The Historical Development of the Far Northwest Counselling Center

John F. Smith
Loyola University Chicago

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THE HISTORICAL DEVELOPMENT OF
THE FAR NORTHWEST COUNSELLING CENTER

By
John F. Smith

A Dissertation Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

May
1981
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VITA

The author, John Francis Smith, is the son of James and Susan Sheridan Smith. He was born September 6, 1940 in Chicago.

His elementary education was obtained at St. Mel-Holy Ghost, Chicago and St. Catherine of Sienna, Oak Park, grammar schools, and his secondary education at Quigley Preparatory Seminary.

In June 1974, he received the Bachelor of Arts degree in Philosophy from St. Mary of the Lake Seminary, Mundelein, Illinois, and the Masters of Arts was conferred with distinction in Counselling from DePaul University, Chicago in June 1977. He was elected a member of Kappa Delta Pi that same year. A paper based on his Master's thesis entitled "Deinstitutionalization of Out-Patient Services", was presented at the Midwest Psychological Association, May, 1978.

He has worked extensively in the community mental health field both as a therapist and an administrator. He served on the Governor's task-force for the revision of the Illinois Mental Health Code in 1973. He served as Community Relations Coordinator for the Illinois Department of Mental Health from 1972 until 1979.

Currently, he is assistant program director at Far Northwest Counselling Center. He and his wife, Suzanne Noonan Smith, live in Chicago, Illinois.
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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 Mental
Health Centers Construction Act,\textsuperscript{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.\textsuperscript{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.\textsuperscript{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


\textsuperscript{2}Ibid.

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. 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. 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.

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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5 Ibid., p. 859.
6 Ibid., p. 858.
concrete recommendations to meet those needs. 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.

This message of President Kennedy resulted in legislative action by the Congress in the passage of Community Mental Health Centers Act of 1963. 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.


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


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.  

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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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 Perspectivess 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. 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.  

In response to Public Law 88-164, the individual


15 Public Law, Title II - Regulations, p. 1.
states have established statewide mental health plans, similar to the Illinois Mental Health Zone Plan.\(^\text{16}\) 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.\(^\text{17}\) This report points out the serious omission of built-in evaluation of community mental health centers in the past.


Along with the lack of ongoing evaluative requirements, there is also a basic lack of research in the field of community mental health. Cowen feels the research needed will never be obtained, considering the small amount of funds currently being spent around the country. Zax and Specter point out that the long-term nature of research on community mental health itself presents a difficulty. 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. 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.
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. 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. He outlined the method by which programs and


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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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.

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:


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.

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 examining 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:

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.  

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.  

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


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 150,000 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

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 clerkytypists. Table 1 describes these positions in detail. All of these staff members were State of Illinois employees.

Table 1

PERSONNEL LISTING

<table>
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<tr>
<th>POSITION</th>
<th>CLASSIFICATION</th>
<th>DEGREE</th>
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<tr>
<td>1. Executive Director</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>2. Therapist</td>
<td>Psychologist III</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>3. Therapist</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
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<tr>
<td>4. Therapist</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
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<tr>
<td>5. Therapist</td>
<td>Psychologist II</td>
<td>M.A.</td>
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<td>6. Therapist</td>
<td>Registered Nurse III</td>
<td>R.N.</td>
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<tr>
<td>7. Therapist</td>
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<td>9. Physician</td>
<td>Licensed Psychiatrist I</td>
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</tr>
<tr>
<td>10. Secretary</td>
<td>Clerk-Typist II</td>
<td>Diploma</td>
</tr>
<tr>
<td>11. Secretary</td>
<td>Clerk-Typist II</td>
<td>Diploma</td>
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</tbody>
</table>
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

<table>
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<th>MONTH</th>
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<td><strong>232</strong></td>
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Table 4

FEE INCOME BY MONTH
FOR FISCAL YEARS 1975 AND 1976

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<th>MONTH</th>
<th>1975 INCOME</th>
<th>1976 INCOME</th>
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<td>$1,948.85</td>
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<td>700.65</td>
<td>1,979.40</td>
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<td>1,462.25</td>
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<td>1,376.50</td>
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<td>1,742.95</td>
<td>1,886.35</td>
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<td>2,142.80</td>
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<td>2,199.30</td>
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<td>June</td>
<td>2,071.85</td>
<td>2,841.28</td>
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</table>

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  

3Coordinator, 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

4Edison 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

\(^5\) 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

\(^6\)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. 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 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

\(^{1}\)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. 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.

\(^3\) 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. 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. 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

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<td>June</td>
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Table 6

NUMBER OF CLIENTS SEEN BY MONTH PER FISCAL YEAR

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<tr>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>156</td>
<td>245</td>
<td>230</td>
<td>247</td>
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<tr>
<td>August</td>
<td>200</td>
<td>258</td>
<td>273</td>
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<tr>
<td>September</td>
<td>203</td>
<td>215</td>
<td>253</td>
<td>243</td>
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<tr>
<td>October</td>
<td>220</td>
<td>253</td>
<td>255</td>
<td>251</td>
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<tr>
<td>November</td>
<td>231</td>
<td>272</td>
<td>253</td>
<td>258</td>
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<tr>
<td>December</td>
<td>233</td>
<td>261</td>
<td>214</td>
<td>245</td>
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<td>June</td>
<td>239</td>
<td>238</td>
<td>196</td>
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<tr>
<td>TOTAL YEAR</td>
<td>2,680</td>
<td>3,001</td>
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<tr>
<td>AVERAGE MONTHLY</td>
<td>223</td>
<td>250</td>
<td>242</td>
<td>242</td>
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Table 8

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

<table>
<thead>
<tr>
<th>Month</th>
<th>1977</th>
<th>1978</th>
<th>1979</th>
<th>1980</th>
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</thead>
<tbody>
<tr>
<td>July</td>
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<td>88</td>
<td>63</td>
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<td>August</td>
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<td>September</td>
<td>25</td>
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<td>October</td>
<td>25</td>
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<td>72</td>
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<td>November</td>
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<td>December</td>
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<td>January</td>
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<td>February</td>
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<td>March</td>
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<td>April</td>
<td>85</td>
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<td>76</td>
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<td>May</td>
<td>65</td>
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<td>June</td>
<td>67</td>
<td>68</td>
<td>93</td>
<td>77</td>
</tr>
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<td><strong>TOTAL YEAR</strong></td>
<td><strong>681</strong></td>
<td><strong>731</strong></td>
<td><strong>906</strong></td>
<td><strong>894</strong></td>
</tr>
<tr>
<td><strong>AVERAGE MONTHLY</strong></td>
<td><strong>57</strong></td>
<td><strong>61</strong></td>
<td><strong>75</strong></td>
<td><strong>75</strong></td>
</tr>
<tr>
<td>Month</td>
<td>1977</td>
<td>1978</td>
<td>1979</td>
<td>1980</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
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<tr>
<td>July</td>
<td>40</td>
<td>52</td>
<td>53</td>
<td>61</td>
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<tr>
<td>August</td>
<td>38</td>
<td>40</td>
<td>52</td>
<td>53</td>
</tr>
<tr>
<td>September</td>
<td>44</td>
<td>28</td>
<td>50</td>
<td>75</td>
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<tr>
<td>October</td>
<td>52</td>
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<td>November</td>
<td>72</td>
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<td>December</td>
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<td>February</td>
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<td>March</td>
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<td>April</td>
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<tr>
<td>May</td>
<td>65</td>
<td>96</td>
<td>102</td>
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</tr>
<tr>
<td>June</td>
<td>40</td>
<td>80</td>
<td>66</td>
<td>85</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>TOTAL YEAR</th>
<th>950</th>
<th>884</th>
<th>945</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVERAGE</td>
<td></td>
<td>55</td>
<td>79</td>
<td>74</td>
</tr>
<tr>
<td>MONTHLY</td>
<td></td>
<td>79</td>
<td>79</td>
<td></td>
</tr>
</tbody>
</table>
Table 10 presents the stated objectives, criteria, and evaluation for the Sustaining Care Program. 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. 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.

---


7 Ibid.
**Table 10**

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

<table>
<thead>
<tr>
<th>YEAR</th>
<th>OBJECTIVES</th>
<th>CRITERIA</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1977</td>
<td>1. Relocate clinic to suitable</td>
<td>1. Physical relocation</td>
<td>1. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>2. Public notification of sponsor-ship, relocation, and services</td>
<td>2. Announcements, media information, and dedication</td>
<td>2. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>3. Transfer all sustaining care clients with no more than a 10% drop in clients</td>
<td>3. Statistics on program</td>
<td>3. Fully achieved</td>
</tr>
<tr>
<td>1978</td>
<td>1. Effect linkage with public aid for clients unable to pay for service</td>
<td>1. Linkage agreement for 8 clients by 2nd quarter, and 16 clients by 4th quarter</td>
<td>1. Not achieved - contrary to public aid procedures - individual application only</td>
</tr>
<tr>
<td></td>
<td>2. Establish evening group treatment group</td>
<td>2. Evening group by 2nd quarter</td>
<td>2. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>3. Link clients to daycare program at Ravenswood Hospital</td>
<td>3. Letter of linkage between Center and Ravenswood Hospital</td>
<td>3. Partially achieved - linkage uncertain due to cost</td>
</tr>
<tr>
<td>1979</td>
<td>1. Continue to seek payment from public aid for clients unable to pay</td>
<td>1. Records of payment</td>
<td>1. Fully achieved</td>
</tr>
<tr>
<td>Year</td>
<td>Task</td>
<td>Goal</td>
<td>Status</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------</td>
<td>---------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>1979</td>
<td>2. Link 80% of discharges psychiatric clients</td>
<td>2. Statistics on program</td>
<td>2. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>3. Addition of a staff position for home visit program</td>
<td>3. Establishment of program with new staff position</td>
<td>3. Full achieved</td>
</tr>
<tr>
<td>1980</td>
<td>1. Link 90% of discharged psychiatric clients</td>
<td>1. Two therapy sessions each for this group by 4th quarter</td>
<td>1. Partial achieved - 70%</td>
</tr>
<tr>
<td></td>
<td>2. Establish divorce and loss groups</td>
<td>2. One divorce group by 2nd quarter one widowed group by 3rd quarter</td>
<td>2. Partial achieved - one divorced group by 4th quarter</td>
</tr>
<tr>
<td></td>
<td>3. Provide assistance to local churches in starting divorce and loss groups</td>
<td>3. Link with groups by 3rd quarter</td>
<td>3. Fully achieved</td>
</tr>
<tr>
<td>YEAR</td>
<td>OBJECTIVES</td>
<td>CRITERIA</td>
<td>EVALUATION</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>1977</td>
<td>Same as Sustaining Care Program</td>
<td>Same as Sustaining Care Program</td>
<td>Fully achieved</td>
</tr>
<tr>
<td>1978</td>
<td>1. Continue notification of Center's program to the community</td>
<td>2. Publicity, public education programs</td>
<td>1. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>2. Home-bound client evaluation program</td>
<td>5 to 10 home-bound evaluations</td>
<td>2. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>3. Police liaison for adult clients in crisis</td>
<td>Liaison contact and referrals</td>
<td>3. Partial achieved - need for more mutual work</td>
</tr>
<tr>
<td>1979</td>
<td>1. Continued public information efforts</td>
<td>Newspaper articles, educational seminars</td>
<td>1. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>2. Assign staff member as police liaison</td>
<td>Staff member assigned and referrals recorded</td>
<td>2. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>3. Decrease drop out rate after initial intake</td>
<td>More than 60% of intake cases continue for three sessions</td>
<td>3. Fully achieved</td>
</tr>
<tr>
<td>1980</td>
<td>1. General public information program</td>
<td>Fund-raising event</td>
<td>1. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>2. Continue decrease in drop-out rate after intake</td>
<td>Reduce drop-out rate to 30%</td>
<td>2. Fully achieved</td>
</tr>
<tr>
<td></td>
<td>3. Strengthen Home-Bound program</td>
<td>Answer 100% all appropriate requests</td>
<td>3. Fully achieved</td>
</tr>
</tbody>
</table>
Table 12 states the objectives, criteria, and evaluation for the Children and Adolescent Program.\textsuperscript{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

\textsuperscript{8}Ibid.
# Table 12

## CHILDREN AND ADOLESCENT PROGRAM

### OBJECTIVES WITH CRITERIA AND EVALUATION

**FOR FISCAL YEARS 1977 TO 1980**

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

9 Ibid., Form 1201c.
### PERSONNEL LISTING
FISCAL YEAR 1977

<table>
<thead>
<tr>
<th>POSITION</th>
<th>CLASSIFICATION</th>
<th>DEGREE</th>
</tr>
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<tbody>
<tr>
<td>1. Section Director</td>
<td>Administrator</td>
<td></td>
</tr>
<tr>
<td>2. Executive Director</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>3. Therapist</td>
<td>Psychologist III</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>4. Therapist&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>5. Therapist</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>6. Therapist</td>
<td>Psychologist II</td>
<td>M.A.</td>
</tr>
<tr>
<td>7. Therapist</td>
<td>Registered Nurse III</td>
<td>R.N.</td>
</tr>
<tr>
<td>8. Therapist</td>
<td>Mental Health Specialist II</td>
<td>B.A.</td>
</tr>
<tr>
<td>9. Therapist</td>
<td>Mental Health Specialist II</td>
<td>B.A.</td>
</tr>
<tr>
<td>10. Psychiatrist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Licensed Psychiatrist I</td>
<td>M.D.</td>
</tr>
<tr>
<td>11. Secretary</td>
<td>Clerk-Typist II</td>
<td>Diploma</td>
</tr>
<tr>
<td>12. Secretary</td>
<td>Clerk-Typist II</td>
<td>Diploma</td>
</tr>
</tbody>
</table>

<sup>a</sup> Part time - three days per week
<sup>b</sup> Hourly - two days per week
Table 14

PERSONNEL LISTING
FISCAL YEAR 1978

<table>
<thead>
<tr>
<th>POSITION</th>
<th>CLASSIFICATION</th>
<th>DEGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Section Director</td>
<td>Administrator</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>2. Executive Director</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>3. Therapist</td>
<td>Psychologist III</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>4. Therapist&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>5. Therapist</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>6. Therapist</td>
<td>Psychologist II</td>
<td>M.A.</td>
</tr>
<tr>
<td>7. Therapist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>8. Therapist&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Social Worker I</td>
<td>B.A.</td>
</tr>
<tr>
<td>9. Therapist&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Social Worker I</td>
<td>B.A.</td>
</tr>
<tr>
<td>10. Therapist</td>
<td>Registered Nurse III</td>
<td>R.N.</td>
</tr>
<tr>
<td>11. Psychiatrist&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Licensed Psychiatrist</td>
<td>M.D.</td>
</tr>
<tr>
<td>12. Psychiatrist&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Licensed Psychiatrist</td>
<td>M.D.</td>
</tr>
<tr>
<td>13. Secretary</td>
<td>Secretary II</td>
<td>Diploma</td>
</tr>
<tr>
<td>14. Secretary</td>
<td>Secretary II</td>
<td>Diploma</td>
</tr>
<tr>
<td>15. Receptionist&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Receptionist I</td>
<td>Diploma</td>
</tr>
</tbody>
</table>

<sup>a</sup> Part time - three days per week

<sup>b</sup> New position

<sup>c</sup> Change in classification

<sup>d</sup> Hourly - one day per week

<sup>e</sup> New position - one day per week

<sup>f</sup> New position - two days per week
### Table 15

**PERSONNEL LISTING**  
**FISCAL YEAR 1979**

<table>
<thead>
<tr>
<th>POSITION</th>
<th>CLASSIFICATION</th>
<th>DEGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administrative Director</td>
<td>Administrator</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>2. Program Director</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>3. Therapist</td>
<td>Psychologist III</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>4. Therapist&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>5. Therapist</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>6. Therapist</td>
<td>Psychologist II</td>
<td>M.A.</td>
</tr>
<tr>
<td>7. Therapist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>8. Therapist&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>9. Therapist</td>
<td>Social Worker II</td>
<td></td>
</tr>
<tr>
<td>10. Therapist</td>
<td>Social Worker I</td>
<td>B.A.</td>
</tr>
<tr>
<td>11. Therapist&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>12. Therapist&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>13. Therapist&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>14. Secretary</td>
<td>Secretary II</td>
<td>Diploma</td>
</tr>
<tr>
<td>15. Receptionist</td>
<td>Secretary I</td>
<td>Diploma</td>
</tr>
<tr>
<td>16. Psychiatrist&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Licensed Psychiatrist</td>
<td>M.D.</td>
</tr>
<tr>
<td>17. Psychiatrist&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Licensed Psychiatrist</td>
<td>M.D.</td>
</tr>
<tr>
<td>18. Maintenance&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Hourly</td>
<td>Diploma</td>
</tr>
</tbody>
</table>

<sup>a</sup> Part time - three days per week  
<sup>b</sup> Change in classification - new hire  
<sup>c</sup> New position  
<sup>d</sup> New position - hourly two days per week  
<sup>e</sup> Hourly - one half day per week  
<sup>f</sup> Hourly - two days per week
Table 16

PERSONNEL LISTING
FISCAL YEAR 1980

<table>
<thead>
<tr>
<th>POSITION</th>
<th>CLASSIFICATION</th>
<th>DEGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administrative Director</td>
<td>Administrator</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>2. Program Director</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>3. Therapist</td>
<td>Psychologist III</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>4. Therapist&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Social Worker V</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>5. Therapist</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>6. Therapist</td>
<td>Psychologist III</td>
<td>M.A.</td>
</tr>
<tr>
<td>7. Therapist</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>8. Therapist</td>
<td>Social Worker III</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>9. Therapist</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>10. Therapist</td>
<td>Social Worker I</td>
<td>B.A.</td>
</tr>
<tr>
<td>11. Therapist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>12. Therapist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>13. Therapist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Social Worker II</td>
<td>M.S.W.</td>
</tr>
<tr>
<td>14. Administrative Assistant&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Secretary III</td>
<td>Diploma</td>
</tr>
<tr>
<td>15. Secretary</td>
<td>Secretary I</td>
<td>Diploma</td>
</tr>
<tr>
<td>16. Maintenance&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Hourly</td>
<td>Diploma</td>
</tr>
<tr>
<td>17. Receptionist&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Hourly</td>
<td>Student</td>
</tr>
<tr>
<td>18. Receptionist&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Hourly</td>
<td>Student</td>
</tr>
<tr>
<td>19. Psychiatrist&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Licensed Psychiatrist</td>
<td>M.D.</td>
</tr>
<tr>
<td>20. Psychiatrist&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Licensed Psychiatrist</td>
<td>M.D.</td>
</tr>
</tbody>
</table>

<sup>a</sup> Part time - three days per week
<sup>b</sup> Hourly - two days per week
<sup>c</sup> Change in classification
<sup>d</sup> Hourly - two days per week
<sup>e</sup> New position - hourly - two and a half days a week
<sup>f</sup> 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.\textsuperscript{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.\textsuperscript{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.

\textsuperscript{10}Ibid., Form 120lc.
\textsuperscript{11}Ibid., Form 120lc.
Table 17

EXPENSE AND INCOME\textsuperscript{a}
FOR FISCAL YEARS 1977 to 1980

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>173,121</td>
<td>176,957</td>
<td>202,206</td>
<td>208,472</td>
</tr>
<tr>
<td>Contractual</td>
<td>17,433</td>
<td>41,012</td>
<td>50,108</td>
<td>68,936</td>
</tr>
<tr>
<td>Total</td>
<td>190,554</td>
<td>217,969</td>
<td>252,314</td>
<td>277,408</td>
</tr>
</tbody>
</table>

| 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 |

\textsuperscript{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. 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. 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

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

the community. In addition, an open house for the general public was held later that same day.\textsuperscript{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.\textsuperscript{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

\textsuperscript{14}Far Northwest Counselling Center, \textit{Dedication Report}, October 1976.

Table 18

SOURCE OF REFERRAL BY PERCENTAGE
FOR FISCAL YEARS 1979 and 1980

<table>
<thead>
<tr>
<th>SOURCE OF REFERRAL</th>
<th>1979</th>
<th>1980</th>
</tr>
</thead>
<tbody>
<tr>
<td>State aided facility</td>
<td>12.76</td>
<td>13.29</td>
</tr>
<tr>
<td>Hospital/Physician</td>
<td>5.71</td>
<td>3.80</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>-</td>
<td>0.60</td>
</tr>
<tr>
<td>Corrections or Court</td>
<td>1.43</td>
<td>2.40</td>
</tr>
<tr>
<td>Employer</td>
<td>0.71</td>
<td>0.50</td>
</tr>
<tr>
<td>Family</td>
<td>32.24</td>
<td>43.96</td>
</tr>
<tr>
<td>Self</td>
<td>14.59</td>
<td>11.59</td>
</tr>
<tr>
<td>School</td>
<td>10.82</td>
<td>4.50</td>
</tr>
<tr>
<td>Other State agency</td>
<td>2.24</td>
<td>2.20</td>
</tr>
<tr>
<td>State Law Enforcement</td>
<td>-</td>
<td>0.08</td>
</tr>
<tr>
<td>County Law Enforcement</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>City Law Enforcement</td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td>Community</td>
<td>19.20</td>
<td>16.78</td>
</tr>
</tbody>
</table>
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.\textsuperscript{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.

\textsuperscript{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

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

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 outpatient 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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State of Illinois, Department of Mental Health. **Agency Plan:** Far Northwest Counselling Center, Fiscal Years 1977 through 1980, Forms 1201, and 1201c.

State of Illinois, Department of Mental Health, **Chicago Area Zone Plan, 1967.**
State of Illinois, Department of Mental Health, Division of Informational Services. Far Northwest Counselling Center, Yearly Client Service Reports, Fiscal Years 1977 through 1980.

State of Illinois, Department of Mental Health, Edison Park Planning Area Profile, 1970.
Region 2 - North

Served by
Chicago Road Mental Health Center
6500 W. Irving Park Road
Chicago, Illinois 60634

Illinois Department of Mental Health
NAME: ____________________________
ALIASES OR MAIDEN NAME: ______________

(last) (first) (middle)

CURRENT ADDRESS:
(street & number) (city) (state) (county) (zip) RENT: yes ____ No ___
OWN HOME: yes ____ No ___

TIME AT ABOVE ADDRESS: ________ yrs.

SEX BIRTH DATE AGE MARITAL STATUS RACE YEARS IN ILLINOIS

PLACE OF BIRTH YEARLY INCOME SOCIAL SECURITY NUMBER PUBLIC ASSISTANCE YES ____ NO

EDUCATION YES ____ NO

VETERAN YES ____ NO

EMPLOYED YES ____ NO

EMPLOYED YEARS HOW LONG EMPLOYED

NO. __________

PAST PSYCHIATRIC HOSPITALIZATION OR OTHER MAJOR TREATMENT (Include dates)

SERVICES DESIRED:

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)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation</th>
<th>Age</th>
<th>Name</th>
<th>Relation</th>
<th>Age</th>
</tr>
</thead>
</table>

DO NOT WRITE BELOW THIS LINE

PROVISIONAL DIAGNOSIS: ____________________________ Geographic Code: ______

DIAGNOSTIC CODE: ____________________________ INTAKE WORKER:

AABD AFDC INCI TNK
PA CUR PO PA CUR PO

DISPOSITION OF APPLICATION

__ Applicant Withdraw
__ Not accepted-No Referral
__ Referred to:

Facility: ____________________________
Worker There: ____________________________
Date of App.: ____________________________
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
Illinois Department of Mental Health
SOCIAL SERVICE ELIGIBILITY DETERMINATION (Preliminary Form)

Name of facility __________________________________________ Facility Reporting No. __________________________

Name of client ________________________________ (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

B. [ ] Blind Assistance

[ ] Federal Medical Assistance (minor child in the family)

[ ] 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:

<table>
<thead>
<tr>
<th>Annual Income in $</th>
<th>Family Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>0 to 3,000</td>
<td></td>
</tr>
<tr>
<td>3,001 to 4,500</td>
<td></td>
</tr>
<tr>
<td>4,501 to 6,000</td>
<td></td>
</tr>
<tr>
<td>6,001 to 7,500</td>
<td></td>
</tr>
<tr>
<td>7,501 to 9,000</td>
<td></td>
</tr>
<tr>
<td>9,001 to 12,000</td>
<td></td>
</tr>
<tr>
<td>12,001 to 15,000</td>
<td></td>
</tr>
<tr>
<td>15,001 and Up</td>
<td></td>
</tr>
</tbody>
</table>

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 older 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
**Case Opening Form**

**Align Form, Align Type an 'X' in One Box at Left — Type an 'X' in One Box at Right.**

### Case Opening Details

- **Facility or Clinic**: [INSERT]
- **Unit Code**: [INSERT]
- **Client ID No.**: [INSERT]
- **Case Opening Date**: [INSERT]
- **Transaction Code**: [INSERT]
- **Transfer/Case Closed Date**

<table>
<thead>
<tr>
<th>CLIENT</th>
<th>FIRST NAME</th>
<th>INITIAL</th>
<th>LAST NAME</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL INFORMATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- **Social Security Number (omit dashes)**: 
- **Social Service Eligibility**:
- **Race**:
- **Diagnosis**:
- **Treatment Category**:
- **Status**:
- **Community Placement**:
- **Delivery Mode (Expected)**:
- **Sex**:
- **Facility or Clinic**
- **Client ID No.**
- **Case Opening Date**: [INSERT]

### Responsible Staff Details

**Source of Referral**
- [ ] Self
- [ ] Family relatives
- [ ] Friends
- [ ] State Hospital/Inmates
- [ ] Private mental hospital
- [ ] Public mental hospital (federal, county, city)
- [ ] Psychiatric service general hospital
- [ ] Residential treatment center for children
- [ ] Training school for mental retardates
- [ ] Other psychiatric inpatient facility
- [ ] Private psychiatrists
- [ ] Other outpatient psychiatric clinics
- [ ] Psychiatric day care centers
- [ ] Private physicians
- [ ] Local health departments
- [ ] General hospital (non-psychiatric units)
- [ ] Nursing homes
- [ ] Other medical or health agencies
- [ ] Private psychologists
- [ ] Other psychological services (counseling, etc.)
- [ ] Social agency services: marriage counseling, etc.
- [ ] Court, correctional institution, police, etc.
- [ ] School (elementary, high school, etc.)
- [ ] Clergy
- [ ] Professional (accounting, etc.)
- [ ] Vocational rehabilitation
- [ ] Employment service
- [ ] Boarding care home
- [ ] Other specialty

### Education of Child

- [ ] Under 18 years
- [ ] Unknown
- [ ] Preschool
- [ ] Kindergarten
- [ ] Special education
- [ ] Mentally handicapped
- [ ] Physically handicapped
- [ ] Not applicable: parent is adult

### Education of Adult Patient or Head of Household if Patient Is a Child

- [ ] College not complete
- [ ] College complete
- [ ] 4th or 5th grade
- [ ] 6th, 7th or 8th grade
- [ ] Post graduate college degree
- [ ] Special education
- [ ] Mentally or physically handicapped
- [ ] Other (describe)

### Occupation of Adult Patient or Head of Household if Patient Is a Child

- [ ] Professional, technical, and kindred workers
- [ ] Farmers and farm managers
- [ ] Sales workers
- [ ] Sales workers
- [ ] Operators and kindred workers
- [ ] Professional kindred workers
- [ ] Services workers except private household
- [ ] Farm laborers and farm managers
- [ ] Laborers except farm and home services
- [ ] Unknown, unemployed, not listed, no history of employment
- [ ] Housewife

### Prior Psychiatric Care

- [ ] No prior psychiatric care
- [ ] Prior care: outpatient clinic
- [ ] Prior care: state hospital
- [ ] Prior care: private hospital
- [ ] Prior care: general hospital psychiatric unit

**NOTE:** Completely shaded fields are optional. If 'X' does not fall within boxes, re-align form and repeat.
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUTHORIZATION FOR RELEASE OF INFORMATION</strong>&lt;br&gt;BY DEPARTMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TO</strong> Zone Admr. /Superintendent (Facility name, City and Zone No.)</td>
<td>2. Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Patient's name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. ID No.</td>
<td>5. Social Security No.</td>
<td>6. County of admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Admitted as:</td>
<td></td>
<td></td>
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<tr>
<td>8. Purpose of request for information:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. My personal physician (name and address)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Mental Health Clinic serving my home area (name and address)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. After-care facility to which I will be released, if known (name and address)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Other authorized person or agency (including Insurance Companies and Social Security Administration for purpose of obtaining benefits) (name and address)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Signature of Patient, Guardian or Conservator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Relationship to patient</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>16. Address of Guardian or Conservator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Witness (name and address)</td>
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<td></td>
</tr>
</tbody>
</table>

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: ____________________
**ILLINOIS DEPARTMENT OF MENTAL HEALTH & DEVELOPMENTAL DISABILITIES**  
DIVISION OF INFORMATION SERVICES  

**CLOSING FORM**

<table>
<thead>
<tr>
<th>FACILITY OR CLINIC</th>
<th>UNIT CODE</th>
<th>CLIENT ID NO.</th>
<th>CASE CLOSING DATE</th>
<th>TRANSACTION CODE</th>
<th>DIAGNOSIS AT CLOSING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

**DATE OF LAST INTERVIEW**

**LEVEL OF CLOSING**

1. Treatment  
2. Diagnostically only - incomplete  
3. Diagnostically only - complete  
4. Psychosocially unsound only  
5. Other

**DIAGNOSTIC SERVICES (more than one may be checked)**

1. Neuropathology  
2. Electroencephalogram  
3. Medical, lab tests, etc.  
4. Psychiatric social work

**TREATMENT SERVICES (more than one may be checked)**

1. Neurological  
2. Vocational  
3. Physical therapy  
4. Group psychotherapy  

**A. PSYCHIATRIC CONDITION OF TREATED CASE**

1. Recovered  
2. Improved  
3. Unimproved

**B. SERVICE STATUS OF CASE NOT IN TREATMENT**

1. Service suspensions  
2. Service improvements

**INCODE**

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

**NUMBER OF INTERVIEWS**

<table>
<thead>
<tr>
<th>Place interviewed by:</th>
<th>Percent interviewed by:</th>
<th>Service rendered by:</th>
<th>Other contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>10%</td>
<td>Psychologist</td>
<td>10%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>10%</td>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>Other associate</td>
<td>10%</td>
<td></td>
<td>10%</td>
</tr>
</tbody>
</table>

**DISPOSITION OF CASE**

- Client withdrew  
- Clinic terminated

**DISPOSITION OF CASE FOR AFTER-CARE LINKAGE CLIENTS ONLY**

- Client referred to community service  
- Client referred to other agency  
- Client referred to other service

**DISPOSITION OR REFERRAL RECOMMENDATION (check one only)**

- Client referred - moved, died, or ill  
- Client referred - other reason  
- Client not referred  
- Client terminated - without referral  
- Further care not indicated at this time  
- Additional services/services needed but not available at this time  
- Community resources other than this client needed but not available now  
- Community resources other than this client needed and available - patient not ready  
- Additional services/services needed, but patient or family not ready

**DATE OF LAST INTERVIEW**

**LEVEL OF CLOSING**

- Treatment  
- Diagnostically only - incomplete  
- Diagnostically only - complete  
- Psychosocially unsound only  
- Other

**DIAGNOSTIC SERVICES (more than one may be checked)**

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- Electroencephalogram  
- Medical, lab tests, etc.  
- Psychiatric social work

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- Neurological  
- Vocational  
- Physical therapy  
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- Improved  
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**B. SERVICE STATUS OF CASE NOT IN TREATMENT**

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- Service improvements

**INCODE**

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- Readmission, last discharge in this fiscal year  
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<table>
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<th>Percent interviewed by:</th>
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<tr>
<td>Psychiatrist</td>
<td>10%</td>
<td>Psychologist</td>
<td>10%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>10%</td>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>Other associate</td>
<td>10%</td>
<td></td>
<td>10%</td>
</tr>
</tbody>
</table>
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 jurisdiction 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.
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

Single
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.
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) Committees 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.
   - alcoholism
   - drug abuse
   - school problems
   - unemployment
   - marriage problems
   - family communications
   - child abuse or neglect
   - gambling
   - juvenile delinquency
   - serious money problems
   - lack of activities for senior citizens
   - lack of services for the mental handicapped
   - lack of services for the mentally ill
   - other

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 ______________________

____________________________
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 F. Petersen, ACSW
Acting Executive Director

JFP/did

cc: D. Goos
    W. Rasmussen

RECEIVED
DEC 11 1975
Subregion 8
MEMO

TO: The Edison Park Community Mental Health Clinic Advisory Board

FROM: Robert Geigner, Administrator, Subregion 8

SUBJECT: Sponsorship Program

DATE: March 8, 1976

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
DATE: March 24, 1976
MEMO TO: Mr. Robert Anderson, Deputy Director
Division of Community Services
FROM: Prakash N. Desai, M.D.
Regional Administrator
ADDRESS: Illinois Department of Mental Health
and Developmental Disabilities
INTER-OFFICE CORRESPONDENCE

SUBJECT: Transfer of Function of Edison Park Community Mental Health 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:

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<tr>
<th>Unit #</th>
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<th>Amount</th>
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<tr>
<td>40</td>
<td>01 Sus. Care</td>
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<td>40</td>
<td>21 Sus. Care C &amp; A</td>
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<td>40</td>
<td>02 Outpatient</td>
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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.
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  - $ 26,547

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
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<th>Race</th>
<th>Date of 1st Contact</th>
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1. Statement of problems, precipitating factors, etc.
2. Current life situation:
3. Pertinent genetic factors:
4. Impressions of patient and recommendations:
5. Disposition
LUTHERAN WELFARE SERVICES 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

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<th>No. of dependent children</th>
<th>Ages</th>
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GROSS FAMILY INCOME

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

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<th>Employer</th>
<th>[Use either or both]</th>
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<td>Yearly</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
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</tr>
<tr>
<td>3.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

A. Sub-total

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

1. ________________________________

B. Sub-total

III. FAMILY INCOME FROM OTHER SOURCES

<table>
<thead>
<tr>
<th>Yearly</th>
<th>Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: __________________________
### Case Opening Form

**Illinois Department of Mental Health**  
**Division of Information Systems**

**Case Opening Form**

- **No.** 172  
- **Client ID No.** 123456789  
- **Case Opening Date** 11-1-12

**Client Address**  
- **Social Security Number** (omit dashes)

**Social Service Eligibility**  
- **Race**

**Diagnosis**  
- **Treatment Category**

**Facility or Clinic**  
- **Client ID No.**

**Marital Status**

**Source of Referral**

- **Educatio of Child (Under 18 Years)**
  - **Occupation of Adult Patient or Head of Household IP Patient**
  - **Employment**

**Prior Psychiatric Care (Check all that apply)**

---

**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.**

---

**NOTE:** Completely shaded fields are optional.
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: ____________________________
NAME OF PATIENT ____________________________
COORDINATOR: ____________________________
DATE ASSIGNED: ____________________________ DATE CLOSED ____________________________
NUMBER OF INTERVIEWS: ____________________________
**CLOSING FORM**

**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.

<table>
<thead>
<tr>
<th>FACILITY OR CLINIC</th>
<th>UNIT CODE</th>
<th>CLIENT I.D. NO.</th>
<th>CASE CLOSING DATE</th>
<th>TRANSACTION CODE</th>
<th>DIAGNOSIS AT CLOSING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Initial Number</td>
<td>Month Day Year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DISPOSITION OF CASE**

**DISPOSITION OF CASE FOR AFTER-TIRE DISHKE CLIENTS ONLY**

<table>
<thead>
<tr>
<th>CLIENT WITHDRAWN</th>
<th>CLINIC TERMINATED</th>
<th>SERVICE NOTIFIED</th>
<th>SERVICE NOTIFIED</th>
<th>REFERRAL</th>
<th>REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**LEVEL OF CLOSING**

- Treatment
- Diagnostic only - complete
- Diagnostic only - incomplete
- Psychiatric testing only
- Other

**DIAGNOSTIC SERVICES**

- Not applicable
- Psychological
- Psychiatric social work
- Sum of codes

**TREATMENT SERVICES**

- Not applicable
- Acupuncture therapy
- Intensive psychotherapy
- Supportive therapy
- Other psychotherapy

**PSYCHIATRIC CONDITION OF TREATED CASE**

- Recovered
- Improved
- Unimproved
- Service status of case not in treatment
- Service complete
- Service incomplete

**INCODE**

- First admission
- Readmission, last discharge in this facility
- Readmission, last discharge in a prior facility

**NUMBER OF INTERVIEWS**

- Patients interviewed by professional
- Patients interviewed by psychiatric
- Other interview
- Separately interviewed by professional
- Separately interviewed by psychiatric
- Other separately interviewed
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.

Date July 27, 1981

Director's Signature

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