental Health Zone Plan.[16] These statewide plans typically divide a state into regions of sizable geographic and population proportions with smaller service areas served by local community clinics. Basically, centers are an outgrowth of the deinstitutionalization of the state mental hospital programs of the past.

There seems to be a general pattern of organization of community mental health centers with the states taking the initiative to provide and channel funds for their establishment. The private and semi-private sector such as church-related charitable organizations, universities, and community hospitals have joined in the venture by providing a community base of operations, administrative expertise, and a network of services.

The effectiveness of community mental health centers is an issue which has been increasingly debated in recent years. Ralph Nader's Study Group Report entitled "The Madness Establishment," calls into serious question their effectiveness.[17] This report points out the serious omission of built-in evaluation of community mental health centers in the past.

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[16]Illinois Department of Mental Health, Illinois Zone Plan (1968), p. 1.

[17]Chu, Franklin D., and Trotter, Sharland. The Madness Establishment: Ralph Nader's Study Group Report on the National Institute of Mental Health (New York: Grossman Publishers, 1974), p. 204.

Along with the lack of ongoing evaluative requirements, there is also a basic lack of research in the field of community mental health.[18] Cowen feels the research needed will never be obtained, considering the small amount of funds currently being spent around the country.[19] Zax and Specter point out that the long-term nature of research on community mental health itself presents a difficulty.[20] To determine whether a given program has had a significant impact often requires long-term study. Keeping track of the subjects involved in a mental health program over the long term presents a very difficult challenge.

Among the new developments in community mental health centers, the trend to view them as but one component in a network of human services seems to be gaining acceptance. No longer is society looking to community psychiatry or community mental health centers as the main "cure-all" for problems of poverty, racism, class tensions, and crime.[21] However, the trend to ambulatory care rather than hospital treatment, and to purchase of service rather

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[18] Zax, Intro. to Community Psyc., pp. 420-423.

[19] Cowen, E.L. Emergent Approaches to Mental Health Problems: An Overview and Directions for Future Work (New York: Appleton-Century-Crofts, 1967), pp. 389-455.

[20] Zax, Intro. to Community Psyc., pp. 450-451.

[21] Chu, The Madness Establishment, p. 204.

than government owned and operated programs seems well established.

Research on the establishment, organization, and development of specific community mental health centers has been sparse in the professional literature. Kellam and Schiff reported on several community mental health centers, notable among them, the Woodlawn Mental Health Center in Chicago, Illinois.[22] Established in the early nineteen-sixties, the Woodlawn Mental Health Center provided an example of the organizational stages involved in the establishment of a new center: 1. Partnership of governmental bodies with community representatives, 2. Development of a plan of action, 3. Needs assessment of the community, 4. Development of a mental health program to meet these needs. The approach of the report was a developmental, case study detailing the events leading to the establishment of the center.

Rieman reported on the need for community organization in the development of a community mental health program.[23] He outlined the method by which programs and

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[22]Kellam, S.G. and Schiff, S.K. "An Urban Community Mental Health Center" from L.F. Duhl and R.L. Leopold, eds., Mental Health and Urban Social Policy (San Francisco: Jossey-Bass Inc. Publishers, 1968), pp. 56-72.

[23]Rieman, D.W. "Midway: A Case Study of Community Organization Consultation" from M.F. Shore and F.V. Mannino, eds., Mental Health and the Community: Problems, Programs, and Strategies (New York: Behavioral Publicagions, 1969), pp. 41-58.

services were planned and developed from a community perspective. He highlighted several key factors in the organizational process:

1. Effective problem definition
2. Role of a consultant to the community
3. Local involvement in all planning
4. Flexible timetable
5. Coordination of organizational efforts.

Similarly, Freed and Miller stressed the importance of organizational considerations in their case study of a Community Mental Health Center in Chicago, Illinois, with special emphasis on the need for "broadening the base" of community support and participation.[24]

Cohen's "Anatomy of a Local Mental Health Program: A Case History," details the following organizational phases:

1. Establishing Lines of Communication
2. Developing Formal Structures
3. Acceptance of the Program by Community Institutions
4. Achieving Community Integration.[25]

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[24]Freed, Harvey, and Miller, Louis. "Planning a Community Mental Health Program: A Case History." Community Mental Health Journal, Vol. 7, (2), 1971, pp. 107-119.

[25]Cohen, Raquel E. "Anatomy of a Local Mental Health Program: A Case History." American Journal of Orthopsychiatry, Vol. 42, (3), April 1972, pp. 490-498.

The Department of Health, Education, and Welfare contracted with Abt Associates Inc. to evaluate the effectiveness of the seed money approach in financing community mental health centers in accord with Community Mental Health Center's program objectives. The resulting research, entitled Community Mental Health Centers--A Decade Later in April 1978, utilized the case study analysis approach to examine 29 representative community mental health centers. Significant areas of investigation were these:

1. Funding Mixture
2. Descriptive Characteristics
    a) Ownership
    b) Location
    c) Affiliations
    d) Cost of Services
3. Environmental Factors
4. Center Activities
5. Service Delivery Patterns.[26]

Although this study was primarily concerned with cost and funding issues in federally funded centers, in addition it provided an illustration of the application of the case study method to community mental health centers.

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[26]Naierman, N., Haskins, B., et al. Community Mental Health Centers: A Decade Later (Cambridge, Mass.: Abt Books, 1978).

Models

Rappaport and Chinsky attempted a simple, yet useful division among existing mental health service delivery models. Contrasting styles of delivery, they established two main modes:

1. Waiting mode - Mental illness and disease explanations of abnormal behavior. Experts diagnose, prescribe, and treat. Client seeks out treatment.
2. Seeking mode - Service is located outside traditional expert's office or hospital. Combination of professional and non-professional staff render preventative as well as remedial service, including educational and social programs. Outreach to the community is a top priority.[27]

The authors pointed out that this second mode came closest to the current concept of community mental health. Their analysis indicated the necessity of recognizing social organizational factors in the study of community mental health centers.

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[27]Rappaport, Julian, and Chinsky, Jack M. "Models for Delivery of Service from a Historical and Conceptual Perspective." Professional Psychology, February 1974, pp. 42-50.

Development

The continued development of community mental health centers as a growing enterprise has come under serious question in the latter part of the nineteen-seventies. Borus in examing some of the issues critical to the survival of community mental health, identified several key needs:

1. Clarification of Priorities
2. Collaboration with the Community
3. Evaluation Research
4. Stabilization of Funding.[28]

In summary, the author urged development of the "uniqueness" of a center in terms of its services to the community to insure its continued viability and development.

Partnership Role

Burd and Richmond suggested that continued development of human service organizations such as community mental health centers may depend upon the effective partnership of the public and private sector. The authors review the existing literature on this partnership and find a new emerging view about its prospectus:

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[28]Borus, Jonathan F., "Issues Critical to the Survival of Community Mental Health." American Journal of Psychiatry 135, (9), September 1978, pp. 1029-35.

> Upon realizing that many of its objectives are synonymous with those of the public health and welfare sector, the private agency can move from under the protective cover of separatism for the sake of retaining the mantle of autonomy. With its own identity established, the private agency can confidently join forces with the public sector. If done carefully and properly, the benefits that the private agency will derive upon entering into a grant or contractual relationship with a government unit can affect every facet of its organizational being--its philosophy, programs, personnel, and fiscal affairs.[29]

The authors described several major benefits from the formation of such a new partnership:

1. Advancement of Organizational Goals
2. Expansion of Client Base
3. Increased Funding
4. Systematic Analysis of Services
5. Coordination of Services.[30]

Summary

In this survey of literature the relevant stages in the history of community psychiatry and community psychology have been examined as a means of understanding the community mental health movement. The embodiment of that movement has been the community health center. The major impetus for the establishment of these centers has been Public Law 88-164, "The Mental Retardation Facilities

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[29]Burd, Ronald, and Richmond, Julius, "The Public and Private Sector: A Developing Partnership in Human Services." American Journal of Orthopsychiatry, 49(2), April 1979, pp. 218-229.

[30]Ibid.

and Community Mental Health Centers Construction Act" and subsequent federal and state legislation, and their implementation.

Although the literature reveals major questions as to the ideal organization and effectiveness of these centers, an expanding fund of knowledge about these centers has been reported over the past two decades. Case histories have been done on several community mental health centers. Other studies have examined the organization and development of these centers with a view towards identifying common trends and creative innovations for the continued survival of these centers.

The present study attempts to add to this body of research by tracing the establishment, organization, and development of the Far Northwest Counselling (sic) Center. It provides an in-depth analysis of one of the most recently established mental health centers in Illinois. Also, it is distinctive in that relatively few historical case studies have been done on community mental health centers. Hopefully, the present study will contribute to the research which is essential for the advancement of community mental health.

CHAPTER II

METHODOLOGY

Research Procedure

The research procedure for this study is the historical documentary method of research. This methodology combines the chronological and thematic approaches utilizing a case study format. As such the study is organized to present the events leading up to the establishment of a community mental health center, and the subsequent years of its operation in the community. On the basis of this in-depth chronicle an attempt will be made to establish central themes relating to the development of the Center. Emphasis in these themes will be placed on relationships pointing to development of the Far Northwest Counselling Center as a community mental health center.

Sources of Data

The methodology entails the collection and evaluation of relevant documents relating to the establishment, organization, and development of the Center. The following types of informational sources will be used to trace this historical process:

1. Pertinent documents relating to the general

plan for establishment of community mental health centers according to the federal, state, and local guidelines.

2. Monthly and yearly records pertaining to services rendered, number and types of clients served, and programs offered.

3. Annual agency plans, including proposed budgets, sources of income, audited profit and loss statements, and projected objectives.

4. Professional Staff and Advisory Board members listings in community grants.

5. Correspondence, newspaper articles, and published informational materials of the Center.

The data involved in the study are materials which are a matter of public record. The concealment of the identity of the subjects involved and the confidentiality surrounding them are provided for through a blind coding system.

Definition of Terms

In addition to the general terms outlined in the survey of literature, several terms are peculiar to this study:

Case-load per month - A numerical total of all registered clients in a given month.

Number of clients seen - A numerical total of all registered clients who have received services in a given month.

Client contacts - A numerical total of all contacts with registered clients and collaterals in a given month.

Community location - A location within the geographic area to be served, distinct from any state hospital property. In this study, the area referred to as "community" is the catchment area, namely the five Chicago neighborhoods of Edison Park, Norwood Park, Jefferson Park, Dunning, and O'Hare.

Mental health services - In this study these are the mental health treatment services provided by the Center to persons who are not hospitalized. These include individual and group therapy, medication, crisis intervention, diagnostic service, and consultation and education. These services are provided under three treatment program designations: Sustaining Care (01), Out-patient (02), and Children and Adolescent (62).

Ownership - Legal right to possession and operation including management, fiscal responsibility, liability, and policy making powers.

Private Social Service Agency - Non-profit social organization which provides human services to the general public. In this study this term refers to Lutheran Social Services of Illinois, an Illinois not-for-profit corporation providing a variety of services to children, adolescents, adults, and aged persons through 70 institutional and non-institutional programs serving over 130,000 people

yearly. Previous to 1977, this agency was known as Lutheran Welfare Services of Illinois.

State ownership - Ownership by the Illinois Department of Mental Health and Developmental Disabilities, the legally designated Department of the State of Illinois charged with the provision of mental health programs and care.

Limitations

The study is limited to the historical development of the Far Northwest Counselling Center. The focus of the study is the policies, developments, and events which led to the establishment, organization, and development of the Center as a community mental health center. The study does not consider the influence of individuals, political activities, or other contemporary factors. Also as a documentary study, it does not concern itself with statistical analysis of the factors studied. These equally interesting and useful areas are left to other subsequent studies.

CHAPTER III

HISTORICAL DEVELOPMENT TO 1976

The Chicago Area Zone Plan envisaged the creation of local mental health services for each designated community in metropolitan Chicago.

> The Chicago Area Zone provides the opportunity for an effective alliance between the Illinois Department of Mental Health and community resources to cope with problems of mental disturbance in a complex urban setting. The past has shown that prevention and early intervention of mental disorders is impossible without community concern and involvement. Likewise, recovery and rehabilitation are hindered without participation by sources of community support such as family, friends, employment and social welfare agencies.[1]

The establishment of the Far Northwest Counselling Center in the community was a logical outcome of this plan. Its establishment involved the relocation and transfer of sponsorship of an existing program into the community. This metamorphosis from state mental hospital outpatient program to a community mental health center is presented in this chapter. Historically, this challenge involved two interrelated happenings: (1) prior operation as the Chicago-Read Mental Health Center outpatient program, and (2) implementation of the plan for the transfer of the

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[1]State of Illinois, The Chicago Area Zone Plan, p. 1.

outpatient program to community ownership and location. Each of these occurrences will be examined separately. Both are essential historical elements.

Part I

Psychiatric Hospital Outpatient Program

Background

The Chicago Area Zone Plan began in 1968. At that time the outpatient department at Chicago-Read Mental Center served 28 separate neighborhoods and suburban villages. Through intensive community development programs, more than a dozen community mental health clinics were established in these areas from October 1968 to December 1973. As these clinics began serving their own geographic area, that territory was no longer served by the outpatient department. By January 1, 1974, the outpatient department served only one designated community service area known as the Edison Park Planning Area. This community service area consisted of the five City of Chicago neighborhoods of Edison Park, Norwood Park, Jefferson Park, Dunning, and O'Hare. (See Appendix A, p. 94 for map of the area.)

Description of Service Area

In 1970 the Edison Park Planning Area consisted of a population of 133,000 residents, 99% Caucasian with a median family income of $13,000. Ethnically the residents

were chiefly Polish, German, and Italian. The median educational level was 11.9 years. The population was relatively stable with only 29% of persons five years of age and over in 1970 residing in a different house than in 1965. The community was a white, working class area with no formal mental health services available in the community other than those of the outpatient program.[2]

Program

The outpatient program provided mental health services under three program designations: Outpatient, Sustaining Care, and Children and Adolescent. These three program designations are defined in Chapter II. Within each of these programs, treatment services included diagnostic evaluation, individual, family, marital, and group psychotherapy, as well as referral, crisis intervention, and community consultation.

Staff

The staff consisted of an executive director, seven therapists, one consulting psychiatrist, and two clerk-typists. Table 1 describes these positions in detail. All of these staff members were State of Illinois employees.

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[2]State of Illinois, Edison Park Planning Area Profile, 1970, p. 1.

Table 1

PERSONNEL LISTING

	POSITION	CLASSIFICATION	DEGREE
1.	Executive Director	Social Worker V	M.S.W.
2.	Therapist	Psychologist III	Ph.D.
3.	Therapist	Social Worker V	M.S.W.
4.	Therapist	Social Worker III	M.S.W.
5.	Therapist	Psychologist II	M.A.
6.	Therapist	Registered Nurse III	R.N.
7.	Therapist	Mental Health Specialist II	B.A.
8.	Therapist	Mental Health Specialist II	B.A.
9.	Physician	Licensed Psychiatrist I	M.D.
10.	Secretary	Clerk-Typist II	Diploma
11.	Secretary	Clerk-Typist II	Diploma

Facilities

The entire program occupied 2477 square feet of office space at Chicago-Read Mental Health Center, 4200 North Oak Park Avenue, Chicago, 60634.

Clients Served

In fiscal year 1975, an average of 349 cases per month were registered at the clinic with an average of 225 cases seen per month. In fiscal year 1976, an average of 327 cases were registered with an average of 232 cases seen per month. These monthly and yearly statistics are reported in Tables 2 and 3. In fiscal year 1976, many inactive cases were closed resulting in a drop of the registered cases.

Fee Structure

Under the provisions of a State of Illinois fee policy, each client was expected to pay part of the cost of service on a sliding scale plan based on income and family size. The fee income figures for fiscal years 1975 and 1976 are presented in Table 4. In fiscal year 1976 greater emphasis was placed on accurate fee determination and collection as reflected in the figures.

Budget and Costs

There was no separate program budget for fiscal years 1975 and 1976. The cost of the outpatient program was included in the general budget of Chicago Read Mental

Table 2

NUMBER OF CASES SEEN AND CASE-LOAD
BY MONTH FOR FISCAL YEAR 1975
JULY 1, 1974 - JUNE 30, 1975

MONTH	CASES SEEN			CASE-LOAD		
	Adult	Child	Total	Adult	Child	Total
July	76	23	99	213	105	318
August	145	26	171	192	34	226
September	196	21	217	312	42	354
October	212	32	244	294	43	337
November	171	35	208	304	47	351
December	122	37	159	296	45	341
January	222	40	262	325	55	380
February	212	43	255	306	60	366
March	232	56	288	321	77	398
April	234	51	285	326	72	398
May	216	54	270	328	66	394
June	209	43	252	273	55	328
TOTALS:	2,247	461	2,710	3,490	701	4,191
AVERAGES:	187	38	225	290	58	349

TABLE 3

NUMBER OF CASES SEEN AND CASE-LOAD
BY MONTH FOR FISCAL YEAR 1976
JULY 1, 1975 - JUNE 30, 1976

MONTH	CASES SEEN			CASE-LOAD		
	Adult	Child	Total	Adult	Child	Total
July	179	37	216	272	53	325
August	201	30	231	264	43	307
September	224	27	251	284	39	323
October	223	25	248	298	42	340
November	202	39	241	303	47	350
December	198	36	234	297	54	351
January	179	35	214	268	50	318
February	210	44	254	297	60	357
March	196	41	237	304	63	367
April	220	31	251	326	58	384
May	177	27	204	210	27	237
June	190	19	209	239	32	271
TOTALS:	2,399	391	2,790	3,362	568	3,930
AVERAGES:	199	32	232	280	47	327

Table 4

FEE INCOME BY MONTH
FOR FISCAL YEARS 1975 AND 1976

MONTH	1975 INCOME	1976 INCOME
July	$ 1,416.60	$ 1,948.85
August	1,438.05	2,065.80
September	700.65	1,979.40
October	1,462.25	2,356.30
November	1,376.50	2,255.85
December	1,212.50	1,993.50
January	1,726.76	2,256.75
February	1,742.95	1,886.35
March	2,142.80	2,838.83
April	2,199.30	3,190.10
May	2,459.00	2,644.47
June	2,071.85	2,841.28
TOTALS:	$ 19,949.20	$ 28,257.48
AVERAGES:	$ 1,662.43	$ 2,354.79

Health Center. As such a portion of the overall operating expenses of the entire facility was allocated to the outpatient program. This figure included items such as support services, administrative expenses, and building costs, as well as the actual costs of operating the outpatient program. For fiscal year 1976, the estimated cost of the outpatient program was $272,450.

Records

The program had an established recordkeeping system pertaining to intake, case openings, treatment, fees, case closing, and other statistical and clinical data. The forms for these records are presented in Appendix B, p. 96. These records furnished key information concerning the history of the Center.

Summary

From this review of the operation of the outpatient program, a picture emerges of an organized mental health program providing service to a large urban community. This perspective on the early stages of development of the program is important for an understanding of the implementation of the transfer of the program to community ownership and location.

Part II

Transfer Plan

Background

As early as August 1972 the outpatient program began identifying itself as providing service exclusively for the Edison Park Planning Area as evidenced in its program statement:

> The only patients currently being accepted in the Outpatient Services are those living in the Edison Park Planning Area. . . . Currently, initial surveys have concluded that there is no other mental health service operating in the area. For now, the outpatient program is prepared to continue being the clinic that will provide direct treatment services to this area.[3]

This identity with the Edison Park Planning Area was increased in the following year and one-half through a series of interrelationships with community helping professionals such as teachers, clergy, and physicians. A community profile was developed locating the agencies which provided human services, including schools, churches, social welfare organizations, hospitals, and political groups. In April 1973 a survey was undertaken of the community in order to determine the need for mental health service. A copy of the survey and the results are reported in Appendix C, p. 105 . Based on the results of the survey, an open house was held on October 17, 1973, with the theme

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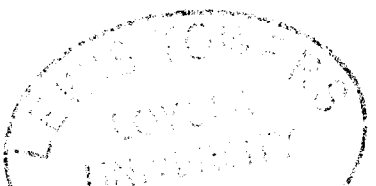
[3]Coordinator, Outpatient Services, memo, August 2, 1972.

being "Community Needs in Mental Health". The event was helpful in that it established the first official community-wide contact between the clinic and the professionals in the community. Also, it set the stage for the next major development, the creation of a Community Advisory Board for the clinic.

Preparation for Transfer

The community survey and open house helped to increase lines of communication with the community. To further identify with the community, the outpatient program was renamed the Edison Park Community Mental Health Clinic in January 1974. This name change not only defined more clearly the geographic area served, but also emphasized the community mental health mission of the program.

At this time, the Department of Mental Health launched an intensive effort to transfer the clinic to community ownership and location. This transfer effort involved two simultaneous and interrelated projects: (1) the formation of a Community Advisory Board, and (2) the search for a community sponsor. Although these two projects were separate endeavors, they happened over the same period of time, January 1974, to June 1976. As such they will be examined concurrently in this study.



Formation Stage

The Department of Mental Health contacted several key community leaders with its proposal for the formation of an Advisory Board. The purpose of the Advisory Board was twofold: (1) to provide community participation in giving advice about the operation of the clinic, and (2) to make the clinic better known. Among these leaders were a prominent banker who also was the president of a very strong community council, and a vice-president of the local, highly respected private hospital. These two persons and several others formed an Ad Hoc Committee on mental health needs. They set out inviting significant social, civic, political and religious organizations to join them in creation of an Advisory Board.

At this first public meeting in February 1974, the response of the community leaders was very favorable. After lengthy discussion of the proposal for an Advisory Board, a steering committee was established. This committee divided its work into four areas: (1) Community Advisory Board formation, (2) Community Fact Finding, (3) Publicity, and (4) Membership. Plans were made for a meeting in March with an agenda to develop more community contacts and to invite presidents of other community mental health advisory boards to speak to the group on the process of organizing a board.[4]

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[4]Edison Park Community Mental Health Advisory Board, minutes, February 1974.

Meanwhile, the Department of Mental Health was actively seeking a sponsor for the clinic in the community. Early in January 1974 it proposed the idea of sponsorship to Resurrection Hospital, a large, private hospital within the service area of the clinic. Sponsorship as referred to in this context, means transfer of ownership of the clinic with staff and grant-in-aid funding support for the program coming from the Department. Details of the transfer were to be worked out after a suitable sponsor was secured. After several months of consideration, Resurrection Hospital declined the project in March 1974, due to its own expansion program in other areas of health care.

From April to September of 1974, the steering committee occupied itself with the formation of an Advisory Board for the Edison Park Community Mental Health Clinic. Through a series of meetings over this period, a set of by-laws was developed, and a community survey of mental health needs was undertaken. A copy of the survey is presented in Appendix D, p. 110 . The priorities identified in the survey pointed to family and community mental health problems. For instance, family communications, drug abuse, emotional problems relating to school, and alcoholism were identified as the four top needs. The survey had the desired effect: to bring the mental health needs of the community to the attention of the clinic.

By September 1974, the steering committee was ready to organize as an official Advisory Board. At this juncture, the Department of Mental Health proposed that the organization incorporate as a Board and work towards sponsoring the clinic in the community. This would have entailed applying for a state charter and assuming a policy making function with regard to the clinic. The group declined this proposal and voted instead to remain exclusively advisory in nature. As an Advisory Board they set as their objective the development of the Advisory Board, including becoming more familiar with the operation of the clinic, and developing contact and communication with the community between the clinic and the Advisory Board.[5]

During the succeeding six months, the Advisory Board refined its role and structure, while conducting a community out-reach program. This latter activity included presentations by Board members at various civic organizations, clubs, schools, and churches to explain the work of the clinic and the Board.

Throughout 1974, and the first two months of 1975, the Department of Mental Health continued to seek a community sponsor for the clinic. In March 1975, these efforts became sharply focused through the development of an action

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[5]Edison Park Community Mental Health Advisory Board, minutes, September 1974.

plan to secure a sponsor for the clinic. The plan called for determining the most likely candidates for possible sponsorship and contacting them about their interest in the proposal. Lutheran Welfare Services of Illinois, Leyden Family Services and Mental Health Center, and the Salvation Army were the three agencies selected for sponsorship based upon their previous expertise in delivering and administering mental health services, and their previously indicated interest in such a project.

Over the next four months, separate meetings were held with each agency, furnishing them with descriptions of the current operation of the clinic, and the work of the Advisory Board, as well as demographic information about the community. As a consequence of these discussions, only Lutheran Welfare Services of Illinois emerged as an appropriate and viable potential sponsor.

During the period of this action plan, March to June 1975, the Advisory Board continued to meet monthly. The Department of Mental Health continued to keep the Board informed as to the progress of seeking a potential sponsor for the clinic. As a result of this dialogue, the Board requested clarification of the future of the clinic as an outpatient program housed at Chicago-Read Mental Health Center. At the June 1975 Board Meeting, the position of the Department of Mental Health was restated. The goal for the clinic was community ownership and location

with stress on the partnership between the Department of Mental Health and the community. The Board was generally satisfied with this explanation of the direction of the sponsorship plan.[6]

In July 1975, the Department of Mental Health entered into serious negotiations with Lutheran Welfare Services of Illinois for the sponsorship of the Edison Park Community Mental Health Clinic. During the next nine months, each aspect of the sponsorship venture was examined in detail and agreements worked out. The following is a listing of the key issues covered:

1. Service issues such as monthly and yearly number of clients registered and seen; treatment programs; and referral sources.
2. Community issues such as community relations; role of the Advisory Board; and acceptance of the clinic in the community.
3. Program issues such as staff; budget and fees; and program objectives.

During this negotiation period, both the staff and the Advisory Board met with representatives from Lutheran Welfare Services of Illinois in order to discuss the proposed sponsorship and to have their questions answered. On November 19, 1975, the Advisory Board agreed that these

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[6]Edison Park Community Mental Health Advisory Board, minutes, June 1975.

negotiations should be continued with sponsorship by Lutheran Welfare Services of Illinois as the eventual goal.[7] By December 1975, the negotiations proceeded successfully enough for Lutheran Welfare Services of Illinois to issue an official letter outlining its intention to conclude the sponsorship program. A copy of this letter is displayed in Appendix E, p. 114 .

The negotiating process continued making progress with the terms of the transfer being successfully decided. Generally, the transfer agreement stated that Lutheran Welfare Services would assume responsibility for the clinic as of April 1, 1976, with all present staff transferring from State of Illinois employment to Lutheran Welfare Services employment. A grant-in-aid agreement for the remainder of fiscal year 1976 (April, May and June 1976) would provide for salaries and expenses. By July 1976, the clinic would move to a suitable community and a new grant-in-aid agreement would cover fiscal year 1977 (July 1, 1976, to June 30, 1977). Staff and clients, as well as furniture, equipment and records would be transferred to this new community location. The grant-in-aid award letters for both grants are contained in Appendix E, p. 114.

On March 8, 1976, the Department of Mental Health announced its intention to transfer the clinic to Lutheran

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[7]Edison Park Community Mental Health Advisory Board, minutes, November 1975.

Welfare Services of Illinois as of April 1, 1976. A copy of this announcement is presented in Appendix E, p.114 . The president of the Advisory Board called a special meeting of the Board to discuss this announcement. At the meeting the president expressed his opposition to sponsorship by Lutheran Welfare Services and the clinic's locating in the community, maintaining that the clinic was solely the responsibility of the Department of Mental Health. But the weight of opinion of the Board members was for supporting the sponsorship and the move to the community. The Advisory Board as constituted dissolved, with most members volunteering to serve on a reconstituted Advisory Board with Lutheran Welfare as the sponsor of the clinic after April 1, 1976.

Part III

Transfer

Although the ownership and management of the clinic was assumed by Lutheran Welfare on April 1, 1976, it continued to be housed at Chicago-Read Mental Health Center until June 14, 1976. During that period several important preparations for the transfer into the community took place. A newly reconstituted Advisory Board was formed and they renamed the clinic "The Far Northwest Counselling Center." This change in name deemphasized the "mental illness" connotations associated with a large state mental hospital.

In addition it was more encompassing of the area served which included more than the Edison Park neighborhood.

In addition the program was allowed to retain the fee income for this three month period. Previously, the fee income went into the General Fund of the State of Illinois. But this income was retained and allocated toward the start-up costs at a new location.

Finally, a new site was selected and prepared for the program. The site selected was a medical office building located at 6075 North Northwest Highway, Chicago, Illinois. This facility provided 2,275 square feet of space, comparable to the 2,477 at its former location. With alterations and decorating the new site provided sufficient offices and waiting room space to accommodate the program. On June 15, 1976, the Far Northwest Counselling Center opened its doors as a community owned and located mental health center. A map showing the location is presented in Appendix A, p. 95 .

Summary

This Chapter has traced the outgrowth of the Far Northwest Counselling Center from its origins as part of the Chicago Area Plan, to its years of operation as a psychiatric outpatient clinic, and finally to its transfer to community ownership and location. The significance of those events will be discussed in Chapter V.

CHAPTER IV

THE PRESENT AGENCY: 1976-1980

The subject of this chapter is the experience of the Far Northwest Counselling Center as a community owned and located mental health center for the fiscal years of 1977 to 1980 (July 1, 1976, to June 30, 1980). The examination of the Center over this time period will be done in a horizontal fashion, mapping each year's activities to three key areas: 1. Client oriented factors, 2. Program oriented factors, and 3. Community oriented factors.

When the Far Northwest Counselling Center became a community owned and located mental health center, it became part of a larger human service system meeting clients' other needs. Through Lutheran Welfare Services of Illinois, the Center was linked to the total caregiving system.[1] Besides the obvious implications for total service to clients in need, this change meant that the Center became more accountable and subject to greater evaluation. The State of Illinois which had been the owner of the program, now became the monitor of the

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[1]Lutheran Social Services of Illinois, Program Statement, June 1976, p. 1.

program. Whereas before the Center operated without a defined budget, now it became responsible for organizing an annual budget and staying within its limits. With the transfer to community operation, the Center needed to demonstrate its performance, holding its activity up to public view.

A. Client Oriented Factors

Client oriented factors are defined as those programs, activities, and initiatives relating to the treatment, identification, and prevention of mental illness in the clients served by the Center. In this study, five client oriented factors were identified: (1) treatment programs, (2) case-load, (3) number of clients seen, (4) client contacts, (5) program objectives.

Treatment programs fell under three designations: Sustaining Care, Out-patient, and Children and Adolescent.[2] The Sustaining Care program provided evaluation, intervention, and follow-up treatment for those clients who had psychiatric hospitalization or who presented themselves a risk of psychiatric hospitalization. This program included the medication clinic with client follow-up provided by the consultant psychiatrist. The Out-patient program provided diagnostic evaluation including screening,

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[2]Illinois Department of Mental Health, Agency Plan: Far Northwest Counselling Center, 1976, Form 1201.

treatment planning, and linking to resources as well as therapy. The majority of the clients in this program never had a psychiatric hospitalization. The Children and Adolescent program provided basic outpatient service to children (ages 3-14) and adolescents (ages 14-18). Special groups, play therapy and school consultation were included, as well as individual and family therapy.

These three program designations remained constant throughout the four years under study. However, as seen in the following examination, each of these programs grew considerably.

The case-load per month is a numerical total of all registered clients in any given month. This figure includes those clients who received service in a given month, and those clients who may not have received service.

In fiscal year 1978 a concentrated effort was made to close cases which were inactive for more than 12 months. This resulted in a reduction of 462 cases in the total case-load for fiscal year 1978 as compared with fiscal year 1977.[3] Since fiscal year 1978, the Center has maintained a practice of closing cases after three months of inactivity.

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[3]Illinois Department of Mental Health, Division of Informational Services, Far Northwest Counselling Center Yearly Client Service Reports, Fiscal Years 1977 through 1980.

Table 5 reports the case-load by month per fiscal year for fiscal years 1977 through 1980.[4] These figures indicate a progressive increase of the number of registered cases in fiscal year 1979 and 1980.

The number of clients seen are the numerical total of all registered clients who have received service in a given month. Table 6 presents the number of clients seen by month per fiscal year. As with the case-load, the number of clients seen grew substantially indicating a progressive pattern of growth over the four year period.

The client contacts represent the numerical total of all contacts with registered clients and the family members and friends. These client contacts are reported by programs: Table 7 Sustaining Care, Table 8 Out-Patient, and Table 9 Children and Adolescent.[5] These figures indicate an increase of service both to the clients themselves and to the members of their immediate support systems, namely their families and friends.

Program Objectives are stated goals in the grant-in-aid agreement which the Center intended to accomplish for the fiscal year. At the outset of the year evaluative criteria were stated which were later used to measure the progress towards the attainment of the goals.

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[4] Ibid.

[5] Ibid.

Table 5

CASE-LOAD BY MONTH PER FISCAL YEAR

Year	1977	1978	1979	1980
Month				
July	488	479	518	574
August	568	475	520	552
September	514	492	530	608
October	578	468	532	603
November	601	497	507	628
December	512	530	511	595
January	578	523	539	538
February	566	571	578	608
March	585	611	583	652
April	624	586	584	652
May	602	574	617	680
June	599	547	614	646
TOTAL	6,815	6,353	6,633	7,336
AVERAGE MONTHLY	568	529	553	611

Table 6

NUMBER OF CLIENTS SEEN BY MONTH PER FISCAL YEAR

Year	1977	1978	1979	1980
Month				
July	192	295	313	320
August	266	260	349	321
September	210	238	336	338
October	232	274	335	339
November	247	333	331	339
December	254	323	291	324
January	290	330	316	369
February	316	379	342	345
March	292	384	364	361
April	317	389	356	386
May	290	349	379	351
June	283	332	330	366
TOTAL YEAR	3,189	3,886	4,402	4,159
AVERAGE MONTHLY	266	324	337	347

Table 7

CLIENT CONTACTS IN SUSTAINING CARE
PROGRAM BY MONTH PER FISCAL YEAR

Year	1977	1978	1979	1980
Month				
July	156	245	230	247
August	200	258	273	231
September	203	215	253	243
October	220	253	255	251
November	231	272	253	258
December	233	261	214	245
January	234	251	221	291
February	248	277	253	230
March	230	253	259	227
April	240	249	242	249
May	246	229	251	214
June	239	238	196	223
TOTAL YEAR	2,680	3,001	2,900	2,909
AVERAGE MONTHLY	223	250	242	242

Table 8

CLIENT CONTACTS IN OUT-PATIENT
PROGRAM BY MONTH PER FISCAL YEAR

Year	1977	1978	1979	1980
Month				
July	57	88	63	88
August	70	50	88	80
September	25	51	81	77
October	25	65	72	82
November	38	86	71	69
December	50	41	66	80
January	61	27	68	68
February	61	37	73	53
March	77	78	68	67
April	85	66	76	75
May	65	74	87	78
June	67	68	93	77
TOTAL YEAR	681	731	906	894
AVERAGE MONTHLY	57	61	75	75

Table 9

CLIENT CONTACTS IN CHILDREN AND ADOLESCENT PROGRAM BY MONTH PER FISCAL YEAR

Year	1977	1978	1979	1980
Month				
July	40	52	53	61
August	38	40	52	53
September	44	28	50	75
October	52	35	65	87
November	72	72	70	67
December	45	76	58	68
January	64	96	63	105
February	76	128	83	90
March	58	124	114	84
April	65	123	108	83
May	65	96	102	82
June	40	80	66	85
TOTAL YEAR	659	950	884	945
AVERAGE MONTHLY	55	79	74	79

Table 10 presents the stated objectives, criteria, and evaluation for the Sustaining Care Program.[6] The objectives in the first year reflected an emphasis on successful transition of the program to the community, and making the services of the Center known to the community. By the second year, the objectives pointed up the new stance of the Center as community mental health center working out linkage agreements with other institutions. In the third and fourth years, the objectives focused more on internal programming, such as new treatment modalities and home visit as a means of serving clients.

Table 11 displays the stated objectives, criteria, and evaluation for the Out-patient Program.[7] The concern for a successful transition marked the thrust of these objectives for the first year also. In the succeeding years, the objectives reflected the emphasis of the Out-patient Program itself, namely the prevention and treatment of mental illness in persons who had never had a psychiatric hospitalization. Mainly the objectives were concerned with early detection by building a network within the community.

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[6] Illinois Department of Mental Health, Agency Plans: Far Northwest Counselling Center, 1976 through 1980, form 1201.

[7] Ibid.

Table 10

SUSTAINING CARE PROGRAM OBJECTIVES
WITH CRITERIA AND EVALUATION
FOR FISCAL YEARS 1977 TO 1980

YEAR	OBJECTIVES	CRITERIA	EVALUATION
1977	1. Relocate clinic to suitable	1. Physical relocation	1. Fully achieved
	2. Public notification of sponsorship, relocation, and services	2. Announcements, media information, and dedication	2. Fully achieved
	3. Transfer all sustaining care clients with no more than a 10% drop in clients	3. Statistics on program	3. Fully achieved
1978	1. Effect linkage with public aid for clients unable to pay for service	1. Linkage agreement for 8 clients by 2nd quarter, and 16 clients by 4th quarter	1. Not achieved - contrary to public aid procedures - individual application only
	2. Establish evening group treatment group	2. Evening group by 2nd quarter	2. Fully achieved
	3. Link clients to daycare program at Ravenswood Hospital	3. Letter of linkage between Center and Ravenswood Hospital	3. Partially achieved - linkage uncertain due to cost
1979	1. Continue to seek payment from public aid for clients unable to pay	1. Records of payment	1. Fully achieved

1979	2.	Link 80% of discharges psychiatric clients	2. Statistics on program	2. Fully achieved
	3.	Addition of a staff position for home visit program	3. Establishment of program with new staff position	3. Full achieved
1980	1.	Link 90% of discharged psychiatric clients	1. Two therapy sessions each for this group by 4th quarter	1. Partial achieved - 70%
	2.	Establish divorce and loss groups	2. One divorce group by 2nd quarter one widowed group by 3rd quarter	2. Partial achieved - one divorced group by 4th quarter
	3.	Provide assistance to local churches in starting divorce and loss groups	3. Link with groups by 3rd quarter	3. Fully achieved

Table 11

OUT-PATIENT PROGRAM OBJECTIVES
WITH CRITERIA AND EVALUATION
FOR FISCAL YEARS 1977 TO 1980

YEAR	OBJECTIVES	CRITERIA	EVALUATION
1977	Same as Sustaining Care Program	Same as Sustaining Care Program	Fully achieved
1978	1. Continue notification of Center's program to the community	2. Publicity, public education programs	1. Fully achieved
	2. Home-bound client evaluation program	2. 5 to 10 home-bound evaluations	2. Fully achieved
	3. Police liaison for adult clients in crisis	3. Liaison contact and referrals	3. Partial achieved - need for more mutual work
1979	1. Continued public information efforts	1. Newspaper articles, educational seminars	1. Fully achieved
	2. Assign staff member as police liaison	2. Staff member assigned and referrals recorded	2. Fully achieved
	3. Decrease drop out rate after initial intake	3. More than 60% of intake cases continue for three sessions	3. Fully achieved
1980	1. General public information program	1. Fund-raising event	1. Fully achieved
	2. Continue decrease in drop-out rate after intake	2. Reduce drop-out rate to 30%	2. Fully achieved
	3. Strengthen Home-Bound program	3. Answer 100% all appropriate requests	3. Fully achieved

Table 12 states the objectives, criteria, and evaluation for the Children and Adolescent Program.[8] As with the other programs, the first year's objectives had to do with successful transition into the community. Over the remaining three years the program objectives took two forms: 1. internal organization, and 2. building a network with the schools and community.

This examination of the objectives, their criteria, and evaluation points to an evolving self-definition of the program, moving from the early stages of survival and transition to the later stages of self-examination and expansion of service to the community. Further implications of this evolution will be examined in Chapter V.

B. Program Oriented Factors

Program oriented factors are those aspects of the Center's operation which are associated with the provision of services. In this study, the program oriented factors examined are: (1) facilities, (2) staff, (3) fee structure, (4) budget, and (5) records.

Facilities refer to the physical location, size, and space of the building in which the program was housed. The new facility was located on a commercial street in the center of the Norwood Park business district. Previously a medical office building, the site afforded 2,275

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[8] Ibid.

Table 12

CHILDREN AND ADOLESCENT PROGRAM
OBJECTIVES WITH CRITERIA AND EVALUATION
FOR FISCAL YEARS 1977 TO 1980

YEAR	OBJECTIVES	CRITERIA	EVALUATION
1977	Same as Sustaining Care Program	Same as Sustaining Care Program	Fully achieved
1978	1. Expand referral linkage with schools	1. 12 additional referral from schools	1. Fully achieved
	2. Establish agreement for short term hospitalization with private hospitals	2. Agreements and use of the hospitals	2. Fully achieved
	3. Additional staff position for evaluation of cases	3. Hiring an additional staff person	3. Fully achieved
1979	1. Strengthen existing program	1. Equal or greater number served	1. Fully achieved
	2. Equipment for play therapy	2. Purchase of play materials	2. Fully achieved
	3. Consultation for program	3. Contracting with a consultant	3. Fully achieved
1980	1. Maintain current program effort	1. Statistical report	1. Fully achieved
	2. Conduct 10 week parenting workshop	2. Workshop by 4th quarter	2. Partial achieved planning only
	3. Continue school consultation program	3. Record of consultations	3. Fully achieved

square feet of space, sufficient enough for existing staff offices, waiting room, and reception area. As the number of staff and clients increased, and as the need for more group therapy grew, the facilities became increasingly inadequate for the needs of the Center.

The Staff consisted of an executive director, seven therapists, one consulting psychiatrist, and two clerk typists with additional management hours provided by the section director from Lutheran Social Services in fiscal year 1977. In fiscal year 1978, an additional therapist, another consulting psychiatrist, and a part-time receptionist were added. In fiscal 1979, another full time therapist, and three part-time therapists, as well as a maintenance position were added. With the increase in clients and the increased record keeping work, two part-time receptionist positions were added in fiscal 1980. The changes in personnel are listed by fiscal year in tables 13, 14, 15 and 16.[9] Over the four years in the community, the staff increased in the number of professional positions, as well as in clerical positions necessary to meet the expanding work-load. Also, there was significant upgrading of some staff positions.

The Fee structure was the fee policy previously in effect before the transfer of the Center to the community. This fee policy set fees based on the family size and

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[9] Ibid., Form 1201c.

Table 13

PERSONNEL LISTING
FISCAL YEAR 1977

	POSITION	CLASSIFICATION	DEGREE
1.	Section Director	Administrator	
2.	Executive Director	Social Worker V	M.S.W.
3.	Therapist	Psychologist III	Ph.D.
4.	Therapist[a]	Social Worker V	M.S.W.
5.	Therapist	Social Worker III	M.S.W.
6.	Therapist	Psychologist II	M.A.
7.	Therapist	Registered Nurse III	R.N.
8.	Therapist	Mental Health Specialist II	B.A.
9.	Therapist	Mental Health Specialist II	B.A.
10.	Psychiatrist[b]	Licensed Psychiatrist I	M.D.
11.	Secretary	Clerk-Typist II	Diploma
12.	Secretary	Clerk-Typist II	Diploma

[a] Part time - three days per week

[b] Hourly - two days per week

Table 14

PERSONNEL LISTING
FISCAL YEAR 1978

	POSITION	CLASSIFICATION	DEGREE
1.	Section Director	Administrator	M.S.W.
2.	Executive Director	Social Worker V	M.S.W.
3.	Therapist	Psychologist III	Ph.D.
4.	Therapist[a]	Social Worker V	M.S.W.
5.	Therapist	Social Worker III	M.S.W.
6.	Therapist	Psychologist II	M.A.
7.	Therapist[b]	Social Worker II	M.S.W.
8.	Therapist[c]	Social Worker I	B.A.
9.	Therapist[c]	Social Worker I	B.A.
10.	Therapist	Registered Nurse III	R.N.
11.	Psychiatrist[d]	Licensed Psychiatrist	M.D.
12.	Psychiatrist[e]	Licensed Psychiatrist	M.D.
13.	Secretary	Secretary II	Diploma
14.	Secretary	Secretary II	Diploma
15.	Receptionist[f]	Receptionist I	Diploma

[a] Part time - three days per week

[b] New position

[c] Change in classification

[d] Hourly - one day per week

[e] New position - one day per week

[f] New position - two days per week

Table 15

PERSONNEL LISTING
FISCAL YEAR 1979

	POSITION	CLASSIFICATION	DEGREE
1.	Administrative Director	Administrator	M.S.W.
2.	Program Director	Social Worker V	M.S.W.
3.	Therapist	Psychologist III	Ph.D.
4.	Therapist[a]	Social Worker V	M.S.W.
5.	Therapist	Social Worker III	M.S.W.
6.	Therapist	Psychologist II	M.A.
7.	Therapist[b]	Social Worker III	M.S.W.
8.	Therapist[c]	Social Worker III	M.S.W.
9.	Therapist	Social Worker II	
10.	Therapist	Social Worker I	B.A.
11.	Therapist[d]	Social Worker II	M.S.W.
12.	Therapist[d]	Social Worker II	M.S.W.
13.	Therapist[d]	Social Worker II	M.S.W.
14.	Secretary	Secretary II	Diploma
15.	Receptionist	Secretary I	Diploma
16.	Psychiatrist[e]	Licensed Psychiatrist	M.D.
17.	Psychiatrist[e]	Licensed Psychiatrist	M.D.
18.	Maintenance[f]	Hourly	Diploma

[a] Part time - three days per week

[b] Change in classification - new hire

[c] New position

[d] New position - hourly two days per week

[e] Hourly - one half day per week

[f] Hourly - two days per week

Table 16

PERSONNEL LISTING
FISCAL YEAR 1980

	POSITION	CLASSIFICATION	DEGREE
1.	Administrative Director	Administrator	M.S.W.
2.	Program Director	Social Worker V	M.S.W.
3.	Therapist	Psychologist III	Ph.D.
4.	Therapist[a]	Social Worker V	M.S.W.
5.	Therapist	Social Worker III	M.S.W.
6.	Therapist	Psychologist III	M.A.
7.	Therapist	Social Worker III	M.S.W.
8.	Therapist	Social Worker III	M.S.W.
9.	Therapist	Social Worker II	M.S.W.
10.	Therapist	Social Worker I	B.A.
11.	Therapist[b]	Social Worker II	M.S.W.
12.	Therapist[b]	Social Worker II	M.S.W.
13.	Therapist[b]	Social Worker II	M.S.W.
14.	Administrative Assistant[c]	Secretary III	Diploma
15.	Secretary	Secretary I	Diploma
16.	Maintenance[d]	Hourly	Diploma
17.	Receptionist[e]	Hourly	Student
18.	Receptionist[e]	Hourly	Student
19.	Psychiatrist[f]	Licensed Psychiatrist	M.D.
20.	Psychiatrist[f]	Licensed Psychiatrist	M.D.

[a] Part time - three days per week
[b] Hourly - two days per week
[c] Change in classification
[d] Hourly - two days per week
[e] New position - hourly - two and a half days a week
[f] Hourly - one half day a week

income ranging from a minimum fee of $1.00 to a maximum of $40.00. The fee income is reported in Table 17 as part of the income figures.[10] The income increased steadily for the four years, enabling the Center to retire the mortgage on the building and to expand services.

The Budget included the income and expenses for each fiscal year. Table 17 presents final figures for each fiscal year.[11] The budget process gave the Center the means of assessing its economic potential for providing service on a planned basis for the four years. Through this process, additional professional and clerical positions were made available to support the program of the Center.

The Records included forms used for intake, case openings, treatment, fees, case closings and other statistical data. Essentially these forms remained the same as those used in the outpatient program with minor revisions. These forms conformed to the requirements of statistical reporting by the Department of Mental Health for community programs. Also using basically the same type of records insured continuity of record keeping and case information. The revised forms for Far Northwest Counselling Center are presented in Appendix F, p. 119 .

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[10] Ibid., Form 1201c.

[11] Ibid., Form 1201c.

Table 17

EXPENSE AND INCOME[a]
FOR FISCAL YEARS 1977 to 1980

YEAR	1977	1978	1979	1980
Expenses:				
Personnel	173,121	176,957	202,206	208,472
Contractual	17,433	41,012	50,108	68,936
Total	190,554	217,969	252,314	277,408
Income:				
Grant Funds	171,045	175,905	180,364	189,630
Fee Income	57,247	78,483	85,560	102,478
Total	228,292	254,388	265,924	292,108

[a] Surplus in income was allocated for retirement of mortgage on property and for other expenses.

This examination of program oriented factors describes the gradual development of fiscal and personnel segments of the Center's operation over the four periods studied. In Chapter V, these segments will be discussed further.

C. Community Oriented Factors

Community oriented factors are the features of the Center's operation which intersect with the larger community. In this study, the community oriented factors examined are: (1) Lutheran Social Services of Illinois, (2) the Advisory Board, (3) consultation, (4) referral network, and (5) community education.

Lutheran Social Services of Illinois was the non-profit, social welfare organization which sponsored the Center in the community. Yearly it provided social services to over 150,000 persons in Illinois through 70 institutional and community programs. During the four years studied, Lutheran Social Services of Illinois provided fiscal and programmatic expertise for the Center. With its network of church, school, and community support, Lutheran Social Services of Illinois provided a built-in "entree" into the community for the Center. Throughout the four years Lutheran Social Services focused on the service aspect of the Center with the community, providing direction and advocacy for its programs.

The Advisory Board was the formally constituted group of community residents who serve in an advisory capacity to the Center and the director on matters of community interest. Its function included making community needs known, helping to make the Center known to the community, and advising on the direction of the Center's services.[12] An Advisory Board functioned during the years studied. Among its projects were an annual "garage sale" with the dual purpose of raising funds for the Center and making the Center better known. In addition, it sponsored an open house for the Center in June 1979.

Consultation is defined as an indirect intervention. Unlike other treatment, the consultant does not meet with the client directly, but attempts to influence intermediaries who do have direct contact with the client. Examples of such intermediaries or "caregivers" are clergy, law enforcement agents, and school personnel.[13] In order to develop consultative relationships with the community caregivers, the Center sponsored a clergy open house on August 20, 1976, to acquaint the clergy with the Center and its services. This event was followed by a dedication of the Center on October 13, 1976, with invitations to 450 social, political, educational, and religious leaders of

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[12]Far Northwest Counselling Center Advisory Board, minutes, Fiscal Year 1977 through 1980.

[13]Mann, Philip A. Community Psychology (New York: The Free Press, 1978), pp. 91-2.

the community. In addition, an open house for the general public was held later that same day.[14] These events marked the beginnings of the consultative relationships with the community by the staff. Both of these events were well attended and received newspaper coverage in the local press. Since that time, a referral network has been developed.

The referral network involved all those agencies, institutions, churches, and schools, as well as civic and political organizations which made referrals to the Center or to which the Center made referrals. Table 18 presents the tabulation of sources of referrals by percentage for fiscal years 1979 and 1980.[15] A substantial number of referrals came from this referral network in both years.

Community education is those activities, programs, and contacts with the community, by the Center, which educated and instructed the general public about mental health. During the four years studied, the Center published a newsletter describing the work of the Center and the educational programs available to the public. In addition, in fiscal years 1978 and 1979, the Center sponsored a lecture series on mental health issues presented by staff members. Along with these efforts, special groups

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[14]Far Northwest Counselling Center, Dedication Report, October 1976.

[15]Illinois Department of Mental Health, D.I.S., F.N.C.C. Yearly Client Services Reports, Fiscal Years 1979 and 1980.

Table 18

SOURCE OF REFERRAL BY PERCENTAGE
FOR FISCAL YEARS 1979 and 1980

SOURCE OF REFERRAL	1979	1980
State aided facility	12.76	13.29
Hospital/Physician	5.71	3.80
Alcoholics Anonymous	-	.60
Corrections or Court	1.43	2.40
Employer	.71	.50
Family	32.24	43.96
Self	14.59	11.59
School	10.82	4.50
Other State agency	2.24	2.20
State Law Enforcement	-	.08
County Law Enforcement	.10	.10
City Law Enforcement	.20	.20
Community	19.20	16.78

were conducted on parenting and on stress. In addition, in all four years the staff members lectured to P.T.A. groups, civic organizations, and church groups about mental health issues.[16]

Reviewing the community oriented factors, the Center utilized the identification with Lutheran Social Services of Illinois for entree into the community. During the four years studied, the Center undertook initiatives through its Advisory Board and also through its consultation and community education efforts to increase its working relationships with the community.

Summary

This Chapter reported the results of a study of the historical development of the Far Northwest Counselling Center for the four fiscal years of 1977 to 1980. This study examined three key factors in that historical development: (1) client oriented factors, (2) program oriented factors, and (3) community oriented factors. The importance of these factors will be discussed in Chapter V.

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[16]Far Northwest Counselling Center, Community Education Descriptions, Fiscal Years 1977 through 1980.

CHAPTER V

SUMMARY AND DISCUSSION

Summary

This study has concentrated on the historical development of the Far Northwest Counselling Center as a community mental health center. It emerged from the Chicago Area Zone Plan, which envisaged the creation of local mental health service for each designated community in metropolitan Chicago. By January 1974, the predecessor to the Center, the Out-patient Program at Chicago-Read Mental Health Center, served only one service area, the Edison Park Planning area. This "catchment" area consisted of the five City of Chicago neighborhoods of Edison Park, Norwood Park, Jefferson Park, Dunning and O'Hare.

In January 1974, the outpatient program was renamed the Edison Park Community Mental Health Clinic to more accurately reflect the geographic area served as well as the clinic's community mission. From January 1974, until April 1976, the clinic operated as a quasi-community mental health center providing service to the community. In this two year period, the clinic progressed considerably both in organization and in program development. At the time

of the transfer to community ownership and location, the outpatient program had developed the structural basis upon which to build a community mental health center. During this same period, the Department of Mental Health conducted an intensive effort to transfer the clinic to community ownership and location. This transfer effort took two simultaneous and interrelated forms: (1) the formation of a community Advisory Board, and (2) the search for a community sponsor.

In January 1974, the formation of a Community Advisory Board was begun by contacting key community leaders in order to gain their interest and participation. This core group of community representatives formed an Ad Hoc Committee on Mental Health which over a period of nine months developed into an Advisory Board with By-laws and elected officers. In September 1974, the Department of Mental Health proposed that this Board incorporate and sponsor the clinic in the community. But the Board declined this proposal, deciding rather to concentrate on its own development and contact with the community in a strictly advisory capacity to the clinic.

Meanwhile, during this same period of time, the Department of Mental Health was seeking actively for a potential suitable sponsor for the clinic. In March 1975, the search narrowed to three viable candidates: Leyden Family Services and Mental Health Center, Lutheran Welfare

Services of Illinois, and the Salvation Army. After several months of discussion, Lutheran Welfare Services of Illinois emerged as the most appropriate and interested potential sponsor. By December 1975, this Agency declared its intention to sponsor the clinic in the community.

On March 8, 1976, after months of negotiation in order to work out the transfer agreement, the Department of Mental Health announced its intention to transfer the program to Lutheran Welfare Services of Illinois as of April 1, 1976. The president of the Advisory Board called a special meeting to discuss this announcement. He voiced his opposition to the transfer, but the majority of the Board supported the transfer.

On June 14, 1976, the clinic opened at 6075 North Northwest Highway, Chicago, under the name of the Far Northwest Counselling Center. The first four years of operation (July 1, 1976 to June 30, 1980) witnessed the development of three key factors: client oriented factors, program oriented factors, and community oriented factors. In each of these areas, the survival and transition stage gave way to a stage of expansion and self-definition. That is, the center experienced a successful transition from an outpatient program for a state mental health hospital to a community owned and located mental health center.

The client oriented factors studied were: (1) treatment programs, (2) case-load, (3) number of clients seen,

(4) client contacts, (5) program objectives. In each of these areas, there was substantial growth over the period of the study. The clients who were served exhibited a dramatic increase. The program objectives reflected the movement away from survival concerns to a focus of expansion and development. Likewise, the program oriented factors indicated the growth process of the center. These factors were: (1) facilities, (2) staff, (3) fee structure, (4) budget, and (5) records. By the end of the four years, the facilities had become too small for the expanding needs of the program. At the same time, the size of the staff and income from fees had experienced significant growth. Finally, the community oriented factors also showed signs of maturity. These factors were: (1) Lutheran Social Services of Illinois, (2) Advisory Board, (3) consultation, (4) referral network, and (5) community education. In addition to providing management expertise, Lutheran Social Services of Illinois furnished a respected entree into the community. Although less effective than it might have been, the Advisory Board through its activity made the Center more widely known in the community. Over the four years studied, the Center developed its consultation and referral network through formal and informal contacts with the community caregivers. In addition, the Center made some initiatives in community mental health education through lectures and special "self-help" groups.

This summary presents the results of a study of the Far Northwest Counselling Center from its inception to its transfer to the community to its present day operation. It documents the historical development of the Center over a period of six years. The picture that emerges is that of an organized, growing community mental health program providing service to a large urban community.

A review of the significant components of the historical development of the Far Northwest Counselling Center reveals a process which may be termed a metamorphosis. The term metamorphosis has been used by organizational theorists to describe new views on the life cycles of organizations reflecting changes in conditions and structures. All assume a multi-stage cycle.[1]

Far Northwest Counselling Center fits the metamorphosis model in that it grew in several stages. The early stage was the large outpatient program at Chicago-Read Mental Health Center, followed by the middle stage as the Edison Park Community Clinic, and the final stage as the Far Northwest Counselling Center. With each of these stages, the program experienced changes resulting in a clearer self-definition of the Center and its community orientation.

As with many other centers, Far Northwest Counselling

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[1]Messal, Judith L. "Organizational Growth and Change: The Life Cycle of a Community Mental Health Center" Administration in Mental Health 8, (1) (Fall 1980), pp. 12-22.

Center was a "spin-off" of a pre-existing governmental program to one of community ownership and location. With this transfer, the clients, staff, programs, and area served remained the same immediately before and after the transition. This overall consistency seems to have aided in the successful transplanting of the Center into the community. This high degree of "sameness" defined more clearly what was being transferred.

The preparation and planning invested in the program during its years as the Edison Park Community Clinic seems to have assisted the transition process. The early surveys and community needs assessments focused the program on the unmet mental health needs of the community. At the same time, the dialogue between the Advisory Board and the Department of Mental Health provided a public forum in which to discuss the direction and plan for the program. Similarly, the activities of the clinic itself and the Advisory Board built bridges with the existing caregivers and institutions in the community.

The question arises as to what would have been the outcome had the Advisory Board accepted the Department of Mental Health proposal to incorporate and sponsor the program? Perhaps the program would have become a community mental health center earlier than it did eventually. Also, the Center might have had more of a "grass-roots" community identity with a Citizen Board as its sponsor. However, the

Advisory Board did not feel ready or willing to assume this fiscal and programatic responsibility. Assuming this type of responsibility without readiness, expertise, or enthusiasm would seem to augur poorly for the success of such an arrangement.

As cited in Chapter I, Burd and Richmond argue for the benefits of an effective partnership of public and private sectors in the provision of human services.[2] The benefits they identified will be examined to see if they apply to the partnership between the Department of Mental Health and Lutheran Social Services of Illinois in the sponsorship of the Far Northwest Counselling Center. On the side of the public service agency, the benefits are these: (1) efficient expansion of services, (2) critical analysis of services, (3) professional cross-fertilization, and (4) better coordination of services.

In the present case, the services were expanded without having to increase the size of the public bureaucracy. In fact, the opposite occurred, with the government employees becoming part of the private workforce. Also, the transfer allowed the public agency to become the "outside" monitor of the program. However, since the contacts between the two entities were of a limited

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[2]Burd, Ronald, and Richmond, Julius: "The Public and Private Sector: A Developing Partnership in Human Services" American Journal of Orthopsychiatry 49 (2), (April, 1979): pp. 218-229.

formal nature, there was little opportunity for professional cross-fertilization. The transfer plan allowed the governmental agency to plan with the sponsoring agency and the Center for the delivery, costs and objectives of the desired services.

On the side of the private sector, the benefits are these: (1) advancement of organizational goals, (2) expansion of client base, (3) increased funding support, (4) contributions to system-wide improvement.

In this instance, Lutheran Social Services of Illinois was able to advance its community service mission by sponsoring the program. Similarly, it was able to reach a greater client base with a defined set of mental health needs. The funding of the agency was increased both through the grant-in-aid funds and through the fee income. Finally, as a private agency operating in the public arena, it was able to influence decision making and policy development in the area of mental health delivery systems.

From an historical point of view, the sponsorship by Lutheran Social Services of Illinois was a turning point in the development of the program. The sponsorship provided the management expertise on a community level and a well known and respected entree into the community. During the four years of the operation in the community, Lutheran Social Services of Illinois has continued to provide both of these valuable functions for Far Northwest Counselling Center.

The name change from the Edison Park Community Mental Health Clinic to the Far Northwest Counselling Center provided a dramatic illustration of the change from state hospital ownership and location to community ownership and location. And as the results illustrate, the Center experienced significant growth in client oriented factors, program oriented factors, and community oriented factors during the four years in the community. From a cost-effectiveness perspective, the increase in service was effected through relatively moderate increases in costs. However, the less than effective development of the Advisory Board pointed to a need for restructuring in order to make it more useful to the program. The size of the present facilities presented a burden on existing programs and a block to future expansion.

The Center seems to have the means at hand to deal with the implications of its rapid development. Its funding in grant-in-aid funds has remained stable with moderate increases over the past four years. Equally important, its fee income has risen to meet increasing costs of operating the program. From a community standpoint, the Center has enjoyed good consultative and referral relationships with the caregivers and institutions in the community. These identified strengths could provide the means for continued development of the Center as a community mental health center.

Conclusion

For this summary and discussion of the historical development of the Far Northwest Counselling Center as a community mental health center, several conclusions and recommendations appear appropriate.

Conclusions

1. The Chicago Area Zone Plan was the enabling public policy which insured that the Edison Park Planning Area would eventually develop its own community mental health center.

2. The prior operation of the outpatient program at Chicago-Read Mental Health Center as a quasi-community mental health center for fiscal years 1975 and 1976 made the program an available and suitable candidate for "spin-off" to community ownership and location.

3. The open and public nature of the search for a community sponsor and the activity of the Advisory Board during fiscal years 1975 and 1976 aided the public readiness to accept the transfer of the program to the community.

4. During fiscal years 1977 through 1980, the Far Northwest Counselling Center experienced rapid and substantial growth as evidenced in three key areas: (1) clients served, (2) programs, and (3) community activities.

5. The sponsorship by Lutheran Social Services of Illinois was pivotal to the successful transfer of the

program to the community. Continued sponsorship by Lutheran Social Services has insured continued access to the community and provided necessary management expertise for the operation of the program.

6. The consistent implementation of the fee policy with the resulting increase in fee income contributed greatly to the financial viability of the Center.

7. The socio-economic stability of the community enabled the Center to provide basic counseling services to a great number of community residents without extensive program changes.

Recommendations

1. Based on the rapid development of the Far Northwest Counselling Center, the Center should initiate a goal-setting process in order to establish priorities and to plan for continued development in the coming years.

2. A careful analysis should be undertaken of the current funding structures with emphasis on documentation of the program's cost effectiveness with a view towards expanding funding.

3. The Advisory Board should be encouraged to participate more actively in the direction and development of the Center. This would imply development of the Advisory Board itself and its function as a bridge to and from the community.

4. A community outreach program including

community education, consultation, and network building, should become a permanent objective of the Center to strengthen ties with the community and to identify unmet needs and underserved clients.

5. As part of this community outreach program, further analysis should be conducted on the economic, ethnic, religious, and civic resources in the community to identify the needs of the community.

Implications

The study of the historical development of the Far Northwest Counselling Center implies that an affiliation with a respected social service agency provides for the effective access to a community. Also the consistent implementation of an equitable fee policy contributes greatly to the financial stability of a center. In addition, a center needs to continually reach out to the existing caregivers in the community in order to be responsive to the total community. The continued growth of this Center, and perhaps other centers, seems to depend on close collaboration with the community and sound fiscal management.

Future Research

The present research was an historical documentary case study of the development of the Far Northwest Counselling Center as a community mental health center. Future

studies should focus on the influence of individuals, political and social forces, or other contemporary factors as a means of describing the development of the Center. During the early formation stages when the transfer plan was being implemented these factors were most evident. For the period of fiscal years 1975 and 1976, the Department of Mental Health was represented by several key administrators, including the Subregion Director, and his successor, and the Coordinator of Community Relations.

The Subregion Director and his successor represented the Department in the overall direction and implementation of the transfer plan. They had the authority to commit personnel and funding to the transfer as well as to make policy commitments. The Coordinator of Community Relations worked with the Subregion Director as his representative to the community, the Advisory Board, and the potential sponsoring agencies. During the transition stage, he played a key role in the direction and execution of the transfer plan and the negotiations with Lutheran Social Services. Throughout fiscal year 1975 and 1976, these individuals were responsible for the consistent implementation of the transfer plan.

As mentioned earlier, the Advisory Board provided a bridge between the program and the community. The composition of the Advisory Board aided in this vital task. The Advisory Board was composed of individuals indigenous to the community.

A survey of the Board revealed that the Board members represented all five geographic areas served by the program with members from the religious, political, educational and social segments of the community. Notable among these were a representative from the local Alderman's office, an administrator from the local private hospital, and a representative of the District Police Commander. In addition the other members represented business connections to the community, as well as memberships in local community organizations, churches, and Parent Teacher Associations. The Advisory Board reflected the "grass-roots" of the community while at the same time its membership included members connected with the influential social, educational, and political institutions of the community.

During the time of its transition, and after its establishment in the community, the program enjoyed extensive newspaper coverage. This coverage allowed the wider community to become aware of the Center while it helped to focus public opinion on the activity surrounding the Center. The editors of the community newspapers followed the development of the Center extensively. Their personal interest and the resulting coverage helped the Center become a "community entity".

These factors: the role of the Department of Mental Health; the "representativeness" of the Advisory Board members; and the newspaper coverage; all combined to support

and strengthen the transition of the program from an out-patient psychiatric clinic to a community mental health center. These forces could be studied as a means of assessing the Center's development as a community mental health center. Also, an experimental or factorial analysis of the Center for the period studied might prove valuable. As far as the Center is concerned, a permanent research effort could generate valuable knowledge on community mental health issues for the entire field.

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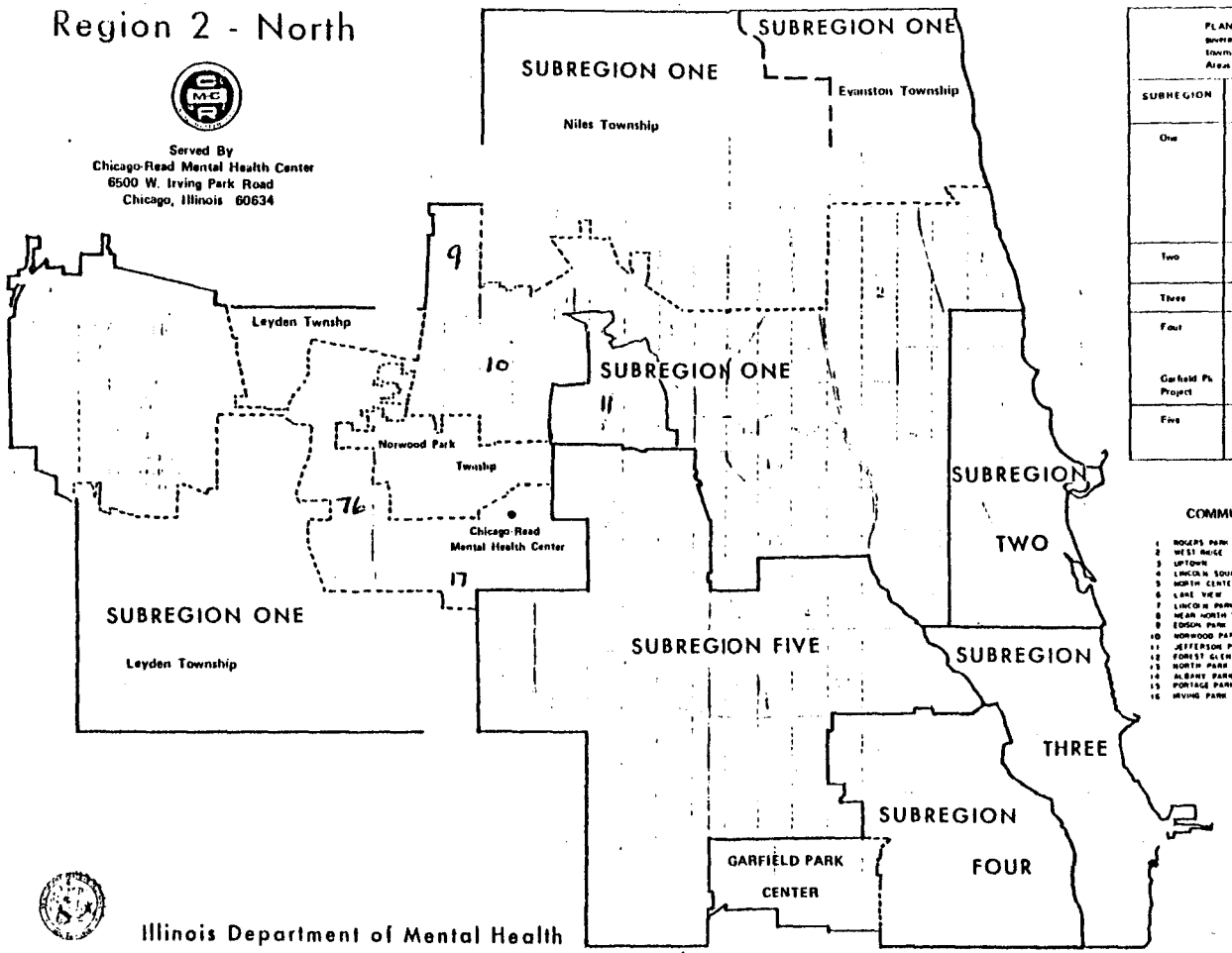
APPENDIX A

Region 2 - North

Served By
Chicago-Read Mental Health Center
6500 W. Irving Park Road
Chicago, Illinois 60634



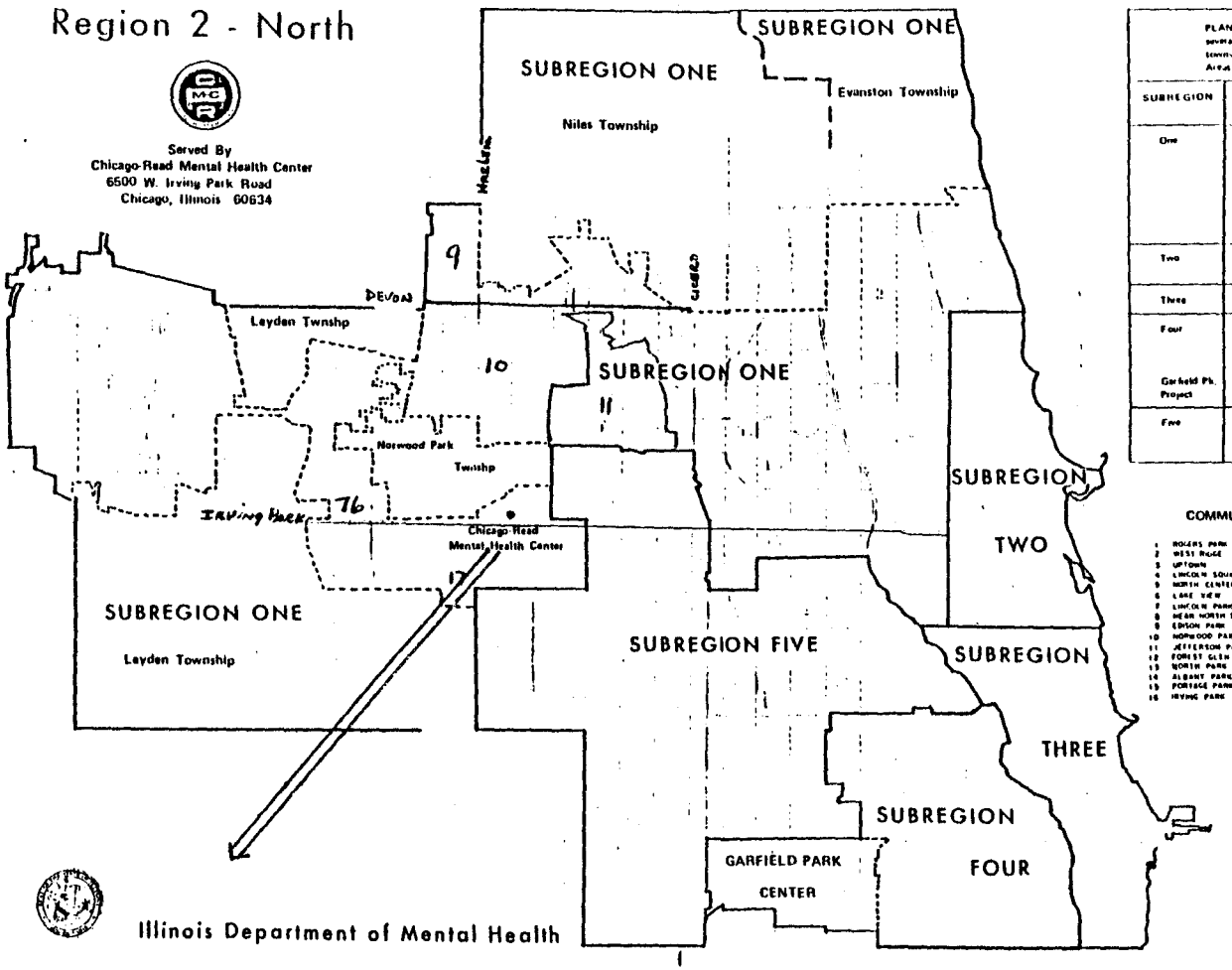
PLANNING AREAS share the borders of several city community areas and/or townships. To draw in your own Planning Areas on the map, use the following guide		
SUBREGION	PLANNING AREA	COMMUNITY AREA(s)
One	11	Niles Township
	12	Evanston Township
	13	Leyden & Norwood Park Township's
	14	8, 10, 11, 17, 76
	15	1, 2, 12, 13
	17	14, 16
	18	4, 6
Two	19	3
	20	5
Three	23	7, 8, 32
Four	25	24
	26	28 (that part north of Roosevelt Road)
Garfield Pk Project	24	26, 27
Five	16	15, 18, 19, 20
	21	23, 25
	22	21, 22

COMMUNITY AREA NAMES

1	ROGERS PARK	17	DUNNING
2	WEST RIDGE	18	MONTCLARE
3	UPTOWN	19	BELMONT CRAGIN
4	LINCOLN SQUARE	20	HERMOSA
5	NORTH CENTER	21	AVONDALE
6	LAKE VIEW	22	LOGAN SQUARE
7	LINCOLN PARK	23	HUMBOLDT PARK
8	NEAR NORTH SIDE	24	WEST TOWN
9	EDISON PARK	25	AUSTIN
10	NORWOOD PARK	26	WEST GARFIELD PK
11	JEFFERSON PARK	27	EAST GARFIELD PK
12	FOREST GLEN	28	NEAR WEST SIDE
13	NORTH PARK	29	NORTH LAWNDALE
14	ALBANY PARK	30	SOUTH LAWNDALE
15	PORTAGE PARK	31	LOWER WEST SIDE
16	IRVING PARK	32	LOOP

Illinois Department of Mental Health

Region 2 - North



Served By
Chicago-Read Mental Health Center
6500 W. Irving Park Road
Chicago, Illinois 60634

Illinois Department of Mental Health

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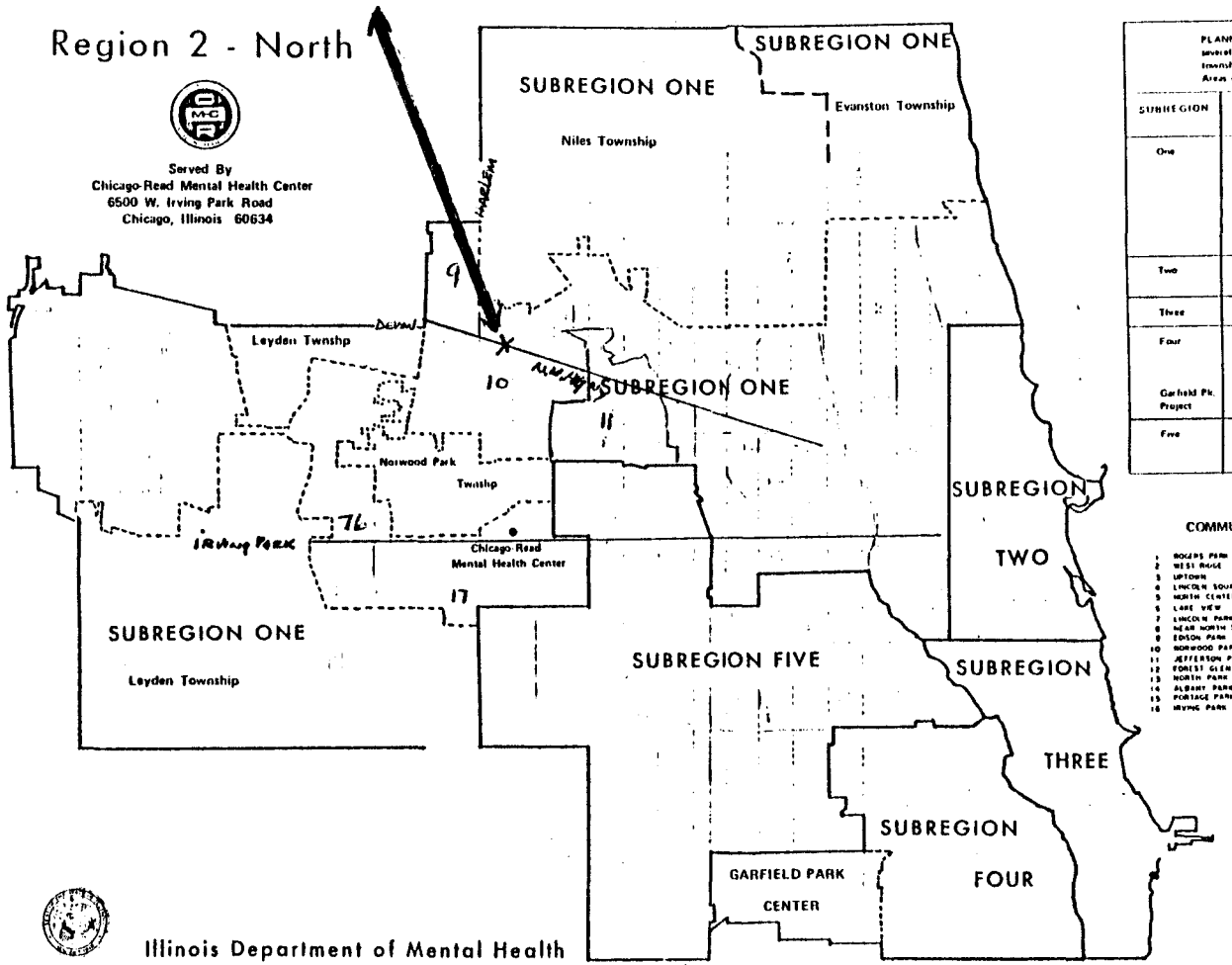
Garfield Pk. Project	24	26, 27
Five	16	15, 18, 19, 20
	21	23, 25
	22	21, 22

COMMUNITY AREA NAMES

1	ROGERS PARK	17	QUIVING
2	WEST RIDGE	18	MONTCLARE
3	UPTOWN	19	BELMONT CRAGIN
4	LINCOLN SQUARE	20	HERMOSA
5	NORTH CENTER	21	AVONDALE
6	LAKE VIEW	22	LOGAN SQUARE
7	LINCOLN PARK	23	HUMBOLDT PARK
8	NEAR NORTH SIDE	24	WEST TOWN
9	EDISON PARK	25	AUSTIN
10	NORWOOD PARK	26	WEST GARFIELD PARK
11	JEFFERSON PARK	27	EAST GARFIELD PARK
12	FOREST GLEN	28	NEAR WEST SIDE
13	NORTH PARK	29	NORTH LAWNDALE
14	ALBANY PARK	30	SOUTH LAWNDALE
15	PORTAGE PARK	31	LOWER WEST SIDE
16	IRVING PARK	32	LOOP

Chicago-Read Location
1974-1976

Region 2 - North



Served By
Chicago-Read Mental Health Center
6500 W. Irving Park Road
Chicago, Illinois 60634

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	21	23, 25
	22	21, 22

COMMUNITY AREA NAMES

1	ROGERS PARK	17	DUNNING
2	WEST RIDGE	18	MONTCLARE
3	UPTOWN	19	BELMONT CRAGIN
4	LINCOLN SQUARE	20	HERMOSA
5	NORTH CENTER	21	AVONDALE
6	LAKE VIEW	22	LOGAN SQUARE
7	LINCOLN PARK	23	HUMBOLDT PARK
8	NEAR NORTH SIDE	24	WEST TOWN
9	EDISON PARK	25	AUSTIN
10	NORWOOD PARK	26	WEST GARFIELD PK
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12	FOREST GLEN	28	NEAR WEST SIDE
13	NORTH PARK	29	NORTH LAWNDALE
14	ALBANY PARK	30	SOUTH LAWNDALE
15	PORTAGE PARK	31	LOWER WEST SIDE
16	IRVING PARK	32	LOOP

Illinois Department of Mental Health

Far Northwest Counselling
Center Location 1976-1980

APPENDIX B

EDISON PARK COMMUNITY MENTAL HEALTH CENTER
INTAKE QUESTIONNAIRE

100

DATE: _____

DMH I.D. No. _____

NAME: _____ ALIASES OR MAIDEN NAME: _____
(last) (first) (middle)

CURRENT ADDRESS: _____ HOME PHONE: _____
(street & number) (city) (state) (county) (zip) RENT: yes _____ No _____

TIME AT ABOVE ADDRESS: _____ yrs. OWN HOME: yes _____ No _____

SEX	BIRTH DATE	AGE	MARITAL STATUS	RACE	YEARS IN ILLINOIS	RELIGION	OCCUPATION

PLACE OF BIRTH	YEARLY INCOME	SOCIAL SECURITY NUMBER - - - - - - - - -	PUBLIC ASSISTANCE YES____ NO____ NUMBER - - - - - - - - - - -

EDUCATION Yrs	VETERAN YES ___ NO ___ DEPENDENT OF VET? YES ___ NO___	EMPLOYED YES ___ N ___	HOW LONG EMPLOYED _____ HOW LONG UNEMPLOYED _____

PAST PSYCHIATRIC HOSPITALIZATION OR OTHER MAJOR TREATMENT (Include dates)

SERVICES DESIRED: _____

	NAME	ADDRESS OR DATE DECEASED	PHONE NO.
FAMILY PHYSICIAN			
HUSBAND OR WIFE			
FATHER			
MAIDEN NAME OF MOTHER			
IN CASE OF EMERGENCY			
CONSERVATOR (in charge of estate)			
GUARDIAN			

HOUSEHOLD COMPOSITION
(Other People Living In Home)

Name	Relation	Age	Name	Relation	Age

DO NOT WRITE BELOW THIS LINE

PROVISIONAL DIAGNOSIS: _____ Geographic Code: _____ SR _____

DIAGNOSTIC CODE: _____ INTAKE WORKER: _____

AABD			AFDC			INEL	UNK
PA	CUR	PO	PA	CUR	PO		

___DISPOSITION OF APPLICATION
___Applicant Withdrew
___Not accepted-No Referral
___Referred to:
Facility: _____
Worker There: _____
Date of Appt:

FOR MEDICAL STAFF ONLY
Accept for Inpatient Care
Type of Admission - Inf.___Vol___ PC___Emer:___
D&E___Ct. Order___ PAE___ OTHER _____
Admission Ward is: _____
Parent Ward (If different): _____

INTAKE SUMMARY
READ - CHICAGO STATE MENTAL HEALTH CENTER

Patient's Name_____ Staff Worker_____

Address_____ Telephone No._____

Age___ Sex_____ Marital Status_____ Race____ Date of 1st Contact_____

1. Statement of problems, precipitating factors, etc; 2. Current life situation
3. Pertinent genetic factors; 4. Impressions of patient and recommendations;
5. Disposition

DMH-1075
Rev. 4/72

Illinois Department of Mental Health
SOCIAL SERVICE ELIGIBILITY DETERMINATION (Preliminary Form)

Name of facility _____ Facility Reporting No. _____

Name of client _____ ID. No. _____
(Last) (First)

Social Security No. _____

I. Are you entering the facility voluntarily*? Yes ☐ No ☐

II. If the answer to Question (I) is Yes, answer the following questions. If the answer is No, mark the Ineligible category at the bottom of (V) below.

1. Have you or your family received Federal Public Aid Assistance within the last two years? Yes ☐ No ☐
2. Are you or your family currently receiving Federal Public Aid Assistance? Yes ☐ No ☐
3. Do you or your family have pending an application for Federal Public Aid Assistance? Yes ☐ No ☐

III. If the answer to any of the questions in (II) above is Yes, indicate the applicable category of Public Assistance:

A. ☐ Aid to Families with Dependent Children
☐ Federal Medical Assistance (minor child in the family)

B. ☐ Blind Assistance
☐ Old Age Assistance
☐ Disability Assistance
☐ Federal Medical Assistance (no minor child in the family)

IV. Fill out the following table using the definitions of Family Size** and Income:***

Income-Family Size Table

Annual Income in $	Family Size				
	1	2	3	4	5 or more
0 to 3,000					
3,001 to 4,500					
4,501 to 6,000					
6,001 to 7,500					
7,501 to 9,000					
9,001 to 12,000					
12,001 to 15,000					
15,001 and Up					

V. Instructions for determining Social Service Eligibility:

AFDC: Applicable if:
a) Either box under (IIIA) is checked or
b) There is a minor child included in the family size and a check mark appears above the heavy line in the Income-Family Size Table

AABD: Applicable if:
a) Any box under (IIIB) is checked or
b) A check mark appears above the heavy line in the Income-Family Size Table, and
(1) The individual is 60 years of age or older, or
(2) The individual has a progressive eye condition likely to result in blindness within five years, or
(3) The individual is 13 years of age or over and has a physical or mental condition that impairs his ability to work****

Ineligible: Applicable if the answer to Question (I) is No or all answers to questions Number (II-1) and (II-2) and (II-3) are No and if the check mark on the Income-Family Size Table appears below the heavy dividing line.

Social Service Eligibility: _____ 1 AABD _____ 2 AFDC _____ 3 Ineligible

Date of Determination _____ Name of Interviewer _____ Unit _____

(Definitions on back)

FEE DETERMINATION

Patient's Name_____ Age_____

Modality and frequency of service_____

Income and number of dependents_____

Recommended fee_____

Actual fee_____ Date determined_____

Justification_____

_____

_____

_____

Worker's signature and classification_____

_____

CR260

ILLINOIS DEPARTMENT OF MENTAL HEALTH
DIVISION OF INFORMATION SYSTEMS

CASE OPENING FORM

NO. _____ 104 DMH1006 Rev. 11-1-73

NOTE: Completely shaded fields are optional

PICA ELITE

ALIGNMENT INSTRUCTIONS
INSERT FORM, ALIGN. TYPE AN 'X' IN ONE BOX AT LEFT — TYPE AN 'X' IN ONE BOX AT RIGHT.
IF 'X'S' DO NOT FALL WITHIN BOXES, RE-ALIGN FORM AND REPEAT.

ELITE PICA

FACILITY OR CLINIC	UNIT CODE	CLIENT ID NO (INITIAL / NUMBER)	CASE OPENING DATE (MO / DAY / YR)	TRANSACTION CODE (OPENING CHANGE)	DISPOSITION IF CASE CLOSED AT INTAKE (CLIENT WITHDREW / CLINIC TERMINATED: W REFERRAL / W/OUT REF)
				1 2	1 | 2 3

CLIENT - FIRST NAME	INITIAL	LAST NAME	BIRTH DATE (MO / DAY / YR)

CLIENT ADDRESS - NO & STREET	CITY	ZIP	GEOGRAPHIC CODE (COUNTY / SUB / CA)

SOCIAL SECURITY NUMBER (OMIT DASHES)	SOCIAL SERVICE ELIGIBILITY (A: 1 PRESENT, 2 POTENTIAL; B: 3 PAST, 4 PRESENT, 5 POTENTIAL; 6 INELIGIBLE, 7 UNKNOWN)	RACE (1 WHITE, 2 BLACK, 3 MEXICAN, 4 PUERTO RICAN, 5 AMER INDIAN, 6 ORIENTAL, 7 OTHER)
	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7

DIAGNOSIS	TREATMENT CATEGORY (1 W/EMOT DIST, 2 MR, 3 DRUG ABUSE, 4 ALCOHOLISM, 5 OTHER)	STATUS (1 AFTER CARE, 2 PRE CARE)	COMMUNITY PLACEMENT	DELIVERY MODE (EXPECTED) (1 OUT-PATIENT, 2 FIELD CARE, 3 DAY CARE, 4 INPATIENT)	SEX (1 MALE, 2 FEMALE)
	1 1 1 1 1	1 2	1	1 2 3 4	1 2

MARITAL STATUS (1 NEVER MARRIED, 2 MARRIED, 3 WIDOWED, 4 DIVORCED, 5 SEPARATED, 6 OTHER, 7 UNKNOWN)
1 2 3 4 5 6 7

FACILITY OR CLINIC	CLIENT ID NO. (INITIAL / NUMBER)	CASE OPENING DATE (MO / DAY / YR)

This section of the form is ONLY to be used to correct "Clinic Code" and/or "Client ID" and/or "Opening Date" which was previously submitted in error. (See procedure manual for correction instructions)

RESPONSIBLE STAFF - LAST NAME	STAFF ID NO.	REPORTING DATE	REPORTED BY

SOURCE OF REFERRAL

01 ☐ Self
10 ☐ Family relatives
11 ☐ Friends

20 ☐ State Hospital (Name) _____
21 ☐ Private mental hospital
22 ☐ Public mental hospital (federal, county, city)
23 ☐ Psychiatric service general hospital
24 ☐ Residential treatment center for children
25 ☐ Training school for mental retardation
29 ☐ Other psychiatric inpatient facility

31 ☐ Private psychiatrist
32 ☐ Other outpatient psychiatric clinic
33 ☐ Psychiatric day care center

41 ☐ Private physician
42 ☐ Local health department
43 ☐ General hospital (not psychiatric unit)
44 ☐ Nursing home
49 ☐ Other medical or health agency

51 ☐ Private psychologist
59 ☐ Other psychological services (counseling, etc.)

60 ☐ Social service agency (marriage counseling, etc.)
70 ☐ Court, correctional institution, police, etc.
80 ☐ School (elementary, high school, etc.)

91 ☐ Clergy
92 ☐ Alcoholics Anonymous
93 ☐ Vocational Rehabilitation
94 ☐ Employment service
95 ☐ Boarding care home
99 ☐ Other (specify) _____

EDUCATION OF CHILD (Under 18 years)

0 ☐ Unknown
1 ☐ Preschool
2 ☐ Kindergarten
3 ☐ Special education for mentally handicapped
4 ☐ Special education for physically handicapped
5 ☐ 1st, 2nd or 3rd grade
6 ☐ 4th, 5th or 6th grade
7 ☐ 7th, 8th or 9th grade
8 ☐ 10th, 11th or 12th grade
9 ☐ High School completed
X ☐ College student
Y ☐ Not applicable (patient is adult)

EDUCATION OF ADULT PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A CHILD

0 ☐ Unknown
1 ☐ Less than 4th grade
2 ☐ 4th, 5th, 6th or 7th grade
3 ☐ 8th grade
4 ☐ High School not complete
5 ☐ High School complete
6 ☐ College not complete
7 ☐ College complete
8 ☐ Post graduate college degree
X ☐ Special education for mentally or physically handicapped
Y ☐ Techno-academic (nurses, etc.)

OCCUPATION OF ADULT PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A CHILD

0 ☐ Professional, technical and kindred workers
1 ☐ Farmers and farm managers
2 ☐ Managers, officials and proprietors except farm
3 ☐ Clerical and kindred workers
4 ☐ Sales workers
5 ☐ Craftsmen, foremen, and kindred workers
6 ☐ Operative and kindred workers
7 ☐ Private household workers
8 ☐ Service workers except private household
9 ☐ Farm laborers and foremen
X ☐ Laborers except farm and mine
Y ☐ Unknown, unemployed, not listed, no history of employment
Z ☐ Housewife

PRIOR PSYCHIATRIC CARE (Check all types applicable)

0 ☐ No prior psychiatric care
1 ☐ Prior care - outpatient clinic
2 ☐ Prior care - state hospital
4 ☐ Prior care - private sanitaria
8 ☐ Prior care - general hospital psychiatric unit

_____ Sum of codes

DMH-146
Rev. 3/71

State of Illinois
Department of Mental Health

AUTHORIZATION FOR RELEASE OF INFORMATION BY DEPARTMENT

TO Zone Admr. /Superintendent (Facility name, City and Zone No.)	2. Date

3. Patient's name

4. ID No.	5. Social Security No.	6. County of admission

7. Admitted as:

☐ Informal
☐ Voluntary
☐ Phys. Certificate
☐ Emergency
☐ Court Order
☐ Mentally retarded
☐ Other _____

8. Purpose of request for information:

9. Having been fully informed of the circumstances in connection with the request for information from my clinical record, I hereby grant to the Department of Mental Health the authority to release such information to (see DMH-Rule 5. 01):

10. My personal physician (name and address)

11. Mental Health Clinic serving my home area (name and address)

12. After-care facility to which I will be released, if known (name and address)

13. Other authorized person or agency (including Insurance Companies and Social Security Administration for purpose of obtaining benefits) (name and address)

14. Signature of Patient, Guardian or Conservator

15. Relationship to patient

16. Address of Guardian or Conservator

17. Witness (name and address)

If the patient is legally competent he must sign this himself. If he is legally incompetent, it must be signed by the guardian or conservator only. If patient is a minor, parent may sign. If patient is competent but unable to sign, his mark or consent may be witnessed.

CLOSING SUMMARY

Name of Patient_____COORDINATOR:_____

DATE ASSIGNED:_____DATE CLOSED:_____

NUMBER OF INTERVIEWS:_____

107

ILLINOIS DEPARTMENT OF MENTAL HEALTH & DEVELOPMENTAL DISABILITIES
DIVISION OF INFORMATION SERVICES

NO. _____ DMH1007

Rev. 8/74

CLOSING FORM

PICA ☐ ELITE ☐

ALIGNMENT INSTRUCTIONS
INSERT FORM, ALIGN. TYPE AN 'X' IN ONE BOX AT LEFT — TYPE AN 'X' IN ONE BOX AT RIGHT.
IF 'X'S' DO NOT FALL WITHIN BOXES, RE-ALIGN FORM AND REPEAT.

ELITE ☐ PICA ☐

FACILITY OR CLINIC	UNIT CODE	CLIENT I.D. NO.		CASE CLOSING DATE			TRANSACTION CODE		DIAGNOSIS AT CLOSING
		INITIAL	NUMBER	MO.	DAY	YEAR	CLOSING	CHANGE	

CLIENT — FIRST NAME — INITIAL — LAST NAME	PSYCHIATRIC CONDITION		
	RECOVERED	IMPROVED	UNIMPROVED

DISPOSITION OF CASE				DISPOSITION OF CASE FOR AFTERCARE LINKAGE CLIENTS ONLY					
CLIENT WITHDREW		CLINIC TERMINATED		CLIENT REFUSED SERVICE	CLIENT COULD NOT BE LOCATED	CLIENT MOVED FROM SERVICE AREA - REFRD	CLIENT MOVED FROM SERVICE AREA - NOT REFRD	CLIENT READMITTED TO DMHDD FAC.	OTHER
CLINIC NOTIFIED	CLINIC NOT NOTIFIED	WITH REFERRAL	WITHOUT REFERRAL						

THIS SECTION OF THE FORM IS ONLY TO BE USED TO CORRECT "CLOSING DATE" WHICH WAS PREVIOUSLY SUBMITTED IN ERROR. (SEE PROCEDURE MANUAL FOR CORRECTION INSTRUCTIONS).

CASE CLOSING DATE		
MO.	DAY	YEAR

REPORTING DATE	REPORTED BY

DATE OF LAST INTERVIEW ____/____/____ (Month / Day / Year)

LEVEL OF CLOSING
1 ☐ Treatment
2 ☐ Diagnostic only - complete
3 ☐ Diagnostic only - incomplete
4 ☐ Psychological testing only
5 ☐ Other

DIAGNOSTIC SERVICES (more than one may be checked)
0 ☐ Not applicable
1 ☐ Psychiatric
2 ☐ Psychological
4 ☐ Psychiatric social work
____ Sum of codes
1 ☐ Neurological
2 ☐ Electroencephalogram
4 ☐ Medical, lab tests, etc.
____ Sum of codes

TREATMENT SERVICES (more than one may be checked)
0 ☐ Not applicable
1 ☐ Intensive psychotherapy
2 ☐ Supportive therapy
4 ☐ Milieu therapy
____ Sum of codes
1 ☐ Adjunctive therapy
2 ☐ Physical therapy
4 ☐ Group psychotherapy
____ Sum of codes

A. PSYCHIATRIC CONDITION OF TREATED CASE
1 ☐ Recovered
2 ☐ Improved
3 ☐ Unimproved

B. SERVICE STATUS OF CASE NOT IN TREATMENT
4 ☐ Service complete
5 ☐ Service incomplete

INCODE
1 ☐ First admission
2 ☐ Readmission, last discharge in this fiscal year
3 ☐ Readmission, last discharge in a prior fiscal year

DISPOSITION OR REFERRAL RECOMMENDATION (check one only)

Patient withdrew from clinic service
01 ☐ Clinic notified - moved, died, or ill
02 ☐ Clinic notified - other reason
03 ☐ Clinic not notified

Clinic terminated - without referral
10 ☐ Further care not indicated at this time
11 ☐ Additional clinic service needed but not available at this time
12 ☐ Community resources other than this clinic needed but not available now
13 ☐ Community resources other than this clinic needed and available - patient not ready
14 ☐ Additional clinic services needed, but patient or family not ready

Clinic terminated - with referral
20 ☐ State mental institution
21 ☐ Private mental hospital
22 ☐ Public mental hospital (federal, county, city)
23 ☐ Psychiatric service of general hospital
24 ☐ Residential treatment center for children
25 ☐ Training school for mental retardation
30 ☐ Other psychiatric inpatient facility
31 ☐ Private psychiatrist
32 ☐ Other outpatient psychiatric clinic
33 ☐ Psychiatric day care center
41 ☐ Private Physician
42 ☐ Local health department
43 ☐ General hospital (not psychiatric unit)
44 ☐ Nursing home
49 ☐ Other medical or health agency
51 ☐ Private psychologist
59 ☐ Other psychological services (counseling, etc.)
60 ☐ Social service agency (marriage counseling, etc.)
70 ☐ Court, correctional institution, police, etc.
80 ☐ School (elementary, high school, etc.)
91 ☐ Clergy
92 ☐ Alcoholics Anonymous
93 ☐ Vocational rehabilitation
94 ☐ Employment service
95 ☐ Boarding care home for aged
96 ☐ Other (specify)

NUMBER OF INTERVIEWS

Patient interviewed by:		Parent interviewed by:		Spouse interviewed by:		Other collateral interviewed by:	
Psychiatrist	____	Psychiatrist	____	Psychiatrist	____	Psychiatrist	____
Psychologist	____	Psychologist	____	Psychologist	____	Psychologist	____
Other discipline	____	Other discipline	____	Other discipline	____	Other discipline	____

APPENDIX C

REPORT ON THE SURVEY OF THE HELPING PROFESSIONS IN THE EDISON PARK PLANNING AREA

The following report is the results of 160 questionnaires which were sent to twenty-five schools, sixty doctors, fifty-four Clergyman, and twenty-one other agencies in the Edison Park Planning Area (Edison Park, Norwood Park, Jefferson Park, Dunning, and The Unincorporated Area around O'Hare Airport). Thirty questionnaires were completed and returned. This figure represents a random sample of some 19% of those surveyed. This sample provides an adequate basis for some general conclusions and projections.

On the basis of this data the following can be asserted: The Clergy and doctors deal with the widest range of emotional and mental problems of the greatest number of persons in the widest social, economic, marital, employment, and age groups. In most instances the helping professions surveyed rely on private referral sources, and private hospitals.

In those cases were Department of Mental Health Services were used, doctors and agencies used them most. Outpatient, in-patient hospitalization and Children and Adolescent Services were the most frequently used services in that order.

Those who did use Department Services were satisfied with the follow through and the feedback provided, as well as the treatment given. Only a small percentage experienced difficulties, mostly relating to juristriction and catchment area.

Major concerns of the group were marital and family problems, emotional problems of children and adolescence, and alcoholism. Drug Abuse, delinquency and problems with the elderly didn't seem like significant issues.

The group seemed interested in crisis intervention, with the majority rating the questions "What can be done for a person who is need of immediate mental health treatment," and "what can I do for someone threatening to harm himself or others," as the areas they are interested in learning more about.

As for learning more about Department of Mental Health Services, the group indicated a high preference for learning more about individual, marital, and family therapy, Adult Outpatient Program and Children and Adolescent Programs.

The majority expressed a willingness to attend an Open House and many expressed a desire to get further information about the Department of Mental Health and Subregion Programs.

RECOMMENDATIONS AND CONCLUSIONS:

That an Open House be planned for the Edison Park Planning Area sponsored by the Subregion with special programs featuring Adult Out-patient Services, Children and Adolescent Program, and Crisis Intervention.

That the Invitation include a pamphlet similar to the Community Mental Health Pamphlet sent for the Clergy Institute outlining Subregion services and resources.

That the agencies and helping groups not covered by this survey, such as police be polled as to need of service.

That the possibility of a walk-in center be explored for the Edison Park Planning Area in view of the extensive use of private facilities and professionals.

QUESTIONNAIRE

I. Name and Title_____

II. Agency or Profession_____

Address_____Phone_____

III. Type of Service Provided_____

_____

IV. Of What Kinds of Emotional Difficulties do the people you serve most frequently Complain OF?_____

_____

V. Where Do You Usually Refer People For Psychiatric Service?_____

_____

VI. Have You Ever Referred a Case to Chicago-Read Mental Health Center, 4200 N. Oak Park Avenue?_____Yes _____No

If Yes, Did You Refer for Hospitalization_____

Out Patient Program_____

Children and Adolescent's Program_____

Day Treatment School_____

VII. Did the Person follow Through on your Referral?_____

VIII. Did You Expect Feedback From our Agency?_____Did You Get It?_____

IX. Did You or the Person Encounter Difficulties in Your Referral?_____

If so, what were they?_____

_____

X. Was Patient Treated to Your Satisfaction?_____

_____

XI. The Majority of People I Deal with are:

_____Children _____Single _____Employed _____Low ($7-10,000)

_____Adolescents _____Married _____Unemployed _____Middle ($10-12,000

_____Adults _____Divorced _____Unemployed _____Upper (over $12,000)

_____Elderly _____Separated

_____Widowed

XII. From Your Experiences in This Community, How Would You Rank the Following in Terms of least to most Prevalent?

(From 1 to 7) _____Marital Problems _____Family Problems _____Alcoholism

_____Drug Abuse _____Delinquency _____Problems with Elderly

_____Emotional Problems of Childhood and Adolescence.

XIII. I would be interested in learning more about the following:

_____What can be done for a person who is in need of immediate mental health treatment?

_____What are a patient's rights?

_____What I can do for someone threatening to harm himself or others?

_____How I can participate in a Citizen's Advisory Board to this center?

XIV. I am primarily interested in learning more about the following services at Read:

1. Children and Adolescent Programs (794-3875)
2. Adult Outpatient Program (794-3602 or 794-3610)
3. In-patient services (hospitalization) (794-3880)
4. Individual, Marital, and Family Therapy (794-3602 or 794-3610)
5. Crisis Intervention (crisis telephone 794-3609)
6. Home Intervention Team (794-3604)

XV. I am interested in:

1. _____Attending the open house on April 4, 1973.
2. _____Not attending myself, but will send a substitute.
3. _____Not attending.
4. _____Getting further information.

APPENDIX D

NAME:_____

ADDRESS:_____

_____

TELEPHONE: Business_____HOME_____

TYPE OF WORK:_____

ORGANIZATIONS: (e.g. P.T.A., Community Groups)_____

_____

COMMUNITY AREA: (please check one)

_____ (1) Edison Park

_____ (2) Norwood Park

_____ (3) Jefferson Park

_____ (4) Dunning

_____ (5) O'Hare

_____ (6) Other_____

I would like to participate on the following committees.

_____ (1) Community Advisory Board

_____ (2) Search Committee

_____ (3) Membership Committee - to enlist help on committees

_____ (4) Fact Finding - to discover community needs

_____ (5) Fund Raising - to help support the center

_____ (6) Volunteer - to work on Chicago-Read units

_____ (7) Speakers Bureau to address community groups

_____ (8) Publicity - to inform the community

_____ (9) Drug Abuse - and Alcoholism - to help work with this problem

_____ (10) Committee for the Mentally Retarded - to determine their needs

_____ (11) Others - please specify

Residents of the following communities, Edison Park, Jefferson Park, Norwood Park, Dunning and O'Hara, are planning a community mental health clinic. We are conducting a survey of our neighbors to help us decide which services are needed in this area.

1. Do you live or work in one of these areas?

_____ Edison Park
_____ Jefferson Park
_____ Norwood Park
_____ Dunning
_____ O'Hara
_____ Other

2. Please check any items below that you consider to be problems in your community.

_____ 1. alcoholism
_____ 2. drug abuse
_____ 3. school problems
_____ 4. unemployment
_____ 5. marriage problems
_____ 6. family communications
_____ 7. child abuse or neglect
_____ 8. gambling
_____ 9. juvenile delinquency
_____ 10. serious money problems
_____ 11. lack of activities for senior citizens
_____ 12. lack of services for the mental handicapped
_____ 13. lack of services for the mentally ill
_____ 14. _____
_____ 15. _____

3. From the above list which problems do you think are the three most serious ones in your community. (List the most serious problem first).

1. # _____
2. # _____
3. # _____

4. Which of the following services should the clinic offer to community residents?

_____ marriage counseling
_____ family counseling
_____ medicine for those who need it
_____ drug counseling
_____ follow up care for patients from mental health hospitals
_____ help for families with mentally handicapped children
_____ help refer residents to other services
_____ (other specify)

5. Should the people who come to the clinic be asked to pay a fee if they can afford it, and in proportion to their ability to pay, or not asked to do so?

_____ asked to pay a fee
_____ not asked to pay a fee

6. In which area should a community mental health clinic be placed?

_____ Edison Park
_____ Jefferson Park
_____ Norwood Park
_____ Dunning
_____ O'Hara
_____ Other
_____ No opinion

7. I would like to participate in the community mental health clinic in the following ways:

_____ a) to be on your mailing list
_____ b) To serve on a committee

_____ membership
_____ to find a place for the clinic
_____ publicity
_____ fact finding
_____ fund raising
_____ drug abuse
_____ mental retardation
_____ other _____

_____ c) to be a volunteer at the clinic
_____ d) to be a volunteer at Chicago Read Hospital
_____ e) to be on the advisory board
_____ f) to donate money to the clinic
_____ g) other _____

8. If you are able to help in one of the above ways, please include your name, address and telephone here _____

_____

_____

APPENDIX E

LUTHERAN WELFARE SERVICES OF ILLINOIS
4840 WEST BYRON CHICAGO ILLINOIS 60641 PHONE 312-282-7800

December 1, 1975

Mr. Robert Geigner
Director of Sub-Region 8
Administration Building
4201 North Oak Park Avenue
Chicago, Illinois 60634

Dear Mr. Geigner:

This letter is to verify that Lutheran Welfare Services of Illinois is interested in the sponsorship of the Edison Park Mental Health Center. The agency will continue its work with community representatives and with the Sub-Region staff in implementing relocation to the community.

Sponsorship by Lutheran Welfare is subject to assurance of grant-in-aid funding which will cover the staff personnel costs. The fee income would cover administrative and managerial costs such as rent, telephone, billing, community development work, etc.

We will be expecting to hear from you in response to this letter of interest.

Sincerely yours,

The Rev. John P. Petersen, ACSW
Acting Executive Director

JPP/dld

cc: D. Goos
W. Rasmussen

STATE OF ILLINOIS
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
REGION 2

INTER-OFFICE
CORRESPONDENCE

SUBREGI(
6500 W. Irving P
Chicago, Illinoi

MEMO TO: The Edison Park Community Mental Health Clinic Advisory Board

DATE: March 8, 1976

FROM: Robert Geigner
Administrator
Subregion 8

SUBJECT: Sponsorship Program

The Department of Mental Health, Subregion Eight is pleased to announce that the Board of Directors of Lutheran Welfare Services of Illinois has accepted the sponsorship of the Edison Park Community Mental Health Clinic. As of April 1, 1976 Department of Mental Health Grant-In-Aid funds will be available to Lutheran Welfare Services to underwrite the operation of the clinic.

Negotiations for sponsorship of the clinic by Lutheran Welfare Services have been taking place since July 1975. At the November 19, 1975 Advisory Board Meeting, it was agreed that these negotiations be continued with sponsorship by Lutheran Welfare Services as the eventual goal. Mrs. Goos, Director of the North Section of Lutheran Welfare, is anticipating meeting with the Advisory Board as soon as possible to discuss the implications of the sponsorship and plans for its full implementation.

JFS:lc

cc: Carrie Graham
Dorothy Goos

Illinois Department of Mental Health
and Developmental Disabilities

120

INTER-OFFICE CORRESPONDENCE

DATE March 24, 1976

MEMO TO: Mr. Robert Anderson, Deputy Director
Division of Community Services

RECEIVED
MAR 29 1976
Subregion 8

FROM: Prakash N. Desai, M.D.
Regional Administrator

ADDRESS:

SUBJECT: Transfer of Function of Edison Park Community M.H. Clinic Fac.#286-40

A supplemental award of $44,329 is recommended by the Region 2 Office to Lutheran Welfare Services for the transfer of function of the Edison Park Community Mental Health Clinic from the Chicago-Read Mental Health Center.

The grant is for the 4th quarter of FY76 to start April 1, 1976. The annualized cost of this clinic, including personnel and other support costs is $175,074. The amount of the MI supplemental award is as follows:

Unit #	Program #	Amount
40	01 Sus. Care	$27,765
40	21 Sus. Care C & A	9,519
40	02 Outpatient	7,045
	Total	44,329

Included in this packet are the revised agency plan, revised GR-1, program descriptions, as well as mutual agreements with other service providers.

We hope immediate action from your office to complete this transaction.

PND/CD

cc: Bob Geigner - SR 8
Helen Sunukjian, Ph. D.

xxxxxxxxxxxxxxxxxx

LeRoy P. Levitt, M.D. - Director

121

xxxx 4153

May 18, 1976 SUBREGION 8

Mr. Ruben Jessop
Executive Director
Lutheran Welfare Services of Illinois
4840 W. Byron
Chicago, Illinois 60641

Dear Mr. Jessop:

We are pleased to inform you that a grant-in-aid award of $171,000 has been recommended for Lutheran Welfare Services to operate the Edison Park Community Mental Health Clinic. This recommendation was made after analyzing both the anticipated annualized expenses and the estimated local income projected for FY-77.

The amount of the recommended grant award, by program, is as follows:

(01) Sustaining Care	-	$108,113
(21) Sustaining Care C&A	-	$ 36,240
(02) Outpatient	-	$ 26,647
TOTAL		$171,000

This FY-77 recommended award is to be applied to the personnel costs and fringe benefits of the former DMH staff positions at the Edison Park Mental Health Clinic. This award is given with the understanding that Lutheran Welfare Services will administer this transferred function, ensuring adequate continuation of the services provided to the Edison Park Planning Area by the former Subregion Eight Outpatient Program as broken out in the above programs.

In making this award, we anticipate that the Clinic will strive to meet its grant application objectives, particularly those objectives relating to Community Outreach and service to the high-risk population. We look forward to a close working relationship with Lutheran Welfare Services and this new community Clinic. We commend you for your leadership in providing the sponsorship of this vital community mental health service.

Sincerely,

Robert D. Geigner, ACSW
Administrator - Subregion 8

RDG:ar
cc: Prakash N. Desai, M.D.
Dorothy Coos
Carrie Graham

APPENDIX F

FAR NORTHWEST COUNSELLING CENTER

I.D.# _____ DATE: _____

NAME: _____ ALIAS OR MAIDEN NAME: _____
(last) (first) (middle)

CURRENT ADDRESS: _____ HOME PHONE: _____
(street & number) (city) (zip) WORK PHONE: _____
CONTACT AT: _____

TIME AT ABOVE ADDRESS _____

SEX	BIRTH DATE	AGE	MARITAL STATUS	RACE	RELIGION	OCCUPATION

PLACE OF BIRTH	YEARLY INCOME	SOCIAL SECURITY NUMBER - - - - - - - - -	PUBLIC ASSISTANCE YES ___ NO ___ P.A.# _____

EDUCATION _____ years	EMPLOYED YES _____ NO _____	HOW LONG EMPLOYED _____ HOW LONG UNEMPLOYED _____

PAST PSYCHIATRIC HOSPITALIZATION OR OTHER MAJOR TREATMENT (Include dates) _____

SERVICES DESIRED: _____

REFERRED TO US BY: _____

NAME	ADDRESS OR DATE DECEASED	PHONE
HUSBAND OR WIFE		
FATHER		
MOTHER		
FAMILY PHYSICIAN		
IN CASE OF EMERGENCY		

HOUSEHOLD COMPOSITION
(All Other People Living in Home)

Name	Relation	Age	Name	Relation	Age

Do Not Write Below This Line

PROVISIONAL DIAGNOSIS: _____
DIAGNOSTIC CODE: _____
Geographic Code: _____ Intake Worker: _____

DISPOSITION OF APPLICATION
_____ Accepted F.N.C.C.
_____ Applicant Withdrew
_____ Referred to: _____
Worker: _____
Date of Appointment: _____

LOGGED TO: _____
DATE: _____
BY: _____

FAR NORTHWEST COUNSELLING CENTER
INTAKE SUMMARY

Patient's Name_____ Staff Worker_____

Address_____ Telephone No._____

Age_____Sex_____ Marital Status_____ Race_____Date of 1st Contact_____

1. Statement of problems, precipitating factors, etc: 2. Current life situation:
3. Pertinent genetic factors; 4. Impressions of patient and recommendations:
5. Disposition

Fee $_____

Date_____

LUTHERAN WELFARE SERIVCES OF ILLINOIS

Confidential Income Information for Fee Determination

Name_____ Telephone_____

Home Address_____ Rent _____ Own Home_____

City	State	Zip	Business Address	Phone

Composition of Family Household

Total number of persons_____

No. of dependent children_____ Ages ___ ___ ___ ___

No. of working children _____ Ages ___ ___ ___ ___

No. of other dependents _____ Relationship_____

GROSS FAMILY INCOME

I. GROSS SALARIES (i.e., before deductions) AND/OR NET INCOME FROM OWN BUSINESS

Family Member Name	Employer	(Use either or both*) Yearly	Weekly
1.			
2.			
3.			
	A. Sub-total		

II. ADDITIONAL INCOME FROM OVERTIME, BONUSES, COMMISSIONS, ETC.

	Yearly	Weekly
1.		
B. Sub-total		

III. FAMILY INCOME FROM OTHER SOURCES

	Yearly	Weekly
a) Alimony and Child support		
b) Workmen's Compensation/Unemployment		
c) Interests, Dividends, Rent, Annuities, Insurance		
d) Social Security and/or Pension		
e) Relatives/Other (specify)		
C. Sub-total		

TOTAL OF GROSS YEARLY AND/OR WEEKLY INCOME (Add A,B,C) _____ _____

CHOICE OF PAYMENT: In Person_____ Monthly Billing_____ Other_____

DATE_____ CLIENT'S SIGNATURE_____

(*) indicate whether employment is full or part time

FAR NORTHWEST COUNSELLING CENTER

FEES

A fee of $15.00 is charged for the initial visit to our facility.

Subsequent fees which are based on a sliding scale will be determined during your interview and the fee is payable at the time of each visit. Your insurance policy may help pay for our services. The cost for services is $40.00 an hour and the agency subsidizes the portion not paid by you. Exceptions to the negotiated fee will need approval of the Director.

Service may be terminated if fees become past due. If a problem arises in paying the fee, please discuss this with your counsellor.

Cancellation of an appointment is required at least 24 hours in advance. Failure to cancel in advance will result in a charge for the missed appointment.

(To be completed during first interview with assigned therapist)

FEE: _____

CLIENT: _____

WORKER: _____

DATE: _____

./30

ILLINOIS DEPARTMENT OF MENTAL HEALTH
DIVISION OF INFORMATION SYSTEMS

NO. [ ]

127 DMH1006
Rev. 11-1-73

CASE OPENING FORM

NOTE: Completely shaded fields are optional

PICA ELITE

ALIGNMENT INSTRUCTIONS
INSERT FORM, ALIGN. TYPE AN 'X' IN ONE BOX AT LEFT — TYPE AN 'X' IN ONE BOX AT RIGHT.
IF 'X'S' DO NOT FALL WITHIN BOXES, RE-ALIGN FORM AND REPEAT.

ELITE PICA

FACILITY OR CLINIC	UNIT CODE	CLIENT ID NO (INITIAL / NUMBER)	CASE OPENING DATE (MO / DAY / YR)	TRANSACTION CODE (OPENING CHANGE)	DISPOSITION IF CASE CLOSED AT INTAKE (CLIENT WITHDREW / CLINIC TERMINATED W REFERRAL / CLINIC TERMINATED W/OUT REF)
				1 2	1 2 3

CLIENT - FIRST NAME	INITIAL	LAST NAME	BIRTH DATE (MO / DAY / YR)

CLIENT ADDRESS - NO. & STREET	CITY	ZIP	GEOGRAPHIC CODE (COUNTY / TWP / CA)

SOCIAL SECURITY NUMBER (OMIT DASHES)	SOCIAL SERVICE ELIGIBILITY (A PAST / A CURRENT / A POTENTIAL / C PAST / C CURRENT / C POTENTIAL / INELIGIBLE / UNKNOWN)	RACE (WHITE / BLACK / MEXICAN / PUERTO RICAN / AMER INDIAN / ORIENTAL / OTHER)
	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7

DIAGNOSIS	TREATMENT CATEGORY (W/ SHUT OUT / MR / DRUG ABUSE / ALCOHOLISM / OTHER)	STATUS (AFTER CARE / PRE CARE)	COMMUNITY PLACEMENT	DELIVERY MODE (EXPECTED) (OUT-PATIENT / FIELD CARE / DAY CARE / INPATIENT)	SEX (MALE / FEMALE)
	1 1 1 1 1	1 2	1	1 2 3 4	1 2

FACILITY OR CLINIC	CLIENT ID NO. (INITIAL / NUMBER)	CASE OPENING DATE (MO / DAY / YR)

MARITAL STATUS (NEVER MARRIED / MARRIED / WIDOWED / DIVORCED / SEPARATED / OTHER / UNKNOWN)
1 2 3 4 5 6 7

This section of the form is ONLY to be used to correct "Clinic Code" and/or "Client ID" and/or "Opening Date" which was previously submitted in error. (See procedure manual for correction instructions)

RESPONSIBLE STAFF - LAST NAME	STAFF ID NO.	REPORTING DATE	REPORTED BY

SOURCE OF REFERRAL

01 ☐ Self
10 ☐ Family relatives
11 ☐ Friends

20 ☐ State Hospital (Name) _____
21 ☐ Private mental hospital
22 ☐ Public mental hospital (federal, county, city)
23 ☐ Psychiatric service general hospital
24 ☐ Residential treatment center for children
25 ☐ Training school for mental retardation
29 ☐ Other psychiatric inpatient facility

31 ☐ Private psychiatrist
32 ☐ Other outpatient psychiatric clinic
33 ☐ Psychiatric day care center

41 ☐ Private physician
42 ☐ Local health department
43 ☐ General hospital (not psychiatric unit)
44 ☐ Nursing home
49 ☐ Other medical or health agency

51 ☐ Private psychologist
59 ☐ Other psychological services (counseling, etc.)

60 ☐ Social service agency (marriage counseling, etc.)
70 ☐ Court, correctional institution, police, etc.
80 ☐ School (elementary, high school, etc.)

91 ☐ Clergy
92 ☐ Alcoholics Anonymous
93 ☐ Vocational Rehabilitation
94 ☐ Employment service
95 ☐ Boarding care home
99 ☐ Other (specify) _____

EDUCATION OF CHILD (Under 18 years)

0 ☐ Unknown
1 ☐ Preschool
2 ☐ Kindergarten
3 ☐ Special education for mentally handicapped
4 ☐ Special education for physically handicapped
5 ☐ 1st, 2nd or 3rd grade
6 ☐ 4th, 5th or 6th grade
7 ☐ 7th, 8th or 9th grade
8 ☐ 10th, 11th or 12th grade
9 ☐ High School completed
X ☐ College student
Y ☐ Not applicable (patient is adult)

EDUCATION OF ADULT PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A CHILD

0 ☐ Unknown
1 ☐ Less than 4th grade
2 ☐ 4th, 5th, 6th or 7th grade
3 ☐ 8th grade
4 ☐ High School not complete
5 ☐ High School complete
6 ☐ College not complete
7 ☐ College complete
8 ☐ Post graduate college degree
X ☐ Special education for mentally or physically handicapped
Y ☐ Techno-academic (nurses, etc.)

OCCUPATION OF ADULT PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A CHILD

0 ☐ Professional, technical and kindred workers
1 ☐ Farmers and farm managers
2 ☐ Managers, officials and proprietors except farm
3 ☐ Clerical and kindred workers
4 ☐ Sales workers
5 ☐ Craftsmen, foremen, and kindred workers
6 ☐ Operative and kindred workers
7 ☐ Private household workers
8 ☐ Service workers except private household
9 ☐ Farm laborers and foremen
X ☐ Laborers except farm and mine
Y ☐ Unknown, unemployed, not listed, no history of employment
Z ☐ Housewife

PRIOR PSYCHIATRIC CARE (Check all types applicable)

0 ☐ No prior psychiatric care
1 ☐ Prior care - outpatient clinic
2 ☐ Prior care - state mental
4 ☐ Prior care - private sanitaria
8 ☐ Prior care - general hospital psychiatric unit

_____ Sum of codes

FAR NORTHWEST COUNSELLING CENTER
6075 NORTHWEST HIGHWAY CHICAGO ILLINOIS 60631 PHONE 312-774-7555

AUTHORIZATION FOR RELEASE OF INFORMATION FROM
FAR NORTHWEST COUNSELLING CENTER

Date_____

I,_____ Responsible Guardian or Patient

hereby give my consent to the Far Northwest Counselling Center to release information regarding _____

To: _____

Address: _____

Name: _____

Address:_____

Phone: _____

Chicago, Illinois

Witness: _____

FAR NORTHWEST COUNSELLING CENTER
CLOSING SUMMARY

NAME OF PATIENT_____ COORDINATOR:_____

DATE ASSIGNED:_____ DATE CLOSED_____

NUMBER OF INTERVIEWS:_____

ILLINOIS DEPARTMENT OF MENTAL HEALTH & DEVELOPMENTAL DISABILITIES
DIVISION OF INFORMATION SERVICES

NO. _____

130
DMH1007
Rev. 8/74

CLOSING FORM

PICA ☐☐ ELITE ☐☐☐

ALIGNMENT INSTRUCTIONS
INSERT FORM, ALIGN. TYPE AN 'X' IN ONE BOX AT LEFT — TYPE AN 'X' IN ONE BOX AT RIGHT.
IF 'X'S' DO NOT FALL WITHIN BOXES, RE-ALIGN FORM AND REPEAT.

ELITE ☐☐☐ PICA ☐☐☐

FACILITY OR CLINIC	UNIT CODE	CLIENT I.D. NO.		CASE CLOSING DATE			TRANSACTION CODE		DIAGNOSIS AT CLOSING
		INITIAL	NUMBER	MO.	DAY	YEAR	CLOSING	CHANGE	

CLIENT – FIRST NAME	– INITIAL	– LAST NAME	PSYCHIATRIC CONDITION		
			RECOVERED	IMPROVED	UNIMPROVED

DISPOSITION OF CASE				DISPOSITION OF CASE FOR AFTERCARE LINKAGE CLIENTS ONLY					
CLIENT WITHDREW		CLINIC TERMINATED		CLIENT REFUSED SERVICE	CLIENT COULD NOT BE LOCATED	CLIENT MOVED FROM SERVICE AREA - REFRD	CLIENT MOVED FROM SERVICE AREA - NOT REFRD	CLIENT READMITTED TO DMHDD FAC.	OTHER
CLINIC NOTIFIED	CLINIC NOT NOTIFIED	WITH REFERRAL	WITHOUT REFERRAL						

THIS SECTION OF THE FORM IS **ONLY** TO BE USED TO CORRECT "CLOSING DATE" WHICH WAS PREVIOUSLY SUBMITTED IN ERROR. (SEE PROCEDURE MANUAL FOR CORRECTION INSTRUCTIONS).

CASE CLOSING DATE		
MO.	DAY	YEAR

REPORTING DATE	REPORTED BY

DATE OF LAST INTERVIEW ___/___/___ (Month / Day / Year)

LEVEL OF CLOSING
1 ☐ Treatment
2 ☐ Diagnostic only - complete
3 ☐ Diagnostic only - incomplete
4 ☐ Psychological testing only
5 ☐ Other

DIAGNOSTIC SERVICES (more than one may be checked)
0 ☐ Not applicable
1 ☐ Psychiatric
2 ☐ Psychological
4 ☐ Psychiatric social work
___ Sum of codes
1 ☐ Neurological
3 ☐ Electroencephalogram
4 ☐ Medical, lab tests, etc.
___ Sum of codes

TREATMENT SERVICES (more than one may be checked)
0 ☐ Not applicable
1 ☐ Intensive psychotherapy
2 ☐ Supportive therapy
4 ☐ Milieu therapy
___ Sum of codes
1 ☐ Adjunctive therapy
2 ☐ Physical therapy
4 ☐ Group psychotherapy
___ Sum of codes

A. PSYCHIATRIC CONDITION OF TREATED CASE
1 ☐ Recovered
2 ☐ Improved
3 ☐ Unimproved
B. SERVICE STATUS OF CASE NOT IN TREATMENT
4 ☐ Service complete
5 ☐ Service incomplete

INCODE
1 ☐ First admission
2 ☐ Readmission, last discharge in this fiscal year
3 ☐ Readmission, last discharge in a prior fiscal year

DISPOSITION OR REFERRAL RECOMMENDATION (check one only)
Patient withdrew from clinic service
01 ☐ Clinic notified - moved, died, or ill
02 ☐ Clinic notified - other reason
03 ☐ Clinic not notified

Clinic terminated - without referral
10 ☐ Further care not indicated at this time
11 ☐ Additional clinic service needed but not available at this time
12 ☐ Community resources other than this clinic needed but not available now
13 ☐ Community resources other than this clinic needed and available - patient not ready
14 ☐ Additional clinic services needed, but patient or family not ready

Clinic terminated - with referral
20 ☐ State mental institution
21 ☐ Private mental hospital
22 ☐ Public mental hospital (federal, county, city)
23 ☐ Psychiatric service of general hospital
24 ☐ Residential treatment center for children
25 ☐ Training school for mental retardation
29 ☐ Other psychiatric inpatient facility
31 ☐ Private psychiatrist
32 ☐ Other outpatient psychiatric clinic
33 ☐ Psychiatric day care center
41 ☐ Private Physician
42 ☐ Local health department
43 ☐ General hospital (not psychiatric unit)
44 ☐ Nursing home
49 ☐ Other medical or health agency
51 ☐ Private psychologist
59 ☐ Other psychological services (counseling, etc.)
60 ☐ Social service agency (marriage counseling, etc.)
70 ☐ Court, correctional institution, police, etc.
80 ☐ School (elementary, high school, etc.)
91 ☐ Clergy
92 ☐ Alcoholics Anonymous
93 ☐ Vocational rehabilitation
94 ☐ Employment service
95 ☐ Boarding care home for aged
99 ☐ Other (specify)

NUMBER OF INTERVIEWS

Patient interviewed by:		Parent interviewed by:		Spouse interviewed by:		Other collateral interviewed by:	
Psychiatrist	___	Psychiatrist	___	Psychiatrist	___	Psychiatrist	___
Psychologist	___	Psychologist	___	Psychologist	___	Psychologist	___
Other discipline	___	Other discipline	___	Other discipline	___	Other discipline	___

APPROVAL SHEET

The dissertation submitted by John Francis Smith has been read and approved by the following committee:

John A. Wellington, Director
Professor, Guidance and Counseling, Loyola

Manuel S. Silverman
Associate Professor, Guidance and Counseling, Loyola

John M. Wozniak
Professor, Foundations of Education, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for degree of Doctor of Philosophy.

July 27, 1981
Date

John A. Wellington
Director's Signature