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MEMORANDUM OF CALL

TO:

☐ YOU WERE CALLED BY— ☐ YOU WERE VISITED BY—

OF (Organization)

☐ PLEASE CALL → PHONE NO. CODE/EXT.

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

☐ RETURNED YOUR CALL ☐ WISHES AN APPOINTMENT

MESSAGE

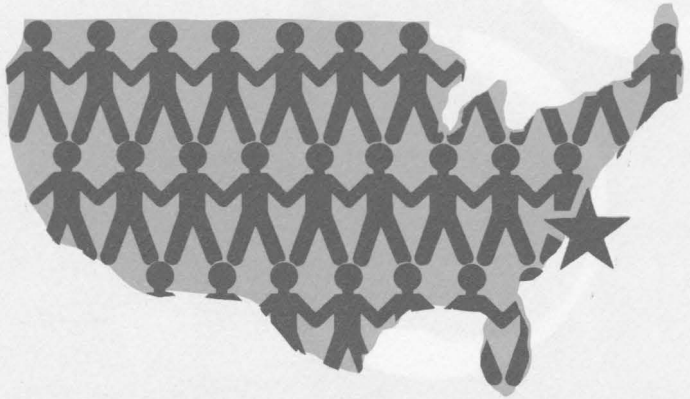
~~H.DC~~

4 pm
C-830 Shoreham

RECEIVED BY	DATE	TIME

STANDARD FORM 63 GPO : 1969—c48—16—80341-1 332-389 63-108
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-11.6

MENTAL HEALTH: NETWORK FOR ACTION



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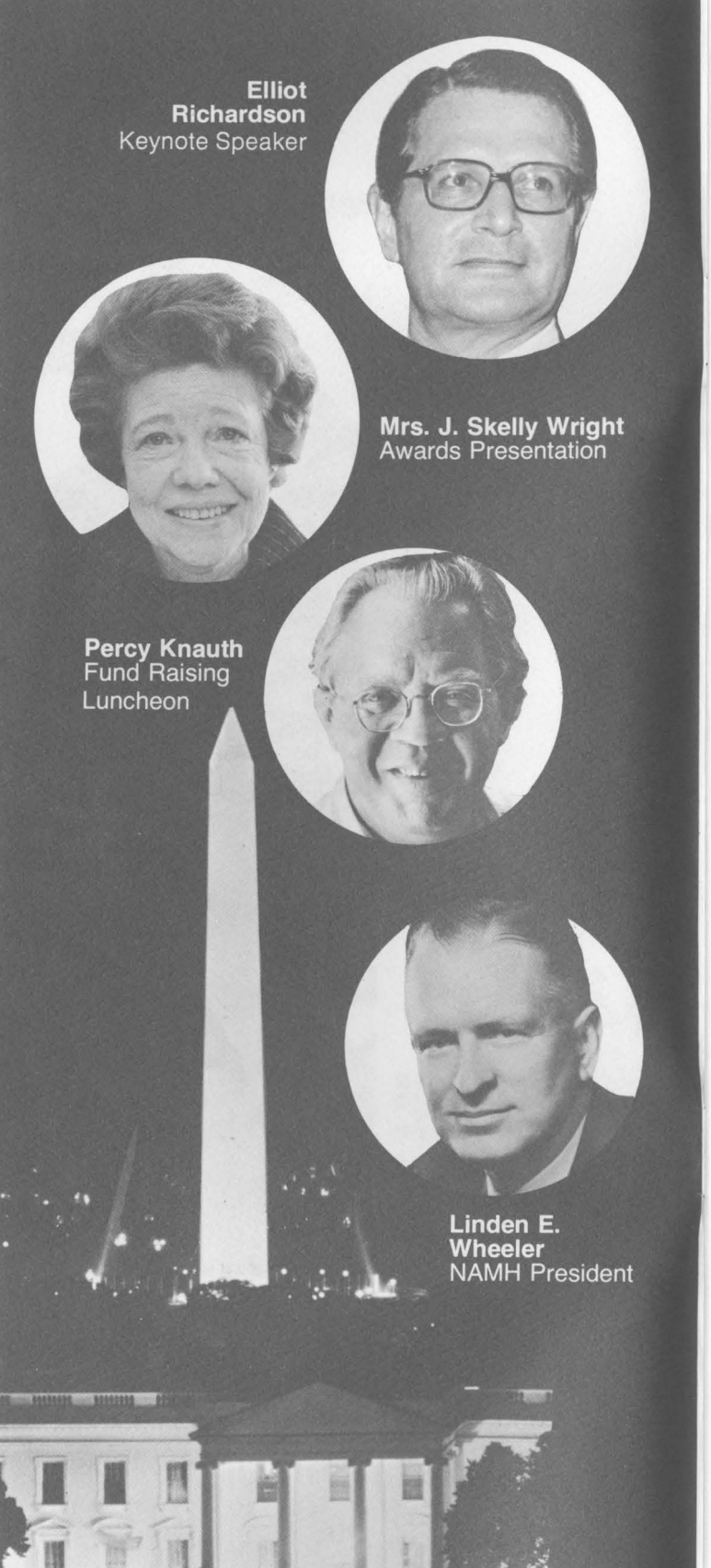


Elliot Richardson
Keynote Speaker

Mrs. J. Skelly Wright
Awards Presentation

Percy Knauth
Fund Raising Luncheon

Linden E. Wheeler
NAMH President

MENTAL HEALTH: NETWORK FOR ACTION

In determining the theme for the 1974 Annual Meeting and Mental Health Assembly, the Annual Meeting Task Force decided to focus on the responsibilities of our three-level organization in providing assistance to the mentally ill in the community, state and the nation.

"Mental Health: Network for Action," was selected as the theme designed to improve our organizational capacity by working cooperatively in the areas of social action, litigation and education.

GENERAL INFORMATION

Workshop Registration

It is important to register for the Thursday Program and Organizational Workshops and the Friday Fund Raising sessions at your earliest convenience, to insure beneficial group discussion. Attendance is limited. To register, complete the enclosed reservation form and send it to the National Office. Space permitting, limited registration will be accepted at the Mental Health Information Desk.

Room Locations

Please note that most Annual Meeting activities take place on the main and upper lobby levels. A map of the meeting rooms is provided in the centerfold.

Information

The Information Desk is located on the Lobby Level. Facts about the Annual Meeting or the Washington, D.C. area will be available. Also, Annual Meeting Task Force and National Staff members are prepared to assist you.

Messages

Inform your family or office that if you need to be reached and you're not in your room, the calling party should ask the hotel operator for the Mental Health Association Headquarters Room. We will attempt to locate you or will post a message for you on the Headquarters Bulletin Board.

Hospitality Room

Heritage Room. Open 8:00 a.m.-6:00 p.m.

Exhibits

Upper Lobby

Many exhibits will be staffed during at least part of the conference. You'll have an opportunity to discuss the projects on display with someone knowledgeable from that Chapter or Division.

Registration and Ticket Sales

Main Lobby

Open: Wednesday, November 20 . . . . 9:00 a.m. - 7:30 p.m.
Thursday, November 21 . . . . . 7:30 a.m. - 8:15 p.m.
Friday, November 22 . . . . . 7:45 a.m. - 6:15 p.m.
Saturday, November 23 . . . . . 7:45 a.m. - 12:15 p.m.

Badges

Please wear your identification badges for admission to all meetings and functions. The following have ribbon badges for quick identification:

NAMH Board Members and
Voting Delegates . . . . . Blue Ribbon
Host City Volunteer Hosts
and Hostesses . . . . . Yellow Ribbon
Honored Guests . . . . . Purple Ribbon

Offices

Upper Lobby Level

Open 7:30 a.m. - 7:30 p.m.

Headquarters and Board Room

Council Room

Annual Meeting Operations Room

Cabinet Room

Press Rooms

Committee, Caucus and Press Rooms

Idea Exchange Center

Upper Lobby

Test your knowledge of mental health and the MHA! Take the quiz! Get new ideas for programs, publicity and fund raising. Share your ideas with others. Open 8:00 a.m. - 7:00 p.m.

Marketplace

Upper Lobby

Purchase such items as medallions, books, packets of various pamphlets, and MH subscriptions.

Films

Mental Health films will be shown in the Diplomat Room, Thursday and Friday from 7:15 a.m. - 8:15 a.m. Coffee and sweet rolls may be purchased from the hotel in the film room.

Weather

Weather in Washington, D.C. tends to be cool with a daytime average of 54 degrees and a nighttime average of 44 degrees. Precipitation during November is 2.90 inches.

Press Releases

Press releases, copies of some speeches and other materials will be available in the press rooms.

WEDNESDAY, November 20

9:00 a.m. - 5:00 p.m. Research Committee Meeting *Board Room*

9:00 a.m. - 3:00 p.m. Committee on Mental Health Services for the Ethnic Minorities and the Poor *Club B*

10:00 a.m. - 12 noon Host City Volunteer Orientation & Annual Meeting Task Force Hotel Tour *Executive Room*

1:00 p.m. - 1:30 p.m. Congressional Briefings (receive updated mental health legislation information prior to visits on the Hill). Irving Chase, Chairman, Public Affairs Committee *Ambassador Room*

2:00 p.m. - 5:00 p.m. Organization Committee Meeting *Sales Conference Room*

2:00 p.m. - 4:00 p.m. Resolutions Committee Meeting *Suite*

2:00 p.m. - 3:30 p.m. General Meeting for All Staff *Empire Room*

Briefing on current issues: Executive Director's Report (Volunteers are welcome to attend)

2:30 p.m. - 4:00 p.m. NAMH Legislative Network Volunteers *Ambassador Room*

3:30 p.m. - 5:30 p.m. Staff Council Membership Meeting *Tudor Room*

Presiding:
David Ziegenhagen, President-elect, MHA Staff Council

4:00 p.m. - 4:30 p.m. Congressional Briefings (Repeat of 1:00 session) *Ambassador Room*

4:30 p.m. - 6:30 p.m. Caucus on Minority Concerns (Open to all) *Empire Room*

5:30 p.m. - 6:00 p.m. Staff Council Board Meeting *Tudor Room*

6:30 p.m. - 7:30 p.m. Reception (Cash Bar) *Ambassador Room*

7:30 p.m. - 10:00 p.m. Opening Dinner *Palladian Room*

Presiding:
Gerridee Wheeler, President-elect

Invocation: Congressman **Walter E. Fauntroy,** District of Columbia

Speaker:
The Honorable Elliot Richardson

THURSDAY, November 21

7:00 a.m. - 8:15 a.m. Delegate Caucus Breakfast *Palladian Room*

Seating by Divisions — Discussion of Issues on Membership Agenda

7:15 a.m. - 8:15 a.m. Mental Health Film Previews, Featuring Films From the NAMH Film Service Rental Library (Coffee & Rolls Available From Hotel) *Diplomat Room*

8:30 a.m. - 12 noon Annual Meeting of the Membership — Opening Session *Regency Ballroom*

Presiding:
Linden E. Wheeler, President
Invocation: **The Rev. Lawrence A. Davies,** Delegate Virginia Division

Agenda
(Order subject to change. The final agenda will be the one contained in the Membership Meeting folder.)

Report on Implementation of Resolutions & Other Business Passed at Last Year's Membership Meeting

Explanations and Questions to Clarify the Resolutions and Other Issues Which Are Before the Membership This Year. Includes Initial Report of the Resolutions Committee
Linden E. Wheeler, President
Charles Mahoney, Esq., Chairperson, Resolutions Committee

Consideration of Resolutions and Other Business
Charles Mahoney, Esq.

12:00 p.m. - 12:30 p.m. Cash Bar *Blue Room*

12:30 p.m. - 3:00 p.m. Program Luncheon *Blue Room*

Presiding:
Carter L. Lowe, NAMH Vice President for Program

Invocation:
The Reverend Henry T. Gruber, Past President, Maryland Division

Speaker:
Bertram Brown, M.D., Director, National Institute of Mental Health
Subject: The Community Mental Health Center As a System for Prevention

3:30 p.m. - 5:30 p.m. **Program Workshops (9)**
Advance Registration Required

Workshop 1 **The Why and How of CMHC Site Visitations** *Board Room*

Moderator:
Mrs. Leif Valand, Member, NAMH Board, Past President, North Carolina MHA

Panelists:
Harold Goldstein, Ph.D., Chief, CMHC Support Branch Division of Mental Health Service Programs National Institute of Mental Health

Mrs. Muriel Weeks, Member, NAMH Board, President, Pennsylvania Mental Health

James Bunkley
Associate Director, Metropolitan Atlanta MHA

Workshop 2 **An Integrated Mental Health Care Delivery System: Defining Responsibility and Accountability for Patient Care** *Directors Room*

Moderator:
Mrs. Jeanne Sloan, Member, NAMH Board, Past President, MHA of Florida

Panelists:
Edwin Folk, AIP, Consultant, Pennsylvania Mental Health

Gerard Hunt, Ph.D.
Associate Professor of Sociology in Psychiatry, University of Maryland School of Medicine

Allan Moltzen
President, San Francisco MHA
Vice President, California AMH

Workshop 3 **Mental Hospital Patients and the Fair Labor Standards Act** *Executive Room*

Moderator:
Frank Nelson, Jr., Chairman, Anti-Peonage Task Force United Mental Health, Inc., Pittsburgh, Pennsylvania

Panelists:
Arthur Korn, Director
Division of Special Minimum Wages
U.S. Department of Labor

Gene Vaughn, President
MHA in Indiana

Workshop 4 **Insurance for Mental Health** *Blue Room*

Moderator:
Irving Chase, NAMH Public Affairs Committee, Past President, NAMH

Panelists:
Mrs. Jack Robbins, Vice Chairman
NAMH Public Affairs Committee
Past President, Pennsylvania Mental Health

Bill Fullerton, Staff Assistant
House Ways and Means Committee
United States Congress

Workshop 5 **Litigation as a Means of Achieving Mental Health Program Goals** *Blue Room*

Moderator:
Paul Friedman, Director
Mental Health Law Project
Washington, D.C.

Panelists:
Jonas Morris, Executive Director
National Council of Community Mental Health Centers
Washington, D.C.

Jerome Wagshal, Attorney in the case of NAMH vs. Weinberger, et al, Washington, D.C.

Workshop 6

The Community Mental Health Center as a System for Prevention
Heritage Room

Moderator:
C. Kay Allen, President, MHA of Colorado

Panelists:
Frank Ochberg, M.D., Acting Director, Division of Mental Health Service Programs, NIMH

James J. Messina, Ph.D., Director of Preventive Education Services CMHC of Escambia County, Inc. Board Member, MHA of Escambia County, Pensacola, Florida

Workshop 7

Are Mentally Ill Children Receiving the Education to Which They Are Entitled *Colonial Room*

Moderator:
Mary Akerley, President, National Society for Autistic Children, Member, NAMH Public Affairs Committee

Panelists:
Ms. Lisa Walker, Professional Staff Member, Senate Committee on Labor & Public Welfare, United States Congress

Frederick Weintraub, Assistant Executive Director for Governmental Relations, Council for Exceptional Children

Mrs. Babette Krause, Member of Board, MHA of Minnesota

Workshop 8

Multi-Lingual Mental Health Services *Blue Room*

Moderator:
Lorenzo Patino, NAMH Board Member, Member, NAMH Committee on Ethnic Minorities and the Poor

Panelists:
Ford Kuramoto, D.S.W., Executive Assistant to the Director, Division of Mental Health Services, NIMH

Ms. Barbara Izaguirre, Acting Executive Director, District of Columbia MHA

Alex Rodriguez, NAMH Board Member, Member, NAMH Committee on Ethnic Minorities and the Poor

Ms. Juanita Braddock, Board Member, D.C. Division Member, NAMH Committee on Ethnic Minorities and the Poor

Workshop 9

A Look at the California Mental Health Delivery System
Sales Conference Room

Moderator:
Robert Renouf, California AMH, NAMH Board Member

Panelists:
Valerie Bradley
Arthur Bolton Associates

James Lowry, M.D., Former Commissioner of Mental Health, State of California, Member NAMH Research Committee

3:30 p.m. - 5:30 p.m. **Organization Workshops (7)**
Advance Registration Required

Workshop 1 **Training Nominating Committees** *Empire Foyer A*

Moderator:
William McFadzean, Chairman, NAMH Nominating Committee, NAMH Board Member

Panelists:
Arnold B. Barach, Member NAMH Board & Nominating Committee

James W. (Chico) Hijar, Member NAMH Board & Nominating Committee

Judy Schotzko, President-elect Minnesota Division

Workshop 2 **Accounting, Internal Controls, Audits** *Empire Foyer B*

Moderator:
Tom Green, NAMH Controller

Panelists:
J. E. VanDyke, Assistant Director Pennsylvania MHA

James A. Teeter, Jr., Executive Director, South Carolina MHA

Workshop 3 **Hiring and Retaining Staff** *Tudor Room*

Moderator:
Clayton Droullard, NAMH Vice President, Region III

Panelists:
Brian O'Connell, NAMH Executive Director

David Ziegenhagen, Executive Director, Minnesota AMH, President, MHA Staff Council

Paul G. Pitz, Vice President, Indiana Division

Workshop 4 **Building Relationships with the News Media** *Empire 1/2*

Moderator:
Percy Knauth, 1975 Mental Health Chairman

Panelists:
William E. Perry, Jr., Director, NAMH Communications Department

William Rice, Vice President, NAMH Communications Department, President, Demiris, Rice & Associates

Workshop 5 **Planning Effective Board and Committee Meetings** *Empire 1/2*

Moderator:
Mrs. William F. Pell, Jr., NAMH Board Member, President, Illinois State Committee

Panelists:
John Westrom, President, Minnesota Division

Earle H. Harbison, President MHA of St. Louis

Workshop 6 **Developing Effective Chapter Annual Meetings** *Forum 1/2*

Moderator:
Robert Andreen, NAMH Vice President, Region V

Panelists:
Mrs. Harriet Whitten, President, Lynchburg (Virginia) MHA

Franklin G. Myers, Ph.D., 1st Vice President, Marion County MHA (Indianapolis, Ind.)

Workshop 7 — **Establishing Program & Organizational Priorities** *Forum 1/2*

Moderator:
Sandford F. Brandt, NAMH Vice President, Region II

Panelists:
Mrs. J. Skelly Wright, Immediate Past President, NAMH

Mrs. Beverly Long, President, Georgia Division, NAMH Board Member

Donald Farrow, Executive Director, Montgomery County MHA (Ohio)

5:30 p.m. - 7:15 p.m. — Hometown Photos — Lower Lobby

5:30 p.m. - 7:15 p.m. — Nancy Covert Smith Reception, Sponsored by Word Publishing Company in Recognition of Her New Book OF PEBBLES & PEARLS *Executive Room*

6:30 p.m. - 7:30 p.m. — Reception (Cash Bar) *Diplomat Room*

7:30 p.m.-9:30 p.m. — Research Dinner *Palladian Room*

Presiding:
Alan Levenson, M.D., Chairman, NAMH Research Committee

Invocation:
A. Edward Bell, Ph.D., Member, NAMH Committee on Ethnic Minorities and the Poor

Remarks: **The Honorable Paul G. Rogers,** Chairman, House Interstate & Foreign Commerce, Subcommittee on Public Health Environment

Presentation of the Mental Health Association Research Achievement Award and the McAlpin Medal to **Erik Erikson, Sc.D., L.L.D.**

Response: Professor Erikson

10:00 p.m. - 12 midnight — Regional Meetings and Receptions

Region I	*Forum Room*
Region II	*Diplomat Room*
Region III	*Palladian Room*
Region IV	*Empire Room*
Region V	*Heritage Room*

FRIDAY, November 22

7:00 a.m. - 8:15 a.m. — Eye Opener Breakfast Conversations *Palladian Room*

Take Your Pick of Table Conversations — 30 Tables — 30 Divisions and Chapter Projects. The Following Are Some of the Topics which will be Discussed over Buffet Breakfast:

The Role of a MHA in a Natural Disaster — Xenia, Ohio

New Leaf Rehabilitation Project — Chicago Junior League

Delaware Association's Full-Time Ombudsman for Mental Patients

Indiana Services the Mentally Ill Deaf

South Carolina Trains Supervisory Personnel To Be Aware of Emotional Problems Affecting Employee Production

7:15 a.m. - 8:15 a.m. — Mental Health Film Previews, Featuring Films From the NAMH Film Service Rental Library, Coffee & Rolls Available From the Hotel. *Diplomat Room*

7:00 a.m. - 8:15 a.m. — Public Affairs Committee Breakfast Meeting *Directors Room*

7:00 a.m. - 8:15 a.m. — Fund Raising Faculty Breakfast Session *Executive Room*

8:30 a.m. - 12 noon — Annual Meeting of the Membership (Reconvened) *Regency Ballroom*
Consideration of Resolutions and Other Business

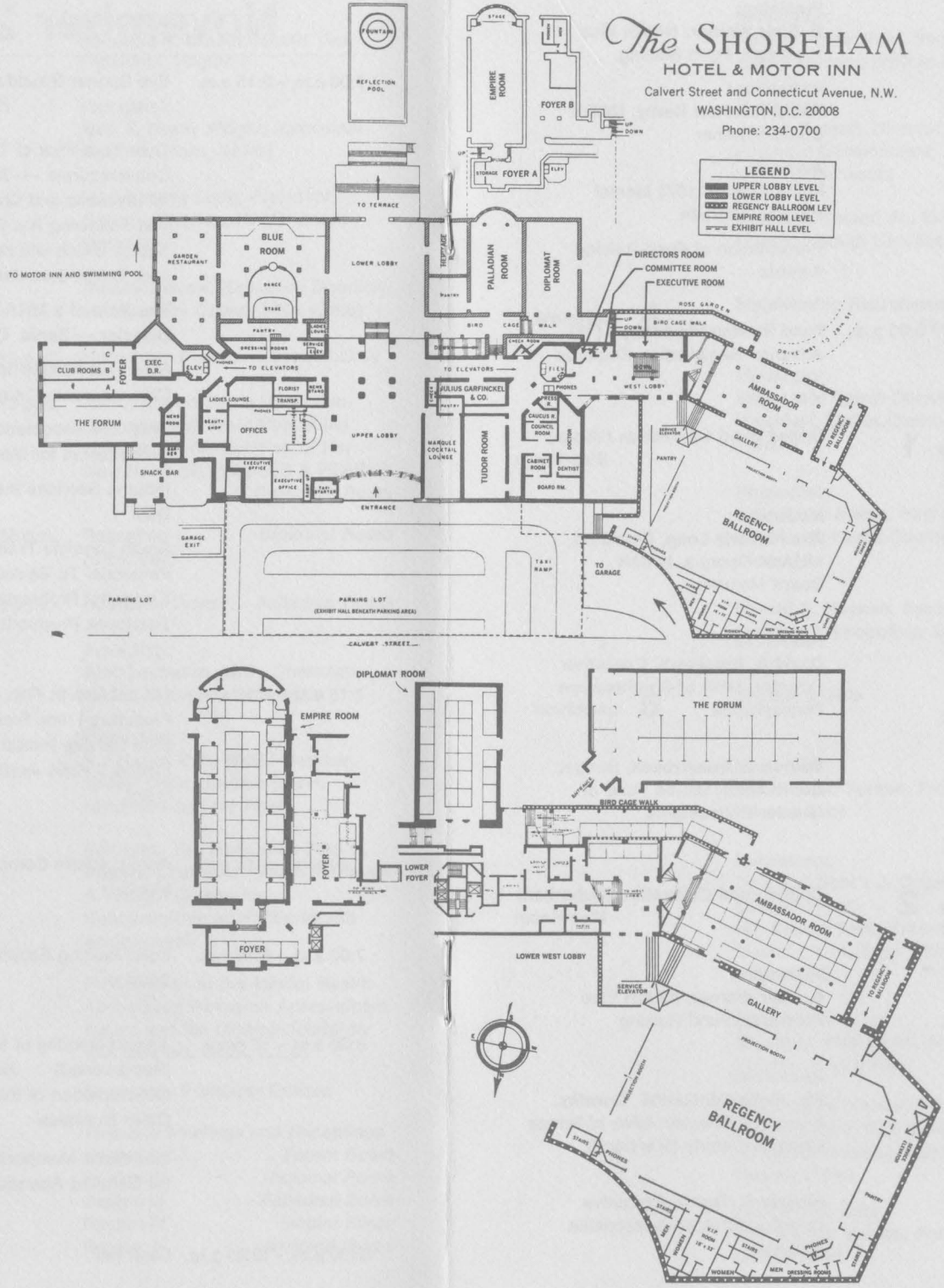
See White Membership Packet for Detailed Agenda

12:00 p.m. - 12:30 p.m. — Cash Bar *Palladian Room*

The SHOREHAM

HOTEL & MOTOR INN

Calvert Street and Connecticut Avenue, N.W.
WASHINGTON, D.C. 20008
Phone: 234-0700



12:30 p.m. - 2:45 p.m. 1975 Mental Health Fund Raising Kickoff Luncheon *Palladian Room*

Presiding:
E. Blair Warner, NAMH Vice President, Fund Raising

Invocation:
Rabbi Matthew Derby, NAMH Board Member

Address:
Percy Knauth, 1975 Mental Health Chairman

Presentation of Fund Raising Awards

3:00 p.m. - 5:00 p.m. **Fund Raising Workshops (15)**
Advance Registration Required

Workshop 1 **United Fund Cultivation (Urban)**
Blue Room

Moderator:
Mrs. Beverly Long, President, MHA of Georgia, NAMH Board Member

Resources:
David B. Bernhardt, Executive Director, MHA of Southeastern Pennsylvania

Warren L. Swartzbeck, Budget Coordinator, United Fund of Greater Philadelphia

Workshop 2 **United Fund Cultivation (Suburban)**
Blue Room

Moderator:
E. Blair Warner, NAMH Vice President, Fund Raising

Resources:
Ms. Betty McGarvie Crowley, Executive Director, MHA of Prince Georges County (Maryland)

Stanley E. Taylor, Executive Director, MHA of Jacksonville (Florida)

Workshop 3 **Division/United Fund Cultivation**
Executive Room

Moderator:
Adrian VanderMast, Immediate Past President, MHA in Indiana

Resources:
James Barnett, Director of Financial Development, MHA of Minnesota

James A. Teeter, Jr., Executive Director, South Carolina MHA

Workshop 4 **Membership Recruitment**
Heritage Room

Moderator:
Honorable Oswin Chrisman, President, Dallas County MHA (Texas)

Resources:
John Kirby Ewing, Past President, Houston & Harris County MHA (Texas)

Gerald R. Noonan, Associate Director, Metropolitan Atlanta MHA

Workshop 5 **Special Events**
Tudor Room

Moderator:
Mrs. Marion Vernon, President Kansas AMH

Resources:
Do's and Dont's in Organizing a Special Event
Ms. Blanca Reid, Executive Director, San Diego MHA (California)

Galaxy Ball
Ms. Mary Ellen Nudd, Associate Director, Texas AMH

Mrs. John A. Nance, Fund Raising Chairman and 1974 Galaxy Ball Chairman, Houston/Harris County Chapter (Tex.)

The Garage Sale
Mrs. Marion Vernon, President Kansas AMH

Workshop 6 — Rural Campaigning

Forum 1 / 2

Moderator:
Herb Miller, President
North Dakota MHA

Resources:
Watts Line Rural Campaigning
Mrs. Myrt Armstrong, Executive Director, North Dakota MHA

Rural Membership Campaigns
Ms. Mabel Palmer, Executive Director, Louisiana AMH

Workshop 7 — Doorbell Ringer Campaign & Alternatives

Forum 1 / 2

Moderator:
Mrs. Albert Kohn, President
MHA of Connecticut

Resources:
The Neighbor to Neighbor Campaign
S. Steven Rosner, Executive Director, Massachusetts AMH

The Telephone Method
Mrs. Connie Prout, Associate Director, Northwestern Connecticut AMH

Workshop 8 — Small Business, Block Solicitation & Specialized Mailings

Empire 1 / 2

Moderator:
Mrs. Nancy Petry, Board Member
Kentucky AMH

Resources:
Health Statement
Louis J. Bandell, Director of Field Services, Maryland AMH

Small Business Mailing
Ashar S. Tullis, Executive Director
Kentucky AMH

Workshop 9 — Commerce & Industry

Empire 1 / 2

Moderator:
Mr. Arthur H. Burton, Jr., Chairman
Financial Development Committee
MHA of Greater Chicago

Resources:
Loaned Executive Program and Corporate Luncheons
Frank Cooper, Executive Director
MHA of Los Angeles County (California)

Combined Health Appeal in Industry
Mrs. Devy Bendit, Executive Director, Metropolitan Baltimore AMH

Corporate Solicitations
Robert Leys, NAMH National Corporate Gifts Chairman
Vice President, Allstate Insurance Company

Workshop 10 — Bequests

Empire Foyer A

Moderator:
Matthew J. Heartney, Jr., Esq.
NAMH Board Member

Resources:
Morgan West, Board Member
Pennsylvania Mental Health

Harry Rubin, Esq., Board Member
Pennsylvania Mental Health

Workshop 11 — Foundations

Empire Foyer B

Moderator:
Arnold B. Barach
Secretary, Kiplinger Foundation
NAMH Board Member

Resources:
Ms. Rosemary Plesset, Executive Director, United Mental Health, Inc. (Pittsburgh, Pa.)

William G. McFadzean, Chairman of Financial Development
Minnesota AMH

William T. Beaty, II, Secretary
Ittleson Family Foundation
(New York)

Workshop 12 **Fund Raising Planning** *Club Foyer*

Moderator:
Wilder D. Baker, Jr., Financial Development Council
Massachusetts AMH

Resources:
J. E. Van Dyke, Assistant Executive Director, Pennsylvania MH

Earl W. Hildebrandt, Assistant Executive Director, Wisconsin AMH

Workshop 13 **Division Role in Assisting Chapters with Fund Raising** *Palladian Room*

Moderator:
Jack Hughes, Membership/Fund Campaign Chairman
MHA in Indiana

Resources:
Joseph R. Brown, Executive Director, MHA in Indiana

George W. Sawyer, Jr., Executive Director, Maryland AMH

Workshop 14 **Motivating the Fund Raising Volunteer and Donor** *Board Room*

Moderator:
Dr. Howard Rogers, Chairman of Public Information
Connecticut AMH

Resources:
John Abbott, Executive Director
Connecticut AMH

Dr. Howard Rogers, Chairman of Public Information
Connecticut AMH

Dr. H. LaMarr Rice, President
Kansas City MHA (Missouri)

Workshop 15 **Fund Raising/Communications** *Palladian Room*

Moderator:
Percy Knauth, 1975 Mental Health Chairman

Panelists:
Joseph Goodpasture, Executive Director, North Carolina MHA

William E. Perry, Jr., Director NAMH Communications Department

7:00 p.m. - 11:00 p.m. Host City Special Event *Regency Ballroom*

Presiding:
Mrs. Alice Davis, President
Washington, D.C. MHA

Dinner, Entertainment, Dancing

SATURDAY, November 23

7:00 a.m. - 8:15 a.m. Fund Raising Council Breakfast
Directors Room

8:30 a.m. - 12 noon Annual Meeting of the Membership (reconvened)
Regency Ballroom

Consideration of Resolutions and Other Business

Nominating Committee Report
William G. McFadzean, Chairperson

Election of Officers & Directors

President's Inaugural Address
Gerridee Wheeler

See White Membership Packet for Detailed Agenda

12:00 p.m. - 12:30 p.m. Cash Bar *Blue Room*

12:30 p.m. - 3:00 p.m. Awards Luncheon *Blue Room*

Presiding
Thomas Watkins, NAMH Vice President, Organization & Development

Invocation:
The Rev. E. C. Black, Jr.
South Carolina Delegate

Presentation of Awards:
Mrs: J. Skelly Wright
NAMH Past President

Recipients of Awards:
Mental Health Bell Awards

Daily Category:
Boca Raton News, with special award to reporter **Virginia Snyder**
Boca Raton, Florida

St. Paul Dispatch and Pioneer Press
St. Paul, Minnesota

Honorable Mention:
St. Louis Globe-Democrat
St. Louis, Missouri

Radio:
WPTW
Piqua, Ohio

Honorable Mention:
KOSI
Aurora, Colorado

Katherine Hamilton Volunteer of the Year
Robert G. Melander
East Hartford, Connecticut

Special Volunteer Award
Raymond and Mary Houk
Indianapolis, Indiana

Employer of the Year Awards

Public Sector
Crownsville Hospital Center
Crownsville, Maryland

Private Sector (less than 200 employees)
Mr. Woodie's Gift Shop
St. Thomas, Virgin Islands

Private Sector (200 or more employees)

Fairchild Camera & Instrument Corporation
Mountain View, California

The Foxboro Company
Foxboro, Massachusetts

Special Recognition Award
Senator Richard S. Schweiker
Ranking Republican — Senate Health Subcommittee

3:00 p.m. - 5:00 p.m. Annual Meeting of the Membership
Regency Ballroom
(Reconvened, if necessary)

3:00 p.m. - 5:00 p.m. Open Meeting of the Board
Diplomat Room
(If Membership Meeting is not reconvened, or immediately following Membership Meeting). This special meeting will be called if there are Divisions to be considered for disaffiliation and they wish to present their points of view to the Board.

5:00 p.m. - 6:30 p.m. Finance Committee Meeting
Directors Room

5:00 p.m. - 6:30 p.m. Annual Meeting Task Force Committee *Board Room*

6:30 p.m. - 10:30 p.m. Board of Directors Dinner
Forum Room

SUNDAY, November 24

9:00 a.m. - 4:00 p.m. Board of Directors Meeting
Tudor Room

Thanks to the Washington, D.C. Division for hosting this our 1974 Annual Meeting and Mental Health Assembly. The hard work, cooperation and skills of volunteers, staff and members, including the President, Alice Davis, and Host City Chairman, Barbara Stockton, and their Hosts & Hostesses, have helped make this meeting a success.

Miss Margaret Hickey, Chairperson
1974 Annual Meeting Task Force

1974 ANNUAL MEETING TASK FORCE

Chairperson: Miss Margaret Hickey, National Board Member, Tucson, Arizona

Arnold Barach, National Board Member Washington, D.C.

D. Mitchell Cox, National Board Member Sherman, Connecticut

Mrs. Alice Davis, President, District of Columbia MHA, Washington, D.C.

Ruth Allen Fouché, Secretary, NAMH Chicago, Illinois

Matthew J. Heartney, Jr., National Board Member, Des Moines, Iowa

Carter L. Lowe, Vice President, Program, NAMH, Framingham, Massachusetts

Mrs. Franklin B. McCarty, Jr., National Board Member, Winnetka, Illinois

E. Blair Warner, Vice President, Fund Raising, NAMH, South Bend, Indiana

Arnold Webster, Executive Director, D.C. Mental Health Association, Washington, D.C.

Mrs. Gerridee Wheeler, President-elect, NAMH, Bismarck, North Dakota

HOST CITY PLANNING COMMITTEE

Chairperson: Miss Barbara Stockton
Mrs. Alexander Chase
Mrs. T. Wilkens Davis
Miss Alice T. Dodge
Mrs. Charles B. E. Freeman
Mrs. Alvin Goins
Mrs. Stanford Hicks
Mrs. Charles C. Johnson
Mrs. Joel Madison
Mrs. Robert Martin
Mrs. Wilbur Michaeux
Miss Dorothy S. Proctor
Mrs. R. Stewart Randall
Juliette M. Simmons, M.D.
Mrs. Cleveland Smith
Mrs. Margie Sneed
Mrs. John T. Stewart
Mrs. William Tompkins
Mrs. Winston Willoughby
Mr. Aubrey Zephyr

Representatives of the D.C. Alumnae Chapter of Delta Sigma Theta Sorority

D.C. Auxiliary of the National Medical Association

Representatives of the Area Mental Health Associations

OFFICERS

President
Linden E. Wheeler
Chicago, Illinois

President-elect
Mrs. Gerridee Wheeler
Bismarck, North Dakota

Vice President, Region I
Mrs. Hilda H. Robbins
Ft. Washington, Pennsylvania

Vice President, Region II
Sandford F. Brandt
Norris, Tennessee

Vice President, Region III
Clayton Droullard
Whitewater, Wisconsin

Vice President, Region IV
Warren Welliver
Columbia, Missouri

Vice President, Region V
Robert Andreen
San Diego, California

Vice President, Fund Raising
E. Blair Warner
South Bend, Indiana

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The National Association for Mental Health, Inc.

Citizens Who Make a Difference

1800 North Kent Street, Rosslyn Station
Arlington, Virginia 22209

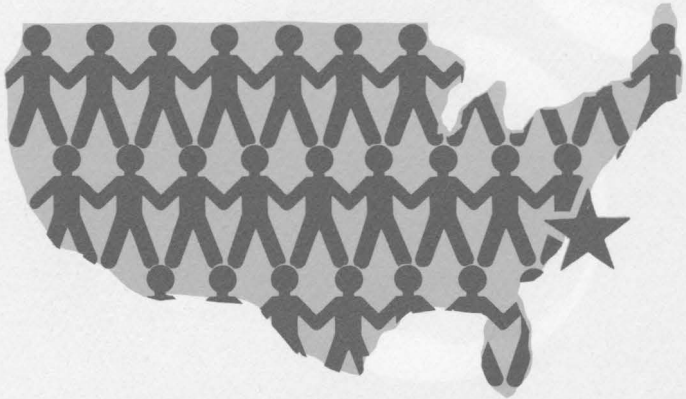
1974
ANNUAL
MEETING
AND
MENTAL
HEALTH
ASSEMBLY

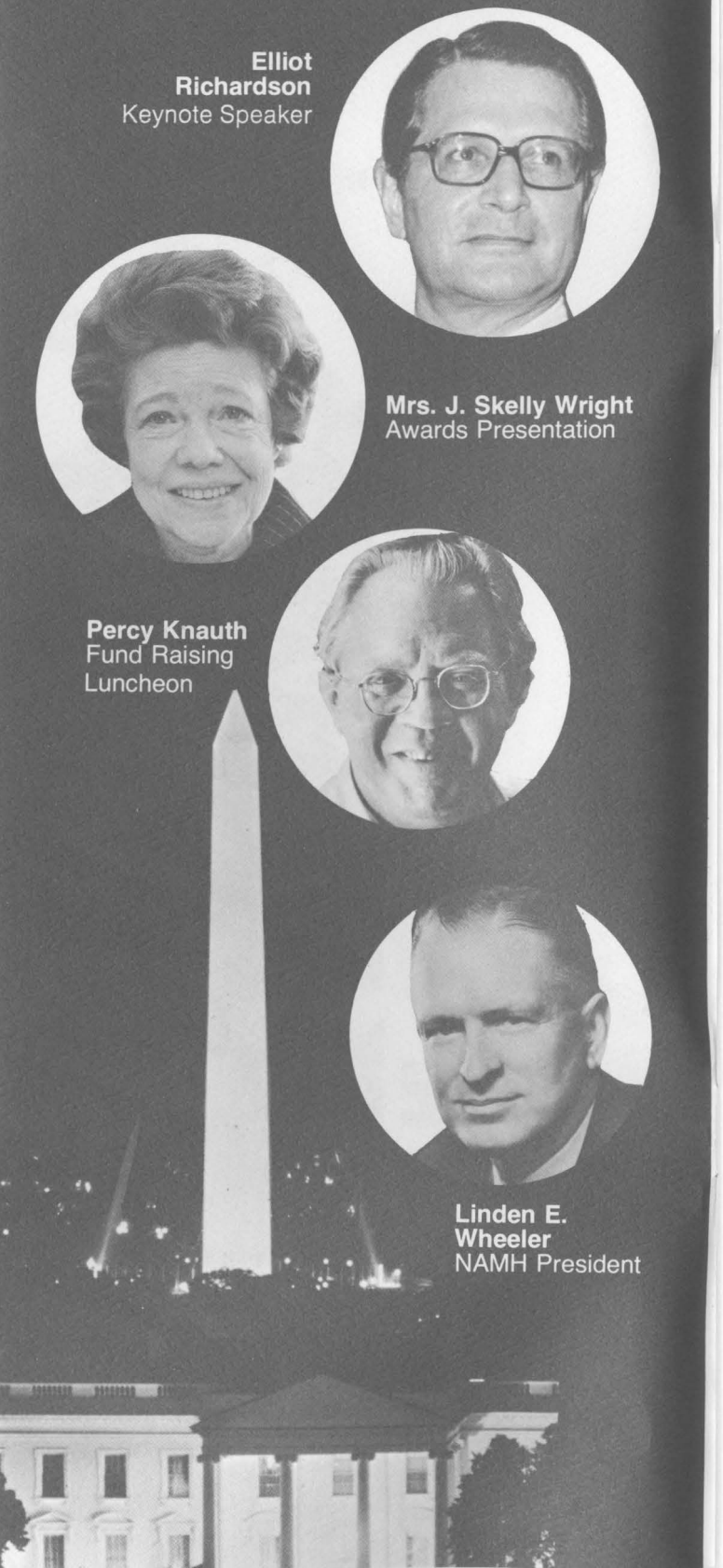
NOVEMBER
20-23

Shoreham Americana
Washington,
D.C.

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

MENTAL HEALTH: NETWORK FOR ACTION





MENTAL HEALTH: NETWORK FOR ACTION

In determining the theme for the 1974 Annual Meeting and Mental Health Assembly, the Annual Meeting Task Force decided to focus on the responsibilities of our three-level organization in providing assistance to the mentally ill in the community, state and the nation.

"Mental Health: Network for Action," was selected as the theme designed to improve our organizational capacity by working cooperatively in the areas of social action, litigation and education.

GENERAL INFORMATION

Workshop Registration

It is important to register for the Thursday Program and Organizational Workshops and the Friday Fund Raising sessions at your earliest convenience, to insure beneficial group discussion. Attendance is limited. To register, complete the enclosed reservation form and send it to the National Office. Space permitting, limited registration will be accepted at the Mental Health Information Desk.

Room Locations

Please note that most Annual Meeting activities take place on the main and upper lobby levels. A map of the meeting rooms is provided in the centerfold.

Information

The Information Desk is located on the Lobby Level. Facts about the Annual Meeting or the Washington, D.C. area will be available. Also, Annual Meeting Task Force and National Staff members are prepared to assist you.

Messages

Inform your family or office that if you need to be reached and you're not in your room, the calling party should ask the hotel operator for the Mental Health Association Headquarters Room. We will attempt to locate you or will post a message for you on the Headquarters Bulletin Board.

Hospitality Room

Heritage Room. Open 8:00 a.m.-6:00 p.m.

Exhibits

Upper Lobby

Many exhibits will be staffed during at least part of the conference. You'll have an opportunity to discuss the projects on display with someone knowledgeable from that Chapter or Division.

Registration and Ticket Sales

Main Lobby

Open: Wednesday, November 20 ....9:00 a.m. - 7:30 p.m.
Thursday, November 21 .....7:30 a.m. - 8:15 p.m.
Friday, November 22 .....7:45 a.m. - 6:15 p.m.
Saturday, November 23 .....7:45 a.m. - 12:15 p.m.

Badges

Please wear your identification badges for admission to all meetings and functions. The following have ribbon badges for quick identification:

NAMH Board Members and
Voting Delegates .....Blue Ribbon
Host City Volunteer Hosts
and Hostesses .....Yellow Ribbon
Honored Guests .....Purple Ribbon

Offices

Upper Lobby Level

Open 7:30 a.m. - 7:30 p.m.

Headquarters and Board Room

Council Room

Annual Meeting Operations Room

Cabinet Room

Press Rooms

Committee, Caucus and Press Rooms

Idea Exchange Center

Upper Lobby

Test your knowledge of mental health and the MHA! Take the quiz! Get new ideas for programs, publicity and fund raising. Share your ideas with others. Open 8:00 a.m. - 7:00 p.m.

Marketplace

Upper Lobby

Purchase such items as medallions, books, packets of various pamphlets, and MH subscriptions.

Films

Mental Health films will be shown in the Diplomat Room, Thursday and Friday from 7:15 a.m. - 8:15 a.m. Coffee and sweet rolls may be purchased from the hotel in the film room.

Weather

Weather in Washington, D.C. tends to be cool with a daytime average of 54 degrees and a nighttime average of 44 degrees. Precipitation during November is 2.90 inches.

Press Releases

Press releases, copies of some speeches and other materials will be available in the press rooms.

WEDNESDAY, November 20

9:00 a.m. - 5:00 p.m. Research Committee Meeting *Board Room*

9:00 a.m. - 3:00 p.m. Committee on Mental Health Services for the Ethnic Minorities and the Poor *Club B*

10:00 a.m. - 12 noon Host City Volunteer Orientation & Annual Meeting Task Force Hotel Tour *Executive Room*

1:00 p.m. - 1:30 p.m. Congressional Briefings (receive updated mental health legislation information prior to visits on the Hill). Irving Chase, Chairman, Public Affairs Committee *Ambassador Room*

2:00 p.m. - 5:00 p.m. Organization Committee Meeting *Sales Conference Room*

2:00 p.m. - 4:00 p.m. Resolutions Committee Meeting *Suite*

2:00 p.m. - 3:30 p.m. General Meeting for All Staff *Empire Room*

Briefing on current issues: Executive Director's Report (Volunteers are welcome to attend)

2:30 p.m. - 4:00 p.m. NAMH Legislative Network Volunteers *Ambassador Room*

3:30 p.m. - 5:30 p.m. Staff Council Membership Meeting *Tudor Room*

Presiding:
David Ziegenhagen, President-elect, MHA Staff Council

4:00 p.m. - 4:30 p.m. Congressional Briefings (Repeat of 1:00 session) *Ambassador Room*

4:30 p.m. - 6:30 p.m. Caucus on Minority Concerns (Open to all) *Empire Room*

5:30 p.m. - 6:00 p.m. Staff Council Board Meeting *Tudor Room*

6:30 p.m. - 7:30 p.m. Reception (Cash Bar) *Ambassador Room*

7:30 p.m. - 10:00 p.m. Opening Dinner *Palladian Room*

Presiding:
Gerridee Wheeler, President-elect

Invocation: Congressman **Walter E. Fauntroy,** District of Columbia

Speaker:
The Honorable Elliot Richardson

THURSDAY, November 21

7:00 a.m. - 8:15 a.m. Delegate Caucus Breakfast *Palladian Room*

Seating by Divisions — Discussion of Issues on Membership Agenda

7:15 a.m. - 8:15 a.m. Mental Health Film Previews, Featuring Films From the NAMH Film Service Rental Library (Coffee & Rolls Available From Hotel) *Diplomat Room*

8:30 a.m. - 12 noon Annual Meeting of the Membership — Opening Session *Regency Ballroom*

Presiding:
Linden E. Wheeler, President
Invocation: **The Rev. Lawrence A. Davies,** Delegate Virginia Division

Agenda
(Order subject to change. The final agenda will be the one contained in the Membership Meeting folder.)
Report on Implementation of Resolutions & Other Business Passed at Last Year's Membership Meeting
Explanations and Questions to Clarify the Resolutions and Other Issues Which Are Before the Membership This Year. Includes Initial Report of the Resolutions Committee
Linden E. Wheeler, President
Charles Mahoney, Esq., Chairperson, Resolutions Committee
Consideration of Resolutions and Other Business
Charles Mahoney, Esq.

12:00 p.m. - 12:30 p.m. Cash Bar *Blue Room*

12:30 p.m. - 3:00 p.m. Program Luncheon *Blue Room*

Presiding:
Carter L. Lowe, NAMH Vice President for Program
Invocation:
The Reverend Henry T. Gruber, Past President, Maryland Division
Speaker:
Bertram Brown, M.D., Director, National Institute of Mental Health
Subject: The Community Mental Health Center As a System for Prevention

3:30 p.m. - 5:30 p.m. **Program Workshops (9)**
Advance Registration Required

Workshop 1

The Why and How of CMHC Site Visitations *Board Room*

Moderator:
Mrs. Leif Valand, Member, NAMH Board, Past President, North Carolina MHA

Panelists:
Harold Goldstein, Ph.D., Chief, CMHC Support Branch Division of Mental Health Service Programs National Institute of Mental Health

Mrs. Muriel Weeks, Member, NAMH Board, President, Pennsylvania Mental Health

James Bunkley
Associate Director, Metropolitan Atlanta MHA

Workshop 2

An Integrated Mental Health Care Delivery System: Defining Responsibility and Accountability for Patient Care *Directors Room*

Moderator:
Mrs. Jeanne Sloan, Member, NAMH Board, Past President, MHA of Florida

Panelists:
Edwin Folk, AIP, Consultant, Pennsylvania Mental Health

Gerard Hunt, Ph.D.
Associate Professor of Sociology in Psychiatry, University of Maryland School of Medicine

Allan Moltzen
President, San Francisco MHA
Vice President, California AMH

Workshop 3

Mental Hospital Patients and the Fair Labor Standards Act *Executive Room*

Moderator:
Frank Nelson, Jr., Chairman, Anti-Peonage Task Force United Mental Health, Inc., Pittsburgh, Pennsylvania

Panelists:
Arthur Korn, Director
Division of Special Minimum Wages
U.S. Department of Labor

Gene Vaughn, President
MHA in Indiana

Workshop 4

Insurance for Mental Health *Blue Room*

Moderator:
Irving Chase, NAMH Public Affairs Committee, Past President, NAMH

Panelists:
Mrs. Jack Robbins, Vice Chairman
NAMH Public Affairs Committee
Past President, Pennsylvania Mental Health

Bill Fullerton, Staff Assistant
House Ways and Means Committee
United States Congress

Workshop 5

Litigation as a Means of Achieving Mental Health Program Goals *Blue Room*

Moderator:
Paul Friedman, Director
Mental Health Law Project
Washington, D.C.

Panelists:
Jonas Morris, Executive Director
National Council of Community Mental Health Centers
Washington, D.C.

Jerome Wagshal, Attorney in the case of NAMH vs. Weinberger, et al, Washington, D.C.

Workshop 6

The Community Mental Health Center as a System for Prevention
Heritage Room

Moderator:
C. Kay Allen, President, MHA of Colorado

Panelists:
Frank Ochberg, M.D., Acting Director, Division of Mental Health Service Programs, NIMH

James J. Messina, Ph.D., Director of Preventive Education Services CMHC of Escambia County, Inc. Board Member, MHA of Escambia County, Pensacola, Florida

Workshop 7

Are Mentally Ill Children Receiving the Education to Which They Are Entitled *Colonial Room*

Moderator:
Mary Akerley, President, National Society for Autistic Children, Member, NAMH Public Affairs Committee

Panelists:
Ms. Lisa Walker, Professional Staff Member, Senate Committee on Labor & Public Welfare, United States Congress

Frederick Weintraub, Assistant Executive Director for Governmental Relations, Council for Exceptional Children

Mrs. Babette Krause, Member of Board, MHA of Minnesota

Workshop 8

Multi-Lingual Mental Health Services *Blue Room*

Moderator:
Lorenzo Patino, NAMH Board Member, Member, NAMH Committee on Ethnic Minorities and the Poor

Panelists:
Ford Kuramoto, D.S.W., Executive Assistant to the Director, Division of Mental Health Services, NIMH

Ms. Barbara Izaguirre, Acting Executive Director, District of Columbia MHA

Alex Rodriguez, NAMH Board Member, Member, NAMH Committee on Ethnic Minorities and the Poor

Ms. Juanita Braddock, Board Member, D.C. Division Member, NAMH Committee on Ethnic Minorities and the Poor

Workshop 9

A Look at the California Mental Health Delivery System
Sales Conference Room

Moderator:
Robert Renouf, California AMH, NAMH Board Member

Panelists:
Valerie Bradley
Arthur Bolton Associates

James Lowry, M.D., Former Commissioner of Mental Health, State of California, Member NAMH Research Committee

3:30 p.m. - 5:30 p.m. **Organization Workshops (7)**
Advance Registration Required

Workshop 1 **Training Nominating Committees** *Empire Foyer A*

Moderator:
William McFadzean, Chairman, NAMH Nominating Committee, NAMH Board Member

Panelists:
Arnold B. Barach, Member NAMH Board & Nominating Committee

James W. (Chico) Hijar, Member NAMH Board & Nominating Committee

Judy Schotzko, President-elect Minnesota Division

Workshop 2 **Accounting, Internal Controls, Audits** *Empire Foyer B*

Moderator:
Tom Green, NAMH Controller

Panelists:
J. E. VanDyke, Assistant Director Pennsylvania MHA

James A. Teeter, Jr., Executive Director, South Carolina MHA

Workshop 3 **Hiring and Retaining Staff** *Tudor Room*

Moderator:
Clayton Droullard, NAMH Vice President, Region III

Panelists:
Brian O'Connell, NAMH Executive Director

David Ziegenhagen, Executive Director, Minnesota AMH, President, MHA Staff Council

Paul G. Pitz, Vice President, Indiana Division

Workshop 4 **Building Relationships with the News Media** *Empire 1/2*

Moderator:
Percy Knauth, 1975 Mental Health Chairman

Panelists:
William E. Perry, Jr., Director, NAMH Communications Department

William Rice, Vice President, NAMH Communications Department, President, Demiris, Rice & Associates

Workshop 5 **Planning Effective Board and Committee Meetings** *Empire 1/2*

Moderator:
Mrs. William F. Pell, Jr., NAMH Board Member, President, Illinois State Committee

Panelists:
John Westrom, President, Minnesota Division

Earle H. Harbison, President MHA of St. Louis

Workshop 6 **Developing Effective Chapter Annual Meetings** *Forum 1/2*

Moderator:
Robert Andreen, NAMH Vice President, Region V

Panelists:
Mrs. Harriet Whitten, President, Lynchburg (Virginia) MHA

Franklin G. Myers, Ph.D., 1st Vice President, Marion County MHA (Indianapolis, Ind.)

Workshop 7 — **Establishing Program & Organizational Priorities** *Forum 1/2*

Moderator:
Sandford F. Brandt, NAMH Vice President, Region II

Panelists:
Mrs. J. Skelly Wright, Immediate Past President, NAMH

Mrs. Beverly Long, President, Georgia Division, NAMH Board Member

Donald Farrow, Executive Director, Montgomery County MHA (Ohio)

5:30 p.m. - 7:15 p.m. — Hometown Photos — Lower Lobby

5:30 p.m. - 7:15 p.m. — Nancy Covert Smith Reception, Sponsored by Word Publishing Company in Recognition of Her New Book OF PEBBLES & PEARLS *Executive Room*

6:30 p.m. - 7:30 p.m. — Reception (Cash Bar) *Diplomat Room*

7:30 p.m.-9:30 p.m. — Research Dinner *Palladian Room*

Presiding:
Alan Levenson, M.D., Chairman, NAMH Research Committee

Invocation:
A. Edward Bell, Ph.D., Member, NAMH Committee on Ethnic Minorities and the Poor

Remarks: **The Honorable Paul G. Rogers,** Chairman, House Interstate & Foreign Commerce, Subcommittee on Public Health Environment

Presentation of the Mental Health Association Research Achievement Award and the McAlpin Medal to **Erik Erikson, Sc.D., L.L.D.**

Response: Professor Erikson

10:00 p.m. - 12 midnight — Regional Meetings and Receptions

Region I	*Forum Room*
Region II	*Diplomat Room*
Region III	*Palladian Room*
Region IV	*Empire Room*
Region V	*Heritage Room*

FRIDAY, November 22

7:00 a.m. - 8:15 a.m. — Eye Opener Breakfast Conversations *Palladian Room*

Take Your Pick of Table Conversations — 30 Tables — 30 Divisions and Chapter Projects. The Following Are Some of the Topics which will be Discussed over Buffet Breakfast:

The Role of a MHA in a Natural Disaster — Xenia, Ohio

New Leaf Rehabilitation Project — Chicago Junior League

Delaware Association's Full-Time Ombudsman for Mental Patients

Indiana Services the Mentally Ill Deaf

South Carolina Trains Supervisory Personnel To Be Aware of Emotional Problems Affecting Employee Production

7:15 a.m. - 8:15 a.m. — Mental Health Film Previews, Featuring Films From the NAMH Film Service Rental Library, Coffee & Rolls Available From the Hotel. *Diplomat Room*

7:00 a.m. - 8:15 a.m. — Public Affairs Committee Breakfast Meeting *Directors Room*

7:00 a.m. - 8:15 a.m. — Fund Raising Faculty Breakfast Session *Executive Room*

8:30 a.m. - 12 noon — Annual Meeting of the Membership (Reconvened) *Regency Ballroom*
Consideration of Resolutions and Other Business

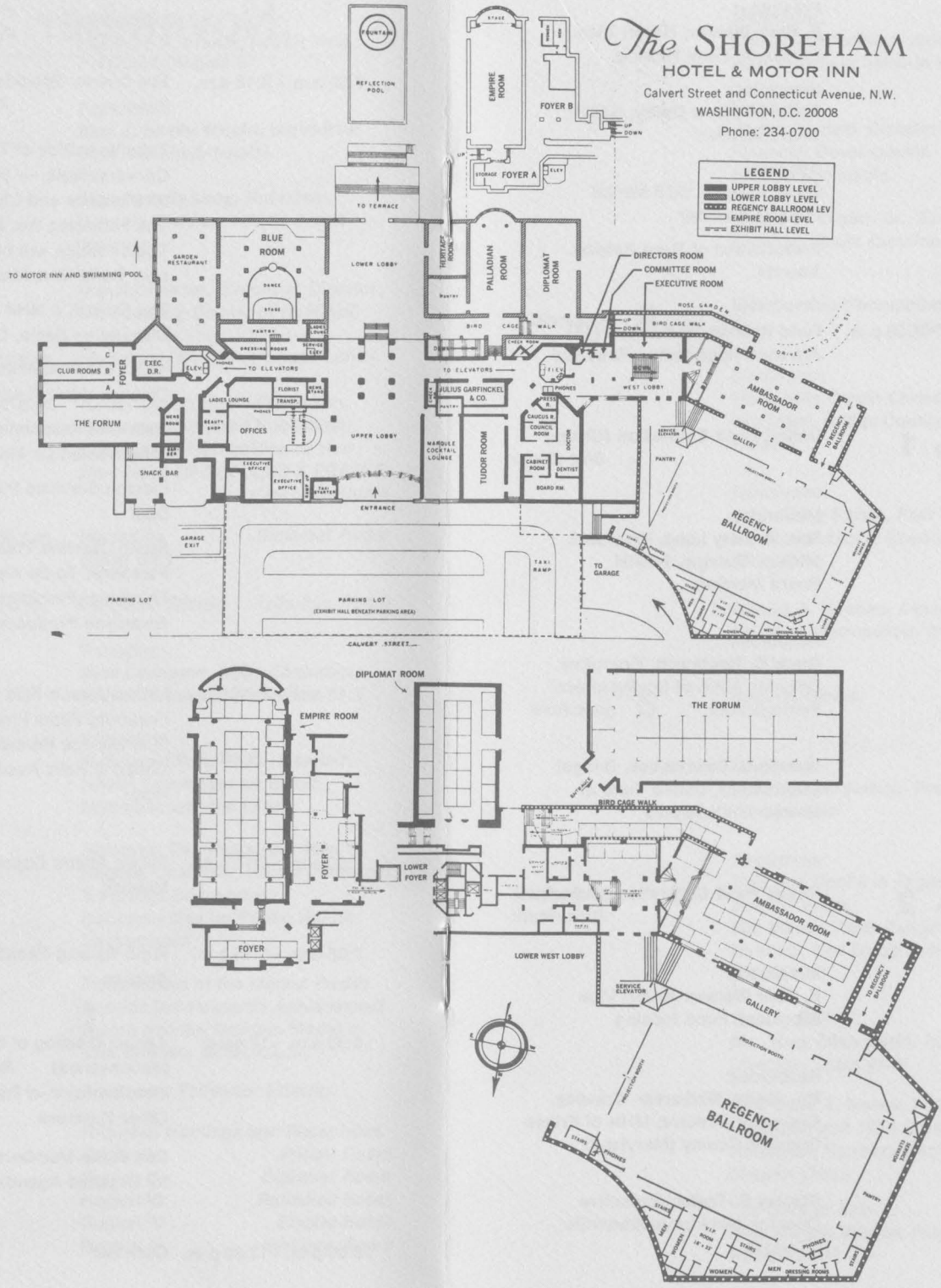
See White Membership Packet for Detailed Agenda

12:00 p.m. - 12:30 p.m. — Cash Bar *Palladian Room*

The SHOREHAM

HOTEL & MOTOR INN

Calvert Street and Connecticut Avenue, N.W.
WASHINGTON, D.C. 20008
Phone: 234-0700



12:30 p.m. - 2:45 p.m. 1975 Mental Health Fund Raising Kickoff Luncheon *Palladian Room*

Presiding:
E. Blair Warner, NAMH Vice President, Fund Raising

Invocation:
Rabbi Matthew Derby, NAMH Board Member

Address:
Percy Knauth, 1975 Mental Health Chairman

Presentation of Fund Raising Awards

3:00 p.m. - 5:00 p.m. **Fund Raising Workshops (15)**
Advance Registration Required

Workshop 1 **United Fund Cultivation (Urban)**
Blue Room

Moderator:
Mrs. Beverly Long, President, MHA of Georgia, NAMH Board Member

Resources:
David B. Bernhardt, Executive Director, MHA of Southeastern Pennsylvania

Warren L. Swartzbeck, Budget Coordinator, United Fund of Greater Philadelphia

Workshop 2 **United Fund Cultivation (Suburban)**
Blue Room

Moderator:
E. Blair Warner, NAMH Vice President, Fund Raising

Resources:
Ms. Betty McGarvie Crowley, Executive Director, MHA of Prince Georges County (Maryland)

Stanley E. Taylor, Executive Director, MHA of Jacksonville (Florida)

Workshop 3 **Division/United Fund Cultivation**
Executive Room

Moderator:
Adrian VanderMast, Immediate Past President, MHA in Indiana

Resources:
James Barnett, Director of Financial Development, MHA of Minnesota

James A. Teeter, Jr., Executive Director, South Carolina MHA

Workshop 4 **Membership Recruitment**
Heritage Room

Moderator:
Honorable Oswin Chrisman, President, Dallas County MHA (Texas)

Resources:
John Kirby Ewing, Past President, Houston & Harris County MHA (Texas)

Gerald R. Noonan, Associate Director, Metropolitan Atlanta MHA

Workshop 5 **Special Events**
Tudor Room

Moderator:
Mrs. Marion Vernon, President Kansas AMH

Resources:
Do's and Dont's in Organizing a Special Event
Ms. Blanca Reid, Executive Director, San Diego MHA (California)

Galaxy Ball
Ms. Mary Ellen Nudd, Associate Director, Texas AMH

Mrs. John A. Nance, Fund Raising Chairman and 1974 Galaxy Ball Chairman, Houston/Harris County Chapter (Tex.)

The Garage Sale
Mrs. Marion Vernon, President Kansas AMH

Workshop 6 — Rural Campaigning

Forum 1 / 2

Moderator:
Herb Miller, President
North Dakota MHA

Resources:
Watts Line Rural Campaigning
Mrs. Myrt Armstrong, Executive Director, North Dakota MHA

Rural Membership Campaigns
Ms. Mabel Palmer, Executive Director, Louisiana AMH

Workshop 7 — Doorbell Ringer Campaign & Alternatives

Forum 1 / 2

Moderator:
Mrs. Albert Kohn, President
MHA of Connecticut

Resources:
The Neighbor to Neighbor Campaign
S. Steven Rosner, Executive Director, Massachusetts AMH

The Telephone Method
Mrs. Connie Prout, Associate Director, Northwestern Connecticut AMH

Workshop 8 — Small Business, Block Solicitation & Specialized Mailings

Empire 1 / 2

Moderator:
Mrs. Nancy Petry, Board Member
Kentucky AMH

Resources:
Health Statement
Louis J. Bandell, Director of Field Services, Maryland AMH

Small Business Mailing
Ashar S. Tullis, Executive Director
Kentucky AMH

Workshop 9 — Commerce & Industry

Empire 1 / 2

Moderator:
Mr. Arthur H. Burton, Jr., Chairman
Financial Development Committee
MHA of Greater Chicago

Resources:
Loaned Executive Program and Corporate Luncheons
Frank Cooper, Executive Director
MHA of Los Angeles County (California)

Combined Health Appeal in Industry
Mrs. Devy Bendit, Executive Director, Metropolitan Baltimore AMH

Corporate Solicitations
Robert Leys, NAMH National Corporate Gifts Chairman
Vice President, Allstate Insurance Company

Workshop 10 — Bequests

Empire Foyer A

Moderator:
Matthew J. Heartney, Jr., Esq.
NAMH Board Member

Resources:
Morgan West, Board Member
Pennsylvania Mental Health

Harry Rubin, Esq., Board Member
Pennsylvania Mental Health

Workshop 11 — Foundations

Empire Foyer B

Moderator:
Arnold B. Barach
Secretary, Kiplinger Foundation
NAMH Board Member

Resources:
Ms. Rosemary Plesset, Executive Director, United Mental Health, Inc. (Pittsburgh, Pa.)

William G. McFadzean, Chairman of Financial Development
Minnesota AMH

William T. Beaty, II, Secretary
Ittleson Family Foundation
(New York)

Workshop 12 **Fund Raising Planning** *Club Foyer*

Moderator:
Wilder D. Baker, Jr., Financial Development Council Massachusetts AMH

Resources:
J. E. Van Dyke, Assistant Executive Director, Pennsylvania MH

Earl W. Hildebrandt, Assistant Executive Director, Wisconsin AMH

Workshop 13 **Division Role in Assisting Chapters with Fund Raising** *Palladian Room*

Moderator:
Jack Hughes, Membership/Fund Campaign Chairman MHA in Indiana

Resources:
Joseph R. Brown, Executive Director, MHA in Indiana

George W. Sawyer, Jr., Executive Director, Maryland AMH

Workshop 14 **Motivating the Fund Raising Volunteer and Donor** *Board Room*

Moderator:
Dr. Howard Rogers, Chairman of Public Information Connecticut AMH

Resources:
John Abbott, Executive Director Connecticut AMH

Dr. Howard Rogers, Chairman of Public Information Connecticut AMH

Dr. H. LaMarr Rice, President Kansas City MHA (Missouri)

Workshop 15 **Fund Raising/Communications** *Palladian Room*

Moderator:
Percy Knauth, 1975 Mental Health Chairman

Panelists:
Joseph Goodpasture, Executive Director, North Carolina MHA

William E. Perry, Jr., Director NAMH Communications Department

7:00 p.m. - 11:00 p.m. Host City Special Event *Regency Ballroom*

Presiding:
Mrs. Alice Davis, President Washington, D.C. MHA

Dinner, Entertainment, Dancing

SATURDAY, November 23

7:00 a.m. - 8:15 a.m. Fund Raising Council Breakfast
Directors Room

8:30 a.m. - 12 noon Annual Meeting of the Membership (reconvened)
Regency Ballroom

Consideration of Resolutions and Other Business

Nominating Committee Report
William G. McFadzean,
Chairperson

Election of Officers & Directors

President's Inaugural Address
Gerridee Wheeler

See White Membership Packet for Detailed Agenda

12:00 p.m. - 12:30 p.m. Cash Bar *Blue Room*

12:30 p.m. - 3:00 p.m. Awards Luncheon *Blue Room*

Presiding
Thomas Watkins, NAMH Vice President, Organization & Development

Invocation:
The Rev. E. C. Black, Jr.
South Carolina Delegate

Presentation of Awards:
Mrs: J. Skelly Wright
NAMH Past President

Recipients of Awards:
Mental Health Bell Awards

Daily Category:
Boca Raton News, with special award to reporter **Virginia Snyder**
Boca Raton, Florida

St. Paul Dispatch and Pioneer Press
St. Paul, Minnesota

Honorable Mention:
St. Louis Globe-Democrat
St. Louis, Missouri

Radio:
WPTW
Piqua, Ohio

Honorable Mention:
KOSI
Aurora, Colorado

Katherine Hamilton Volunteer of the Year
Robert G. Melander
East Hartford, Connecticut

Special Volunteer Award
Raymond and Mary Houk
Indianapolis, Indiana

Employer of the Year Awards

Public Sector
Crownsville Hospital Center
Crownsville, Maryland

Private Sector (less than 200 employees)
Mr. Woodie's Gift Shop
St. Thomas, Virgin Islands

Private Sector (200 or more employees)

Fairchild Camera & Instrument Corporation
Mountain View, California

The Foxboro Company
Foxboro, Massachusetts

Special Recognition Award
Senator Richard S. Schweiker
Ranking Republican — Senate Health Subcommittee

3:00 p.m. - 5:00 p.m. Annual Meeting of the Membership
Regency Ballroom
(Reconvened, if necessary)

3:00 p.m. - 5:00 p.m. Open Meeting of the Board
Diplomat Room
(If Membership Meeting is not reconvened, or immediately following Membership Meeting). This special meeting will be called if there are Divisions to be considered for disaffiliation and they wish to present their points of view to the Board.

5:00 p.m. - 6:30 p.m. Finance Committee Meeting
Directors Room

5:00 p.m. - 6:30 p.m. Annual Meeting Task Force Committee *Board Room*

6:30 p.m. - 10:30 p.m. Board of Directors Dinner
Forum Room

SUNDAY, November 24

9:00 a.m. - 4:00 p.m. Board of Directors Meeting
Tudor Room

Thanks to the Washington, D.C. Division for hosting this our 1974 Annual Meeting and Mental Health Assembly. The hard work, cooperation and skills of volunteers, staff and members, including the President, Alice Davis, and Host City Chairman, Barbara Stockton, and their Hosts & Hostesses, have helped make this meeting a success.

Miss Margaret Hickey, Chairperson
1974 Annual Meeting Task Force

1974 ANNUAL MEETING TASK FORCE

Chairperson: Miss Margaret Hickey, National Board Member, Tucson, Arizona

Arnold Barach, National Board Member Washington, D.C.

D. Mitchell Cox, National Board Member Sherman, Connecticut

Mrs. Alice Davis, President, District of Columbia MHA, Washington, D.C.

Ruth Allen Fouché, Secretary, NAMH Chicago, Illinois

Matthew J. Heartney, Jr., National Board Member, Des Moines, Iowa

Carter L. Lowe, Vice President, Program, NAMH, Framingham, Massachusetts

Mrs. Franklin B. McCarty, Jr., National Board Member, Winnetka, Illinois

E. Blair Warner, Vice President, Fund Raising, NAMH, South Bend, Indiana

Arnold Webster, Executive Director, D.C. Mental Health Association, Washington, D.C.

Mrs. Gerridee Wheeler, President-elect, NAMH, Bismarck, North Dakota

HOST CITY PLANNING COMMITTEE

Chairperson: Miss Barbara Stockton
Mrs. Alexander Chase
Mrs. T. Wilkens Davis
Miss Alice T. Dodge
Mrs. Charles B. E. Freeman
Mrs. Alvin Goins
Mrs. Stanford Hicks
Mrs. Charles C. Johnson
Mrs. Joel Madison
Mrs. Robert Martin
Mrs. Wilbur Michaeux
Miss Dorothy S. Proctor
Mrs. R. Stewart Randall
Juliette M. Simmons, M.D.
Mrs. Cleveland Smith
Mrs. Margie Sneed
Mrs. John T. Stewart
Mrs. William Tompkins
Mrs. Winston Willoughby
Mr. Aubrey Zephyr

Representatives of the D.C. Alumnae Chapter of Delta Sigma Theta Sorority

D.C. Auxiliary of the National Medical Association

Representatives of the Area Mental Health Associations

OFFICERS

President
Linden E. Wheeler
Chicago, Illinois

President-elect
Mrs. Gerridee Wheeler
Bismarck, North Dakota

Vice President, Region I
Mrs. Hilda H. Robbins
Ft. Washington, Pennsylvania

Vice President, Region II
Sandford F. Brandt
Norris, Tennessee

Vice President, Region III
Clayton Droullard
Whitewater, Wisconsin

Vice President, Region IV
Warren Welliver
Columbia, Missouri

Vice President, Region V
Robert Andreen
San Diego, California

Vice President, Fund Raising
E. Blair Warner
South Bend, Indiana

Vice President, Organization & Development
Thomas H. Watkins
Austin, Texas

Vice President, Program
Carter L. Lowe
Framingham, Massachusetts

Vice President, Communications
William D. Rice
Salt Lake City, Utah

Treasurer
Arnold H. Brown
Kansas City, Missouri

Secretary
Ruth Allen Fouché, Ph.D.
Chicago, Illinois

Immediate Past President
Mrs. J. Skelly Wright
Washington, D.C.

Executive Director
Brian O'Connell
McLean, Virginia

BOARD OF DIRECTORS

Edwin E. Aldrin, Jr., ScD.
Hidden Hills, California

Alan R. Anderson
Wayzata, Minnesota

*Robert E. Andreen
San Diego, California

Mrs. Rose K. Ashin
Little Silver, New Jersey

Richard Bajus
Piqua, Ohio

*Arnold B. Barach
Washington, D.C.

Mildred M. Bateman, M.D.
Charleston, West Virginia

David G. Belton, Jr.
Winnsboro, South Carolina

*Sandford F. Brandt
Norris, Tennessee

*Arnold H. Brown
Kansas City, Missouri

Irving H. Chase
Cambridge, Massachusetts

Jerry W. Cole
Wichita, Kansas

*D. Mitchell Cox
Sherman, Connecticut

Arthur L. Cunningham
Minneapolis, Minnesota

Rabbi Matthew Derby
Knoxville, Tennessee

*Clayton Droullard
Whitewater, Wisconsin

Mrs. Helen Farabee
Wichita Falls, Texas

*Ruth Allen Fouché, Ph.D.
Chicago, Illinois

Mrs. Joseph Gershon
Tucson, Arizona

Samuel S. Goldstein
Hartford, Connecticut

Harry R. Gonzalez
Palm Beach, Florida

Richard C. Hardenbergh
Haddonfield, New Jersey

*Matthew J. Heartney, Jr.
Des Moines, Iowa

Mrs. Roy L. Hellander
Missoula, Montana

William H. Hewes, M.D.
Ypsilanti, Michigan

*Miss Margaret Hickey
Tucson, Arizona

Dale G. Higer
Boise, Idaho

James W. Hijar
Wilmington, Delaware

Miss Celeste Holm
New York, New York

John S. Hoar
Sumter, South Carolina

Harley B. Howcott, Jr.
New Orleans, Louisiana

Ralph C. Kennedy, M.D.
Fresno, California

*Mrs. Dorothy H. Knox
New York, New York

Valerie Jean Lawlor
Columbia, Missouri

Milton Leech
El Paso, Texas

Robert Leys
Northbrook, Illinois

Mrs. Beverly Long
Atlanta, Georgia

*Carter L. Lowe
Framingham, Massachusetts

Charles F. Luce
New York, New York

Frank Luther
Window Rock, Arizona

James A. Mackay
Atlanta, Georgia

Mrs. Roger Marshall
Arlington, Virginia

Walter J. Matthews
Indianapolis, Indiana

Mrs. Franklin B. McCarty Jr.
Winnetka, Illinois

*William G. McFadzean
Minneapolis, Minnesota

Mrs. Nancy P. McVey
Fayetteville, Arkansas

Mrs. Lou Melnick
Denver, Colorado

Stewart E. Meyers, Jr.
Oklahoma City, Oklahoma

Wesley J. Mooney
New York, New York

Mrs. F. Philip Nash, Jr.
Providence, Rhode Island

R. D. O'Connor
Brandon, Mississippi

Mrs. John Oliver
Montgomery, Alabama

Lorenzo Patino
Sacramento, California

Mrs. Wilbur F. Pell Jr.
Evanston, Illinois

Earl Pippin
Montgomery, Alabama

Richardson Reid, D.D.
South Dennis, Massachusetts

Robert W. Renouf
Tustin, California

*William D. Rice
Salt Lake City, Utah

*Mrs. Hilda H. Robbins
Ft. Washington, Pennsylvania

Alexander Rodriguez
Boston, Massachusetts

Harry J. Rubin
York, Pennsylvania

Roland D. Sagum, Sr.
Honolulu, Hawaii

Reuben Shiling
Baltimore, Maryland

A. Wilson Simmons, Jr.
Murray, Kentucky

Juliette M. Simmons, M.D.
Washington, D.C.

Mrs. Jeanne A. Sloan
Ft. Pierce, Florida

Willis M. Slott
Rapid City, South Dakota

Mrs. Norman Stark
Cheyenne, Wyoming

Eli Tash
Milwaukee, Wisconsin

Monte C. Throdahl
St. Louis, Missouri

Mrs. Leif Valand
Raleigh, North Carolina

Samuel Walton
New York, New York

*E. Blair Warner
South Bend, Indiana

*Thomas H. Watkins
Austin, Texas

Muriel Weeks
Export, Pennsylvania

*Warren D. Welliver
Columbia, Missouri

*Linden E. Wheeler
Chicago, Illinois

*Mrs. Gerridee Wheeler
Bismarck, North Dakota

Robert I. Winslow
Portland, Oregon

*Mrs. J. Skelly Wright
Washington, D.C.

**Executive Committee*

The National Association for Mental Health, Inc.

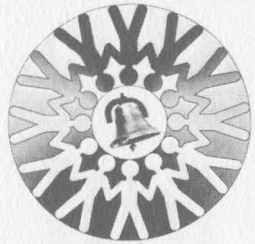
Citizens Who Make a Difference

1800 North Kent Street, Rosslyn Station
Arlington, Virginia 22209

1974 ANNUAL MEETING AND MENTAL HEALTH ASSEMBLY

NOVEMBER 20-23

Shoreham Americana Washington, D.C.



GERALD R. FORD LIBRARY

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Program Workshop Registration Form

Thursday, November 21, 1974
3:30-5:30 P.M.

Please indicate your first three preferences for Program Workshops. Your first choice should be indicated by a #1, second choice, #2, and third choice, #3. Attendance is limited to provide maximum discussions. Only if your first choice has reached capacity will you be notified that you are assigned to a second or third choice.

1. The Why and How of CMHC Site Visitations ___
2. An Integrated Mental Health Care Delivery System: Defining Responsibility and Accountability for Patient Care ___
3. Mental Hospital Patients and the Fair Labor Standards Act ___
4. Insurance for Mental Health ___
5. Litigation as a Means of Achieving Mental Health Program Goals ___
6. The Community Mental Health Center as a System for Prevention ___
7. Are Mentally Ill Children Receiving the Education to Which They Are Entitled ___
8. Multi-Lingual Mental Health Services ___
9. A Look at the California Mental Health Delivery System ___

Mail to: **Program Department**
National Association for Mental Health
1800 N. Kent Street
Arlington, Virginia 22209

Name _____

Address _____

_____

Organization Workshop Registration Form

Thursday, November 21, 1974
3:30-5:30 P.M.

Please indicate your first three preferences for Organization Workshops. Your first choice should be indicated by a #1, second choice, #2, and third choice, #3. Attendance is limited to provide maximum discussions. Only if your first choice has reached capacity will you be notified that you are assigned to a second or third choice.

1. Training Nominating Committees ____
2. Accounting, Internal Controls, Audits ____
3. Hiring and Retaining Staff ____
4. Building Relationships with the News Media ____
5. Planning Effective Board and Committee Meetings ____
6. Developing Effective Chapter Annual Meetings ____
7. Establishing Program & Organizational Priorities ____

Mail to: **Organization & Development Department**
National Association for Mental Health
1800 N. Kent Street
Arlington, Virginia 22209

Name _____

Address _____

_____

Fund Raising Workshop Registration Form

Friday, November 22, 1974
2:45 P.M.-5:00 P.M.

Please indicate your first three preferences for Fund Raising Workshops. Your first choice should be indicated by a #1, second choice, #2, and third choice, #3. Attendance is limited to provide maximum discussions. Only if your first choice has reached capacity will you be notified that you are assigned to a second or third choice.

1. United Fund Cultivation (Urban) ____
2. United Fund Cultivation (Suburban) ____
3. Division/United Fund Cultivation ____
4. Membership Recruitment ____
5. Special Events ____
6. Rural Campaigning ____
7. Doorbell Ringer Campaign & Alternatives ____
8. Small Business, Block Solicitation & Specialized Mailings ____
9. Commerce & Industry ____
10. Bequests ____
11. Foundations ____
12. Fund Raising Planning ____
13. Division Role in Assisting Chapters With Fund Raising ____
14. Motivating the Fund Raising Volunteer and Donor ____
15. Fund Raising/Communications ____

Mail to: **Fund Raising Department**
National Association for Mental Health
1800 N. Kent Street
Arlington, Virginia 22209

Name _____

Address _____

_____

I will be attending the Caucus on Minority Concerns at the 1974 Annual Meeting on Wednesday, November 20, from 4:30-6:30

Name: _____
(Please Print)

Chapter/Division _____

_____

Please check one: Staff _____ Volunteer _____

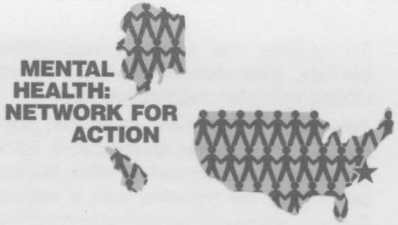
This is my first Annual Meeting: Yes ____ No ____

Address _____

_____

Phone: _____

ah _____



REGISTRATION FORM

National Association for Mental Health
1974 Annual Meeting and Mental Health Assembly
November 20-23, 1974/Washington, D. C.

NAME

(Please Print Name to Appear on Badge)

ADDRESS

CITY STATE ZIP

ORGANIZATION

CAPACITY AT MEETING:

- Voting Delegate to Membership Meeting ☐
- National Board Member ☐
- Program Participant ☐
- Mental Health Association Member ☐
- MHA Staff ☐
- Other (_____) ☐

☐ Please check if this is your first Annual Meeting

ADDRESS DURING MEETING

See Other Side For Advance Registration Savings On Registration And Meals

1974 NAMH ANNUAL MEETING AND MENTAL HEALTH ASSEMBLY

Please enclose a check payable to NAMH Annual Meeting for registration fee and cost of meals checked below. If one check is made out for several persons, please make certain that a complete card is forwarded for *each* person.

If you do not have an official hotel reservation card, check here ☐

To receive the advance registration savings, your remittance must be enclosed with your registration form.

Advance registration must be postmarked no later than November 4, 1974. Registrations postmarked after November 4 may be returned with a request that you register upon arrival in Washington, D. C.

	Advance Registration	At Meeting Cost
Registration Fee for Entire Meeting	$10.00 ☐	$12.00 ☐
(One Day Registration Fee May be Paid at Meeting — $4.25)		
Wed. Nov. 20 Opening Dinner	10.75 ☐	11.75 ☐
Thurs. Nov. 21 Division Delegate Caucus Breakfast	3.25 ☐	3.75 ☐
Thurs. Nov. 21 Prevention Luncheon	9.25 ☐	10.00 ☐
Thurs. Nov. 21 Research Dinner	13.75 ☐	14.75 ☐
Fri. Nov. 22 Eye Opener Breakfast Conversations	3.25 ☐	3.75 ☐
Fri. Nov. 22 Mental Health Fund Raising "Kick-Off" Luncheon	9.50 ☐	10.25 ☐
Fri. Nov. 22 Host City Special Event	15.00 ☐	16.00 ☐
Sat. Nov. 23 Awards Luncheon	9.25 ☐	9.75 ☐
Total Registration Package	$84.00 ☐	$92.00 ☐

Mail TODAY to The National Association for Mental Health, 1800 N. Kent Street, Arlington, Virginia, 22209

Total amount enclosed $_____

Memorandum

October 18, 1974

TO: Voting Membership

FROM: Linden E. Wheeler, President

SUBJECT: AGENDA AND ATTACHMENTS FOR THE ANNUAL MEETING OF THE MEMBERSHIP TO BE HELD THURSDAY, FRIDAY AND SATURDAY, NOVEMBER 21, 22 & 23, 8:30 A.M. TO 12:00 NOON EACH DAY AT THE SHOREHAM AMERICANA HOTEL, WASHINGTON, D.C.

Enclosed is the Agenda with related materials for our Annual Membership Meeting which will begin on Thursday, November 21, at 8:30 a.m. in the Regency Ballroom of the Shoreham Americana Hotel, 2500 Calvert Street, N.W., Washington, D.C.

To provide maximum opportunity for consideration and debate of the issues, the Membership Meeting will again be held in three segments: Thursday, Friday and Saturday mornings from 8:30 a.m. to 12:00 noon. I've taken the liberty of suggesting a very rough timetable to help guide us. I hasten to indicate that this will be as flexible as the Membership wishes.

We do have several major action items on the Agenda. I would like to call particular attention to the Report of the Ad Hoc Committee on Unity and Standards which is included in the Rear Pocket and is the culmination of two years' work by that Committee. Although the Report does not come up for official action this year, we are hopeful that the Membership will study the report in advance of the meeting and come prepared to react when it is presented on Friday.

I hope most of you can be on hand for the opening dinner Wednesday night, November 20, when Elliot Richardson will be the Keynote Speaker.

We urge everyone who is attending the Annual Meeting to try to arrange to have your Congressmen attend the opening dinner with you. If they cannot attend the Wednesday evening dinner, then we hope they can be present for one of the other luncheons or dinners. We will have an arrangement by which all of the Congressmen who are present at each function can be introduced. We've asked the Division President and Executive Director to coordinate the contacts, particularly with the Senators. Renewal of the community mental health center legislation and funding for CMHCs are two major issues likely to be under active consideration by Congress at that time. If your Congressman can't come to one of the functions, please arrange an appointment with him to present your arguments for renewal of the Community Mental Health Center Act and funding for it. To help in your contacts we will have a public affairs information desk in the lobby of the hotel.

It will be good to see you in our Capitol city.

LEW:nm

--over--

GERALD R. FORD LIBRARY

Some of you may be concerned that we are forwarding this packet by First Class mail. We have found, however, that Third and Fourth Class mail often takes as long as 10 days to 2 weeks to reach its destination. Because we have already worked so hard to be sure that we could get the materials to you for advance study and consultation, we believe it is an important and justifiable expense to be sure you have the benefit of this advance preparation.

LIST OF VOTING MEMBERSHIP
(As of October 10, 1974)

The numbers in parentheses refer to the authorized number of Delegates for each state. The number is determined according to several factors, including population and financial support.

ALABAMA (6)

Kidd, Mrs. Alice
Pippin, Earl
Solomon, Mrs. Adele
Weeks, Barney
Wells, Henry

ARIZONA (5)

Gershon, Mrs. Joseph
Glass, Dr. John
Janavitz, David M.
Janavitz, Mrs. David M.
Sewell, Mrs. Charles T., Jr.

ARKANSAS (5)

Greer, Mrs. Wilma
McKeever, Mrs. Esther
McVey, Mrs. Nancy
Sain, David

COLORADO (6)

Allen, C. Kay
Gaylord, Mrs. Charles
Lane, Fred O.
Litz, Mrs. John
Melnick, Mrs. Lou
Peaker, Mrs. Howard

CONNECTICUT (6)

Cromwell, Mrs. Margaret
Egan, Daniel J.
Kohn, Mrs. Albert
Rogers, Howard S.
Wilson, Mrs. Margaret
Zaluda, Jack

DELAWARE (5)

Bradford, William
Gates, Joseph E., II

DISTRICT OF COLUMBIA (5)

Braddock, Mrs. Juanita
Davis, Mrs. Alice
Johnson, John L., Ed.D.
Simmons, Juliette, M.D.
Weibusch, Herman

FLORIDA (8)

Ariko, Mrs. John
Benjamin, Frank
Creel, Frank L., M.D.
Gibson, Rev. Theodore
Herndon, Mrs. Richard
Madden, John W.
McGee, Mrs. Jan
Miller, Wesley

GEORGIA (7)

Callaway, Bob
Denny, Willis P.
Law, Rev. John
Letson, Rev. Samuel H., Jr.
Segal, Mendel
Thomas, Rev. Dan R., Jr.
Woodruff, Dr. Marguerite

HAWAII (7)

Fiske, Robert W.

IDAHO (5)

Hubler, Sharon
Loening, Marilyn
Scudder, Brad
Webb, LaDonna
Weyen, Daryl

INDIANA (11)

Howard, Mrs. Phyllis
Peters, Mrs. Barbara
Pitz, Paul G.
Smith, Mrs. Laurence
Smith, Mrs. Wilanna
VanderMast, Adrian C.
Vaughn, Gene
White, Charles H.

IOWA (6)

KANSAS (6)

Carder, Gerald M.
Goodman, Jack D.
Gray, Charles E.
Marshall, Mrs. J. Ralph
Smoot, Leroy
Vernon, Mrs. C. A., Jr.

KENTUCKY (6)

Baron, Mrs. Charlet
Fischer, Carl, Jr.,
Petry, Mrs. Joan A.
Schmidt, Mrs. Craig
Smith, Judge Macauley
Stith, Jack B.

LOUISIANA (6)

Danti, Dr. August
Flanders, Dudley

LOUISIANA (cont'd)

Johnson, Mrs. Gertrude
Matheny, Thomas H.
Mills, Rev. Keith
Purcell, Dr. Ken

MARYLAND (7)

Gisselbeck, The Rev. Loren
Grimm, Mr. Karl
Gruber, The Very Rev. Henry T.
Hill, Mrs. T'jon N.
Schuster, Arnold P., Esq.
Shiling, Reuben, Esq.
Van Sickle, Mrs. Max

MASSACHUSETTS (7)

Baker, Wilder D., Jr.
Lavan, Spencer
Mahoney, Charles F.
Rawlins, Mrs. Elizabeth
Rubin, Mrs. Barbara

MICHIGAN (10)

Capek, Mrs. C. A.
Carron, Dean P., M.D.
Denise, Malcolm
Eisenach, Richard C.
Frost, Jerrold A., Jr.
McBain, Mrs. Robert J.
Roark, Mrs. Mayford L.
Stack, Jack M., M.D.
Stasiak, Mrs. Edward
Upton, David F.

MINNESOTA (6)

Givens, Archie, Jr.
Klingle, Jane
Krause, Babette
Schotzko, Judy
Sinex, Robert
Westrom, John

MISSISSIPPI (6)

MISSOURI (7)

Cope, Anne B.
Mitchell, Mrs. Mary Jane
Mitchell, William
Rice, Dr. H. Lamarr
Thiel, John E.
Thompson, Warren A.
Welliver, Warren

MONTANA (5)

Ashton, Mrs. Doug
Leuthold, Mrs. Grace
McFadden, Mrs. LaVerna
Riese, Dr. Harlan
Van Arsdale, Mrs. Eva

NEW JERSEY (8)

DeGross, Mrs. Joseph
Ellis, Joel
Emile, Philip, Jr.
Grant, Robert
Hallinan, Richard J.
Jaksch, Mary G., M.D.
Rudner, Mrs. Campbell
Wilson, Carol Ann

NORTH CAROLINA (7)

Cranor, Mrs. Betty
Edwards, Jack
Honeycutt, Chester
McMillan, Mrs. Angie
Stancil, M. W.
Twiggs, Howard F.

NORTH DAKOTA (7)

Bachmeier, Father Willibrord O.
Davick, Rev. Wade E.
Knutson, Mrs. Gilman
Leehan, Mrs. Leo
Miller, Herbert E.
Schoregge, Mrs. Robert
Svedjan, Kenneth D.

OHIO (5)

Bajus, Richard
Foster, Mrs. Lucy
Glaesner, Rev. Kay M.
Headington, Mrs. Shirley J.
Jones, Mary L.

OKLAHOMA (6)

Dudgeon, Mrs. Gleason
Earnest, Mrs. Gene F.
Fuller, Col. Leonard H.
Joyce, J. C.
McLeod, Mrs. Robert
Powers, Ronald L.

OREGON (6)

PENNSYLVANIA (11)

Atwell, Howard
Calloway, Mrs. Anna Belle
Camp, William P., M.D.
Mann, William M., Jr., M.D.
McGrath, Mrs. Joseph
Miller, Stanley A.
Nelson, Aaron
Patton, Robert F., Esq.
Santorum, Aldo, Ph.D.
Spilman, Mrs. William
West, Morgan L., Jr.

RHODE ISLAND (5)

Hoffer, Otto
McLean, Diana
Nash, Mrs. F. Philip, Jr.
Schechter, David
Walker, Mrs. Leonard

SOUTH CAROLINA (6)

Black, Rev. E. C., Jr.
Hardie, Dr. Virginia S.
Harvin, C. Alex, Jr.
McLeod, Mrs. Daniel R.
Mustard, Allan C.
Wall, E. Craig, Jr.

SOUTH DAKOTA (5)

Gemmell, Bud
Hadrick, Rev. Donald
Ham, Arlene
Hunter, Rev. Wes
Larson, Betty

TENNESSEE (7)

Binkley, Thomas C.
Browning, Mrs. Helen
Hoffman, Herbert
Russell, Mrs. Betty
Wallace, Mrs. Carl
Weber, Mrs. Harry C.
Vaden, Mrs. Farris

TEXAS (11)

Blaylock, Lloyd
Brunson, Howard
Caldwell, Tom J., Jr.
Chrisman, Judge Oswin
Ewing, John Kirby
Ewing, Virginia
Marsters, Mrs. Pollard
Pinkett, Mrs. Carole A.
Ransone, W. R.
Roddy, Mrs. P. E.
Watkins, Sally M.

UTAH (7)

Ashton, Conway A.
Hummel, John O.
Jensen, Carlyle
Reid, Evan
Rice, William D.

VIRGINIA (6)

Davies, Rev. Lawrence A.
Desper, Meryl
Kinnier, Mrs. Edgar O., Jr.
Lampe, Henry
Overton, W. C.
Sheusi, Charles V.

WISCONSIN (7)

Blum, LaVon M.
Bouman, James
Ott, Rev. Lester A.
Pitz, Mrs. G. M.
Markert, David Ph.D.
Witt, Mrs. Judith

WYOMING (5)

Haines, David
Hathaway, Mrs. Stan
Howard, Mrs. Ross
Hickey, Mrs. J. J.
Stark, Mrs. Norman

The National Association for Mental Health, Inc.

ANNUAL MEETING OF THE MEMBERS
Regency Ballroom
Shoreham Americana Hotel
2500 Calvert Street, N.W.
Washington, D.C.

8:30 a.m. - 12:00 noon, Thursday, November 21, 1974
8:30 a.m. - 12:00 nooon, Friday, November 22, 1974
8:30 a.m. - 12:00 noon, Saturday, November 23, 1974

* * * * *

The Official Role of the Membership is Described in Attachment #1

Front Pocket Items Include:
Current List of Voting Delegates
Copy of the Full Program for the Annual Meeting
Annual Report of the Board of Directors

Rear Pocket Items Include:
Basic Chart of Motions (Parliamentary Procedures)
Report of the Ad Hoc Committee on Unity and Standards

Starred Items (*) Require Action

CHAIRMAN: Linden E. Wheeler, President, NAMH

THURSDAY, NOVEMBER 21
8:30 A.M. - 12:00 NOON, REGENCY BALLROOM

Suggested Timetable		
8:30 a.m.	1. INVOCATION	*Rev. Lawrence A. Davies*
8:35 a.m.	2. WRITTEN REPORT ON IMPLEMENTATION OF RESOLUTIONS AND OTHER BUSINESS PASSED AT LAST YEAR'S MEMBERSHIP MEETING (ATTACHMENT #2)	*Dr. Ruth Allen Fouche, Secretary*
8:45 a.m.	3. FINANCIAL REPORT (ATTACHMENT #3)	*Arnold Brown, Treasurer*

8:55 a.m.	4.	EXPLANATION AND QUESTIONS TO CLARIFY THE RESOLUTIONS AND OTHER ISSUES WHICH ARE BEFORE THE MEMBERSHIP THIS YEAR (ATTACHMENT #4 contains the policies governing submission of resolutions)	*Mr. Wheeler & Hon. Charles Mahoney, Chairman of the Resolutions Committee*
9:10 a.m.	* 5.	PROPOSAL TO PROVIDE SOME VOTING PRIVILEGES FOR AFFILIATES OPERATING AS "STATE COMMITTEES" (ATTACHMENT #5)	*Thomas Watkins, VP for Organization and Development*
9:20 a.m.	6.	ANNUAL REPORT OF THE BOARD OF DIRECTORS AND PRESIDENT'S FINAL REPORT The By-Laws stipulate that the President, on behalf of the Board of Directors, shall make an annual report to the Members. For the past several years this has been a written report, providing the Delegates with a document for reporting to Division Boards and Chapters. The 1974 Report is in the Front Pocket. Attached to the Report are the Position Papers adopted since the last Annual Meeting.	*Mr. Wheeler*
9:30 a.m.	* 7.	RECOMMENDED POLICY ON THE NATIONAL BOARD'S USE OF GOVERNMENT FUNDS (ATTACHMENT #6) Please note that the proposed policy would apply only to the National level of the Association.	*Irving Chase, Ch. of Public Affairs Committee*
9:50 a.m.	8.	DISCUSSION OF WHETHER THE ASSOCIATION SHOULD ADOPT A POLICY ON USE OF GOVERNMENT FUNDS BY DIVISIONS & CHAPTERS	*Mr. Chase*
10:15 a.m.	B R E A K		
10:30 a.m.	* 9.	DETERMINATION OF THE 1975 NATIONAL PUBLIC AFFAIRS PROGRAM (ATTACHMENT #7) Because the influence of all Members and Divisions and Chapters is so essential to the successful pursuit of the National Public Affairs Program, the full Voting Membership participates in determining what the program shall be.	*Hilda Robbins, Ch. of the 1975 Public Affairs Committee*

10:50 a.m. 10. SPECIAL REPORT OF THE COMMITTEE ON MENTAL HEALTH SERVICES FOR ETHNIC MINORITIES AND THE POOR — *Dorothy Knox, Ch. & Ralph Kennedy, M.D.*

a. Progress Report on Increasing Representation within the Association

b. Review and Discussion of the Award Winning Documentary Film "Eye of the Storm"

The Voting Members Meeting will recess at noon. Please refer to the printed program for information about the luncheon and the afternoon and evening programs.

FRIDAY, NOVEMBER 22
8:30 A.M. - 12:00 NOON, REGENCY BALLROOM

Annual Meeting of the Members Reconvened

8:30 a.m. 11. SPECIAL REPORT ON THE CRISIS IN MANY STATES BROUGHT ABOUT BY LACK OF COMMUNITY PREPAREDNESS FOR HANDLING DISCHARGED PATIENTS AND OTHER INCREASED SERVICE EXPECTATIONS — *Jeanne Sloan*

What lessons are we learning?

9:15 a.m. * 12. RECOMMENDED BY-LAWS CHANGES — *Dr. Fouché*

* a. To Allow for Meetings of the Executive Committee at Time of Board and Annual Meetings (ATTACHMENT #8)

* b. To Limit the Term of President to One Year (ATTACHMENT #9)

Please note that this proposed change should be brought up in conjunction with the related Massachusetts Resolution which appears next on the agenda.

	* 13.	RESOLUTION FROM MASSACHUSETTS TO CHANGE THE BY-LAWS TO PROVIDE THAT THE PRESIDENT MAY SERVE TWO ANNUAL TERMS IN THAT OFFICE (ATTACHMENT #10)	*Mr. Mahoney & Rep. from Mass.*
9:40 a.m.	* 14.	CONSIDERATION OF GEORGIA RESOLUTION TO DEVELOP A COMPREHENSIVE PUBLICATION TO BETTER INFORM OUR MEMBERS (ATTACHMENT #11)	*Mr. Mahoney & Beverly Long*
9:50 a.m.	* 15.	CONSIDERATION OF MISSOURI RESOLUTION TO EXPAND OUR POLICY ON NONDISCRIMINATION TO INCLUDE SEX AND AGE AS WELL AS RACE, COLOR AND CREED (ATTACHMENT #12)	*Mr. Mahoney & John Thiel*
9:55 a.m.	* 16.	CONSIDERATION OF MASSACHUSETTS RESOLUTION ON DEINSTITUTIONALIZATION AND COMMUNITY BASED TREATMENT (ATTACHMENT #13)	*Mr. Mahoney & Rep. from Mass.*
10:10 a.m.	* 17.	CONSIDERATION OF ALABAMA RESOLUTION FOR STUDY AND REPORT ON PLEA "NOT GUILTY BY REASON OF INSANITY" (ATTACHMENT #14)	*Mr. Mahoney & Earl Pippin & Henry Wells*
10:25 a.m.	18.	PRESENTATION OF SPECIAL CITATIONS	*Gerridee Wheeler*
10:30 a.m.	B R E A K		
10:45 a.m.	19.	EXECUTIVE DIRECTOR'S REPORT	*Brian O'Connell*
11:00 a.m.	20.	REPORT OF AD HOC COMMITTEE ON UNITY AND STANDARDS (Rear Pocket) While the Report is not before us for action, our reaction is very necessary. If the Members seem generally favorable to some parts of the Report, the Board will move ahead to prepare appropriate recommendations for action by the Membership in 1975. If we need more time to consider the Report, we'll return to it first thing Saturday morning.	*Milton Leech, Ch. & Members of the Committee*

The meeting will again recess until Saturday morning at 8:30. Please refer to the printed program for information on Friday noon, afternoon and evening programs.

SATURDAY, NOVEMBER 23
8:30 A.M. - 12:00 NOON, REGENCY BALLROOM

Annual Meeting of the Members Reconvened

8:30 a.m.	20.	(continued) FURTHER DISCUSSION OF THE REPORT ON UNITY & STANDARDS	
9:00 a.m.	* 21.	CONSIDERATION OF THE MASSACHUSETTS RESOLUTION ON THE ROLE OF THE RESOLUTIONS COMMITTEE (ATTACHMENT #15)	*Mr. Mahoney & Rep. from Mass.*
9:20 a.m.	* 22.	CONSIDERATION OF INDIANA RESOLUTION ON DIRECT PATIENT SERVICE VOLUNTEERS (ATTACHMENT #16)	*Mr. Mahoney & Gene Vaughn*
9:40 a.m.	* 23.	CONSIDERATION OF THE NEW JERSEY RESOLUTION ON THE RELATIONSHIP OF DIRECT SERVICES TO SOCIAL ACTION (ATTACHMENT #17)	*Mr. Mahoney & Philip Emile*
10:00 a.m.	24.	FINANCIAL RELATIONSHIPS MATTERS	*Mr. Watkins*
		a. Report on Compliance with the Financial Support Policy (ATTACHMENT #18)	
		* b. Recommended Authorization Level for Assessment of Divisions in 1976 (ATTACHMENT #19)	
10:15 a.m.	B R E A K		
10:30 a.m.	25.	PRELIMINARY DISCUSSION OF NEW FIVE YEAR GOALS FOR 1976-80 (ATTACHMENT #20)	*Mr. Wheeler*
10:50 a.m.	26.	THE ASSOCIATION'S AUDIO VISUAL RESOURCES - INCLUDING THE 1975 RADIO AND TV SPOTS	*William Rice, VP for Communications*

11:15 a.m.	* 27.	NOMINATING COMMITTEE REPORT (ATTACHMENT #21)	*William McFadzean, Chairman*
		a. Election of Delegate Board Members	
		b. Election of Directors-at-Large	
		c. Election of Officers	
11:25 a.m.	28.	INSTALLATION OF OFFICERS	*Mr. Wheeler*
11:30 a.m.	29.	PRESIDENT'S INAUGURAL ADDRESS	*Gerridee Wheeler*
	30.	OTHER BUSINESS	

Please refer to the printed program for information about the Awards Luncheon.

ROLE OF THE MEMBERSHIP

Article II, Section 2 of the By-Laws, specifies the Role and Authority of the Membership.

"Section 2. Authority of the Membership. In furtherance and not by way of limitation of the authority of the Membership, and notwithstanding anything in the By-Laws to the contrary:

(a) Resolutions relating to any of the matters specified in paragraph 6 of the Corporation's Restated Certificate of Incorporation must be submitted to the Voting Members at least 30 days in advance of the Annual Meeting of the Membership. The Board shall have the right to advise the Voting Members on such matters, but the decisions of the Voting Members shall be final.

For ease of reference, Paragraph 6 says: 'For the management of the business and for the conduct of the affairs of the Corporation, and in further definition, limitation and regulation of the powers of the Corporation and of its Directors and Members, it is further provided that, notwithstanding anything in the Corporation's By-Laws to the contrary, the Membership shall have final authority on all matters governing:

(i) Standards of Division Affiliation and Recommended Minimum Standards for Chapters;

(ii) Financial Relationships Policy;

(iii) Financial Relationships Authorization Levels;

(iv) Amendments to By-Laws;

(v) Amendments to Certificate of Incorporation;

(vi) Size of the Board of Directors;

(vii) Election of the Board of Directors;

(viii) Election and Removal of Officers;

(ix) Matters other than those stated in subparagraphs (i) through (viii) above which have been approved by the Membership subject to the concurrence of the Board of Directors, in which the Board does not concur, and which have then been reapproved by the Membership.'

(b) Resolutions on matters other than those referred to in paragraph (a) of this Section 2 which are adopted by the Members shall be adopted subject to concurrence by the Board of Directors, except as provided in paragraph (1) below. If the Board does not concur with any resolution, that resolution and the Board's reasons for not concurring will be reported to the Voting Members of record and to the Divisions, and will be presented at the next Annual Meeting of the Membership (with a 30-days' notice required

on all major business coming before the Membership). If the Membership then adopts the same resolution, the resolution shall become effective without the concurrence of the Board of Directors. If, upon resubmission, the Voting Membership passes the resolution, but with amendments, this shall not constitute the 'same resolution' and the action of the Voting Members would require Board concurrence.'

(1) However, if a resolution has been identified and labeled as an 'Emergency Resolution' by its proponents prior to its submission to the Voting Membership, and if it is adopted by a four-fifths vote of the Members voting present, in person or by proxy, it shall be carried into effect by the National Board of Directors forthwith.

(c) In order to carry out the intent of the foregoing paragraphs, the following practices shall be adhered to:

(1) Resolutions on major matters affecting policies or the major directions of the Corporation must be submitted to the Corporation by a Division's Board or by at least five Voting Members of record sixty (60) days before the Annual Meeting;

(2) Such resolutions must in turn be submitted to the Voting Members and to the Divisions at least thirty (30) days before the Annual Meeting;

(3) Notwithstanding the foregoing, by a two-thirds vote of the Members present, in person or by proxy, any written resolution, except one involving a change in the Certificate of Incorporation or By-Laws, may be considered at the Annual Meeting;

(4) Memorials, commendations, recommendations for study and other such less significant resolutions may be submitted during the Annual Meeting of the Membership by a majority vote of the Members present;

(5) The Board shall have the right to advise the Voting Members on any resolution proposed to be submitted to the Annual Meeting. On the basis of its view of the significance of the matters at hand, the Board will:

i. Meet in October, prior to the Annual Meeting;

ii. Meet immediately before and at the same location of the Annual meeting; or

iii. Assign consideration of the proposed resolutions to the Executive Committee.

(6) The President shall report to the Membership in writing at least 30 days in advance of the following Annual Meeting, on the Board's implementation of all resolutions which were passed at the preceding Annual Meeting."

Though the above quotation carries that which is officially the responsibility of this Membership, Article VII, Section 2, National Mental Health Assembly is worthy of review:

> "Section 2. National Mental Health Assembly. At the same time and place as the Annual Meeting, or such other time and place as shall be decided upon by the Board of Directors, the Corporation shall convene a Mental Health Assembly, open to all persons interested in Mental Health. The purpose of said assembly shall include the examining and evaluation of the overall program of the Corporation and its Affiliated Organizations; to share and exchange with each other experiences with respect to program and administrative operation of the Corporation and its Affiliated Organizations; to exchange ideas and attitudes respecting the focus of the Mental Health Program for the ensuing year; and to assess the gains in the field of Mental Health and improvement in the care and treatment of the mentally ill. Such conference is considered a basic need in the performance of the functions of the Corporation. It shall be the responsibility of the Voting Delegates who shall have been designated under Article II, Section 1, Subsection (a) to participate in the Mental Health Assembly and to report back to their Affiliated Organization.

REPORT ON IMPLEMENTATION OF RESOLUTIONS AND OTHER BUSINESS PASSED AT THE 1973 MEMBERSHIP MEETING

1. By-Laws Change

   a. Action of the Membership

   The Nominating Committee's recommendation was accepted calling for the removal of Directors with poor attendance records.

   b. Follow-through

   Article IV, Section 6, was amended with the following addition: "A Director who misses three consecutive Board meetings will automatically be dropped unless the Board acknowledges special circumstances and votes forgiveness."

   This statement appears in the NAMH By-Laws as amended November 16, 1973. The resignations of two Directors were accepted by the Board during 1974 as a result of this By-Laws change.

2. Authorization Level for Assessment of Divisions in 1975

   a. Action of the Membership

   The Membership amended the proposal submitted by the Organization and Executive Committees calling for a 1975 Full Support Obligation of $1,700,000, and a Minimum Obligation of $1,300,000.

   The amended version adopted by the Membership is as follows: Full Support Obligation, $1,775,000; Minimum Obligation, $1,225,000.

   b. Follow-through

   All Divisions were notified by the National Office of their financial obligations for 1975 as authorized by the Membership.

3. Amendment to Financial Support Policy

   a. Action of the Membership

   The Membership approved the recommendation of the Organization and Executive Committees, calling for distribution of funds solicited by NAMH. The policy now calls for the following distribution of funds:

   "Divisions at Full Support: remit the full amount (90%) to the Divisions.

"Divisions at or above Minimum Obligation: Remit half (45%) of the net amount (90%) to the Divisions and credit half (45%) towards the Division's Full Support Obligation."

b. Follow-through

The above policy has been adhered to in the distribution of National Funds.

4. Resolution Calling for NAMH to Provide Greater Efforts to Help Divisions and Chapters to Achieve Coordinated Mental Health Services

a. Action of the Membership

The Connecticut Resolution pointed out that, in most states and communities, there was a lack of coordination among mental health services. This is particularly apparent in the lack of effective relationships between those centers which have been established and the state hospital system. Recognizing that this is a general problem, the Membership approved a Resolution which concluded: "NAMH to examine the issues and, within its resources, develop a program to assist Chapters and Divisions in more effectively integrating coordinated existing mental health services of every type and in establishing a comprehensive system of community-oriented mental health services through social action."

b. Follow-through

A "portfolio" on "Unified Delivery Systems" was created within the Public Affairs Committee. The person handling that portfolio, Jeanne Sloan, of Florida, will make a special report to the 1974 Membership Meeting. She participated in a special seminar on closing of state hospitals and assisted in a Staff Institute seminar designed to develop a paper on "The Integration of Mental Health Services." Her report in Washington will help summarize the problem and the lessons which are being rapidly learned.

5. Resolution Calling for Greater Efforts to Remove Employment Discrimination Based on Prior Treatment

a. Action of the Membership

The Pennsylvania Resolution mandating greater efforts to remove employment discrimination based on prior treatment was passed by the Membership.

b. Follow-through

Success was finally achieved in getting the U. S. Civil Service to remove from its job application forms the question pertaining to a history of

mental illness. This has provided tremendous impetus to achieving similar results with other employers and governmental agencies.

7. Resolution Proposing that National Sponsor a National Conference on Prevention

a. Action of the Membership

The Colorado Resolution, which proposed that National sponsor a national conference on prevention, was amended by the Membership to call for an ad hoc committee to explore the feasibility of such a conference, including costs, outside support and logistics.

b. Follow-through

In compliance with the Colorado Resolution, an Ad Hoc Committee was appointed by the President, headed by Mrs. J. Skelly Wright. Others on the Committee were C. Kay Allen; Ralph Kennedy, M.D.; Thomas Matheny (represented by Garic Baringer); Richardson Reid; Muriel Weeks; David Ziegenhagen; and Carter Lowe (ex-officio), as Vice President for Program.

Interpreting the underlying intent of the Resolution to be the achievement of increased emphasis in the prevention of mental illness and the promotion of mental health, the Ad Hoc committee devoted its attention to how this might be best accomplished through the conference process referred to in the Resolution and whether such an undertaking might be feasible.

Recognizing the advantages of systematic effort as contrasted to random programs, the Committee concentrated its attention on development of the Community Mental Health Center as a system not only for service delivery but also for prevention.

The Committee further concluded that regional conferences rather than a national conference would be the preferred approach wherein CMHCs would be influenced and equipped to give greater and more effective attention to preventive efforts.

At the suggestion of the Committee, the Chairman approached Dr. Bertram Brown, Director of the National Institute of Mental Health, to ascertain his reactions to the proposed series of conferences. His response was highly favorable, indicating that it had always been the position of NIMH that the CMHC should be a prevention system. Dr. Brown also gave indications that financial support would be seriously considered at least for a pilot effort in one or two regions where the conference model could be tested and prepared for use in all regions.

Further exploration with selected Center staff leadership revealed not only a readiness but an eagerness to participate in this kind of effort to increase the focus of Centers on prevention. Attention would be directed to the responsibility of the Centers to comprehend the demographic

nature of their catchment areas, to identify populations at risk, and to develop appropriate interventions to reduce unbearable stresses in such populations.

Staff approaches made to the National Council of Community Mental Health Centers ascertained the readiness of that important organization to serve as a co-sponsor of the proposed conferences, and also to participate actively in the planning and implementation.

It can, therefore, be concluded that regional conferences of the sort described appear to be feasible. Regional conferences to develop systematic prevention effort is a valid concept, there appears to be a readiness on the part of the significant parties to participate, crucial co-sponsorship can be secured, and funds to cover staff and other costs may be available.

Additionally, through the efforts of the Ad Hoc Committee, prevention was adopted as the primary focus for the Program Luncheon at the 1974 Annual Meeting, with special awards to be given to Dr. Lloyd Rowland, recognizing Pierre the Pelican's 25th year of service to new parents, and to Jane Elliot, for her unusual efforts with elementary school children in the recognition and handling of prejudice. Dr. Bertram Brown was also invited and agreed to participate as the principal speaker at the Program Luncheon on the subject "The Community Mental Health Center as a System for Prevention." Finally, one of the Annual Meeting Program Workshops was designed to explore the same subject.

Responsibility created by the Colorado Resolution has not yet been fully discharged. Its effect is long-range, but a clear course of action has been devised and is in the process of implementation.

8. Resolution Opposing Unrestrained Experimentation with Children, Patients and Prisoners

a. Action of the Membership

The D. C. Resolution called for the development of a position paper to be referred to the Board of Directors in February.

b. Follow-through

Position paper was presented to the Board at its February meeting, at which time the Board referred it back to the writers for redrafting and resubmission at the June Board meeting.

The paper was again presented to the Board at its June meeting at which time it was approved.

The full position paper appears in the Board of Directors Report to the Membership (front pocket).

9. Resolution Opposing the Collection, Storage and Use of Psychological and Personal Data on Individuals Except for Limited, Confidential, Professional, Diagnostic, Prescriptive and Treatment Purposes

a. Action of the Membership

The District of Columbia Resolution opposing the collection, storage and use of psychological and personal data on individuals except for limited, confidential, professional, diagnostic, prescriptive and treatment services was referred to the Board of Directors with the instruction that a position paper should be voted by the Board in February.

b. Follow-through

A proposed position paper was presented to the Board at both the February and June meetings. With the concurrence of the sponsors and authors, the Board called for redrafting.

In October, the Executive Committee, acting for the Board, approved the statement which appears in the Board of Directors Report to the Membership in the Front Pocket of the Membership Agenda.

10. Consideration of the Membership's Role in Approving Position Statements

a. Action of the Membership

In 1972, in considering the Report on Roles and Representation, the Membership asked for a report dealing with possible transfer to the Membership of final authority for approval of Position Statements. We acknowledged to the Membership last year that this action had been overlooked and would be pursued in 1974.

b. Follow-through

In the course of reviewing this matter, the Executive Committee took a look at the whole list of existing Position Statements. Members were persuaded that many of the topics (for instance, the Statement on Joint Commission on Mental Health of Children Report, the Statement on Marriage Counselors, and the one on National Health Insurance) required some fairly short deadlines and flexibility. It became clear that Position Statements (as contrasted with policies) are basically reference documents to help guide us when a given matter arises.

Another concern is the availability of time to debate and determine Position Statements at Annual Meetings. These are often fairly technical documents. As we have transferred more authority to the Membership, we have also created a very real problem of Annual Meeting scheduling. If as we transfer authority to the Membership we don't greatly expand the time available for debate, we create an impression that all this democracy is just superficial.

Though the Executive Committee recommends that the Board still have final authority for approval of policy statements, it did agree that these statements should be made known to the Members. The action of the Executive Committee was to recommend that the Board of Directors continue to have final authority on Position Statements, but that all Position Statements should go forward to the Membership so that questions may be raised at the Membership Meeting.

In keeping with that arrangement, the two Position Statements developed in 1974 are attached to the Board of Directors Report which is in the Front Pocket of the Membership packet.

11. Recommendation to Establish as the Association's First Program Priority the Development of 1,500 Effective and Responsive Community Mental Health Systems by 1980

a. Action of the Membership

The Membership voted to establish as the Association's first program priority the development of 1,500 effective and responsive community mental health systems by 1980.

b. Follow-through

Amendment and renewal of the Community Mental Health Centers Act has been our first program priority throughout 1974. Other projects, however, are also attempting to deal with the matter of the effectiveness and responsiveness of the centers. We have now completed the pilot stage of our Citizen Site Evaluation effort, and the resulting guidelines provide encouragement and assistance to all Divisions and Chapters which we hope will periodically do a Citizen Site Evaluation of all centers within their areas. The Committee on Mental Health Services for Ethnic Minorities and the Poor continues to monitor the availability of centers to poor populations and to identify centers which have effective services for urban and rural poor. We've continued to give first priority to center coverage in our Position on National Health Insurance.

In the amendments to the current Community Mental Health Centers Act, we have attempted to build in safeguards for the effectiveness and responsiveness of centers. For instance, we proposed that all centers serving multilingual populations must have multilingual personnel.

12. Resolution to Hold the Annual Meetings More Regularly in Washington

a. Action of the Membership

The Membership voted on the Resolution presented in 1972 for study calling on the Association to have more frequent Annual Meetings in Washington. The Association will conduct its Annual Meeting in Washington every four years during the year a President is inaugurated, commencing in 1977. The Annual Meeting had already been scheduled for Washington in 1974.

b. Follow-through

All arrangements have been completed for holding the 1977 meeting in Washington. (The 1975 Annual Meeting will be in San Diego, in 1976 will be in Philadelphia, and in 1978 in Minneapolis.)

13. 1974 Public Affairs Program

a. Action of the Membership

The Membership and Board approved the 1974 Public Affairs Program. The approved program called for:

(1) Support enactment of Community Mental Health Centers Renewal Legislation.

(2) Expand and provide training to the Association's Public Affairs Network.

(3) Work for inclusion of NAMH principles for mental health provisions in National Health Insurance in all major legislation related to National Health Insurance.

(4) Stimulate increased funding for mental health programs under the National Institute of Mental Health Budget for 1975.

(5) Support a broadened definition of development disabilities to include childhood autism and childhood schizophrenia.

(6) Encourage the Association to promote the use of revenue sharing funds for mental health services.

(7) Continue to monitor 314(d) money under the Comprehensive Health Act.

(8) Support federal and state efforts to strengthen development of more effective maternal and child health programs in child development programs.

(9) Continue evaluation and support of remedial legislation to remove present provisions in the Social Security Act which discriminate against people who are mentally ill.

(10) Continue efforts to change the tax laws related to 501(c)(3) organizations.

(11) Promote state legislation in accordance with need.

(12) Develop a national public affairs conference to educate members of state legislatures on mental health issues, if special funding is available.

(13) Develop further the National Office Clearinghouse function.

(14) Work to change attitudes and practices of the Office of Civil Service in screening former patients.

(15) Invesitgate the affects of real estate zoning on the development of treatment facilities and advise on appropriate action.

b. Follow-through

The Annual Report of the Board of Directors (front pocket) summarizes the progress on our Public Affairs Program.

TREASURER'S REPORT TO MEMBERSHIP

Arnold H. Brown, Treasurer

I. 1973

Income from general fund sources in 1973 amounted to $1,298,480, or a $74,720 decrease from 1973.

The breakdown was:

From Divisions	$852,419
From Direct Contributions	93,240
From Investments (Primarily McAlpin Research Fund)	138,350
From Sales of Literature	193,680
From Miscellaneous	20,791

At the same time, expenditures totaled $1,672,370 up $146,170 over the previous year's. This included approximately $100,000 of writeoffs for bad debts.

The National Office experienced a net operating deficit of $373,891 in 1973.

The deficit was partially offset through the receipt of $86,118 in unrestricted bequest income.

The audited statements are reproduced in the Annual Report, and copies of the 1973 audit will be on hand at the Annual Meeting.

II. 1974

The 1973 budget had to be cut by approximately $150,000. This necessitated vacating three more field (professional) staff positions in addition to the two positions eliminated in 1973. Other significant cuts included a moratorium on the Personnel Development Grant Program, and a reduction in the number and size of committees and meetings.

As of September 30, we have received 61% of budgeted revenues. At the same time, we have spent 77% of our budgeted expenditures. It is anticipated that the 1974 budget will be balanced at year-end.

PROCEDURES IN RELATION TO RESOLUTIONS

Resolutions on major matters affecting policies or the major directions of the Corporation must be submitted to the Corporation by a Division's Board or by at least five Voting Members of record sixty (60) days before the Annual Meeting.

Such resolutions must in turn be submitted to the Voting Members and to the Divisions at least thirty (30) days before the Annual Meeting.

Notwithstanding the foregoing, by a two-thirds vote of the Members present, in person or by proxy, any written resolution, except one involving a change in the Certificate of Incorporation or By-Laws, may be considered at the Annual Meeting.

Memorials, commendations, recommendations for study and other such less significant resolutions may be submitted during the Annual Meeting of the Membership by a majority vote of the Members present.

The Board shall have the right to advise the Voting Members on any resolution proposed to be submitted to the Annual Meeting. On the basis of its view of the significance of the matters at hand, the Board will:

1. Meet in October, prior to the Annual Meeting;

2. Meet immediately before and at the same location of the Annual Meeting; or

3. Assign consideration of the proposed resolutions to the Executive Committee.

The President shall report to the Membership in writing at least 30 days in advance of the following Annual Meeting, on the Board's implementation of all resolutions which were passed at the preceding Annual Meeting.

RECOMMENDATION TO PROVIDE SOME VOTING PRIVILEGES FOR AFFILIATES OPERATING AS STATE COMMITTEES

The Executive Committee has approved the Organization Committee's recommendation that the Membership be asked to provide some voting privileges for affiliates operating as State Committees. This will require unanimous consent.

The Organization Committee has a subcommittee at work to develop guidelines for the organization and operation of "State Committees." In the course of their work the subcommittee realized that, at the present time, State Committees have no voting privileges. This situation exists even if such an affiliate is providing close to its "Minimum Obligation." The subcommittee, and subsequently the Organization and Executive Committees, realized that the whole matter of voting privileges of State Committees has to await completion and approval of the report. These groups are also persuaded that, in the spirit of fairness, these states should be allowed votes proportionate to their support. Under such an arrangement, a State Committee which is providing 75% of its "Minimum Obligation" would be entitled to 75% of its normal quota of Voting Members.

The Executive Committee believes that such a proposal will eventually require a By-laws change and that such changes should await the total report. However, they also agree that the Membership can provide voting privileges for this meeting by unanimous consent.

Therefore, the Executive Committee recommends that the Membership give unanimous consent to representation from the following State Committees (based on their 1973 support):

Illinois	(4)
New York	(3)

EXECUTIVE COMMITTEE'S RECOMMENDATION THAT THE PROPOSED POLICY ON USE OF GOVERNMENT FUNDS SHOULD APPLY, FOR NOW, ONLY TO THE NATIONAL OFFICE

Two years, ago, the Executive Committee and Board approved a proposed Policy on Acceptance of Government Funds.

Because the policy would have such widespread impact, it was agreed that it should be brought forward, for discussion purposes only, at the 1972 Annual Meeting, and then voted on officially in 1973. Because there was so little time for discussion of this issue in Detroit, the Board subsequently agreed to bring the proposed policy forward, for discussion purposes only, in Atlanta, with the intention of voting on it officially in 1974 in Washington.

There was a great deal of discussion in Atlanta. The Executive Committee has carefully reviewed the policy and the reactions to it, and now recommends the following course:

1. That the proposed Policy on Acceptance of Government Funds should be voted on at the 1974 Annual Meeting, but with the understanding that the policy would apply, for now, only to the National level of the organization.

2. That discussion should take place at the 1974 Annual Meeting as to whether this policy or a modification of it should apply to Divisions and Chapters sometime in the future.

There is unanimous agreement among the National Executive Committee that such a policy should apply to the National operation. There is some disagreement whether so strict a policy should apply to Divisions, and particularly to Chapters. Generally, the Executive Committee favors a restrictive policy. However, we recognize that the proposed policy does not seem to be acceptable to a majority of the Members and that to press for so strict a policy may obscure reasonable discussion of the issue.

By adopting the policy for the National Office, we add official protection to our independence at that level and provide some leadership and informal guidelines to Divisions and Chapters. This policy will then form the baseline for consideration of a policy for Divisions and Chapters without limiting opportunity for amendment of the proposal as it might apply to Divisions and Chapters.

The proposed policy is as follows (this includes editing, based on suggestions at the 1973 Membership Meeting):

PROPOSED POLICY ON ACCEPTANCE OF GOVERNMENT FUNDS BY THE NATIONAL BOARD

BACKGROUND

Governmental bodies at all levels of society are engaged in financing or providing mental health services. They constitute the largest source of funding in the field, paying over $3 billion annually, two-thirds of the cost of treatment and prevention of mental illness.

By comparison, NAMH, nationwide, has total annual income from all sources of about $15 million. That's less than four-tenths of one percent of the Government's expenditures. So, what looks like a lot of money to the Mental Health Association is a very small amount to Government officials.

For this reason, and because Government agencies want and need public support for their activities, program grants are frequently offered, and requests for them are usually considered favorably. This looks like easy money to the Association which operates on a low budget of hard-to-raise voluntary donations.

CONSEQUENCES

What are the consequences of the National Board accepting and using Government funds?

(1) Political independence is compromised because a request must be made, controls are required, and accountability is expected.

(2) The public image of the independent citizens' voluntary agency is blurred in the eyes of public officials and the public.

(3) Financial dependence may result as the MHA expands budget or staff to undertake projects.

(4) The MHA is highly vulnerable to termination of these "soft" dollars which cannot easily be replaced with "hard" dollars.

GENERAL PRINCIPLE

It should be the policy of NAMH's Board that, except under notable circumstances, no Government funds will be accepted or administered.

EXTRAORDINARY CIRCUMSTANCES

Exceptions to this General Principle should be so rare as to turn a spotlight on any such transaction and should be considered only within these conditions:

(1) The funds are to finance a special project of social importance which no other agency is competent to undertake.

(2) The funds are not for operating expenses and are kept in separate accounts of pertinent income and expense.

(3) The funding has a finite life of not more than three years, and definite plans are made in advance for its disposition thereafter.

(4) The total of Government funding should not exceed 10 percent of the National Board's budget.

(5) Anyone employed to work on the project should work on it full-time and should be aware of the short-term nature of the project.

PROPOSALS OF THE PUBLIC AFFAIRS COMMITTEE
PRESENTED BY HILDA ROBBINS, CHAIRPERSON-DESIGNATE
AT THE ANNUAL MEETING OF THE MEMBERSHIP
NOVEMBER 20-23, 1974 - WASHINGTON, D.C.
(Approved by the Executive Committee - October 2, 1974)

The Committee proposes the following Public Affairs Program for 1975 for approval by the membership and adoption by the Board:

Top Priority

1. MENTAL HEALTH COVERAGE IN NATIONAL HEALTH INSURANCE

This issue continues to be the highest long-range priority item for the Public Affairs Committee. The Association has testified before the House Ways and Means Committee regarding our position. A number of important NHI bills and the Administration's NHI proposal include coverage based on recommendations from NAMH. It is clear that national health insurance will be one of the major priorities for Congress in 1975. Every effort will be made to assure that the NAMH position is included in that legislation.

2. FEDERAL DOLLARS FOR MENTAL HEALTH PROGRAMS

a. Alcohol, Drug Abuse and Mental Health Administration Budget With Special Emphasis on NIMH

Key officers and staff of NAMH will continue to meet with government officials, including the Secretary of HEW, the Director of the Office of Management and Budget, the Director of the Alcohol, Drug Abuse and Mental Health Administration and key members of Congress regarding the importance of the NIMH budget. It appears that a supplemental budget will have to be enacted in FY75 for community mental health center staffing and construction funds. NAMH will make recommendations regarding the FY76 budget and special emphasis will be placed on obtaining adequate research funds in that budget.

b. Clear away obstacles to the flow of federal funds from multiple agency sources to community mental health programs in the states and determine how these funds can be used for maximum benefit.

The Association will approach various possible sources of federal funds for community mental health centers to encourage those federal sources to recommend to their state and local agents that federal funds can and should be available for use by community mental health centers. Funds may be available to centers from vocational rehabilitation, social rehabilitation services, medicare, medicaid and social services, veterans administration, office of education, developmental disabilities and revenue sharing.

3. CHILDREN-YOUTH LEGISLATION

NAMH will work for enactment of federal legislation related to children. For example, a major effort will probably be mounted in 1975 to enact child development legislation. The Developmental Disabilities Act regulations will have to be watched closely to assure that autistic children get their fair share of programming and funding. Major legislation, the Elementary and Secondary Education Amendments, was passed in 1974 providing funds for education of the handicapped. Regulations related to that legislation must be monitored.

4. TAX LAWS RELATED TO CHARITABLE ORGANIZATIONS

Tax exemption legislation which would have broadened the rights of 501(c)(3) groups to engage in the lobbying process was part of the tax reform legislation that was proposed but not enacted during 1974. Efforts will probably continue in 1975 to work for enactment of such legislation.

5. PUBLISH AND DISTRIBUTE GUIDELINES FOR LEGISLATIVE ACTION

NAMH will publish a booklet to assist divisions and chapters, as well as NAMH volunteers, in understanding the legislative process and developing effective contacts with legislators.

6. LITIGATION

The Association will continue to bring litigation in areas of need and will monitor the implementation of successful litigation.

Second Level of Priorities

1. MONITOR ADMINISTRATION OF REGULATIONS RELATED TO LEGISLATION OF CONCERN TO NAMH FOR PROMPTNESS OF ACTION, ACCURACY OF LANGUAGE, REFLECTING INTENT, AND UNDERSTANDABILITY

Regulations related to community mental health centers will require close attention. The Association will also monitor the development of regulations related to legislation such as developmental disabilities, education of the handicapped and other legislation enacted during FY75.

2. ASSIST DIVISIONS IN IMPLEMENTATION OF ENACTED LEGISLATION

Divisions will play a major role in assuring that enacted legislation is implemented at the state and local level. Some of the legislation that may involve divisions includes:

a. community mental health center renewal
b. education of the handicapped
c. health screening in Title XIX of the Social Security Act (Medicaid)
d. health maintenance organizations
e. comprehensive health planning
f. social rehabilitation services
g. Developmental Disabilities Act
h. tax exemption

3. DEVELOP AND DISTRIBUTE GUIDELINES RELATED TO ZONING REGULATIONS AS APPLIED TO HALFWAY HOUSES AND TREATMENT FACILITIES

The Public Affairs Committee has been reviewing problems related to zoning regulations. Initial information has been drafted by the committee that would relate to such guidelines.

4. ASSISTANCE TO DIVISIONS IN THE CHANGING AND PROMOTION OF STATE LAWS RELATED TO:

a. state insurance mandates
b. commitment laws
c. advocacy systems
d. patient rights
e. right to education
f. liability requirements
g. experimentation on human subjects
h. licensing practices
i. licensing of halfway houses, nursing homes, etc.
j. qualifications for commissioners, superintendents and center directors
k. CMHC Acts

5. SPECIAL EMPHASIS ON INCREASED PARTICIPATION OF MENTAL HEALTH LEADERSHIP AND INCREASED IMPACT OF MENTAL HEALTH VIEWPOINT IN COMPREHENSIVE HEALTH PLANNING AT CHAPTER, STATE AND REGIONAL LEVELS

The Association will continue to follow this legislation closely to assure that planning for mental health is included in that legislation and regulations.

Third Level Priorities

1. PSYCHIATRIC SCREENING OF IMMIGRANTS

Information required on the application form related to immigration asks for data related to past history of mental illness. Efforts will be made to stop this practice.

RECOMMENDED BY-LAWS CHANGE TO ALLOW FOR MEETINGS OF THE EXECUTIVE COMMITTEE AT TIME OF BOARD AND ANNUAL MEETINGS

THE RECOMMENDATION

Article V, Section 1, of the By-Laws, on the Executive Committee, states that: "The Committee shall meet as frequently as required, but at least quarterly. Meetings of the Committee may be called on five-days' notice by the President or by any two members of the Committee."

The Board of Directors recommends the following addition to that section immediately following the above line:

> "Notice may be waived at the time of Membership meetings and any duly called meeting of the Board."

BACKGROUND

At the time of the 1973 Annual Meeting, several Voting Members suggested from the floor that the Executive Committee should meet during the noon hour to advise the Members on a new and difficult matter which had been introduced as new business. When the Executive Committee met, someone asked if the meeting was a legally constituted one. We checked the By-Laws and found that an official meeting of the Executive Committee requires five-days' notice. The official wording is:

> "THE COMMITTEE SHALL MEET AS FREQUENTLY AS REQUIRED, BUT AT LEAST QUARTERLY. MEETINGS OF THE COMMITTEE MAY BE CALLED ON FIVE-DAYS' NOTICE BY THE PRESIDENT OR BY ANY TWO MEMBERS OF THE COMMITTEE."

It was the general impression of those who attended that informal meeting of the Executive Committee in Atlanta that the Executive Committee should be able to meet, if necessary, at the time of the Annual Meeting.

In the course of our discussion we examined whether emergency meetings of the Executive Committee would dilute the authority of the Membership or Board. We recognized it would be very unusual if the Membership or Board would want or expect that Executive Committee to meet, but there may be occasions in the future when some smaller group will need to meet to sort out some unexpected and difficult matter.

Therefore, the Board of Directors recommends to the Membership a change in the By-Laws to provide for emergency meetings of the Executive Committee at the time of Membership meetings and any duly called meeting of the Board.

RECOMMENDED BY-LAWS CHANGE TO LIMIT THE TERM OF PRESIDENT TO ONE YEAR

THE RECOMMENDATION

The Board of Directors recommends the Membership change the By-Laws to limit the terms of President and President-elect to one year. Article VI, Section 2.1, entitled "Election and Term of Office," would be changed as indicated:

> "The Officers shall be elected by the Members at the Annual Meeting. Vacancies may be filled at any meeting of the Members of the Board of Directors, provided notice has been given. Each officer shall hold office until the next Annual Meeting, or until his successor shall have been elected and shall have qualified, or until his death, resignation or removal, with the exception of the Office of President and President-elect, which shall be restricted to one term in each office.

BACKGROUND

In 1969 the Membership called for a study of the President-elect system to determine if this office should be added to the National Roster of Officers.

In 1970 in Los Angeles the Membership and Board approved the adoption of the President-elect system. The study committee and the Executive Committee both recommended that "the President-elect shall become President after serving one year in the office of President-elect." On the floor of the Membership Meeting, the Resolution was amended "to provide that the President-elect shall become President at the termination of the incumbency of the existing President."

The 1972 and 1973 Nominating Committees both found it very awkward to approach their assignment without more definite knowledge as to whether the President-elect would be stepping up. They also found that the indefiniteness added some difficulty in securing acceptance from top President-elect candidates. On this basis, the Nominating Committees recommended to the Board that the President should serve only one term of one year. The Board approved, and legal counsel has suggested the specific By-Laws revision contained in the recommendation above.

THE MASSACHUSETTS RESOLUTION

Attention is called to the next item on the agenda and the next attachment which present the Resolution from Massachusetts "That the By-Laws of the corporation be revised to provide that the President may serve two annual terms in that office."

R E S O L U T I O N

(Massachusetts #1)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the Massachusetts Association for Mental Health and additional Delegates.

RESOLVED that the By-Laws of the Corporation be revised to provide that the President-elect shall be an Officer of the Corporation, to exercise the powers of the President in the event of his absence or disability, to serve as a member of the Executive Committee, to provide that the President-elect shall become President after serving in the office of the President-elect, and to provide that if the President-elect is serving in that position in his sixth year as a member of the Board, he shall be eligible to serve on the Board throughout his terms as President-elect and as President.

THE RESOLUTION

RESOLVED that the National Association for Mental Health By-Laws be amended to provide at the end of Article VI, Section 2.1 "Election and Term of Office :

"The President may serve two annual terms in that office."

THE RESOLUTIONS COMMITTEE

The Resolutions Committee noted that the original resolution did not have the ten signatures which are required in Article X "Amendments" in the By-Laws, and on this basis the Resolution was withdrawn.

THE EXECUTIVE COMMITTEE

Procedural

The Executive Committee learned that the Massachusetts Division still wished to bring this matter forward. Recognizing that the Resolution had been

submitted on time but that there had been a misunderstanding about the number of signatures required for By-Laws changes, the Executive Committee encouraged the Division to send its revised Resolution for inclusion in this Agenda packet, and assured the Division that the Executive Committee will recommend to the Membership that the necessary two-thirds vote be given to bring this matter before the Membership.

Substantive

As outlined in Attachment #10, the full Board is already on record recommending that the President be limited to one year.

R E S O L U T I O N

(Georgia)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the Georgia Association for Mental Health.

THE RESOLUTION

WHEREAS, the National Association for Mental Health is a large and complex organization made up of many Divisions, and is involved in many different programs in order to reach the goals of improved mental health and decreased mental illness; and

WHEREAS, there is a need for a comprehensive vehicle; and

WHEREAS, activities in the health field, including mental health, are of increasing concern to the public; and

WHEREAS, we believe regular news dissemination, in a form that will be seen by the various news media, as well as the more limited groups who are consciously interested in mental health, is urgently needed;

THEREFORE, BE IT RESOLVED that the Membership of the National Association for Mental Health recommend that the Board of Directors consider the feasibility of a comprehensive publication, to be published at least quarterly, available for distribution, as a means of fulfilling our goals.

THE RESOLUTIONS COMMITTEE

The Resolution is in order. No clarification or recommendation made.

THE EXECUTIVE COMMITTEE

Agrees with the Resolution and hopes publication can be decided upon and initiated in early '75.

R E S O L U T I O N

(Missouri)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the Missouri Association for Mental Health.

THE RESOLUTION

WHEREAS, the National Association for Mental Health has sought to eliminate discrimination in its utilization of volunteers, in the employment of staff, and in the provision of services; and

WHEREAS, discrimination in any form must be recognized as a detriment to mental health;

NOW, THEREFORE, BE IT RESOLVED that the National Association for Mental Health amend its policy on nondiscrimination to include sex and age as well as race, color or creed.

THE RESOLUTIONS COMMITTEE

"This Resolution can only help further the goals of the Association."

THE EXECUTIVE COMMITTEE

Concurs and, to be consistent with new federal law, would add sex, age and handicapped, as well as race, color or creed.

R E S O L U T I O N

(Massachusetts #2)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the Massachusetts Association for Mental Health.

THE RESOLUTION

WHEREAS, the National Association for Mental Health wholeheartedly supports the concepts of deinstitutionalization and community-based treatment, and has worked arduously for their realization throughout the nation; and

WHEREAS, because of its commitment to these concepts, NAMH decries the manner in which many states have set about implementing deinstitutionalization to date. In far too many instances, states have discharged patients without proper evaluation of the capacity of the individual patient to successfully adjust to the noninstitutional environment; without adequate preparation of the patient for the transition to life outside an institution; and without the provision of sufficient community-based services and follow-up for discharged patients. In consequence, under the guise of deinstitutionalization, neglect and rejection in the community sometimes replace warehousing in state institutions as the lot of the mentally ill; and

WHEREAS, in many states the patients remaining in state institutions for the mentally ill are still more neglected than in the past; communities react with fear or hostility to patients discharged improperly, or without sufficient preparation and support; and increasingly budgets are cut for the care of the mentally ill, through a misperception of the meaning and cost implications of deinstitutionalization;

NOW, THEREFORE, BE IT RESOLVED that the NAMH work with its affiliates and all other available agencies, to foster the establishment of balanced systems for the care of the mentally ill, that can respond effectively to the needs of all mentally ill persons, both those requiring institutional care and those who can benefit from community-based treatment facilities; and

BE IT FURTHER RESOLVED that the NAMH further commits itself to working to ensure sound selection, adequate preparation and sufficient community-based services and follow-up, for patients discharged from state institutions for the mentally ill; and to educating the public and responsible legislators and public officials to the necessity of planning and providing adequate support for patients discharged from mental hospitals, to foster their reintegration into the life of the community.

THE RESOLUTIONS COMMITTEE

Submitted to the Executive Committee with minor editorial changes.

THE EXECUTIVE COMMITTEE

Believes the intent, as highlighted by the WHEREASES, is entirely consistent with our role and outlook.

The Committee's discussion pointed up some differences of interpretation about "balanced systems." We don't want to perpetuate separate and balanced state-community systems. Rather, we want to emphasize community systems and a close integration of the community services with state services. We found ourselves preferring to use words such as "coordinated" and "integrated" rather than "balanced" or "unified." The reason "unified system" is awkward is that it could play into the hands of those states which are trying to unify all state and community services under state governmental departments.

The Association is already moving rapidly in this area. For instance, there will be a special report to the Membership on the same day this Resolution is considered. The special report is on the "Crisis in Many States Brought About by Lack of Community Preparedness for Handling Discharged Patients and Other Increased Service Expectations."

With the interpretation elaborated here, the Executive Committee supports the Resolution.

R E S O L U T I O N

(Alabama)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the Alabama Association for Mental Health.

THE RESOLUTION

WHEREAS, in criminal law a defendant who contends that he lacked capacity and was not in legal control of his faculties at the time of the commission of a crime must generally raise this defense by a plea framed at common law as "not guilty by reason of insanity"; and

WHEREAS, the use of the world "insanity" is now an archaic term which in the interest of justice should be redefined; and

WHEREAS, it would also be useful for all states to have a model code available for consideration dealing with this problem and making provisions for such a defendant upon a verdict of not guilty for reasons of "insanity," to receive appropriate mental health care, attention and treatment; and

WHEREAS, the Mental Health Association has valuable knowledge and can produce information which would assist in such an endeavor;

NOW, THEREFORE, BE IT RESOLVED that the NAMH survey the efforts of other groups, associations and governmental bodies which are studying this problem and report back to the Executive Committee and Membership on the results of such efforts; and

BE IT FURTHER RESOLVED that the Executive Committee is then authorized to participate in other studies or to appoint a special committee to further study this matter, and the Executive Committee shall report to the Board of Directors and the Membership at the 1975 Annual Meeting.

THE RESOLUTIONS COMMITTEE

This substitute resolution prepared by the Resolutions Committee and accepted by the Alabama Division, deleted the negative aspects and those issues that could not be undertaken by the National Board at this time.

THE EXECUTIVE COMMITTEE

Agrees with spirit and intent, and would make the charge a bit more specific in terms of the importance of consumer involvement in studies undertaken by others, and in terms of the need for the Association to be working toward its own independent Position Statement. To these ends, the following slight changes are suggested in the second RESOLVE:

> "BE IT FURTHER RESOLVED that the Board of Directors is then authorized to participate in other studies, such as those being conducted by the American Bar Association and American Law Institute, to be certain that the consumers' point of view is represented in such studies, and the Board of Directors shall report to the Membership at the 1975 Annual Meeting. Our involvement in such studies will be to ascertain that a consumer's point of view is represented in them and to assist us as we move toward an independent Position Statement by the Association."

R E S O L U T I O N

(Massachusetts #3)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the Massachusetts Association for Mental Health.

THE RESOLUTION

WHEREAS, the present policy of the National policy adopted in 1972 authorizes the appointment of a Resolutions Committee which is authorized to "receive, assemble, study and edit resolutions"; and

WHEREAS, as presently constituted, the Resolutions Committee is not authorized to make "recommendations" to the Executive Committee or to the Membership; and

WHEREAS, volunteer members from throughout the country meet as the appointed Resolutions Committee, carefully study and consider each resolution, and a report of their deliberations and recommendations should be submitted to the Executive Committee and the Membership for their consideration; and

WHEREAS, such recommendation would assist in the timely consideration of resolutions by the Membership at the Annual Meeting;

NOW, THEREFORE, BE IT RESOLVED that the policy of NAMH relating to the functions of the Resolutions Committee be amended to read:

> "The Resolutions Committee shall receive, assemble, study, edit and present resolutions with their recommendations to the Executive Committee. The Resolutions Committee shall present their recommendations and the recommendations of the Executive Committee to the Annual Meeting.
>
> The Committee shall forward copies of its recommendations to the Executive Committee prior to the Annual Meeting.
>
> Nothing shall preclude members of the Resolutions Committee from expressing their individual views respecting any resolution at the time they are before the Membership.
>
> The Chairman of the Committee shall, in the light of the nature of resolutions received in advance of the Annual Meeting, make appropriate plans for the convening of the Committee prior to or during the Annual Meeting, and arrange Committee consultation with the Delegates presenting resolutions."

THE RESOLUTIONS COMMITTEE

It is the strong recommendation of the Resolutions Committee that this Resolution be adopted as presented. If the Resolution is voted down by the Membership, it is the consensus of the 1974 Resolutions Committee that future Resolutions Committees be abolished.

THE EXECUTIVE COMMITTEE

Recommends action be deferred pending outcome of current Executive Committee study of role of the Resolutions Committee.

Two years ago, the Membership approved the major Report on Roles and Representation which transferred from the Board to the Membership much of the basic governing authority. In the preparation and discussion of that Report, a great deal of attention was given to the relative roles of the Board and Membership. There were many who felt it was not efficient or practical to turn over final authorities to the Membership. On the other hand, the majority clearly believed that this transfer should take place. The Report concluded that, if the Membership was to have final authority on most major matters, it was a sensible procedure to ask that the Board of Directors provide its recommendation in relation to Resolutions and other major business coming before the Membership for action. Thus the procedure was established which is outlined in Attachment #1. The Board, or in its place the Executive Committee, is to study each of the matters and provide its recommendations to the Membership. In this process the Members are assured that they will see the Resolution as originally brought forward by a Division or appropriate number of Voting Delegates, and that they will also see the Board or Executive Committee's recommendations. The presentation at the Membership Meeting is handled in the same order.

What the Roles and Representation Committee worked out, and what the Membership seemed enthusiastic about, was a process that transferred final authority to the Membership but guaranteed the Members that before taking action they would have the thinking of supposedly the most knowledgeable group. By being assured that the Members will see the original Resolution, and indeed will see it first and hear it first, there is clearly a means by which the most extreme ideas can be brought immediately before the Membership, and the Members are by no means bound to accept the Board's subsequent recommendations on those matters.

The Executive Committee senses that it would be cumbersome and confusing if the Members were to see the original Resolution and have separate recommendations on the matter from the Resolutions Committee and Executive Committee.

In the Spring of 1974, the staff recommended that the Resolutions Committee be dissolved, but the Executive Committee felt that we should carefully study this matter in order to be certain that our procedures provide for the fairest and most realistic approach to the Membership's business.

The Executive Committee has initiated study of the future role of the Resolutions Committee, and respectfully suggests that the Membership defer action on the Massachusetts Resolution until their study is complete and before you.

R E S O L U T I O N

(Indiana)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the Mental Health Association in Indiana.

THE RESOLUTION

WHEREAS, the image of a Mental Health Association is determined not by what the Association's says it is, but by the way in which the public perceives it as the result of its activities; and

WHEREAS, the individual who renders volunteer service to help individual and groups of patients as identified, in the eye of the public as a generous, helpful and kindly person, and this identification is transferred to the Mental Health Association if it sponsors the work and the volunteer is closely identified with the Mental Health Association by a uniform, or a symbol worn by the worker, or if the reports of the work are made by the Mental Health Association; and

WHEREAS, those volunteers who work directly with the mentally ill are the one best image makers that the Mental Health Association can have since it is possible for the news media to focus on their work and that work is of interest to the viewer or the newspaper reader; and

WHEREAS, this is in sharp contrast to the meetings of legislative committees or any board or committee peopled by the usual volunteers whose activity does not lend itself to use by the media; and

WHEREAS, patient service volunteers project the image of the Mental Health Association as an organization working for people who are severely hurt, the Mental Health Association is then seen as an organization that helps people who are suffering, as contrasted with an organization which helps people find ways of being better people personally or helps people do something for themselves; therefore, the volunteer who works with a mental patient expresses unselfishness, kindness and generosity in a way in which all other volunteers related to the Mental Health Association cannot do, however good and useful their purposes may be; and

WHEREAS, the direct patient service volunteers organized and managed by the Mental Health Association will be a group of people interested in the successful operation of the whole Mental Health Association, and they can make a significant contirbution to the ability of the Mental Health Association to get funds either from the general public or from a United Fund allocations committee; and

WHEREAS, when the public or the members of a United Way allocations committee see people working directly to help patients in the hospital, in the nursing home, while being held in local jails or waiting commitment, or at any other place where the patient needs a helping, friendly hand, the public or allocations committee respond most favorably to the request of the Mental Health Association for financial support; and

WHEREAS, the Mental Health Association connected individuals who work directly with the patient gives the Mental Health Association two indispensable elements in its attempt to influence the decisions of the state legislature or county council (or administrative agencies) in the formation of public policy; the first is their very presence at the places where the care and treatment is carried out gives the Mental Health Association the ability to speak as an authority with intimate knowledge concerning the operation of the facility whose program it is seeking to improve or expand; and second, the individual volunteers who have had the opportunity to work directly with the people in need of more and better service become among the most effective, interested and the most uncompromisingly committed legislative workers; and

WHEREAS, what the direct patient service volunteer workers may lack in knowledge about the law and legal procedures in general, they make up for it in zeal, and zeal is no obstacle to learning about the law and legal procedures, therefore, these people constitute the nearest equivalent for the Mental Health Association to the parents of the mentally retarded or the blind or the crippled who seek programs for their own; and

WHEREAS, these volunteers earn for the Association the right to have an opinion concerning the needs of patients and, also, in the legislative corp, the direct patient service volunteer is indispensable to an in-depth legislative network which enables the Mental Health Association to do more than merely present testimony to committees of the legislature; and

WHEREAS, one Division, Indiana, has a large number, approximately 5,000, direct patient service volunteers working to help patients on a regular weekly basis throughout the year and, also, Indiana has a complete legislative network with committee members in all 150 election districts in the State of Indiana committed to the goals of the Mental Health Association organized and managed by the state Mental Health Association; and

WHEREAS, the Indiana Division also has the highest per capita income, compared with the other Mental Health Associations, being almost double the next nearest reasonably large state (Maryland) with many Chapters and similar organizational problems; and

WHEREAS, it is noteworthy that Maryland also has a large volunteer organization and that Maryland pioneered the program to bring the average citizen into the mental hospital through a Christmas present program each year; and

WHEREAS, the National Association for Mental Health and Mental Health Associations generally are desirous of obtaining increased funds and improved public image and improved social action or legislative capacity ; and

WHEREAS, there is an urgent need for all Mental Health Associations to have this financial capacity and financial influence;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors for the National Association for Mental Health be urged to make a survey of the Divisions of the National Association to determine if those Divisions having substantial numbers of direct patient service volunteers are proportionately better off financially than those Divisions which do not emphasize direct service volunteers; and

BE IT FURTHER RESOLVED that if it is determined that the existence of a substantial number of direct service volunteers contribute greatly to the image, financial, and social action strength of a Mental Health Association the National Board should then instruct its staff to help all Divisions to achieve this type of program so as to accomplish not only service to the mentally ill, but also increased financial support and increased social action capacity.

THE RESOLUTIONS COMMITTEE

This Resolution was not submitted in compliance with Article II, Section 2, paragraphs (c)(1) of the NAMH By-Laws. Therefore, it will take a two-thirds vote of the Membership for its consideration during the Annual Meeting.

This Resolution is submitted to the Executive Committee without comment, and a recommendation to the Indiana Division that it be redrafted for clarity.

THE EXECUTIVE COMMITTEE

Procedural

The Executive Committee was advised that the Resolution had been received several days after the deadline and not in time for it to have gone in writing to members of the Resolutions Committee before its meeting. We agree that it is essential to hold to these deadlines, particularly if a timetable is to be observed which will allow us to get these matters before the Members at least 30 days in advance of the Annual Meeting. On the other hand, because the Resolution was in hand by the time of the Resolutions Committee and well before the Executive Committee meeting, we recommend that it be given the two-thirds vote for consideration during this Annual Meeting.

Accordingly, we encouraged the Indiana Division to come forward with a revision for inclusion in this agenda packet. The Resolution which appears here is the revision.

Substantive

(The Executive Committee worked from the original Resolution and, therefore, as a body has not seen the redraft.)

The Executive Committee noted that the Indiana Division appropriately clarifies that direct patient services by volunteers are not only not precluded by Association policy and attitude, but are encouraged. The Executive Committee also agrees in the value of this survey which would help determine the current degree of such volunteering within the Association, and the impressions of the leaders of those Divisions and Chapters involved as to the value of that volunteering, particularly in relation to the Association's fund raising and social action functions.

The original Resolution called for an in-depth study of the impact of such volunteering on the Association's fund raising and social action programs, and the Executive Committee felt that such a study was for the moment beyond our financial and other resources.

R E S O L U T I O N

(New Jersey)

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Washington, D. C., November, 1974, by the New Jersey Association for Mental Health.

THE RESOLUTION

WHEREAS, several of our Mental Health Association Chapters are engaged in direct services to the mentally ill; and

WHEREAS, the value of the organization is judged by some supporters in part with regard to its direct service contribution so that the elimination of such programs may have substantial effect on the financial support of these Chapters; and

WHEREAS, these Chapters believe their experience indicates that the operation of direct services does not necessarily diminish the effectiveness of the social action role of the Mental Health Association;

NOW, THEREFORE, BE IT RESOLVED that we urge the National Association for Mental Health to establish the appropriate mechanism for an examination of the variety of relationships between the social action role and the operation of direct services; and

BE IT FURTHER RESOLVED that the National Association for Mental Health formulate guidelines for Chapters and Divisions in these aspects of programming, taking into account the experience of Chapters presently engaged in the operation of direct services.

THE RESOLUTIONS COMMITTEE

This resolution was not submitted in compliance with Article II, Section 2, paragraphs (c)(1) of the NAMH By-Laws. Therefore, it will take a two-thirds vote of the Membership for its consideration during the Annual Meeting.

Submitted to the Executive Committee without comment.

THE EXECUTIVE COMMITTEE

Procedural

The Executive Committee was advised that the Resolution had been received several days after the deadline and not in time for it to have gone in writing to members of the Resolutions Committee before its meeting. We agree that it is essential to hold to these deadlines, particularly if a timetable is to be observed which will allow us to get these matters before the Members at least 30 days in advance of the Annual Meeting. On the other hand, because the Resolution was in hand by the time of the Resolutions Committee and well before the Executive Committee meeting, we recommend that it be given the two-thirds vote for consideration during this Annual Meeting.

Substantive

The Executive Committee recommends that this subject be included in the study and discussion relating to a policy on Division and Chapter use of government funds.

We acknowledge that the New Jersey Resolution goes beyond just the matter of whether use of government funds compromises one's social action capacity. However, we feel that much of the basic intent and subject will be covered in the debate on use of government funds, and that it is better to wait for the results of that review before tackling the remaining considerations.

At one point in our discussions we felt that we should indicate that the Association is not in a position to take on a major additional study. However, as we studied the Resolution further, we believed that at least some, and perhaps much, of the purpose will be served by being certain that the Resolution is prominent in the debate on whether or not Chapters and Divisions should be discouraged in any way from use of government funds.

SUMMARY OF IMPLEMENTATION OF FINANCIAL SUPPORT POLICY
1974 ANNUAL MEMBERSHIP MEETING

A. Divisions at or above "Full Support" at the end of 1973: (4)

Hawaii
Indiana
North Dakota
Utah

B. Divisions at or above "Minimum Obligation" at the End of 1973: (32)

Region I

* Connecticut
Delaware
Maryland
Massachusetts
New Jersey
Pennsylvania
Rhode Island

Region II

Alabama
* Florida
Georgia
Mississippi
North Carolina
South Carolina
Tennessee

Region III

Kentucky
Michigan
Minnesota
Wisconsin

Region IV

Arkansas
Iowa
Kansas
Louisiana
Missouri
Oklahoma
South Dakota
Texas

Region V

Alaska (Provisional)
Arizona
Colorado
Montana
Oregon
Wyoming

*Includes a balance remaining which is being carried as a formal account receivable and is being paid off in full in 1974.

C. Divisions below "Minimum Obligation" for the First Time in 1973, and which Are Reaffiliated under the Conditions Set Forth in Section H, "Failure to Meet Obligations," of the Financial Support Policy (3)

The policy states:

"When a Division fails to meet its Minimum Support Obligation, the Division may retain its affiliation for one year if the

following steps are taken cooperatively by National and the Division:

"1. Agreement that the dollar amount by which the Division failed to meet its Obligation shall be carried as a formal debt.

"2. National assessment of Division operations, including Division/Chapter relationships.

"3. Development of a remedial plan including a definite schedule for repayment of the debt and including the cooperative development of the Division's budget which must include the policy support obligation for the current year. The Budget is to be prepared no later than March 31."

The Divisions which fall under this category are:

District of Columbia
Idaho
Virginia

D. States which Are Now under the Direct Management of the National Board and Being Operated as "State Committees": (5)

Illinois
Nebraska
New York
Washington
West Virginia

E. Divisions which Are Reaffiliated for One Year Subject to Specific Conditions Approved by the Full National Board: (2)

California
Ohio

In the spirit of full reporting, the specific conditions of those reaffiliations are included below:

1. California

"1) CAMH budget for 1974 be set at $81,000.

"2) The NAMH support level be set at a minimum of $40,000, payable upon acceptance of this resolution by the NAMH Board of Directors, plus

a) Any income above $121,000 to $190,000 would be shared 80% NAMH, 20% CAMH.

b) Any income above $190,000 would be shared 50/50 until minimum EBI level is met.

"3) On June 30, a complete report and review of income and expenditures will transpire.

"4) The support levels set for Chapters will be equal to or exceed those set in 1973, with the CAMH Organization and Affiliation Committee to continue their successful efforts to bring all Chapters up to EBI.

"5) All funds received shall be deposited in an escrow account requiring signature of both a National Officer and a State Officer.

"6) CAMH will accept a suspended status for 1974 with no voting privileges.

"7) CAMH will request the Los Angeles Chapter to accept an advisory committee to work with them made up of key volunteers and staff from other Chapters, who can assist in redirecting the modus operandi of the Los Angeles Chapter in order that it can begin to meet the same obligations imposed on other Chapters in the CAMH family. (Note: The original resolution calling for the Los Angeles Chapter to be placed in provisional status is moot inasmuch as all Chapters will become provisional if the Division is suspended.)

"8) A planning committee will be established immediately to develop goals within the areas of finance, organization and program, for

a) Immediate development

b) Long-range development.

2. Ohio

"1) All funds received from Chapters and all funds raised by the Division shall be shared on a 50/50 basis with NAMH. This sharing is with the understanding that the National Board will be returning $9,450 to the Division during the first half of the year. At mid-year, June 30, 1974, the Division will be fully abreast of this agreement.

"2) Chapter support levels for 1974 shall be equal to or exceed those set for 1973.

"3) Chapters not meeting minimum support must share income on a 50/50 basis.

"4) The operating budget of the Division shall not exceed one-half of anticipated income.

"5) The National Board shall have veto power over the Division budget.

"6) The Division agrees to turn over control of the Division to the National Board on June 30, 1974, if the Division is unable to comply with the conditions of this agreement. Furthermore, in the event the Ohio Division is unable to comply with the conditions of this agreement during the last six months of 1974, it will turn over control of the Division to the National Board on December 31, 1974."

F. Unorganized States: (5)

Maine
Nevada
New Hampshire
New Mexico
Vermont

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.
1800 NORTH KENT STREET, ARLINGTON, VIRGINIA 22209

REGION	DIVISION	Paid In 1973 (a)	"Minimum Obligation 1974	"Full Support Obligation	Policy Responsibility for 1974 (b)	Paid On Responsiblity as of 9/30/74 (c)
I	Connecticut	$ 27,143	$ 20,835	$ 33,516	$ 27,143	$ - 0 -
	Delaware	2,891	3,119	5,017	3,119+	4,597
	District of Columbia	308	5,966	9,598	5,966+	3,600
	Maryland	31,688	23,507	37,816	32,550+	19,600
	Massachusetts	36,574	35,588	57,250	35,588+	17,800
	New Jersey	48,256	48,108	77,391	48,108+	17,225
	New York	40,000	124,307	199,972	70,000+	1,000
	Pennsylvania	66,619	65,972	106,129	66,531+	22,700
	Rhode Island	5,776	5,345	8,599	5,345+	4,008
	West Virginia	400	7,553	12,151	7,553+	1,475
	Maine	- 0 -	4,646	7,474	- 0 -	- 0 -
	New Hampshire	- 0 -	3,976	6,395	- 0 -	- 0 -
	Vermont	- 0 -	2,208	3,552	- 0 -	- 0 -
	TOTAL	$ 259,655	$ 351,130	$ 564,860	$ 301,903	$ 92,005
II	Alabama	14,328	14,293	22,994	14,293+	6,000
	Florida	36,621	36,568	58,826	36,568+	15,279
	Georgia	22,318	22,155	35, 640	22,155+	16,616
	Mississippi	8,388	8,249	13,270	8,249	6,291
	North Carolina	24,050	23,700	38,127	24,050+	15,936
	South Carolina	11,416	11,505	18,507	11,505+	7,000
	Tennessee	18,700	17,547	28,227	18,700+	13,336
	Virginia	11,848	23,979	38,574	23,979+	18,000
	TOTAL	$ 147,669	$ 157,996	$ 254,165	$ 159,499	$ 98,458

APPENDIX TO ATTACHMENT #18

REGION	DIVISION	Paid In 1973 (a)	"Minimum Obligation 1974	"Full Support Obligation	Policy Responsibility for 1974 (b)	Paid On Responsibility as of 9/30/74 (c)
III	Illinois	$ 39,022	$ 71,453	$ 114,946	$ 50,000	$ 33,500
	Indiana	50,631	28,277	45,490	45,490+	34,155
	Michigan	51,655	51,384	82,662	51,384+	38,538
	Minnesota	23,045	20,952	33,705	23,000+	10,417
	Ohio	688	60,186	96,822	60,186+	19,500
	Wisconsin	23,619	23,708	38,140	23,708+	- 0 -
	Kentucky	14,642	14,608	23,501	14,608+	10,955
	TOTAL	$ 203,302	$ 270,568	$ 435,266	$ 268,376	$ 147,065
IV	Arkansas	8,084	8,018	12,898	8,084+	3,021
	Iowa	15,845	15,654	25,182	15,845+	7,000
	Kansas	18,000	12,688	20,380	18,000+	14,251
	Louisiana	16,792	16,304	26,227	16,792+	11,667
	Missouri	24,822	24,593	36,562	24,822+	8,000
	North Dakota	6,000	3,141	5,052	5,052	6,000
	Oklahoma	12,426	12,318	19,815	12,426+	8,125
	South Dakota	5,100	3,481	5,600	5,100+	3,400
	Texas	58,227	57,646	92,735	57,646	43,232
	Nebraska	- 0 -	8,165	13,152	8,175	- 0 -
	TOTAL	$ 165,296	$ 161,998	$ 260,603	$ 171,942	$ 104,696

REGION	DIVISION	Paid In 1973 (a)	"Minimum Obligation 1974	"Full Support Obligation	Policy Responsibility for 1974 (b)	Paid On Responsibility as of 9/30/74 (c)
V.	Alaska	$ 1,971	$ 1,977	$ 3,180	$ 1,977+	$ - 0 -
	Arizona	9,392	9,295	14,954	9,392+	4,696
	California	1,928	128,003	205,918	40,000+	40,000
	Colorado	19,045	12,049	19,382	19,000+	8,983
	Hawaii	8,328	5,049	8,122	8,122+	8,122
	Idaho	- 0 -	3,253	5,234	3,253+	1,600
	Montana	4,950	3,372	5,428	4,950+	3,600
	Nevada	- 0 -	3,250	5,228	- 0 -	- 0 -
	New Mexico	- 0 -	4,410	7,095	- 0 -	- 0 -
	Oregon	11,277	11,272	18,133	11,277+	8,100
	Utah	8,794	4,882	7,853	7,853	6,597
	Washington	- 0 -	19,867	31,961	- 0 -	- 0 -
	Wyoming	1,688	1,627	2,618	1,688+	1,628
	TOTAL	$ 67,373	$ 208,308	$355,106	$107,512	$ 83,326
	TOTAL ALL REGIONS	$ 843,295	$1,150,000	$ 1,850,000	$ 1,009,232	$ 525,550

NOTES:

(a) The 1973 Support Column:
(1) Includes credited income received directly by National and shared as per Revised Financial Support Policy, November, 1972.
(2) Includes accounts receivable for 1973 Support of $16,041 for Connecticut and $6,063 for Florida.

(b) The "Responsibility" is taken from the Financial Relationships which provides that: Divisions at or above "Full Support Obligation" during the 1970-1972 phasing-in of the new Policy need to comply only with the "Full Support Obligation" determined for the current year. Divisions at or above "Minimum Obligation" but below "Full Support" must increase National Support in the same proportion as their own growth of income; Divisions failing to meet their "Minimum Obligation" must comply with special conditions for continued affiliation, including support requirements.

The (+)plus symbol is shown for those Divisions at or above "Minimum Support" but below "Full Support" meaning their responsibility is "Minimum Support" or the level acheived in 1973 (exclusive of credited income received directly by National), which ever is greater plus an increase in proportion to growth in Division Income.

(c) Figures shown in Column 4 (Paid on Responsibility) represents support payments received as of the date of this statement, and are applicable to the year 1974 only.

RECOMMENDED AUTHORIZATION LEVEL FOR ASSESSMENT OF DIVISIONS IN 1976

The Financial Support Policy stipulates that it is the Membership which sets the Authorization Level.

The 1974 Authorization Level for assessment of Divisions is:

FULL SUPPORT OBLIGATION	$1,850,000
MINIMUM OBLIGATION	1,150,000

The 1975 Level is:

FULL SUPPORT OBLIGATION	$1,775,000
MINIMUM OBLIGATION	1,225,000

(The Executive Committee had recommended $1,700,000 and $1,300,000, respectively, but the Membership amended the proposal.)

Two basic decisions faced the Organization and Executive Committees as they considered the 1976 Levels:

1. How important is it to bring these two levels together?

   (The policy states:

   "Hopefully, within five years the two authorization levels will be sufficiently close together to be abandoned in favor of one uniformly support authorization (with recognition that some variations annually will be inevitable). This is a definitely stated objective, and the plan should be modified to accomplish this at the earliest feasible time.")

2. How much upward adjustment of Minimum Obligation is realistic and fair?

   The dilemma is obvious. If it costs 10% more to do the same, shouldn't there be a corresponding adjustment? On the other hand, can Divisions handle it?

The Committees felt that it was important to bring the two levels together but, after reviewing the specific dollar requirements for Divisions, recognized that achievement of this goal might take three, and perhaps four, years. They looked at three different sets of calculations:

a. A major reduction in Full Support with a modest increase in Minimum Obligation;

b. Modest adjustments in both; and

c. Bringing the two levels together now (1976).

When the Committees studied these figures, they realized that our goal of bringing the two together is probably three years away, and that even this achievement will require the Full Support Level to drop more rapidly than the Minimum Support Level rises.

Both Committees agreed that the most it is safe to drop the Full Support Level for 1976 is $125,000, and the most we can expect to raise the "Minimum" is $100,000.

ON THIS BASIS THE EXECUTIVE COMMITTEE RECOMMENDS TO THE MEMBERSHIP THAT THE FULL SUPPORT OBLIGATION FOR 1976 BE SET AT $1,650,000 AND THE MINIMUM OBLIGATION LEVEL SET AT $1,325,000.

Attached is a projection of Division financial obligations in accordance with this recommendation.

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.
PROJECTION OF DIVISION FINANCIAL OBLIGATIONS FOR 1975

	"E.B.I. PERCENTAGE FACTOR (1972)	"E.B.I. PERCENTAGE FACTOR (1973)	1973 SUPPORT PAYMENT	1975 "FULL SUPPORT OF A $1,775,000 AUTHORIZATION BASED ON 1972 E.B.I.	1976 "FULL SUPPORT OF A $1,650,000 AUTHORIZATION BASED ON 1973 E.B.I.	1974 "MINIMUM OBLIGATION OF A $1,150,000 AUTHORIZATION BASED ON 1971 E.B.I.	1975 "MINIMUM OBLIGATION OF A $1,225,000 AUTHORIZATION BASED ON 1972 E.B.I.	1976 "MINIMUM OBLIGATION OF A $1,325,000 AUTHORIZATION BASED ON 1973 E.B.I.
REGION I								
Connecticut	1.7517	1.7500	36,226	31,093	28,875	20,835	21,458	23,187
Delaware	.2811	.2969	2,891	4,990	4,899	3,119	3,443	3,934
D.C.	.5071	.4883	308	9,001	8,057	5,966	6,212	6,470
Maryland	2.0891	2.0728	31,688	37,082	34,201	23,507	25,591	27,464
Massachusetts	2.9748	2.9161	36,574	52,803	48,116	35,588	36,441	38,638
New Jersey	4.0784	4.1073	48,256	72,392	67,771	48,108	49,960	54,422
N.Y. (S.C.)*	10.1125	9.7428	40,000	179,497	160,756	124,307	123,878	129,092
Penna.	5.7427	5.6606	66,619	101,933	93,400	65,972	70,348	75,003
Rhode Island	.4612	.4606	5,776	8,186	7,600	5,345	5,650	6,103
W.Va. (S.C)	.6861	.6795	400	12,178	11,212	7,553	8,405	9,004
Maine(not a Division)	.4114	.4071	0	7,302	6,717	4,646	5,040	5,394
New Hampshire(Not a Division)	.3413	.3524	0	6,058	5,815	3,976	4,181	4,669
Vermont (not a Division)	.1912	.1869	0	3,394	3,084	2,208	2,342	2,476
TOTAL	29.6286	29.1213	268,738	525,909	480,503	351,130	362,949	385,856
REGION II								
Alabama	1.2937	1.3108	14,328	22,963	21,628	14,293	15,848	17,368
Florida	3.3301	3.5201	36,621	59,109	58,082	36,568	40,794	46,641
Georgia	1.9629	1.9681	22,318	34,841	32,474	22,155	24,045	26,077
Mississippi	.7725	.7666	8,388	13,712	12,649	8,249	9,463	10,157
North Carolina	2.1042	2.0963	24,050	37,350	34,589	23,700	25,776	27,776
South Carolina	1.0075	1.0204	11,416	17,883	16,836	11,505	12,342	13,520
Tennessee	1.6021	1.6196	18,700	28,437	26,723	17,547	19,626	21,460
Virginia	2.1663	2.1758	11,848	38,452	35,901	23,979	26,537	28,830
TOTAL	14.2393	14.4777	147,669	252,747	238,882	157,996	174,431	191,829
REGIONIII								
Illinois (S.C.)	6.1838	6.0312	39,022	109,762	99,515	71,453	75,751	79,914
Indiana	2.4747	2.5105	50,631	43,926	41,423	28,277	30,315	33,264
Michigan	4.6563	4.7950	51,655	82,649	79,117	51,384	57,039	63,533
Minnesota	1.7890	1.8111	23,045	31,755	29,883	20,952	21,915	23,997
Ohio	5.2339	5.2616	688	92,902	86,816	60,186	64,115	69,716
Wisconsin	2.0268	2.0338	23,619	35,976	33,558	23,798	24,828	26,948
Kentucky	1.2893	1.3126	14,642	22,885	21,658	14,608	15,794	17,392
TOTAL	23.6538	23.7558	203,302	419,855	391,970	270,568	289,757	314,764

ATTACHMENT #19

APPENDIX TO
ATTACHMENT #19

REGION IV	"E.B.I. PERCENTAGE FACTOR (1972)	"E.B.I. PERCENTAGE FACTOR (1973)	1973 SUPPORT PAYMENT	1975 "FULL SUPPORT OF A $1,775,000 AUTHORIZATION BASED ON 1972 E.B.I.	1976 "FULL SUPPORT OF A $1,650,000 AUTHORIZATION BASED ON 1973 E.B.I.	1974 "MINIMUM OBLIGATION OF A $1,150,000 AUTHORIZATION BASED ON 1971 E.B.I.	1975 "MINIMUM OBLIGATION OF A $1,225,000 AUTHORIZATION BASED ON 1972 E.B.I.	1976 "MINIMUM OBLIGATION OF A $1,325,000 AUTHORIZATION BASED ON 1973 E.B.I.
Arkansas	.7103	.7290	8,084	12,608	12,029	8,018	8,701	9,659
Iowa	1.3482	1.3553	15,845	23,931	22,362	15,654	16,515	17,958
Kansas	1.1072	1.1238	18,000	19,653	18,542	12,668	13,563	14,890
Louisiana	1.4338	1.4261	16,792	25,450	23,531	16,304	17,564	18,896
Missouri	2.1408	2.1722	24,822	37,999	35,841	24,593	26,225	28,782
North Dakota	.2632	.2830	6,000	4,672	4,670	3,141	3,225	3,750
Oklahoma	1.1063	1.1156	12,426	19,637	18,407	12,318	13,550	14,782
South Dakota	.2881	.2806	5,100	5,114	4,630	3,481	3,530	3,718
Texas	5.1048	5.1285	58,227	90,610	84,620	57,646	62,534	67,953
Nebraska (S.C)	.7115	.7321	0	12,629	12,079	8,175	8,716	9,700
TOTAL	14.2142	14.3462	165,296	252,303	236,711	161,998	174,125	190,088
REGION V								
Alaska	.1738	.1754	1,971	3,085	2,894	1,977	2,129	2,324
Arizona	.9034	.9244	9,392	16,035	15,253	9,295	11,067	12,248
Calffornia	11.0002	10.9325	1,928	195,255	180,386	128,003	134,752	144,856
Colorado	1.1466	1.1895	19,045	20,352	19,627	12,049	14,046	15,761
Hawaii	.4222	.4219	8,308	7,494	6,961	5,049	5,172	5,590
Idaho	.2993	.3195	0	5,312	5,272	3,253	3,666	4,233
Montana	.3071	.3064	4,950	5,451	5,056	3,374	3,762	4,060
Nevada(not a Division)	.2885	.2909	0	5,120	4,800	3,250	3,534	3,855
New Mexico(not a Division)	.4295	.4323	0	7,623	7,133	4,410	5,262	5,729
Oregon	.9911	.9936	11,277	17,592	16,394	11,272	12,142	13,165
Utah	.4638	.4605	8,794	8,232	7,598	4,882	5,681	6,101
Washington (S.C.)	1.6725	1.6835	0	29,687	27,778	19,867	20,490	22,307
Wyoming	.1661	.1686	1,688	2,948	2,782	1,627	2,035	2,234
TOTAL	18.2644	18.2990	67,373	324,186	301,934	208,308	223,738	242,463
GRAND TOTAL	100.0000%	100.0000%	$ 852,378	$ 1,775,000	$ 1,650,000	$1,150,000	$ 1,225,000	$ 1,325,000

* S.C. - State Committee

PRELIMINARY THOUGHTS ABOUT THE FIVE YEAR GOALS FOR 1976-80

The current Five Year Goals were approved by the Membership in November 1970 for the years 1971 through 1975. The summary of conclusions and recommendations which were approved by the Membership are appended to this attachment.

At next year's Annual Meeting the Members will be voting on the Five Year Goals for 1976-80.

During 1973 a Task Force has been at work to give preliminary thought on how we can most effectively approach the job of establishing the major goals for the next five-year period.

The Task Force is agreed that, though the current goals have been very important, most of them are "process" goals rather than specific targets. For example, they call for the organization to strengthen its social action profile and to devote more attention to "capital resources development." Members of the Task Force are inclined to work toward several types of goals in the categories outlined below. It's important at this stage to get the reaction of the Membership in order to be certain that we are moving ahead in a way that will make sense to the Members.

We recommend that the goals be developed in the following four areas:

1. Process Goals

   This would essentially be a reaffirmation of much of what's in the current Five Year Goals re process. For instance, this would call for continued narrowing of our functions to the social action role, further development of the priority of "capital resources development," further emphasis on the need to focus our resources, etc.

   In other words, in this first section we would state that we have made some very substantial progress in the profile of the organization and how the organization accomplishes its goals, but that we need to even further emphasize these essential characteristics of operation in the next five years.

2. Internal Goals

   This section might relate to the Unity and Standards Report. We might point out, for example, that in the next five years we should aim to have developed the comprehensive standards in each of the categories described in the Unity and Standards Report and should be well into the routine periodic evaluations.

3. Fund Raising Goals

   The last time around, largely because of the different timing of the two projects, we separated specific fund raising goals

from other goals. This time the specific fund raising dollar goals for 1980 would be included in the overall report.

4. Program Goals

We would try to identify very specific program goals. Examples (and only that) are:

a. The completion of 1500 community mental health centers.

b. Comprehensive mental health coverage in national health insurance.

c. Routine system of periodic citizen evaluation of community mental health centers.

d. An acceptable prevention role in at least one-half of the centers.

e. Certain public information and education goals relating to specific and quantitative increases in public understanding of certain basic facts.

In approaching this task we would start with a retrospective review. This would of course include an evaluation of our progress on the current Five Year Goals, but we would expect to go even further back to take a look at where the Association and mental health field were 10, and perhaps even 25, years ago to determine where have we come, what were we like many years ago, what were the obstacles, aspirations, priorities, and what have been our accomplishments?

We would hope to use a part of all of the standard meetings so that, at Board Meetings, meetings of the Presidents Council, sessions of the Staff Managers, the Staff Institute, regional gatherings, etc., we could get from as broad a group as possible the various perceptions of what is most important to reach for in 1980.

The Task Force would tie into most major National committees. Current thinking is that the Task Force and appropriate consultants would be involved in two major "retreats." The object would be to bring together the leaders of the groups who are trying to develop the separate parts of the total report. The object of the Spring meeting would be to coordinate these efforts and to be sure we are not biting off more than is realistic to put on the organization for 1976-80. After the Spring session the individuals would go back to finish their recommendations which would then be submitted to an early Fall session. All of this would be aimed at getting a report ready for submission to the Membership at least 30 days in advance of the Annual Meeting.

The reaction and suggestions of the full Membership are welcome and very much needed.

REPORT ON FIVE-YEAR GOALS

Summary of Conclusions and Recommendations

Most reports on NAMH plaintively contrast the Association's sweeping cause with its limited income, regretfully compare that income with what others raise and conclude with a cheerleader's plea that we should all fight harder.

This Report on Five-Year Goals is neither so pleading nor so polite.

We fail to see that the Association has yet devoted itself consistently and methodically to growth and we are conversely impressed that the Association has accepted such a proliferation of emphases, priorities and diverse goals as to utterly obscure successful pursuit of any determined course of growth.

Various reviews and characterizations of the Association also gingerly tiptoe around the issue of whether the National Office is a headquarters or a service center. We don't particularly care whether it's called a corporate headquarters or the hub of a federation, it is the central office and as such must provide dynamic leadership and devote realistic attention to capital resources development.

After participating in the Association as volunteers for many years, and after studying it as planners for one year, we perceive the National five-year goals with unanimous definiteness.

1. The National Board must control the scattering of its resources so that realistic concentrations are possible around efforts which truly count the most.

2. Among the National Board's major concentrations must be the development of this Association's capital resources -- people and dollars.

3. Given the Association's lack of concentration on capital resources development in the past and given the uniqueness of this responsibility to the National level of any organization, the Board must make a major change in its approach to allocation of resources before any sizeable and sustained investment will really occur.

4. Unpleasant administrative practices must be applied in order to lock in the assigned resources to their intended purposes. Included among such devices is an annual evaluation of staff man-hours to determine if they were used as budgeted.

5. The Board has already called for and accepted several reports on major organizational questions, particularly on financial relationships and on Division and Chapter structure. The Board must now be aware that the implementation of these requires a concentration of effort far beyond what is now being applied. The Board must

realize that is is altogether unrealistic to commit itself to such sweeping organizational changes without assigning the necessary resources to see them through.

6. The National level resources which are assigned to immediate program pursuits should be concentrated in patterns designed to achieve the greatest results for the investment available. With the sizeable commitment of national level resources which must be devoted to financial and organizational development the Board must make every iota of attention to program really count. To do this, the Board must give more than lip-service to its previous determination that social action is the basic means by which the organization achieves its program goals. The Association may have its limitations but its still powerful citizen force can be fairly readily translated into millions of dollars of services if we concentrate our effort on the development and extension of comprehensive mental health services at the local, state and national levels.

7. The determination of areas of concentration must be methodically and doggedly followed up by the development of detailed plans by which each of these areas will be minutely pursued. In turn, these programs must be translated into the dollars and man-hours needed to implement them. Otherwise we shall simply have engaged in one more exercise of goal-setting without follow through.

The following pages attempt to provide amplification of these conclusions and recommendations. However, we are eager that the additional volume of even our own words not obscure the basic message which simply stated says: The National Board and Executive Committee have contributed to an absurd proliferation of goals, commitments and targets to the end that these commitments vastly exceed the resources available to achieve them and the result is confusion and impotence. Only the National level can fulfill the central leadership role in helping the organization to build its capacity. The immediate need is obviously "capital resources development", the systematic and determined development of people and dollars.

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

TO THE VOTING MEMBERSHIP:

Consistent with the NAMH By-Laws the Nominating Committee hereby submits the following slates for DELEGATE DIRECTORS, DIRECTORS-AT-LARGE and OFFICERS:

DELEGATE DIRECTORS

		Term of Office
Region I		
District of Columbia	Juliette Simmons, M.D.	3 years
Massachusetts	Richardson Reid	3 years
Region II		
Alabama	Earl Pippin	3 years
Mississippi	Forthcoming	3 years
North Carolina	Mrs. Leif Valand	3 years
Region III		
Indiana	Adrian C. VanderMast	3 years
Ohio	Richard Bajus	3 years
Region IV		
Iowa	Forthcoming	3 years
Kansas	Jerry W. Cole	3 years
Louisiana	Mrs. James W. Reily, Jr.	3 years
North Dakota	Herbert Miller	3 years
Texas	Tom J. Caldwell, Jr.	3 years
Region V		
Arizona	Mrs. Joseph Gershon	3 years
Colorado	Mrs. Charles Gaylord	3 years
Hawaii	Rev. Robert W. Fiske	2 years
Montana	Mrs. Dorothy Hellander	3 years
Oregon	Robert W. Hocks	3 years
Wyoming	Mrs. Norman Stark	3 years

DIRECTORS-AT-LARGE

Class of 1977

Region I	
Connecticut	Mrs. Albert Kohn
Delaware	Charles Dent
District of Columbia	Reaves F. Nahwooksy, Sr.
Region II	
Tennessee	Sandford F. Brandt
Region III	
Illionis	Ruth Allen Fouche', Ph.D.
Indiana	Walter J. Matthews
Minnesota	William G. McFadzean
Wisconsin	Clayton Droullard
Region IV	
Arkansas	Mrs. Wilma Greer
Missouri	Arnold H. Brown
Texas	Milton Leech
Region V	
California	Robert E. Andreen
Colorado	Mrs. Lou Melnick

Class of 1976

Region II	
Florida	Elizabeth L. Metcalf, Ph.D.

Class of 1975

Region I	
Massachusetts	Irving H. Chase
Region III	
Illinois	Robert Leys

OFFICERS

President	Gerridee Wheeler
President-Elect	Thomas H. Watkins
Vice President, Fund Raising	E. Blair Warner
Vice President, Organization & Development	Walter J. Matthews
Vice President, Program	Carter L. Lowe
Vice President, Public Information	William D. Rice
Vice President, Region I	Samuel S. Goldstein
Vice President, Region II	Beverly Long
Vice President, Region III	William G. McFadzean
Vice President, Region IV	Warren D. Welliver
Vice President, Region V	Robert E. Andreen
Treasurer	Arnold H. Brown
Assistant Treasurer	Joseph Greif
Secretary	Ruth Allen Fouche', Ph.D.
Assistant Secretary	Paul Messplay

Respectfully submitted,

NOMINATING COMMITTEE
William G. McFadzean, Chairman
Arnold B. Barach
James W. Hijar
Ralph C. Kennedy, M.D.
Milton Leech
Mrs. Roger Marshall
Mrs. Lou Melnick
Mrs. F. Philip Nash, Jr.
Mrs. Wilbur F. Pell

BASIC CHART OF MOTIONS

	SECOND	DEBATE	AMEND	VOTE	RECONSIDER	INTERRUPTS
PRIVILEGED MOTIONS (high privilege motions)						
Fix a time to which to adjourn	S	—	A	M	R	—
Adjourn	S	—	—	M	—	—
Recess	S	—	A	M	—	—
Raise a question of privilege	—	—	—	Ch.	—	I.S.
Call for orders of the day	—	—	—	Ch.	—	I.S.
(Takes a ⅔ negative vote to prevent return)						
SUBSIDIARY MOTIONS (assisting motions)						
Lay on the table	S	—	—	M	—	—
Previous question (close debate)	S	—	—	⅔	R*	—
Limit or extend debate	S	—	A	⅔	R	—
Postpone to a set time (definite)	S	D	A	M	R	—
(To make Special Order ⅔ vote)						
Commit (refer to a committee)	S	D	A	M	R	—
Amend	S	D	Aa*	M	R	—
Postpone indefinitely	S	D	—	M	R-a	—
MAIN (or Principal) MOTION OR RESOLUTION	S	D	A	M	R	—
NOTE: The above motions hold the rank indicated with the main motion lowest in rank.						
RESTORATORY MOTIONS (main motions)						
Reconsider (the vote)	S	D*	—	M	—	I.P.
Rescind (repeal)	S	D	A	⅔*	R-n	—
Ratify (approve)	S	D	A	M	R-n	—
Take from the table	S	—	—	M	—	—
SPECIAL MAIN MOTIONS						
By-laws (amending or revising)	S	D	A	⅔	R-n	—
Accepting or adopting reports of committees	S	D	A	M	R	—
INCIDENTAL MOTIONS (incidental to the pending question)						
Demands or Requests (decided by the Chair)						
Point of Order	—	—	—	Ch.	—	I.S.
Parliamentary Inquiry	—	—	—	Ch.	—	I.P.
Miscellaneous Information or Requests	—	—	—	Ch.	—	I.P.
Division of Assembly	—	—	—	Ch.	—	I.P.
Withdraw a Motion (by motion S.M. R-n)	—	—	—	Ch.	—	I.P.
Withdraw a second	—	—	—	Ch.	—	I.P.
Question Quorum	—	—	—	Ch.	—	I.S.
Objections						
Objection to General Consent	S	—	—	M	R-n	I.P.
Object to Consideration of a Question	—	—	—	⅔	R-n	I.P.*
Appeal Decision of the Chair	S	D*	—	M	R	I.P.
Reading Papers—Object to	S	—	—	M	R-n	I.P.
Expediters						
Suspend Rules	S	—	—	⅔	—	I.P.
Choose Method of Voting	S	—	A	M	—	I.P.
Close Nominations or Polls	S	—	A	⅔	—	I.P.
Reopen Nominations or Polls	S	—	A	M	R-n	I.P.
Division of Question or Motion	S	—	A	M	—	I.P.
Consideration by Paragraph—Seriatim	S	—	—	M	R-n	I.P.
(Chair may suggest)						
Filling blanks	—*	—	—	M	R-n	I.P.

LEGEND: "S" indicates a second is required.
"D" indicates debatable.
"A" indicates amendable.
"Aa*" under Amend indicates only two amendments can be pending at one time.
"M" (Majority) or "⅔" indicates vote required.
"R" that vote on motion may be reconsidered—if followed by a "n" only negative vote and if by an "a" only the affirmative vote.

"I.S." indicates may interrupt a speaker.
"I.P." indicates may interrupt a proceeding and usually a speaker with consent.
(*) indicates there are one or more exceptions but these can be considered minor as basically the rule indicated applies.
(—) indicates a "NO" under that particular heading.
"Ch." chair decides or rules

GEORGE WATSON COLLEGE LIBRARY


The National Association for Mental Health, Inc.
1973 Annual Report

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Annual Meeting

The annual meeting of the membership will be held on November 20, 1974, in Washington, D.C. A Notice and Proxy Statement will be mailed to all voting members approximately 30 days in advance of the meeting at which time the return of proxies will be requested.

The National Association for Mental Health, Inc. • 1800 North Kent Street • Arlington, Virginia 22209 • (703) 528-6405

To Our Members

Think for a moment how important bridges are in our daily lives. Many of us depend on bridges to get to work — or certainly to complete many important journeys. They play a major role in getting us from where we are to where we want to go.

There are, however, other bridges — very human bridges which are meaning so much to the lives of millions of Americans. The troubled housewife in Boston has a bridge. The man in Denver severely depressed in the transition from job to retirement has a bridge. The woman in Miami, recently widowed — afraid that life has nothing left for her — has a bridge. The hospital patient in Indianapolis — needing a friend, a person to talk to — has a bridge. The child in San Diego, who *can* learn if only given the special help he needs, has a bridge.

That bridge — in rural Kansas or in metropolitan Chicago; in a quiet Texas town or in bustling Philadelphia — is the Mental Health Association. At all three levels — Local Chapter, State Division and National Office we are bridging some very large gaps.

We are a bridge between those who hurt and the services which can help that emotional hurt. We are spanning the gap between weaknesses in mental health care and the legislation which can improve that care. We are the bridge that so many count on for help while hospitalized and when returning to the community.

But most importantly, we are a very real bridge between people — spreading truth and education to replace the myths and fears; giving our message through conversation, public meetings, films, radio and TV spots — wherever and whenever people will listen.

And, they *are* listening. Not only are our volunteer ranks continuing to grow, but businesses are getting more involved. Government officials know we're here and are calling on our help and information. Mental Health professionals understand now — more than ever — the importance of our support.

Our bridges are strong, thanks to each and every volunteer across this land who is doing his or her part for the Mental Health Association.

WE ARE MAKING A DIFFERENCE.

Linden E. Wheeler
President

1973 Highlights

The pages of this report tell of many exciting things going on in the Mental Health Association. But it's only natural to wonder sometimes if we're really doing all we say we're doing. One of my great thrills as President was to be able to visit numerous Divisions and Chapters and see, first-hand, that we *are* making such a difference.

The work of the hundreds of volunteers is making an impact in the smallest community, as well as in national litigation and legislation.

Helen Patton Wright

Mrs. J. Skelly Wright
NAMH President, 1973

For the Mental Health Association, 1973 was by far the most successful in its 65-year history. Through the individual and combined efforts of its nationwide network of volunteers, the Association

- Achieved a major victory in securing renewal of the Community Mental Health Centers Act over the determined opposition of the Administration. As a result of this renewal legislation, Federal appropriations will provide for the start-up of approximately 85 new community mental health centers in Fiscal Year 1973-74. So far, there are 540 such centers operating throughout the country, with only 960 more needed to achieve our goal of 1,500 by 1980.
- Participated with the National Council of Community Mental Health Centers and several other organizations in a successful court action to require the Administration to release $52 million voted by Congress in FY 1972-73 for new community mental health centers and children's programs. The release of this money will provide for the establishment of 94 new centers and several grants for children's services in existing centers.
- Brought another successful suit to require the Administration to release $126 million in impounded funds for mental health manpower, research and alcoholism programs. Not only will these monies expand the nation's mental health manpower pool, but they will also increase its capacity to find the answers to mental illness and to deal with the epidemic of alcoholism.
- Forced the Government to apply minimum wage laws to persons providing productive employment in institutions when that employment is not necessarily related to their therapy. In their joint suit, NAMH and the American Association for Mental Deficiency were, thus, able to end the ritual enslavement of mental patients.
- Fought successfully to gain inclusion of mental health services in Health Maintenance Organization (HMO) legislation. This victory was achieved through the contacts made by Association volunteers with Congressmen who are key members of the health subcommittees of the House and Senate. As a result, any HMO that is set up under Federal

legislation and with Federal funds will be required to provide 20 outpatient visits for the treatment of mental illness. Inpatient care must also be provided if consumers ask for it.

- Worked hard to insure that mental health coverage was included in the Administration's National Health Insurance Proposal. Such efforts were rewarded by an Administration recommendation that included coverage very close to that which has been in the Association's basic proposals for 3 years.
- Witnessed a major breakthrough in the mandating of mental health coverage for health insurance policies sold in Maryland, Massachusetts and Connecticut. These three states have passed pioneering legislation that provides for minimum coverage of mental illness in any health insurance policy sold therein.
- Produced its third major film, *Journey.* Designed to help the public understand more about mental illness, the film delves into the symptoms of emotional upset and how to handle them.
- Helped three major television producers to develop important shows on mental illness — the *60 Minutes* special on depression, *The Fragile Mind,* and *Lisa* — thus, taking a giant step forward in its public education efforts.
- Appointed Dr. Edwin E. "Buzz" Aldrin as 1974 National Mental Health Chairman. The addition of the former astronaut to the growing ranks of dedicated volunteers has provided us with a most important spokesman for the cause. After his historic walk on the moon, Buzz suffered a severe emotional illness that required hospitalization. Instead of keeping the problem a secret, he spoke out on it in an effort to bring the public closer to a better understanding of mental illness and what can be done to treat it.
- Received the second largest bequest ever left it. As part of the will of Roberta Zuhlke of New Jersey, $1,700,000 was placed in a perpetual trust, with the annual income from this coming to the Association.
- Recruited, through the efforts of Robert Leys of Allstate Insurance, key business executives to assist in local fund raising campaigns and activities.
- Recognized the outstanding work of Pulitzer Prize winning author and researcher Dr. Robert Coles of Harvard. For his efforts in establishing firm links between poverty, depravation and mental illness, Dr. Coles received the second annual Mental Health Association Research Achievement Award.
- Promoted increased involvement of ethnic minorities and the poor in the decision-making process at all levels so that mental health services and concerns are more responsive to the special needs of these groups.
- Established a staff traineeship program designed to attract capable, young people who are eager for a career in public service.

These, then, have been some of the major highlights of the past year — a year in which the Mental Health Association achieved unparalleled impact at all of its levels. In 1974, the Association is continuing to build on these successes, especially in the areas of financial development, effective community mental health systems, mental health coverage in National Health Insurance, and organizational operations.

Origin and Purpose

The primary function of the National Association for Mental Health is to promote citizen interest and activity on behalf of the mentally ill and for the cause of mental health. The Association dates its origin from 1909 when Clifford Beers, an ex-mental patient and author of *A Mind That Found Itself,* founded the National Committee for Mental Hygiene. In 1950 the Committee merged with two other organizations, The National Mental Health Foundation and The Psychiatric Foundation, to form a united front as The National Association for Mental Health. The Association's original and continuing purposes are to:

- improve attitudes toward mental illness and the mentally ill;
- improve services for the mentally ill; and
- work for the prevention of mental illness and to promote mental health.

Program

The principal thrust of the organization's program is through social action.

Community Care. Mental Health Association efforts are concentrated on promoting a coordinated system of community-based services. These services are to be easily accessible to anyone within a defined population area who needs them, with their cost covered by health insurance. The outmoded state hospitals of the past are being replaced by smaller, specialized facilities for those patients who require long-term care. Such facilities are to be integrated as a component of the community system.

Prevention. In promoting the community system of care delivery, the Association continues to stress the consultation function of that system as a means of reducing the incidence of mental illness and controlling the forces that may contribute to emotional disability.

Research. Consistent with its focus on social action, the Association also promotes increased mental health research, stimulates the expansion of research resources, and monitors the best possible utilization of knowledge from this research.

Education. Since an informed and understanding public is so vital in any of these programs, the Mental Health Assocation continually communicates a variety of educational messages to its own members, constituents of other organizations, professional groups, and the general public. Media include films, television and print.

Structure and Financing

The Mental Health Association is comprised of 950 chapters serving a city, county, metropolitan area, or combination of counties; 42 divisions (41 state associations and the District of Columbia); 5 State Committees; and a National headquarters.

The gross revenue of the National office, divisions and chapters last year was in excess of $15 million. About one-half of the revenue is derived from United Fund allocations, and one-half from independent sources. The National Program and Operational budget is $1,400,000, of which 70 percent is derived from divisions and local chapters.

Campaign Symbol

The Mental Health Association campaign symbol is a careful blend of the traditional and the new. This popular campaign symbol — first prepared for the 1973 Mental Health Month Campaign — depicts a group of people standing with hands joined, forming an unbroken circle. In the center, or at the heart, of the circle is the Mental Health Association bell, long the traditional symbol of the Association as it engages in its continuing fight for mental health, and against mental illness.

The symbol, which is being used in conjunction with the Association's slogan, *Citizens Who Do Make A Difference,* stresses strength through unity, while making full allowance for individual differences.

As the eye moves around the circle, in either direction, the color of the people changes — from light to dark or dark to light — depending upon where in the circle one starts. The background color changes, too, in contraposition to the people forming the circle.

The changing shades of people, overlayed on the changing shades of the world in which they live, suggests the power of different individuals united to change conditions. The unbroken circle of people suggests togetherness and unity of organization.

Always the central focus, the interior part of the graphic features the Mental Health Association Bell (The original carries the inscription: *Cast from shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness.)* The circle of people with heads towards this bell suggests the many heads concentrating together through an organization trying to find solutions to problems.

That mental health is a full-time, year-round activity is suggested by the fact that there are 12 people forming the circle.

The campaign symbol — which appears in a variety of colors, including black-white-grey — is being used on all Association publications, ads, jewelry, and Mental Health Month campaign materials.

Accountants' Report

To the Board of Directors of
The National Association for Mental Health, Inc.

In our opinion, the accompanying balance sheet and the related statements of public support, revenue and expenses and changes in fund balances and of functional expenditures present fairly the financial position of The National Association for Mental Health, Inc. at December 31, 1973, the results of its operations and the changes in fund balances for the year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year. Our examination of these statements was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

Price Waterhouse & Co.

Washington, D.C.
March 20, 1974

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

BALANCE SHEET

December 31, 1973

With Comparative Totals for 1972

	Unrestricted Funds				Total All Funds	
					December 31	
	General Fund	McAlpin Research Fund	Total	Restricted Fund	1973	1972(1)
Assets						
Cash	$ 93,426	$ 7,989	$ 101,415	$ 44,566	$ 145,981	$ 125,840
Investments (Notes 2 and 4)	100,000	1,507,695	1,607,695		1,607,695	1,550,590
Receivables:						
Affiliated units, net of allowance for uncollectible accounts of $15,000 and $10,000	279,605		279,605		279,605	452,753
Other	25,623		25,623	39,005	64,628	14,750
Inventory of saleable literature and materials, at cost	110,554		110,554		110,554	140,596
Prepaid film production costs	25,331		25,331		25,331	29,642
Prepaid expenses	18,934		18,934		18,934	8,485
Due from other funds				29,589	29,589	5,624
Furniture and equipment less accumulated depreciation of $46,535 and $39,292	16,370		16,370		16,370	17,184
	$669,843	$1,515,684	$2,185,527	$113,160	$2,298,687	$2,345,464
Liabilities and Fund Balances						
Payables:						
Trade	$124,449		$ 124,449	$ 17,873	$ 142,322	$ 82,363
Affiliated units	77,147		77,147		77,147	4,718
Personnel development grants	13,900		13,900		13,900	15,979
Accrued expenses						8,762
Deferred public support	97,360		97,360	69,821	167,181	67,994
Deferred revenue	63,797		63,797		63,797	52,438
Due to other funds	29,589		29,589		29,589	5,624
	406,242		406,242	87,694	493,936	237,878
Fund balance (Note 3)	263,601	$1,515,684	1,779,285	25,466	1,804,751	2,107,586
	$669,843	$1,515,684	$2,185,527	$113,160	$2,298,687	$2,345,464

(1) Restated for comparative purposes.

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

STATEMENT OF PUBLIC SUPPORT, REVENUE, AND EXPENSES AND CHANGES IN FUND BALANCES

Year Ended December 31, 1973

With Comparative Totals for 1972

	Unrestricted Funds				Total All Funds	
	General Fund	McAlpin Research Fund	Total	Restricted Fund	1973	1972
Public support and revenue:						
Public support:						
Contributions (Note 2)	$ 74,970		$ 74,970	$53,222	$ 128,192	$ 95,138
Bequests	86,118		86,118		86,118	75,800
Collected through local membership units	852,419		852,419		852,419	930,001
Allocated from Federal Service Campaign	18,270		18,270		18,270	14,758
Total public support	1,031,777		1,031,777	53,222	1,084,999	1,115,697
Revenue:						
Publication and audiovisual revenue	193,680		193,680	50,500	244,180	219,416
Sale of publications, films and other revenue	223,874		223,874	54,690	278,564	219,471
Less cost of publications and films	(30,194)		(30,194)	(4,190)	(34,384)	(55)
Net publication and audiovisual revenue	2,310	$ 54,295	56,605		56,605	57,857
Investment income		81,745	81,745		81,745	23,564
Realized gain on investments	1,099		1,099	9,795	10,894	35,591
Fees and grants from governmental agencies	19,693		19,693		19,693	245
Miscellaneous	(7,092)	136,040	128,948	5,605	134,553	117,202
Total revenue	1,024,685	136,040	1,160,725	58,827	1,219,552	1,232,899
Total public support and revenue						
Expenses:						
Program services:						
Community services	239,054		239,054	21,420	260,474	193,454
Public health education	292,176		292,176		292,176	254,287
Professional education and training	279,145		279,145	47,296	326,441	312,211
Patient service	53,125		53,125		53,125	37,715
Research	182,243		182,243	3,896	186,139	135,840
Total program services	1,045,743		1,045,743	72,612	1,118,355	933,507
Supporting services:						
Management and general	199,207	6,472	205,679	1,278	206,957	292,420
Fund raising	197,075		197,075		197,075	147,205
Total supporting services	396,282	6,472	402,754	1,278	404,032	439,625
Relocation expenses						218,455
Total expenses	1,442,025	6,472	1,448,497	73,890	1,522,387	1,591,587
Excess (deficiency) of public support and revenue over expenses	(417,340)	129,568	(287,772)	(15,063)	(302,835)	(358,688)
Other change in fund balances:						
Transfer from McAlpin Research Fund	171,650	(171,650)				
Fund balances, beginning of year	509,291	1,557,766	2,067,057	40,529	2,107,586	2,466,274
Fund balances, end of year	$ 263,601	$1,515,684	$1,779,285	$25,466	$1,804,751	$2,107,586

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

STATEMENT OF FUNCTIONAL EXPENSES

Year Ended December 31, 1973

With Comparative Totals for 1972

	Program Services						Supporting Services			Total Expenditures	
	Community Services	Public Health Education	Professional Education and Training	Patient Service	Research	Total	Management and General	Fund Raising	Total	1973	1972
Salaries	$107,612	$131,526	$146,146	$23,914	$ 47,828	$ 457,026	$ 89,677	$ 83,699	$173,376	$ 630,402	$ 621,612
Employee health retirement	10,331	12,627	14,278	2,296	4,591	44,123	8,609	8,035	16,644	60,767	31,619
Payroll taxes	4,567	5,582	4,820	1,015	2,030	18,014	3,805	3,552	7,357	25,371	24,695
Total salaries and related expenses	122,510	149,735	165,244	27,225	54,449	519,163	102,091	95,286	197,377	716,540	677,926
Supplies	6,829	8,347	7,578	1,518	3,035	27,307	5,691	5,311	11,002	38,309	45,001
Telephone and telegraph	7,449	9,104	8,228	1,655	3,311	29,747	6,207	5,793	12,000	41,747	40,054
Professional fees and contract payments	24,404	4,430	5,776	805	1,611	37,026	10,578	2,819	13,397	50,423	34,426
Postage and shipping	3,880	4,607	4,344	838	1,675	15,344	3,140	8,504	11,644	26,988	19,017
Occupancy	11,758	14,370	12,411	2,613	5,225	46,377	9,798	9,145	18,943	65,320	69,095
Outside printing and art work	2,758	2,824	2,995	514	1,027	10,118	1,926	7,368	9,294	19,412	10,149
Conferences	33,530	40,880	36,978	7,433	17,619	136,440	27,873	26,015	53,888	190,328	182,690
Travel	16,779	20,508	23,799	3,729	8,600	73,415	13,982	13,050	27,032	100,447	93,716
Membership dues and support payments	1,429	1,747	28,322	318	635	32,451	1,191	1,112	2,303	34,754	43,844
Research awards and grants					75,997	75,997				75,997	59,200
Personnel development grants	8,640	10,560	9,120	1,920	3,840	34,080	7,200	6,720	13,920	48,000	50,834
Equipment expense	860	1,050	907	191	382	3,390	716	669	1,385	4,775	6,140
Bad debts	17,696	21,628	18,679	3,932	7,865	69,800	14,746	13,764	28,510	98,310	11,658
Interest											11,768
Miscellaneous	652	797	688	145	290	2,572	735	507	1,242	3,814	6,526
Total expenses before depreciation	259,174	290,587	325,069	52,836	185,561	1,113,227	205,874	196,063	401,937	1,515,164	1,362,044
Depreciation	1,300	1,589	1,372	289	578	5,128	1,083	1,012	2,095	7,223	11,088
Total expenses	$260,474	$292,176	$326,441	$53,125	$186,139	$1,118,355	$206,957	$197,075	$404,032	$1,522,387	$1,373,132

NOTES TO FINANCIAL STATEMENTS
December 31, 1973 and 1972

NOTE 1 — ORGANIZATION

The National Association for Mental Health, Inc. (the Association) was organized in 1950 to promote citizen interest and activity on behalf of the mentally ill and the causes of mental illness. The Association is exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code.

NOTE 2 — SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements do not include the accounts of the affiliated state divisions and chapters of the Association, each of which elects its own independent Board of Directors, conducts its own service programs independent of the Association and maintains its own separate financial accounts.

Investments — Investments are recorded at cost or fair market value at date of gift.

Revenues and Expenses

Contributions and bequests are considered to be available for unrestricted use unless specifically restricted by the donors. No amounts have been reflected in the statements for donated services inasmuch as no objective basis is currently available to measure the value of such services. However, a substantial number of volunteers have donated significant amounts of their time to the various program services of the Association.

NOTE 3 — FUNDS

General Fund

The Board of Directors has designated portions of the general fund for the following purposes:

	Contingency Reserve (1)	Personnel Development Program (2)	Legacy Reserve and Uncommitted Funds (3)	Total
Balance, December 31, 1972	$75,000	$ 3,117	$431,174	$509,291
Excess of expenses over public support and revenue		(48,000)	(369,340)	(417,340)
Transfers:				
From McAlpin Research Fund			171,650	171,650
Other		45,000	(45,000)	
Balance, December 31, 1973	$75,000	$ 117	$188,484	$263,601

(1) To offset reductions in public support revenue as a result of possible division disaffiliations.

(2) To provide grants to divisions to aid them in the recruitment of new staff.

(3) Unrestricted bequest revenues and other uncommitted funds.

McAlpin Research Fund

Represents amounts received by the Association as a bequest and allocated by the Board of Directors, in accordance with the donor's expressed desire, to provide funds annually for the Association's research activities.

Restricted Fund

Represents various amounts received by the Association as grants or gifts from foundations and similar donors under the terms of which the donor has restricted or otherwise limited the purpose for which the funds are to be expended.

NOTE 4 — INVESTMENTS

Market value and unrealized appreciation at December 31, 1973 and 1972 are summarized as follows:

	December 31, 1973		December 31, 1972	
	Market Value	Unrealized Appreciation	Market Value	Unrealized Appreciation
General Fund	$ 100,000			
McAlpin Research Fund	2,004,023	$496,328	$2,437,385	$886,902
Restricted Fund			116	9
	$2,104,023	$496,328	$2,437,501	$886,911

NOTE 5 — PENSION PLAN

The Association has a non-contributory pension plan covering substantially all of its employees. Pension expense was $25,574 in 1973 and $4,325 in 1972. The Association's policy is to fund pension cost accrued.

NOTE 6 — LEASED FACILITIES

The Association leases its office space under a lease expiring July 1, 1976 at an annual rental of approximately $65,000.

Divisions

The Alabama Assn. for Mental Health, Inc.
901 South 18th St.
Birmingham, Alabama 35205

Alaska Mental Health Association
1135 West 8th Avenue
Anchorage, Alaska 99501

Arizona Assn. for Mental Health, Inc.
341 West McDowell Road
Phoenix, Arizona 85003

The Arkansas Assn. for Mental Health, Inc.
424 East 6th Street
Little Rock, Arkansas 72202

California Assn. for Mental Health
901 "H" Street, Suite 212
Sacramento, California 95814

Mental Health Assn. of Colorado
1375 Delaware Street
Denver, Colorado 80204

Connecticut Assn. for Mental Health, Inc.
123 Tremont Street
Hartford, Connecticut 06105

Mental Health Assn. of Delaware, Inc.
1813 N. Franklin St.
Wilmington, Delaware 19802

District of Columbia Mental Health Assn., Inc.
2101 16th St., N.W.
Washington, D.C. 20009

Mental Health Assn. of Florida, Inc.
Suite 207, Myrick Building
132 East Colonial Drive
Orlando, Florida 32801

The Georgia Assn. for Mental Health, Inc.
85 Merritts Avenue, N.E.
Atlanta, Georgia 30308

The Mental Health Assn. of Hawaii
200 North Vineyard Blvd., Room 101
Honolulu, Hawaii 96817

Idaho Mental Health Association, Inc.
3105½ State Street
Boise, Idaho 83703

The Illinois State Committee
103 North 5th Street
Room 304
Springfield, Illinois 62701

The Mental Health Assn. in Indiana, Inc.
1433 North Meridian Street
Indianapolis, Indiana 46202

The Iowa Assn. for Mental Health, Inc.
315 E. Fifth Street
Des Moines, Iowa 50309

Kansas Assn. for Mental Health
1205 Harrison Street
Topeka, Kansas 66612

The Kentucky Assn. for Mental Health, Inc.
Suite 104, 310 West Liberty Street
Louisville, Kentucky 40202

The Louisiana Assn. for Mental Health
1528 Jackson Avenue
New Orleans, Louisiana 70130

Maryland Assn. for Mental Health, Inc.
325 East 25th Street
Baltimore, Maryland 21218

Massachusetts Assn. for Mental Health, Inc.
38 Chauncy Street, Rm. 801
Boston, Massachusetts 02111

Michigan Society for Mental Health, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48075

Minnesota Assn. for Mental Health, Inc.
4510 W. 77th Street
Minneapolis, Minnesota 55435

The Mississippi Assn. for Mental Health
402 Executive Bldg., Box 2081
Jackson, Mississippi 39202

Missouri Assn. for Mental Health
411 Madison Street
Jefferson City, Missouri 65101

Montana Assn. for Mental Health
201 S. Last Chance Gulch
Helena, Montana 59601

The Nebraska State Committee
Box 859
Gretna, Nebraska 68028

The New Jersey Assn. for Mental Health, Inc.
60 South Fullerton Avenue
Montclair, New Jersey 07042

The New York State Committee
250 W. 57th Street
Room 1425
New York, New York 10019

North Carolina Mental Health Assn.
Suite 222,
3701 National Drive
Raleigh, North Carolina 27612

North Dakota Mental Health Assn.
P.O. Box 160
Bismarck, North Dakota 58501

Ohio Assn. for Mental Health
Neil House M-59
Columbus, Ohio 43215

The Oklahoma Assn. for Mental Health, Inc.
3113 Classen Boulevard
Oklahoma City, Oklahoma 73118

Mental Health Association of Oregon
718 West Burnside St., Room 301
Portland, Oregon 97209

Pennsylvania Mental Health, Inc.
1207 Chestnut Street
Philadelphia, Pennsylvania 19107

Rhode Island Assn. for Mental Health, Inc.
333 Grotto Avenue
Providence, Rhode Island 02906

South Carolina Mental Health Assn.
1823 Gadsden Street
Columbia, South Carolina 29201

South Dakota Mental Health Assn.
101½ South Pierre Street, Box 355
Pierre, South Dakota 57501

Tennessee Mental Health Association
1717 West End Building
Suite 421
Nashville, Tennessee 37203

The Texas Assn. for Mental Health
103 Lantern Lane
Austin, Texas 78731

Utah Association for Mental Health
211 East 3rd South, Suite 212
Salt Lake Ctiy, Utah 84111

The Virginia Assn. for Mental Health, Inc.
1806 Chantilly St., Suite 203
Richmond, Virginia 23230

The West Virginia State Committee
702½ Lee St.
Charleston, West Virginia 25301

Wisconsin Assn. for Mental Health
119 East Mifflin
P.O. Box 1486
Madison, Wisconsin 53701

Wyoming Assn. for Mental Health
1417 W. 6th Avenue
Cheyenne, Wyoming 82001

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Jackson, Mississippi

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Washington, D.C.

NATIONAL COMMITTEES

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Mrs. J. Skelly Wright
Washington, D.C.

Ad Hoc Committee On Unity & Standards
Milton Leech
El Paso, Texas

Annual Meeting Task Force
Miss Margaret Hickey
Tucson, Arizona

Committee On Mental Health Services For Ethnic Minorities & The Poor
Mrs. Dorothy H. Knox
New York, New York

Communications Awards
Mrs. Geri Joseph
Minneapolis, Minnesota

Finance Committee
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Kansas City, Missouri

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Joint Information Service
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Tucson, Arizona

MH
Richard C. Allen, J.D.
Washington, D.C.

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Nominating Committee
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Minneapolis, Minnesota

Organization Committee
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Panel On Litigation
Kurt Melchior
San Francisco, California

Panel Of Professional Consultants
Robert L. Stubblefield, M.D.
Boulder, Colorado

Public Affairs Committee
Irving H. Chase
Cambridge, Massachusetts

Public Information Task Force
William D. Rice
Salt Lake City, Utah

Research Committee
Alan Levenson, M.D.
Tucson, Arizona

Resolutions Committee
To be elected

State Committees
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Evanston, Illinois

Nebraska—Warren D. Welliver
Columbia, Missouri

New York—Mrs. Hilda H. Robbins
Ft. Washington, Pennsylvania

Washington—David Brofman
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West Virginia—Sandford F. Brandt
Norris, Tennessee

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Assistant Director, Communications

Richard Hunter
Director, Program

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Chief Accountant

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Assistant Director, Fund Raising

David McDonnell
Associate Director, Program (Research)

Paul C. Messplay
Associate Director and Assistant to the Executive Director

Ruth Morse
Director, Fund Raising

Brian O'Connell
Executive Director

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Director, Communications

Robert Smucker
Associate Director, Program (Public Affairs)

John H. Thomas
Assistant Director, Communications

Lawrence F. Uno
Associate Director, Organization and Development

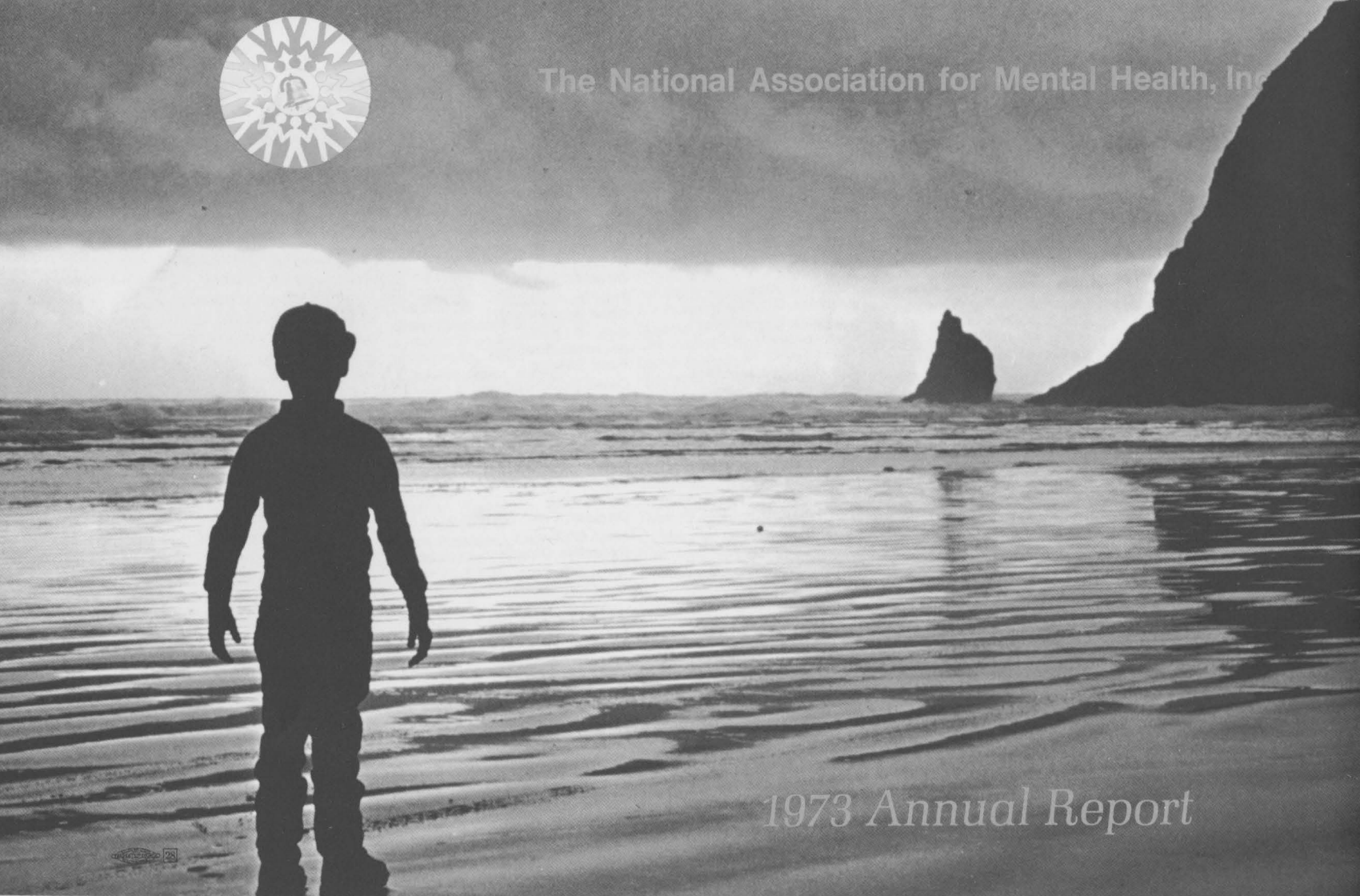
D. Douglas Waterstreet
Director, Organization and Development

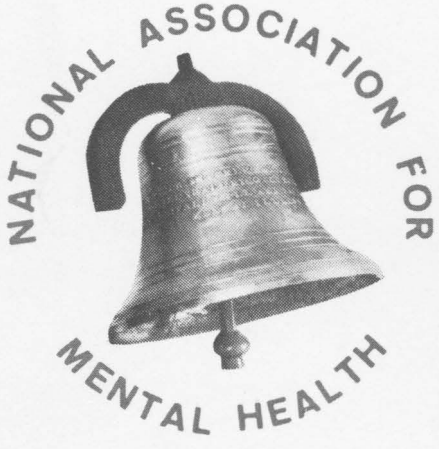
Bequest Form

For those who may wish to remember the National Association for Mental Health in the drawing of their wills, the following bequest form is suggested:

"I bequeath to the National Association for Mental Health, Inc., a corporation organized under the Membership Corporation Laws of the State of New York, having its principal office at 1800 North Kent Street, Arlington, Virginia 22209, the sum of ..... dollars ($.....), to be used by said corporation for the purposes for which it is incorporated."

The National Association for Mental Health, Inc., is an organization exempt from Federal income tax under Section 501 (c) (3) of the Internal Revenue Code as well as under the Tax Reform Act of 1969.


The National Association for Mental Health, Inc
1973 Annual Report



THE NAMH PROGRAM

HOW WE SERVE

- PRINCIPLES
- OBJECTIVES
- BASIC PROGRAM

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.
1800 NORTH KENT ST. • ROSSLYN, VIRGINIA 22209

"We *can* help them. We *must* help them. They need help – that is what their illness means, no matter how disguised. It is a cry for our assistance, and we must know how to answer."– Dr. Karl Menninger

THE NAMH PROGRAM - HOW WE SERVE

The National Association for Mental Health is the national voluntary citizens' organization which is leading the fight against mental illness. Currently focusing on serious mental illness, we in the NAMH are committed to helping the mentally ill, their families, and the community.

To concentrate attention on the needs of the seriously mentally ill, we have chosen four program emphases:

Improved Care and Treatment for Mental Hospital Patients

Aftercare and Rehabilitation Services

Treatment, Education and Special Services for Mentally Ill Children

Community Mental Health Services

We – the national office, divisions, and chapters – support research, engage in social action and legislative activity to stimulate provision of adequate services for mentally ill persons in every community, provide services to patients and their families, and educate and inform the public and special groups about mental illness and the mentally ill.

The three levels of the organization are united in carrying out these functions. Each level supports and assists the others.

All association action – whether national, state or local – is aimed toward the achievement of our common objectives, in a common effort within a common program.

To bring about concerted efforts at all levels, the association has adopted principles, established objectives, and outlined a basic program.

The *Principles* tell why we believe action by the NAMH is necessary.

The *Objectives* are the goals we are trying to achieve in each area of program emphasis. All mental health associations have the same objectives. Some of them we can achieve alone; for most of them, we must work with others – community groups, professional organizations and governmental agencies – stimulating them to do what must be done.

The *Basic Program* represents a method by which a mental health association operates in translating its program commitment into action. It includes all of the elements necessary for an orderly, balanced approach to meeting the needs of the mentally ill.

Before any mental health association undertakes any program activities it must be organized in a manner which assures efficient and effective operation; and it must be capable of raising the funds it needs to support chapter, division and national efforts to fight mental illness and help the mentally ill.

With a foundation of commitment, proper organization and fund-raising capability, an MHA is ready to undertake a basic program. The chart on page 3 shows what the basic program includes.

An association with a fully developed program will be carrying out all of the required actions (listed on left in chart) in each of the four program emphases. Obviously this kind of program cannot be achieved immediately, but it represents the goal toward which every association should strive.

The program committee has overall responsibility for the association's program development. It designates the committee, group or person responsible for directing activities related to each of the program emphases. These committees proceed with fact-finding, determine what needs to be done, and make their recommendations. The board of the association then sets the priorities. To make the best use of funds and manpower, it is essential that every proposed program priority meet strict tests of relevancy, importance and immediacy of significant results.

When choosing an objective or a specific activity, the association should also judge how well it meets the following considerations:

1. Does it provide the opportunity to utilize and involve volunteers in all phases of mental health association?

   By involving volunteers we develop an informed and motivated corps of people to carry out the purposes of the association and provide them with a means of translating their concern into concrete action to help the mentally ill.

2. Will it help alleviate the present acute shortage of mental health manpower?

3. Is it related to present developments in state mental health planning?

   A great deal of Federal financial support and state effort has gone into state mental health planning activities. It is imperative that we utilize this investment in the best interests of the mentally ill.

After priorities have been established, the responsible committees are then ready to undertake whatever action is needed to achieve those objectives.

In providing services to help the mentally ill, their families and others in the community, mental health associations must be guided by the NAMH Policy on Service adopted in November, 1963. "The NAMH Policy on Service: What It Means to Your Association" discusses in detail the four standards which must be applied in providing any service and notes that the policy is "to be observed by all divisions and chapters as participants in the National Association for Mental Health, Inc."

BASIC PROGRAM

FOR NAMH DIVISIONS AND CHAPTERS

to combat serious mental illness

REQUIRED ACTION	PROGRAM EMPHASES			
	Improved Mental Hospitals	Aftercare & Rehabilitation Serv.	Services for Mentally Ill Children	Community Mental Health Serv.
ORGANIZE FOR ACTION Assign responsibility for your association's activity in each program emphasis.				
FACT-FINDING Find out extent of problem and availability of resources to help in establishing program objectives.				
PUBLIC AND SPECIAL GROUP EDUCATION Educate and inform the public and special groups about mental illness and about problems, needs, and association activities. (Education Committee)				
INFORMATION SERVICE Provide reliable information on available services and facilities. (Information Service Committee)				
LEGISLATIVE AND SOCIAL ACTION Work for establishment, improvement, and support of public and private services and facilities. (Leg. & Public Policy Committee)				
SERVICE TO THE MENTALLY ILL AND THE COMMUNITY Carry on service projects. (Program sub-committee or a project committee) Provide volunteer services (Volunteer Committee)				

PROGRAM EMPHASIS: TREATMENT FOR IMPROVED CARE AND MENTAL HOSPITAL PATIENTS

THE PROBLEM - WHY WE ARE CONCERNED

Crippled by acute personnel shortages, inadequate facilities and insufficient equipment, most public mental hospitals cannot provide even minimum psychiatric treatment to all the patients. For every patient who receives any kind of treatment, there is likely to be another who gets nothing except custodial care. Most public mental hospitals are mammoth institutions, often overcrowded, isolated from the community. Patients are thus deprived of the proven benefits of contact with their families, friends, and familiar community resources. The state hospital must become in *fact* what it is now in name only – a hospital.

PRINCIPLES - WHAT WE BELIEVE

1. The National Association for Mental Health is concerned with the welfare of the mentally ill in public mental hospitals and is dedicated to the improvement and extension of hospital treatment services.

2. Mental hospitals should be an integral part of a comprehensive mental health program, able to provide every patient humane care and the best scientific treatment appropriate to his condition.

3. When extended hospitalization is required, it will usually be provided in public mental hospitals under federal, state or local government auspices. When possible, individuals should assume financial responsibility for their treatment, but no one should be denied adequate treatment because of inability to pay.

4. The National Association for Mental Health
   encourages research, education, social action and service to see that the mental hospital, as one of several elements of comprehensive mental health services, provides persons needing hospitalization with the best treatment aimed at their earliest possible return to the community, and
   establishes specific objectives to achieve this goal.

5. The National Association for Mental Health encourages continuous evaluation of all aspects of mental hospital care and the mental health association activities related to this program emphasis.

PROGRAM EMPHASIS: IMPROVED CARE AND TREATMENT FOR MENTAL HOSPITAL PATIENTS

OBJECTIVES - WHAT WE HOPE TO ACHIEVE

OUR AIM: To see that the mental hospital, as one of several elements of comprehensive mental health services, provides persons needing hospitalization with the best treatment aimed at their earliest possible return to the community.

OBJECTIVE I: Improved admission and discharge procedures and protection of the rights of the mentally ill.

1. Enactment of laws which provide for modern admission procedures.

2. Elimination of the practice of jailing mentally ill persons awaiting admission to a mental hospital and support of laws prohibiting the use of inappropriate or harmful conditions of transportation of mentally ill persons.

3. Protection of the personal, civil and constitutional rights of the hospitalized mentally ill and practical assistance to such persons in assuring prompt evaluation, periodic examination, and, when necessary, legal review of their status and their eligibility for return to the community.

4. Prompt restoration of such rights and privileges as may have been restricted by hospitalization—voting, employment, securing of licenses, etc. to the full extent possible and consistent with the public welfare and safety.

5. Adoption of the Interstate Compact in every state.

OBJECTIVE II: Provision of modern treatment of high quality, under medical supervision, for all mentally ill, in appropriate physical environment, and with an adequate number of trained personnel.

1. Accreditation of all public and private mental hospitals in every state in conformity with standards set by the Joint Commission on Accreditation of Hospitals.

2. Appropriation of sufficient funds for each public hospital and establishment of administrative practices to provide modern, high quality medical care, in an appropriate physical environment with an adequate number of qualified personnel.

3. Provision for the mental hospital as one element of coordinated mental health care in each State Plan for Comprehensive Mental Health Services.

4. Assurance that all the mentally ill receive care, treatment, and rehabilitation without regard to race, age or economic status.

5. Evaluation of present programs for caring for the aged mentally ill in mental hospitals and development of suitable alternative arrangements for their care.

6. Increase in number and improvement in quality of all mental hospital personnel through development of professional education programs, recruitment procedures, in-service training, merit advancement programs and recommended salary scales.

OBJECTIVE III: Expanded programs of volunteer help and personal services to the mentally ill and their families.

1. Establishment of a volunteer service program in every mental hospital to provide services to the patients and to provide opportunities for education of the public through involvement as volunteers.

2. Provision of gifts and personal necessities to make every patient more comfortable.

3. Provision of sufficient consultation and information services, and material aid, where appropriate, to help patients and their families overcome some of the special personal problems brought about by mental illness.

OBJECTIVE IV: Improved public attitudes toward mental illness and the hospitalized mentally ill.

1. Development of effective public education programs designed to create an understanding of mental illness and disability which will permit the mentally ill to function in the community.

PROGRAM EMPHASIS: AFTERCARE AND REHABILITATION SERVICES

THE PROBLEM - WHY WE ARE CONCERNED

As better treatment methods become more widely used, more and more patients improve enough to leave the hospital. Yet one out of every three of these patients relapses and has to be readmitted. He can return to the community but without the kind of medical aftercare and social and vocational rehabilitation services he needs, his chances of remaining there are seriously diminished. Such aftercare and rehabilitation services cut readmissions in half and cost only one-tenth of hospital care. The need is great; attempts to meet it have been practically non-existent.

PRINCIPLES - WHAT WE BELIEVE

1. The National Association for Mental Health is concerned with the welfare of the recovering mental patient and is dedicated to the development and utilization of aftercare and rehabilitation services.

2. To achieve continuity of care, a sequence of aftercare and rehabilitation services is necessary to continue therapeutic gains and maintain the mental patient in the community. This requires development of a variety of coordinated, professionally-directed programs that meet the patient's health, social, vocational and economic needs.

3. The provision of aftercare and rehabilitation services is a responsibility of appropriate public and voluntary agencies. Such services should be financed by public funds, voluntary contributions and payment for services through fees and insurance plans.

4. The National Association for Mental Health
   encourages research, education, social action and service to see that persons recovering from mental illness are provided with aftercare and rehabilitation services in each community to help restore them to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable, and
   establishes specific objectives to achieve this goal.

5. The National Association for Mental Health encourages continuous evaluation of the quality and effectiveness of aftercare and rehabilitation services, and the mental health association activities related to this program emphasis.

PROGRAM EMPHASIS: AFTERCARE AND REHABILITATION SERVICES

OBJECTIVES - WHAT WE HOPE TO ACHIEVE

OUR AIM: To see that persons recovering from mental illness are provided with aftercare and rehabilitation services in each community to help restore them to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable.

OBJECTIVE I: Establishment of adequate follow-up medical services in every community, to maintain the convalescent mental patient in the community.

1. Provision for adequate follow-up medical services in every State Plan for Comprehensive Mental Health Services.
2. Cooperation by each mental hospital with follow-up medical services to assure continuity of care.
3. Provision of appropriately located follow-up medical services adequate to the needs of the patients.

OBJECTIVE II: Establishment of adequate vocational rehabilitation services to enable the placement of patients recovering from mental illness in gainful employment or to maintain themselves in the community.

1. Cooperation of all public and private vocational rehabilitation services within an area so that they provide appropriate help in vocational counseling, training and placement.

2. Development and establishment of vocational counseling, training and placement facilities suited to the needs of the recovering mental patient.
3. Development of programs of employer education with emphasis on improved liaison between local rehabilitation centers, vocational counselors and employers in the area of job preparation, job readiness, and placement of recovering patients.
4. Enactment of laws providing adequate safeguards for the employer of mentally restored persons.

OBJECTIVE III: Establishment of social rehabilitation and housing services to provide opportunities for patients recovering from mental illness to develop or to relearn social skills and confidence.

1. Experimentation in various social rehabilitation services to enable recovering patients to return and remain in the community.
2. Inclusion of services for persons recovering from mental illness in already established social and recreational programs.

OBJECTIVE IV: Expanded programs of volunteer help and personal services to patients recovering from mental illness, and their families.

1. Development of volunteer service programs in connection with community mental health facilities, mental hospitals, and rehabilitation agencies to provide services to convalescing patients and their families; and to provide opportunities for education of the public through involvement as volunteers.
2. Provision of consultation and information services and, where appropriate, material aid to help recovering patients and their families meet some of the special personal problems brought about by mental illness.

OBJECTIVE V: Improved public attitudes toward mental illness and the recovering mental patient.

1. Development of effective public education programs designed to create an understanding of mental illness and disability that will permit the recovering patient to function in the community.

OBJECTIVE VI: Increased number and competency of personnel in aftercare and rehabilitation.

1. Development of continuing professional education programs, recruitment procedures, in-service training, merit advancement programs and recommended salary scales.

PROGRAM EMPHASIS: SPECIAL SERVICES

THE PROBLEM - WHY WE ARE CONCERNED

The mentally ill child is too often forgotten. He needs help desperately, yet no help is available. Half a million school age children suffer from the most serious forms of mental illness – childhood schizophrenia and other psychoses. Yet less than one percent of that half million receive adequate care. The rest receive little or none at all. Sometimes children are housed with adult psychotics in state mental hospital wards because there are no separate children's wards or residential units. In half of the states there are no public specialized facilities for the treatment of mentally ill children. In one-third of the states, there are no facilities at all – public or private.

TREATMENT, EDUCATION AND FOR MENTALLY ILL CHILDREN

PRINCIPLES - WHAT WE BELIEVE

1. The National Association for Mental Health is concerned with the welfare of mentally ill children and is dedicated to the provision of the best possible services for their treatment and education.

2. Mentally ill children should be treated and educated in their home communities when this is in the best interest of the child, his family and the community. To this end, the necessary range of facilities should be established as an integral part of the comprehensive mental health program.

   When separation of the child from the family is necessary, residential treatment units should be easily accessible to maintain family contact.

   Every child has a right to an education suited to his needs. Educational services for mentally ill children should be provided within the framework of public education systems.

3. The provision of adequate services for diagnosis, treatment, education and rehabilitation of mentally ill children is a community responsibility and an obligation of the appropriate public authorities, local, state and federal. No child should be denied services because of inability to pay.

4. The National Association for Mental Health
   encourages research, education, social action and service to see that mentally ill children are provided with the diagnosis, treatment, education, and rehabilitation they need to make the most of their capabilities and are given the opportunity they deserve to spend their lives as productive citizens, and
   establishes specific objectives to achieve this goal.

5. The National Association for Mental Health encourages continuous evaluation of the quality and effectiveness of services for mentally ill children and the mental health association activities related to this program emphasis.

PROGRAM EMPHASIS: TREATMENT, EDUCATION AND SPECIAL SERVICES FOR MENTALLY ILL CHILDREN

OBJECTIVES - WHAT WE HOPE TO ACHIEVE

OUR AIM: To see that mentally ill children are provided with the diagnosis, treatment, education and rehabilitation they need to make the most of their capabilities and are given the opportunity they deserve to spend their lives as productive citizens.

OBJECTIVE I: Provision of comprehensive community services for mentally ill children.

1. Designation of Childhood Mental Illness as a specific problem area for special attention and study in every State Plan for Comprehensive Mental Health Services.

2. Inclusion in every plan for community mental health centers of the full range of needed services for children–diagnostic, referral, placement and rehabilitation.

3. Development of effective working relationships between personnel and coordination of services of all official agencies concerned with children–the mental health agencies, the schools, the public health agencies, the welfare agencies and the courts.

4. Provision of services for mentally ill children by existing community agencies–the general hospitals, family service agencies, child care agencies, etc.

OBJECTIVE II: Provision of educational services for mentally ill children, suited to their needs, within the framework of the public school systems.

1. Passage of Federal legislation and the appropriation of funds to encourage and stimulate the development of state programs for the education of mentally ill children.

2. Enactment of state legislation and the appropriation of funds in each state to provide special educational services for mentally ill children.

3. Initiation by local school boards and school administrators of special programs for mentally ill children–special classes, homebound instruction, schooling for children in residential treatment, and pupil personnel services (social work, psychiatric help and psychological services).

4. Appropriation by county and municipal authorities of the funds necessary for such services, either on a matching basis if state funds are available, or independently, to stimulate provision of state funds.

5. Cooperation of other professions (psychiatrists, psychologists, social workers) with educators in the development of public school programs for mentally ill children.

6. Expansion and development of curricula in teacher training programs in colleges and universities for training teachers of mentally ill children.

OBJECTIVE III: Adequate and appropriate residential services for those children who need such services, housed in special units in state hospitals or in separate residential treatment centers.

1. Provision in every statewide Plan for Comprehensive Mental Health Services for residential treatment facilities for mentally ill children–housed either in special units in state hospitals, or in separate residential centers.

2. Establishment of separate units in hospitals to provide treatment and close contact with families.

OBJECTIVE IV: Expanded volunteer help and personal services to mentally ill children and their families.

1. Development of volunteer service programs to provide services to mentally ill children in treatment and educational facilities, and their parents, and to provide opportunities for education of the public through involvement as volunteers.

2. Provision of consultation and information services and, where appropriate, other services to help mentally ill children and their parents.

OBJECTIVE V: Improved public attitudes toward mental illness and mentally ill children.

1. Development of effective public education programs designed to create an understanding of mental illness and disability which will permit the mentally ill to function in the community without the shadow of stigma.

OBJECTIVE VI: Increased number and competency of professionals and others needed to educate and treat mentally ill children.

1. Development of continuing professional education programs, recruitment procedures, in-service training, merit advancement programs and recommended salary scales.

PROGRAM EMPHASIS: COMMUNITY MENTAL HEALTH SERVICES

THE PROBLEM - WHY WE ARE CONCERNED

For years, the mentally ill have been isolated from family, friends and community and sent off to remote, walled asylums. Now it has become evident that the mentally ill should be treated in the community close to where they live. Communities must be encouraged to provide adequate and comprehensive facilities and services for the mentally ill and their families. Treatment for mental illness should be as good and as readily available as treatment for physical illness. Today few general hospitals have psychiatric facilities. Few communities have mental health clinics. Obviously, present services are only a fraction of what is needed.

PRINCIPLES - WHAT WE BELIEVE

1. The National Association for Mental Health is concerned that people who become mentally ill should have prompt access to care and treatment and is dedicated to the provision of comprehensive, community-based services.

2. Community mental health services should provide continuity of care through the complete range of services necessary for the best possible care and treatment. This requires development of programs of comprehensive, coordinated services, accessible to patients, and sufficiently flexible in their organization to permit adaptation to individual needs.

3. Community mental health services will be provided by a variety of public and private organizations. Coordination and cooperation will be necessary to enable continuity of care, permitting a patient to move among the services as his needs dictate. The services should be financed, as appropriate, by public funds, payment for services through fees and insurance plans, and voluntary contributions.

4. The National Association for Mental Health
   encourages research, education, social action and service to see that the mentally ill have a sequence of comprehensive, coordinated, professionally-directed services for diagnosis, treatment, and rehabilitation, close to home and suited to their individual needs, and
   establishes specific objectives to achieve this goal.

5. The National Association for Mental Health encourages continuous evaluation of the quality and effectiveness of community mental health services and of mental health association programs related to this emphasis.

PROGRAM EMPHASIS: COMMUNITY MENTAL HEALTH SERVICES

OBJECTIVES - WHAT WE HOPE TO ACHIEVE

OUR AIM: To see that the mentally ill have a sequence of comprehensive, coordinated, professionally-directed services for diagnosis, treatment and rehabilitation, close to home and suited to their individual needs.

OBJECTIVE I: Effective and continuous planning at the federal, state and local levels for comprehensive community mental health services.

1. Implementation by each state of its plan for the provision of comprehensive mental health services. Such a plan should include:
   A. Enactment of a community mental health act.
   B. Provision of a means of administration of the state mental health program that will insure immediate, comprehensive, continuous care for all persons who become mentally ill.
   C. Development of a state-wide plan for community mental health centers.
2. Provision for continuous planning and evaluation by each state of its mental health program.
3. Planning in each community for mental health programs consistent with the state plan.

OBJECTIVE II: Establishment of community facilities to provide comprehensive mental health services.

1. Continued support of Federal legislation and the appropriation of funds to assist states in the establishing of community facilities to provide comprehensive mental health services.
2. Enactment of state legislation and appropriation of funds in each state for the establishment and operation of community mental health services.

3. Appropriation by county and municipal authorities of the necessary funds for comprehensive mental health services, either on a matching basis, if state funds are available, or independently, to stimulate provision of state funds.
4. Coverage of mental illness under the insurance laws of every state.
5. Extension of comprehensive psychiatric services in general hospitals.
6. Establishment of emergency detention facilities for mentally ill patients in hospitals instead of in jails.
7. Extension of social services to families of the mentally ill through general assistance, child welfare, homemaker service, etc.
8. Evaluation of present programs for caring for the aged mentally ill in the community and the development of suitable community facilities and other programs as an alternative to mental hospital care.

OBJECTIVE III: Effective community information and education services to help people know the nature of mental illness, better understand the mentally ill, and know where to go for help.

1. Development of information and educational services for clergy, teachers, general practitioners, law enforcement officers, lawyers, public health nurses, vocational counselors and others whose vocational responsibilities require an understanding of mental health concepts and practices.
2. Establishment of mental health information services in every community to provide the public with information about mental illness and about facilities and services.
3. Development of effective public education programs designed to create an understanding of mental illness and disability which will permit the mentally ill to function in the community without the shadow of stigma.

OBJECTIVE IV: Expanded volunteer help and personal services to the mentally ill and their families.

1. Development of volunteer service programs in community mental health facilities to provide services to patients and their families, and to provide opportunities for education of the public through involvement as volunteers.
2. Provision of consultation and information services and, where appropriate, material aid to help patients and their families meet some of the special personal problems brought about by mental illness.

OBJECTIVE V: Increased number and competency of mental health professionals and related mental health personnel.

1. Development of special educational and related activities to encourage people to enter mental health careers.
2. Development of continuing professional education programs, recruitment procedures, in-service training, merit advancement programs and recommended salary scales.

NOTES

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC. 1974 AGENDA

(National Level)

LIBRARY

The Annual AGENDA summarizes the National Board's carefully planned aims and major activities for the year. The AGENDA necessarily relates to the Five-Year Goals adopted by the Board and Membership in 1970. Those goals require "that the largest single responsibility of the National operation in the next five years will be to develop the Association's capital resources in terms of people and dollars." In 1974 we will emphasize financial development, establishment of effective community mental health systems, mental health coverage in National Health Insurance, and stronger organizational operations. We will also move substantially to achieve better internal communications so that all of our volunteers are better informed about the Association's activities and progress.

WE WANT OUR VOLUNTEERS AND CONTRIBUTORS TO KNOW THAT THEIR ASSOCIATION IS MAKING A VERY REAL DIFFERENCE.

Linden E. Shelden

President

Program

Communications

Fund Raising

Organization & Development

nanh

Basic Ongoing Functions

Our Basic Ongoing Functions Represent Approximately 60 Percent of National Office Time and Resources.

In the assignment of staff time for special projects for 1974, we had to be aware that more than half of the staff hours available are already committed to ongoing activities necessary to our basic national programs and to our continuing services to Divisions and Chapters. These activities include:

DEPARTMENTAL RESPONSIBILITIES

PROGRAM

Consultation and Training Services for Divisions and Chapters • Services to the Thousands of Individuals who Call and Write Seeking Information and Help • Information Storage and Retrieval to Respond to Requests from Divisions and Chapters and National Committees for Data and Information on a Wide Range of Subjects Ranging from Drugs to Statistics to Civil Rights to Patients • Liaison with Other National Organizations • Service to Congressional Committees • Monitoring of Governmental Departments and Congressional Committees • Development of Program Materials and Guidelines • Development of Association Position Papers • Joint Information Service • Management of the Research Program • Employer of the Year Award • Service to the Public Affairs Network

COMMUNICATIONS

Consultation and Training Services for Divisions and Chapters • Development of Publications and PI Materials • Publication of the Association's magazine *MH* • Publication of the Association's Newsletters • Development and Promotion of Films, Spots, and other Audio Visuals • Service to National and Regional Media • National News Releases • Services for Celebrities • Annual Report and other Reports

FUND RAISING

Consultation and Training Services for Divisions and Chapters • Development of Fund Raising Materials • National Gifts and Leadership Cultivation • United Way Relationships • Federal Services Campaign • Fund Raising Council

ORGANIZATION AND DEVELOPMENT

Organizational Field Services for Divisions and Chapters • Regional Meetings and Training Sessions • Administration of Financial Support Plan • Staff Recruitment and Screening • Staff Institute • Administration of Policy on State Organization Plans • Administration of Internal Reporting Systems • Presidents Council

THE NATIONAL ANNUAL MEETING

PUBLICATION OF REGULAR BRIEFING MEMOS FOR DIVISIONS AND CHAPTERS

SERVICE TO VOLUNTEER LEADERS INVOLVED IN THE NATIONAL OPERATION

Membership • Board • Executive Committee • Nominating Committee • Finance Committee • Resolutions Committee

INTERNAL ADMINISTRATION

Office Management • Shipping and Billing • Controller's Functions • Uniform Accounting • Administrative and Financial Reports • Budget and Budget Control

Priority Projects for 1974

These Represent 40 Percent of National Office Time and Resources.

Program

The Association's principal program goal is the establishment of 1500 effective community mental health systems by 1980. There are now 640 in operation or underway.

PRIORITY PROGRAM SERVICES FOR THE FIELD—1974

- Assist divisions and chapters to develop community mental health services in unserved communities
- Assist divisions and chapters in the training of volunteers to carry out lay citizen evaluations of existing community mental health centers with emphasis on accessibility of services, continuity of care, and citizen participation
- Aid divisions to achieve specified state level legislative objectives, including state laws mandating mental health coverage in health insurance policies
- Work with selected divisions to demonstrate effective models of unified mental health delivery systems (for example, coordination among state and private hospitals, CMHCs, HMOs, private practitioners, etc.) and promulgate such models to other affiliates and organizations
- Assist in the development of state level mental health research promotion, particularly in the states which have now established experimental research committees
- Emphasize in staff and volunteer training opportunities: ☐ prevention, ☐ hospital services, ☐ childhood mental illness, ☐ community mental health, and ☐ aftercare and rehabilitation

NATIONAL LEVEL PROGRAM PRIORITIES—1974

- Community mental health centers: Achieve long-term extension of the Community Mental Health Centers Act with our recommended modifications which emphasize:
  - ☐ inclusion of children, the elderly, minorities and the poor in the services of centers;
  - ☐ expansion of consultation services as the prevention component of CMHCs; and
  - ☐ adequate and appropriate aftercare services for former hospital patients
- Assure the inclusion of mental health coverage meeting NAMH standards in national health insurance proposals
- Research:
  - ☐ Conduct national conference on the status of mental health research
  - ☐ Achieve higher levels of federal funding
  - ☐ Develop NAMH research fellowships
  - ☐ Continue research grant program with new emphasis on depression
  - ☐ Select 1974 winner of NAMH Research Achievement Award
- Mental health services for ethnic minorities and the poor:
  - ☐ Further assist the Association to use its social action influence to be certain that community mental health services are accessible and responsive to the poor
  - ☐ Expand representation of ethnic minorities and the poor within the organization
  - ☐ Further build bridges with organizations representing and serving the poor and ethnic minorities so that we can lend our voice to their efforts to identify and correct social and mental health problems and so that, through our participation with these organizations, we can achieve higher levels of representation within our own Association
- Litigation:
  - ☐ Follow through on suit to release impounded funds for manpower, research and alcoholism

- ☐ Protect and follow through on favorable court decision in our suit to require the application of the Fair Labor Standards Act to patients employed in the facilities where confined
- ☐ Pursue our suit to challenge restrictions on legislative activities of charitable organizations
- ☐ Take appropriate steps to follow through on other litigation initiated in 1973
- ☐ Identify and pursue other appropriate suits which have significant potential for advancing our cause

- Other public affairs priorities:
  - ☐ Protect and expand our priorities in the federal budget
  - ☐ Work for passage of child development and child care legislation conforming to NAMH standards
  - ☐ Seek changes in the federal laws which discriminate against the legislative activities of charitable organizations
  - ☐ Expand and provide training for our Public Affairs Network
- Investigate the feasibility of a National Conference on Prevention
- Develop position statements on confidentiality and experimentation on humans
- Expand information services and the program exchange

OTHER AREAS OF CONCERN—1974

- Work with Rehabilitation Services Administration to gain maximum benefits for the seriously mentally ill, under the recent Rehabilitation Act
- Monitor implementation of HMO legislation
- Support a broadened definition of developmental disabilities
- Monitor the comprehensive health planning legislation to assure retention of the 15 percent mental health set-aside
- Monitor progress of federal legislation intended to provide support to states for education of the handicapped
- Develop a National Public Affairs Conference to educate key members of state legislatures to mental health issues
- Examine zoning practices which unfairly restrict where persons under psychiatric care may live or receive treatment
- Encourage the use of Revenue Sharing funds for mental health services
- Undertake to change provisions in the Social Security Act which discriminate against the mentally ill
- Monitor the action of the Civil Service Commission for modification of employment screening practices unfair to former mental patients
- Develop further the National Office clearinghouse function

Communications

PRIORITY COMMUNICATIONS SERVICES FOR THE FIELD—1974

- Assign and equip Delegate Directors to improve information link between National and other levels
- Expand Association awareness at all levels of the organization's mission, goals and accomplishments
- Train divisions and selected large chapters to expand regional media coverage
- Produce and promote use of special Buzz Aldrin film
- Increase use of radio-TV spots by chapters and divisions
- Promote use of Association films by chapters and divisions
- Increase Mental Health Month coverage

NATIONAL LEVEL COMMUNICATIONS PRIORITIES—1974

- Increase acceptance in all media of MHA point of view
- Promote national exposure of Buzz Aldrin and his identity with MH cause
- Promote use of new film JOURNEY and other MH films to TV and non-MHA groups

- Promote greater use of radio and TV spots on national networks
- Develop and expand readership for *MH* magazine
- Produce new radio-TV spots
- Increase Mental Health Month coverage

Fund Raising

PRIORITY FUND RAISING SERVICES FOR THE FIELD—1974

- Assist those metropolitan areas and divisions with per capita giving of 6¢ or under
- Assist selected large chapters having problems with their United Fund
- Form a "Fund Raising Talent Pool" to expand consultation to divisions and chapters
- Give special fund raising help to the new New York State Committee
- Conduct regional fund raising sessions for staff, focusing on specific fund raising techniques
- Develop pyramid membership recruitment campaigns in at least three additional division or metropolitan areas
- Assist selected affiliates to enlist corporate leaders

NATIONAL LEVEL FUND RAISING PRIORITIES—1974

- Increase corporate support by 50 percent
- Enlist at least 7 additional executives for leadership roles in the National Corporate Gifts Campaign
- Experiment with direct mail appeals in selected areas
- Strengthen United Way understanding of the Association's social action mission and accomplishments
- Explore feasibility of high visibility national fund raising event

Organization and Development

1974 PRIORITIES

- Significantly expand staff and volunteer services to the field
- Work closely with selected large states, particularly California, Illinois and Ohio
- Refine and develop the new organizational category of "State Committee" with first emphasis in New York
- Continue and expand efforts for earlier identification and assistance to divisions faced with financial and organizational problems
- Provide special monitoring and attention for divisions which did not meet their 1973 support obligations
- Assist at least five selected metropolitan chapters which need help
- Research our organizational problems and directions to determine if significant changes are needed

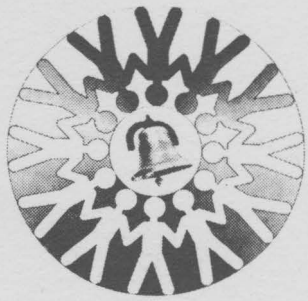
Other Priority Projects

- Continue and complete the work of the Ad Hoc Committee on Unity and Standards
- Initiate work on the Five-Year Plan for 1976-1980

This report does not include the far greater listing of the major responsibilities and special activities of the Association's one thousand State Divisions and Local Chapters where one million citizen volunteers are at work. It is at those levels where by far the major proportion of Association Service is performed.

Citizens Who *Do* Make A Difference

The National Association for Mental Health, Inc.
1800 North Kent Street • Arlington, Virginia 22209



REPORT

OF

AD HOC COMMITTEE ON UNITY AND STANDARDS

To Be Submitted to the Membership
for Study and Reaction
in Washington, D.C.
November 1974

Milton Leech, Chairman

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

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APPENDIX

#1 Resolutions which Were Referred to the Ad Hoc Committee on Unity and Standards

#2 Survey of Names Used by Other National Agencies and their Affiliates

#3 Comparison of National Voluntary Agency Policies and Practices Regarding Standards of Performance, Evaluation of Performance, and Reissuance of Charters

#4 Field Survey of Divisions and Chapters on the Change of Name

#5 Earlier Study of Name Change in 1964

#6 Glossary of Terms Used in Report

#7 Relative Roles and Responsibilities of the Three Units

#8 Codification of Existing Standards

#9 Sample Self-evaluation Form Developed by the North Carolina Division and an Evaluation Form Developed by Special Subcommittee of the Organization Committee

F O R E W O R D

ORIGIN OF THE STUDY

At the 1972 Annual Meeting in Detroit, voting delegates considered several resolutions and recommendations dealing with the general topic of a uniform organization. These matters included a common name, consideration of a common program, identification of minimum levels of performance, and a proposal for standard evaluation procedures.

The Executive Committee of the National Association for Mental Health observed, and the Membership agreed, that the Association was calling for more uniformity of identity, greater uniformity of function, clearer standards of performance, and better means of evaluating performance.

The specific matters submitted to the Membership were as follows:

The Alabama Resolution which called for a change of name so that the Association would use the same name at all three levels.

The Georgia Resolution which called for establishment of the same basic activities and related image for all units of the Association.

The Indiana Resolution which called for the establishment of a direct service volunteer program in all communities using a common symbol.

The Indiana Resolution which identified Chapters' basic responsibility for participation in Division and National public affairs efforts.

The Organization Committee's Recommendation which called for the establishment of minimum standards and for a regular evaluation process.

These resolutions and the Organization Committee's recommendation are included as Appendix #1.

Because these matters had a common thread, the Membership created the Ad Hoc Committee on Unity and Standards and referred these proposals to it.

MEMBERSHIP INVOLVEMENT

After the first year's work, it became obvious to the Committee that there was a need to have certain absolute requirements and mutual responsibilities for the Association, and they believed that the determination of these requirements presented a unique and refreshing opportunity for the Membership to take a new look at the organization.

To that end, the Committee asked the Membership at the 1973 Annual Meeting in Atlanta to think in terms of a rebirth of the Association, what basic profile the Association should project and what, if any, absolute minimum rules and commitments should be established for the achievement of common goals. A two-hour session was scheduled during the Membership Meeting, and the Voting Delegates and participants were divided into 60 discussion groups to outline what they believed to be the most important elements of the Association's function, image and program.

During the last meeting of the full Committee, a subcommittee prepared this summary of the roundtable discussions:

Program

There was strong interest in program development in the areas of education and legislative activity at National and State levels. The next major interest was in prevention and early detection. A fourth area of concern which ranked considerably below the others was that of the advocacy role. Service interests were varied in nature, and no single type was dominant.

National Responsibilities

A large number of members appeared to feel the need for greater involvement and communication with National.

Financial

A large number of the groups recommended that fund raising should be a priority and that National should take a major role in this area.

Structure

There was not clear agreement on the number of levels of organization, but there was a strong interest in development on a regional basis. Interest was also expressed in grassroots involvement and a broadening of the membership base.

Unity

The strongest factor contributing to unity was felt to be increased visibility which many thought could be achieved through service programs.

BOARD OF DIRECTORS' CHARGE TO THE COMMITTEE

1. Make recommendation on name change.

2. Do a codification of all existing policies and approved guidelines, particularly relating to the program profile and standards of the Association, as a necessary first step to developing uniform program and performance standards.

3. Based on current standards and policies, produce a useful draft of an evaluation form. Also put forward proposals as to how this might be used now by interested affiliates and what the Committee's preliminary thoughts are about a routine process for future internal and external evaluations.

4. Determine if the above efforts cover the other resolutions referred by the Membership and, if not, make recommendations dealing with those other resolutions.

5. Consider what further work should be done to develop (1) a more unified profile for the whole Association; (2) more definitive standards of performance; and (3) a more specific evaluation process.

The Committee viewed this charge as one which would bring into focus those ideas and developments which have evolved within the Association, recognizing that the current organizational structure is not in keeping with these ideas and developments.

COMMITTEE PROCEDURES

First Year Tasks

- Survey of names used by other national agencies and their affiliates (Appendix #2) .

- Comparison of national voluntary agency policies and practices regarding standards of performance, evaluation of performance, and reissuance of charters (Appendix #3).

- Study of the relevant material of twelve other agencies.

- Field survey of divisions and chapters on the change of name (Appendix #4).

- Study of policies, procedures and evaluation mechanisms developed by several of our own divisions.

- Review of Association reference material

  --Earlier study of name change - 1964 (Appendix #5)

  --National By-Laws, National Charter Standards, National Policies, Position Statements and Guidelines

- Consideration of name change

  --We realized that this project was taking too much of our time and that Membership consideration of a name change in 1973 would obscure discussion of the other major topics within the Committee's charge. Further discussion of name change was postponed.

- Consideration of standards

  --We codified existing standards, guidelines, recommendations for affiliate performance, by-law requirements, and relevant board and membership actions. These were divided into several subject categories predetermined by the Committee.

  --Review of the codification revealed it cumbersome with a disparate quality. Some were absolute requirements while others were recommendations.

  --We determined that the term standards should refer only to those basic policies for continued affiliation.

  --A recodification based on this definition was completed.

- Basic principles were developed for the evaluation process.

- An awards and recognition system was considered and deferred. This was later dropped. We agreed that, once a firm system of standards and evaluation is instituted, appropriate awards and recognition should be given for excellence.

- A decision was made to recommend that the fullest possible reaction and survey of the Membership be achieved.

- The Interim Report was presented to the full Membership and those attending the 1973 Annual Meeting. Sixty discussion groups reacted to the report.

Second Year Tasks

- Expansion of the Committee to include other points of view and more division and chapter representation.
- Extensive study of the material developed during the roundtables.
- Study of other reactions provided to committee members and National officers, board members and staff.
- Development of an Affiliation Document.
- Reconsideration of name change.
- Revised approach to standards and their categories.
- Recommendations to deal with missing standards.
- Final report drafted and edited.
- Plans made to provide for fullest possible exposure of the report and discussion of it prior to and during the 1974 Annual Meeting.
- Committee identified areas which will need early follow-through.

ORGANIZATION OF THE TASK INTO THREE PARTS

The Committee organized its work and the following report into the three major concerns expressed in the charge given to it. They are:

Commonalities

Standards

Evaluation

I. UNDERLYING CONCLUSION AND RECOMMENDATIONS

A. OUR UNDERLYING CONCLUSION

We should do everything possible to emphasize unity and sameness of purpose, but we cannot and should not try to become a single program, corporate-type organization.

B. THE TWO BASIC RECOMMENDATIONS

1. Given the Broad Range of Problems and Responsibilities, the Mental Health Association Should Not and Probably Cannot Be Forced into a Single Simplified Mold

Many members of the Association believe that it would be easier to raise money and to administer the Association if the total organization had the same program and a single administration. We know that achieving such simplicity was the admirable intent of the originators of this Unity and Standards project but, after two years of exploration, we conclude that, given the broad range of problems and responsibilities, it is not possible to adopt a single program or to propose a single administration.

When we examine what is usually meant by focus, most proposals indicate that every unit of the Association should be doing the same thing at the same time. Whether the argument is general ("the organization has to mean the same thing to volunteers and contributors everywhere") or specific ("the Association should mean 'research,' 'emotionally disturbed children,' 'service in mental hospitals,' or 'prevention'"), the goal was still to have a standard function from which to build a standard image.

We tried to go in the direction dictated to us by our charge, but reality interfered. Two principal counterforces to that direction are at work:

a. Even among those who agree that we should have one program, there is marked disagreement about just what that program should be.

Mental Health Association boards are responsible to current local priorities and will develop programs based on local needs.

It is encouraging to note that there is increasing agreement in the Association that our principal program function is social action and advocacy. This is well-stated in the Five Year Goals Report and was readily apparent from the roundtable discussions.

However, though there is growing agreement about the use of our citizen force to obtain rather than provide services, there is little agreement on any one program within that social action focus.

b. The sphere of mental health, and even the scope of mental illness, are both so broad that they defy a single focus.

If the organization were to narrow its effort to one phase of the attack--such as research, hospitalization or rehabilitation, or to one diagnosis--such as depression, schizophrenia or autism, there is still little likelihood that we would achieve the kind of undivided image that many of us have sought.

2. A Diverse and Federated Organization Carries a Significant Burden to Emphasize Opportunities which Will Give It Focus and Image

It is easy for a group to decide that, because it is a federation with diverse functions, it is inappropriate to try to come up with a single image and operation. We view it differently. We do not think that it is a contradiction to say that an organization characterized by diversity and federation must work even harder than the single-program organization to create identity and focus. This has been the major thrust of our consideration. At first many of us had expected that the solution was to become a single program organization. We now recognize that the task is still the same but it is more difficult.

We must do everything possible to minimize confusion and separateness. We began with the need to have one name. Beyond a common name, we urge that there be common purposes, common membership, common profile, common standards, and a common evaluation process.

The details of these recommendations appear under Section II of this report, beginning on page 6.

These conclusions thwarted our charge to simplify the Association's program and administration. If diversity and federation seem to be the way to go, then it is well to acknowledge these characteristics and to build on the unique strengths which they represent, while all the time emphasizing common identity and purpose.

C. THE NEED FOR AN AFFILIATION DOCUMENT

We recommend that an affiliation document be developed.

This would be the means by which the Membership's decisions on unity, standards and evaluation could be translated into continuing operations.

The affiliation document would consist of the following sections:

PHILOSOPHY OF AFFILIATION
MISSION AND FUNCTIONS OF THE ASSOCIATION
STANDARDS
EVALUATION

In order to give the Membership a tangible example of what an affiliation document might contain, an example is provided under Section III of this report, beginning on page 15.

D. THE NEED FOR A GLOSSARY

We frequently found ourselves in disagreement about the meaning of many words and phrases, and we believe that a glossary would be helpful. It is included as Appendix #6.

II. MAJOR CONSIDERATIONS

The Committee initially considered having a separate section on "unity," which would have stood apart from the sections on "standards" and "evaluation." Indeed, it appeared that way in the first draft of our report. However, the Committee finally decided that standards and evaluation will contribute significantly to unity. Therefore, all of the reports relate to unity and identity. A section on commonalities is presented to illustrate this fact.

A. COMMONALITIES

1. Common Name

In the beginning, we did not seem overly concerned about having all units of the organization under one name. At that point we did not realize how essential diversity and federation were to the fulfillment of our mission. We now believe that a common name is essential as an elementary starting point in providing a common identity.

> We recommend that all units of the Association be known as the MENTAL HEALTH ASSOCIATION.

The National level of the organization would be known as Mental Health Association, Inc.

Divisions and chapters would be known as Mental Health Association in (state, county or region).

We realized that we already have identity as the Mental Health Association and that we should take advantage of this fact. There is an advantage in local identification, and that is why we recommend that divisions and chapters be known as Mental Health Association in (state, county or region).

We believe that it would be confusing if the Association were to try to change its name altogether. We accept that we already are the Mental Health Association and we ought to consolidate around that as soon as possible and move on to other unifying efforts.

In approaching this recommendation, we suggest the following order:

a. To agree in principle on a common name.

b. To consider the name Mental Health Association.

c. To consider the local geographic identification, i.e., Mental Health Association in (state, county or region).

d. To follow legal advice, including protection of the existing names so that others cannot use our current names. Also, we should legally reserve other names such as Mental Health Association of _____.

2. Common Statement of Purpose

We see an urgent need for a common statement of the purpose of the organization. An excellent statement is at hand in a form which should help unite us.

The existing Certificate of Incorporation states:

"The purpose of the corporation shall be as follows:

To promote mental health and to work toward the prevention of mental illness and the improved care and treatment of persons suffering from such illnesses; and to such ends to devote its income, principal and property exclusively for charitable, scientific, literary and educational purposes."

We should take advantage of its historical significance. It has been with us since 1949 and is strikingly similar to statements of purpose going back to the early 1900s.

At several points the Association has attempted to identify the specific activities which will enable it to fulfill its formally stated purposes. For example, the Task Force on Five Year Goals included in its Final Report the following statement:

"Program Goals

1. *National Level Program Pursuits*

   The National level resources which are assigned to immediate program pursuits should be concentrated in patterns designed to achieve the greatest results for the investment available. We are persuaded that this clearly reaffirms social action as the basic means by which we achieve our program goals.

2. *National Program Assistance to Divisions and Chapters*

   A major part of National program responsibility should continue to be devoted to assistance to Divisions and Chapters. Indeed we feel that this responsibility should be expanded and, consistent with our basic theme of developing the organization's major resources, should emphasize the training of staff and volunteers.

3. *Local Program*

   We felt it was beyond the capacity of this Task Force to identify specific program targets but we did feel we had an obligation to present certain basic principles for program growth between now and 1975.

   Our statement is as follows: 'It is not consistent with the basic program responsibilities of Divisions and Chapters for National to stipulate specific program activities for communities and states, provided that affiliates should be out of direct medical services and should be devoting themselves substantially, in a social action way, to as many of the program emphases commensurate with their current resources.'

We are aware that this may seem to be a generalized statement but we feel it has the basic components which are germane to sound effort. These are: (1) local option is acknowledged and reaffirmed; (2) prohibition against direct medical services is made clear; (3) social action is confirmed as the Association's basic means of achieving its program goals; (4) program emphases are acknowledged and reaffirmed; (5) Divisions and Chapters should not undertake program beyond their current resources including the significant commitment to financial and organizational targets."

In view of these earlier determinations, we propose the following:

"The activities involved in the process of achieving the purposes of the Association are the continuing promotion of:

- social action and advocacy
- education and understanding
- evaluation
- research

by knowledgeable active volunteers working in and through the components of the organization with individuals, citizens' groups, organizations, and government bodies."

In addition to identifying the common activities, we felt it was useful to identify the relative and complementary assignments of the three separate units of the organization. A first attempt at a "Functions Chart" is included as Appendix #7.

3. Common Membership

One of the most important unifying steps will be to achieve a common membership throughout the organization.

Our intent is twofold:

a. A member should be a member of the total Association. If a member joins the Mental Health Association in any city, county or state, he should automatically become a member of the total Mental Health Association, and not just a member of a local chapter or division.

b. There should be common definition of membership, including such items as dues, privileges, obligations, and a standard membership card.

We believe that, in terms of identity, fund raising, public affairs, leadership development, and public education, a more clearly identified membership should have the highest priority.

We recommend that the Association move rapidly to fulfill this responsibility.

4. Common Profile

A common name will be the most important step in creating a common profile which will include common symbols, logos and letterheads. We do not find that the bell accomplishes this completely. Most of us like the current campaign symbol, with its emphasis on "Citizens Who Do Make a Difference." This effort alone would have taken all our time and too much of the Membership's consideration. We do not propose that the Membership try to act on specific suggestions, but only react to the need to consider more specific means of creating a common profile. The effort should be aimed at establishing the organization as a citizens' voluntary association dedicated to the accomplishment of its mission through advocacy.

B. COMMON STANDARDS

1. Definition and Breadth of Standards

The definition of standards presented many problems. We considered minimum rules, standards for continued affiliation, minimum standards, standards of excellence and organizational requirements.

Through all of these deliberations, the term standards seemed to survive. Our interpretation of the term involves "that minimum level of performance necessary to continued affiliation." We are eager to establish a process which will have a total inference of positiveness and which will imply vitalization.

The national voting membership, who are the delegates to the Annual Meeting, must vote on all major decisions, including standards. In keeping with our definition of standards, any matter which has the weight of a requirement for continued affiliation must automatically be approved by the Membership.

We hope that the Membership will realize that it is essential to limit standards to those things which are in fact requirements. A proliferation of standards will only weaken the meaning of the truly important ones.

2. Categories of Standards

a. Program Planning and Evaluation

We faced the difficult task of how to deal with program standards without opening up the likelihood of each program interest in the organization coming forward now and in the future with an endless procession of minimum requirements relating to such areas as prevention, children, rehabilitation, centers, hospitalized patients and research.

One of our most important decisions was to reaffirm and protect the principle of local determination. We clearly acknowledge that it is necessary to have standards to provide the baseline organizational profile and to make clear our mutual responsibilities. We matched this conviction with the need for national leadership and a healthy desire for specific standards by which evaluation of performance can take place.

The resolution of our dilemma evolved. Among the limited standards which should exist should be one which requires evidence of an active and creative planning process, sufficiently thorough to provide significant promise of being able to determine the contemporary priority needs and related projects.

> Thus, it is our proposal that we avoid setting minimum standards for each present area of program priority. We believe it will be more significant and longer lasting to set forth a required planning process.

It is possible that now, or in the future, these can be divided into basic standards and standards of excellence.

> Consistent with our thinking about program planning, we propose that there should be standards related to program evaluation.

b. Organizational Standards

In this area, too, there will be a danger to specify an unnecessarily large number of requirements. However, there are some basic standards which should be set down in order to be certain that the organization is being governed in the most effective way possible by responsible volunteers. Examples of organizational standards are the following:

(1) Basic Documents:

Articles of Incorporation
Charter
By-laws
Minutes Book
Policy Statements

(2) Definition of Membership

(3) Internal Administration

c. Interrelationships with other Units of the Organization

There should be standards governing interrelationships between each unit of the Association, Chapter, Division and National such as those on financial support and on common name.

We repeat that the organization should resist putting too many standards into any of these categories, including this one. Things which are better covered under rules and regulations or guidelines or administrative relationships should not creep into a categorization which is intended to imply basic levels of performance necessary to continued affiliation.

We observed from the codification of existing standards that almost all of them relate to finances, and we do not believe this is sufficient to bring about the objectives of the organization.

We reviewed the Report on Roles and Representation, which assigns to the total Membership much of the basic authority governing the organization. This provides a mechanism for the total Mental Health Association to be involved in the determination of the policies by which we will all be governed. We believe it is important that the organization accept its diversity in federation. We also agree that such an organization is entirely dependent on the democratic process for policy determination.

This diversity will pull the organization in different directions unless there is an inner strength which dictates that, once the rules have been arrived at in a democratic manner, all parties will be governed accordingly.

d. Personnel Standards

We are increasingly persuaded that more should be done to strengthen the career staffing component of the organization. To that end, we would include certain basic personnel standards governing recruitment, training, evaluation, compensation, benefits and affirmative action.

e. Fund Raising Standards

As with program, we recommend that the organization avoid requiring each unit of the organization to live by an unreasonable proliferation of requirements. On the other hand, we believe that a process of fund raising planning and evaluation should be required.

Other standards will be necessary in order for the organization to comply with governmental requirements.

f. Membership Standards

We believe that a basic core of members in the organization is essential to our identity, growth and impact. We are aware that there is a temptation to identify membership by relating it either to fund raising or program. We believe it has a separate and essential identity of its own and urge that certain essential aspects of membership development, quotas and service be specified in a separate category under "Standards."

> A member should be a member of the total Association. If a member joins the Mental Health Association in any city, county, region or state, he should automatically become a member of the total Mental Health Association.
>
> There should be common definition of membership. There should be one basic category of membership, but separate classifications can be added as long as these do not obscure the basic category. Definition of the basic category of membership should include dues, privileges, obligations and a standard membership card.

3. Codification of Existing Standards

One of the charges to the Committee was to codify all of the existing standards now applicable to division and chapter performance.

The first draft of these was unmanageably long because it included many things which are not in fact requirements for continued affiliation. We asked the staff to revise the document, screening it down to those things which have been passed by the Membership and the Board and which are requirements for continued affiliation. That codification is contained in Appendix #8.

Even that second review pointed up that the Association is not really clear on what standards are. We have by-law requirements, policies, charter standards, position statements, membership resolutions, board actions and official guidelines.

It was at that point that we agreed that the term standards should refer only to those organizational requirements really necessary to continued affiliation.

We do not suggest a point-by-point review of these standards now. The codification will provide guidelines to any unit of the organization which wishes to do a current self-evaluation. At the present time they do constitute the laws governing the Association.

If the organization undertakes a periodic evaluation of all units, the existing standards will be reexamined for relevancy and clarification.

4. Missing Standards

In the course of our review of the codification of existing standards and our determination of the categories of standards we would recommend to be included, we noted several significant gaps. We were tempted to deal with each one of these, but realized that this was not our charge and that we were not necessarily the appropriate group to undertake these assignments. We do observe, however, that the final affiliation document and any process of standards and evaluation will depend absolutely on the development of more definitive standards in each of the categories recommended. For instance, there are either no standards or there are poorly stated standards related to program planning and evaluation, personnel, fund raising and membership.

C. COMMON EVALUATION PROCESS

The process must be positive. Throughout our discussions and as part of all of our decisions, we were very definite, determined and consistent that the process of evaluation should be creatively constructive, growth achieving and participatory. The process must not be threatening nor punitive. The evaluation should have a higher goal of stimulating creative thinking and action rather than conformity.

1. The Evaluation Process

a. What is Being Evaluated?

Evaluation would relate to the unit's performance and the fulfillment of the basic standards for affiliation agreed upon by the voting membership of the Association.

b. Who Is to Be Evaluated?

Every unit--Chapter, Division and National--would be evaluated periodically.

c. Who Does the Evaluation?

We believe that a peer process should be developed.

As an example, the teams could be composed as follows:

(1) For Local Unit

The local representatives
1 division board member
1 division staff member
1 National Board member or a representative of another chapter

(2) For State Unit

The division representatives
1 National Board member
1 National staff member
1 chapter board member

(3) For National Unit

The National representatives
1 division board member
1 chapter board member
1 division and/or chapter staff member

The teams should involve at least one person independent of the Association

We agreed that the teams will have to be trained so that there is uniformity in the effort and so that the constructive aspects of the process will dominate.

d. Timetable

We recommend an evaluation every three years involving one-third of the divisions each year.

e. Relationship to Planning

Consistent with our recommendation that the evaluation process should be positive and constructive, we underscore that the evaluation should be one stage in the ongoing planning process.

2. Evaluation Form

One of the charges to the Committee was, "based on current standards and policies, produce a useful draft of an evaluation form." That section of the charge went on to ask us to indicate what the Committee's thoughts are about a routine process for future internal and external evaluations.

We concluded that it would not be useful to produce a new comprehensive evaluation form until more definitive standards are available in more of the basic categories. We recognize that many divisions will want to evaluate themselves or involve external evaluators prior to the time the new form and process are developed. Appendix #9 includes material developed by the North Carolina Division and a form which was recommended by a special subcommittee of the Organization Committee. We feel that these, along with an exercise of checking performance against the existing standards which appear in Appendix #8, will give divisions and chapters guidelines for current evaluations.

III. THE AFFILIATION DOCUMENT

We recommend that an affiliation document be developed. This would be the means by which the Membership's decisions on unity, standards and evaluation can be translated into daily operation. The following is an example of what that document might look like.

A. PHILOSOPHY OF AFFILIATION

The Mental Health Association is an independent volunteer citizens' organization, functioning with three interdependent units: National, Division and Chapter.

The Association has a major purpose of advocacy for mental health that permeates and gives meaning and direction to all three units. Each has unique roles and responsibilities to fulfill in order to realize this purpose.

The connecting links between these components which have an identity and autonomy are a common purpose and an affiliation agreement. Such nation-wide and serious undertaking requires minimum rules and commitment to the achievement of common goals. The process of affiliation offers an opportunity for each unit for creativity and compliance in achieving the goals of the Association.

B. MISSION AND ACTIVITIES OF THE ASSOCIATION

1. Basic Purpose of the Association

The purposes of the Association shall be as follows:

> To promote mental health and to work toward the prevention of mental illness and the improved care and treatment of persons suffering from such illnesses; and to such ends to devote its income, principal and property exclusively for charitable, scientific, literary and educational purposes.
>
> *(Source: Certificate of Incorporation)*

2. Activities

The activities involved in the process of achieving the purposes of the Association are the continuing promotion of:

- social action and advocacy
- education and understanding
- evaluation
- research

by knowledgeable active volunteers working in and through the components of the organization with individuals, citizens' groups, organizations and government bodies.

C. STANDARDS

Standards are the basic level of performance necessary to continued affiliation.

Specific standards would appear under each of the following categories.

1. Program Planning and Evaluation

2. Organization

3. Personnel or Career Development

4. Fund Raising

5. Membership

6. Unit Interrelationships

   Would include those unique standards relating to National and Division performance

D. EVALUATION

Until more definitive standards are developed in the basic categories of standards, a detailed evaluation form cannot be developed. The following relates to the process.

1. The Evaluation Process

a. What is Being Evaluated?

Evaluation would relate to the unit's performance and the fulfillment of basic standards for affiliation agreed upon by the voting membership of the Association.

b. Who is to Be Evaluated?

Every unit of the organization--Chapter, Division and National--would be evaluated periodically.

c. Who Does the Evaluation?

We believe that a peer process should be developed.

As an example, the teams could be composed as follows:

(1) For Local Unit

The local representatives
1 division board member
1 division staff member
1 National Board member or a representative of another chapter

(2) For State Unit

The division representatives
1 National Board member
1 National staff member
1 chapter board member

(3) For National Unit

The National representatives
1 division board member
1 chapter board member
1 division and/or chapter staff member

The teams should involve at least one person independent of the Association.

We agreed that the teams will have to be trained so that there is uniformity in the effort and so that the constructive aspects of the process will become dominant.

d. Timetable

We recommend an evaluation of every three years involving one-third of the divisions each year.

e. Relationship to Planning

Consistent with our recommendation that the evaluation process should be positive and constructive, we underscore that the evaluation should be one stage in the ongoing planning process.

IV. SUMMARY

The Membership at the 1972 Annual Meeting in Detroit considered several resolutions and recommendations dealing with the general topic of a uniform organization. These matters included a common name, consideration of a common program, identification of minimum levels of performance and a proposal for standard evaluation procedures. Because these matters have a common thread, the Membership created the Ad Hoc Committee on Unity and Standards and referred these resolutions and recommendations to it. The Committee viewed this charge as one which would bring into focus those ideas and developments which have evolved within the Association, recognizing that the current organizational structure is not in keeping with those ideas and developments.

During the two years of the Committee's existence, the nineteen members represented chapter and division leaders, three members of the National Board and one division executive director. An interim report of the Committee's work was made at the 1973 Annual Meeting in Atlanta.

The Committee organized its work and its report into three major concerns which were expressed in the charge given to it. They are commonalities, standards and evaluation. The Committee arrived at an underlying conclusion which reads:

> *"We should do everything possible to emphasize unity and sameness of purpose, but we cannot and should not try to become a single program, corporate-type organization."*

The two basic recommendations in the Committee's report are:

"1. Given the broad range of problems and of responsibilities, the Mental Health Association should not and probably cannot be forced into a single simplified mold.

Two principal counter forces seem to be at work concerning this recommendation:

a. Even among those who agree that we should have just one program, there is marked disagreement about just what that program should be. Mental Health Association boards are responsible to current local priorities and will develop programs based on local needs.

b. The sphere of mental health and even the scope of mental illness are both so broad that they defy a single focus.

"2. A diverse and federated organization carries a significant burden to emphasize opportunities which will give it focus and image."

"These conclusions thwarted our charge to simplify the Association's program and administration. If diversity and federation seem to be the way to go, then it is well to acknowledge these characteristics and to build on the unique strengths which they represent, while all the time emphasizing common identity and purpose."

In view of this, we recommend that an affiliation document be developed which would be the means by which the Membership's decision on unity, standards and evaluation could be translated into continuing operations.

The three major considerations of the Committee were commonalities, standards and evaluation. The section on commonalities consists of a discussion of common name, a common statement of purpose, a common membership and a common profile. The section on common standards defines and discusses the breadth of standards for the organization and divides standards for consideration into program planning and evaluation, organizational, interrelationships with other units, personnel, fund raising, membership, a codification of existing standards, and those standards that are currently missing.

Acknowledging that we are a federated type organization seemed essential for unity and standards to have a common evaluation process. Our third consideration of this evaluation process concluded that the process must be positive. Throughout our discussion and as part of all our decisions, we were very definite, determined and consistent that the process should be creatively constructive, group achieving and participatory. The process must not be threatening nor punitive; the evaluation should have a higher goal of stimulating creative thinking and action rather than conformity. We concluded that it would not be useful to produce a comprehensive evaluation form until more definitive standards are available in more of the basic categories.

An affiliation document is the means by which the evaluation takes place. A copy of the affiliation document including the philosophy of affiliation, the mission and activities of the Association, the standards which are to be developed in six areas, and a sample evaluation form are included in the document. The report also contains a glossary and appendices.

* * * * *

THE COMMITTEE MEMBERS

During 1973, the Committee membership was as follows:

Milton Leech, Chairman
(Natl. Board of Directors)

Raymond W. Brunell, Jr.
(Exec. Dir. of Conn. Div.)

Oswin Chrisman
(Pres. of Dallas Chapter)

Doug Davis
(Pres. of Craven County, N.C. Chapter)

Jack Goodman
(Past Pres. & Board Member of Kansas Div.)

Virginia S. Hardie
(Pres. of S.C. Div.)

Dorothy Height
(Natl. Board of Directors)

Dale Higer
(Pres. of Idaho Div. & Natl. Board of Directors)

Charles F. Mahoney
(Pres. of Massachusetts Div.)

William Meier
(Pres. of Chicago Chapter)

Elizabeth Metcalf
(Pres. of Dade County, Fla. Div.)

Wesley J. Mooney
(President-elect of Wisconsin Div.)

Kenneth Reed
(Pres. of Indianapolis Chapter)

Robert W. Renouf
(Pres. of California Div.)

Eli Tash
(Pres. of Wisconsin Div.)

The Committee was made up of individuals active at the division and chapter levels. Only three were members of the National Board.

In 1974, the Committee was expanded to include other division and chapter presidents, and John Vitale, the President-elect of the Chicago Chapter, replaced William Meier, that Chapter's President.

The additions were:

Miles Branagan
(President of Los Angeles Chapter)

Philip Emile, Jr.
(President of Essex County, N.J. Chapter)

Kay Glaesner
(President of Ohio Division)

Adrian VanderMast
(President of Indiana Division)

John Vitale
(President-elect of Chicago Chapter)

APPENDICES

R E S O L U T I O N

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Detroit, Michigan, November, 1972, by the Executive Committee of the Alabama Association for Mental Health, Inc.

WHEREAS, membership in the chapter of a Mental Health Association constitutes membership in both the state division and the national portions of the organization; and

WHEREAS, there is a growing need for a single, unified group, representing the mentally ill to be clearly identified by one title; and

WHEREAS, there is a wide disparity of names in chapters and in a few divisions;

NOW, THEREFORE, BE IT RESOLVED that a committee be appointed to review and consider possible names which would include, under one banner, the Mental Health Association at the National, Division, and Chapter levels.

Recommendations of the committee could be brought back before the Board of The Mental Health Association at the National level at a subsequent meeting for its consideration, and subsequent presentation to the delegate body.

Executive Committee Discussion, October 2, 1972

The Executive Committee believes that there is merit in a study to determine if the Mental Health Associations at all three levels should be referred to by the same name. It will be useful to learn if a majority of the Voting Members is inclined toward a common name. This matter will absorb a good deal of time and attention which should be avoided if the Members are basically opposed to a change. Therefore, we hope you will come prepared to indicate your preliminary reaction to change to a common name.

If the majority is sufficiently interested in the idea, the Executive Committee recommends that the Resolution should be passed and referred to the Ad Hoc Committee on Unity, Image and Standards for their consideration.

REFERENCE: Charter Standards for Divisions (revised November 15, 1966)

R E S O L U T I O N

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Detroit, Michigan, November 1972, by the Georgia Association for Mental Health.

RESOLVED, that the National Association for Mental Health take steps to establish certain minimum levels of activity for local, division and national associations as a means of standardizing the image of mental health associations and in an effort to create a stronger organization. These activities should be suggested by the associations that would have to carry them out, but voted on by all NAMH members. Minimal activities should be those that could be carried out by unstaffed associations and should need a very limited budget. To assure implementation of these activities, a three-level reporting system will be utilized.

Executive Committee Discussion, October 2, 1972

The Executive Committee believes there is merit in establishing some basic activities which would be appropriately pursued by all Chapters. The Executive Committee recommends this resolution be referred to the Ad Hoc Committee on Unity, Image and Standards.

REFERENCE: "How We Serve"
Report of Task Force on Five Year Goals

R E S O L U T I O N

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Detroit, Michigan, November, 1972, by the Mental Health Association in Indiana.

WHEREAS, members of the Staff Council have submitted a proposal to the National Association that the National Association have some minimum standard of activity which would be a means of creating a favorable image of the Mental Health Association; and

WHEREAS, the focus of treatment of the mentally ill is moving away from the remote state hospitals to the community thereby creating innumerable opportunities for service by volunteers in nursing homes, comprehensive centers, residential care homes, halfway houses, etc., and

WHEREAS, direct service volunteer work provides the Mental Health Association with the image of kindness, helpfulness and usefulness which is appealing and attractive to the fund-giving populus; and

WHEREAS, there is no other activity or program which has an equal image creating characteristic; and

WHEREAS, the image making function of the volunteer worker is greatly increased if there is a common uniform or other symbol worn by the volunteer while engaged in this work; and

WHEREAS, it is an activity which can be participated in by all groups of people ranging from students in high school to senior citizens; and

WHEREAS, the existence of a strong helpful image in the mind of the general public associated with a clear symbol enables the Mental Health Association to be more effective in the realm of legislation and public affairs; and

WHEREAS, the experience with this activity has been most satisfactory both in terms of the proportion of the population involved and the amount of money raised by this Association;

THEREFORE, BE IT RESOLVED that the Membership of the National Association for Mental Health take all appropriate and feasible steps to encourage and develop a direct service volunteer program utilizing a common symbol in all the communities of the nation; and

BE IT FURTHER RESOLVED that the National Association develop suitable awards to recognize those individuals who have contributed most generously in time and energy to this program and to recognize those divisions and chapters which have made the greatest increases in the percentage of their population in this defined activity on the occasion of the National Assembly in this membership meeting or otherwise as may seem suitable.

Executive Committee Discussion, October 2, 1972

The Executive Committee recommends that this resolution be referred to an Ad Hoc Committee on Unity, Image and Standards.

REFERENCE: The Service Policy (Adopted by National Board, November 23, 1963)
An Action Program for Improved Care and Treatment for Mental Hospital Patients (February 1966)
How We Serve

R E S O L U T I O N

INTRODUCTION

This Resolution is made to the National Association for Mental Health, Inc., at its Annual Meeting in Detroit, Michigan, November 1972, by the Mental Health Association in Indiana.

WHEREAS, members of the Staff Council propose that there be minimum standards of activity in the county chapters to provide the public with a consistent image of the Mental Health Associaton; and

WHEREAS, it has been resolved that all chapters should organize groups of citizen volunteers who provide direct volunteer service to the mentally ill creating thereby a group of people within the Mental Health Association who are held together by a common bond of service; and

WHEREAS, successful efforts to change public policy cannot be achieved without statewide effort since most of the public policy which affects the services and lives of the mentally ill is made by the state and national governments.

THEREFORE, BE IT RESOLVED that all local chapters are responsible for providing volunteers for the social action programs of the State and National Association, recruiting and educating these volunteers as to their responsibilities, and maintaining a full commitment to the goals and policies established by the State and National Association with regard to public policy.

STANDARDS FOR EVALUATING MENTAL HEALTH ASSOCIATIONS

The attached report of the Organization Committee's Subcommittee on Standards and Evaluation presents:

1) the principles and philosophy for dealing with minimum standards for evaluating Mental Health Associations; and

2) a listing of many standards that have been set already by the NAMH membership.

This report has been discussed by the Organization Committee and was referred to the Executive Committee for further deliberation.

When this report was considered along with other significant resolutions calling for a common organizational name, a common basic program, a direct service volunteer program and minimum chapter performance, the Executive Committee recommended:

> . . . THAT AN AD HOC COMMITTEE ON UNITY, IMAGE AND STANDARDS BE APPOINTED AND THAT THESE RESOLUTIONS (LISTED ABOVE) BE REFERRED TO THIS COMMITTEE FOR ACTION AT NEXT YEAR'S ANNUAL MEETING. IT IS FURTHER UNDERSTOOD THAT THIS AD HOC COMMITTEE WILL RELY HEAVILY ON THE DIVISION AND CHAPTER LEADERSHIP FOR INPUT AND REACTIONS.

The proposed timetable for developing more definitive minimum standards and a regular evaluation process for divisions and chapters is on page 6.

REPORT OF THE ORGANIZATION COMMITTEE
SUBCOMMITTEE ON STANDARDS & EVALUATION
ON
STANDARDS FOR EVALUATING MENTAL HEALTH ASSOCIATIONS

There has been considerable discussion of the development and use of standards for Divisions and Chapters of NAMH.

Most discussion of this subject has reflected differing viewpoints as to the purpose of standards and a degree of concern as to their application to specific situations. This has led to a wide variety of specific items to be included in any set of standards and, in turn, there has been a degree of confusion about, as well as hostility toward, their development.

Accordingly, it seems desirable to set forth a number of basic ideas about the set of standards to be proposed. These ideas are in part assumptions or "givens" without which the standards cannot be effective. In part, too, they reflect sources of standards and the aims or objectives which are implicit in developing standards in the first place.

1. A set of standards, if accepted by the Association as a whole, can be an extremely effective means of accomplishing two very necessary objects:

   - They can be a simple and direct statement of goals and objectives for both staff and volunteer leaders.
   - They can be the basis for measurement and evaluation of the performance of Divisions and Chapters.

2. Standards must be used both as objectives and as measuring devices to be effective. They must serve both purposes or they are meaningless.

NAMH records are replete with lofty and well meaning statements of objectives which have remained just that -- statements of objectives. Without the discipline of measurement and evaluation, people do not tend to strive to attain them.

It is equally certain -- though perhaps not as clear -- that there are few means presently available to the leadership of the Association to measure effectively the performance of any unit. We speak of "good" Divisions or "strong" Chapters without any basis for the statement.

3. Standards must be developed by and accepted by the entire organization. They cannot be imposed from on high. Their development and use, however, must be vigorously and diligently promoted.

4. Standards must be clear, simple and meticulously accurate in terms of the objectives of the Association as a whole.

5. Many standards exist presently:

- Uniform Accounting

- Boards of Trustees

- Adoption of a name that insures identification with NAMH at all three levels as a coordinated national organization, or addition of an explanatory phrase that insures identification, such as "a Division of NAMH."

- Agreement to provisions that in case of dissolution, the Division will surrender the NAMH charter and will transfer, subject to the provisions of any state law, title to its net assets, including the right to its corporate name, to NAMH or to such other qualified tax-exempt organization as NAMH may designate.

- Composition of the voting membership and the Board of Directors of the Division in accordance with a pattern approved by NAMH.

- Operation of the Division in accordance with the general policies of NAMH and specifically with certain minimum organization standards, such as:

  A. By-Laws which clearly outline the general purposes of the organization, provide standing committees and define their duties.

  B. Specific By-law provisions for tenure of office and responsibilities of officers and directors, operational procedures, basic programs and standards for chapters.

- Formulation and carrying out of a Division program consonant with the program emphases established for the NAMH.

- Forwarding to NAMH an annual report of activities of the Division.

- Conducting a financial operation in accordance with the policies and procedures of NAMH, such as:

A. Establishment of a fiscal year for the Division which coincides with the fiscal year of NAMH.

B. Preparation of an annual budget and forwarding a copy to NAMH.

C. Maintenance of a bookkeeping system using forms and procedures outlined in an accounting manual furnished by NAMH.

D. An annual audit of Division books by an independent public accountant with a copy of the audit sent to NAMH and a consolidated audit including all affiliated Chapter audits.

E. Bonding of appropriate persons.

- Relating Division income to Structure and Staffing (i.e., minimum requirements for State Organization Plans)
- Five Year Goals
- Raise and/or receive funds in accordance with the policies of NAMH with division of funds following the plan established by NAMH.
- Financial Support Policy
- Fund Raising Targets
- Resolution re. Fund Raising which was passed at the New Orleans Annual Meeting. It states:

  "BE IT FURTHER RESOLVED that in cases where Associations are unable to achieve fair share and a substantial part of the problem relates to the failures of the United Fund/Community Chest to support the Association at a fair-share level or to provide for opportunities for supplemental fund-raising, the National Board shall have the obligation to participate with the Divisions in achieving either fair share dollar support or approval for supplementary campaigning sufficient to bring the Association to a fair share. In turn, Divisions shall have responsibility for assistance to the Chapters; and

  "BE IT FURTHER RESOLVED that in cases where a Division or Chapter is unable to achieve such adequate support and a substantial part of the problem relates to the failure of United Fund/Community Chest to support the

Association at a fair share level or to provide for opportunities for supplementary fund-raising, then it is the policy of the National Association for Mental Health that withdrawal from the United Fund at the earliest practicable date is indicated."

6. Standards should have as an object the attainment of a more uniform effort across the nation by the entire mental health organization. Balancing national uniformity and local autonomy is always a difficult task. The aim should always be a fair balance of the two. But, as an organization, we have certain very specific aims. The purpose of standards is to make more certain that we all are striving effectively together to achieve those aims.

7. Many standards can be mechanical in nature. Particularly in areas of organization, finance and administration, certain things either are done or are not. While mechanical performance of some things does not in and of itself ensure outstanding performance, there are two general statements which tend to be true:

- Where an organization effectively performs the mechanical, objective tasks and follows prescribed administrative procedures, it tends to do other things well.

- Where an organization fails in mechanical functions and does not follow prescribed procedures, it tends to fail or to be weak in other areas.

8. Some few standards should be of a subjective nature, particularly in the program areas. This affords opportunity for individual variations.

9. Some standards may be mandatory but under others, it might be desirable for them to be evaluated by a group of peers on a scale (e.g., 1-5, recognizing that we are after all only human).

10. Recognition should be given to those units achieving a high degree of success in compliance with standards.

- Standards should be used as a motivation for good performance, not as a device for calling attention to faults.

- Standards should be used to strengthen the role and influence, as well as recognition, of good performers while helping to guide and spur poor performers.

11. Standards are not static -- but may evolve with growth of the organization. Some probably should be considered sacrosanct while others may change with new discoveries or developments in the general field.

12. In the evaluation process, the general stated purpose of the Association must be kept in mind. The attainment of this goal -- the elimination of mental illness and our concern for the present and future victims -- is our objective. The fact that we are not satisfied with the progress being made to achieve that objective is the motivation for our existence, and the degree of success we have in attaining that goal is also a measurable standard.

One of the features of this plan is that any level can apply most of the standards to any other level -- even to National. Self-evaluation can thus be done; peers on the same level can do it; or peers from any level can evaluate any other level using this yardstick.

The timetable proposed for getting these clarified, revised, and presented to the membership and finally adopted is:

November	- Submit the report to the membership for them to review, discuss and react to during the next six months. Get their reactions back to the Organization Committee by May 1973 so any necessary revisions can be made.
January/ May 1973	- 1) Reaction described above. 2) Field test the plan in from 3-5 Divisions (no more) for reporting back to the Organization Committee by May 1973.
May/October 1973	- Organization Committee assesses reactions from field and from the tests and makes any revisions in the plan that are thought necessary.
October 1973	- Mail final plan to membership.
November 1973	- Present plan to membership for adoption
1974	- Implementation

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MHA EVALUATION FORM

This form to include sections on:

- Corporate Data
- Organizational and Administrative Data
- Finance and Fund Raising Information
- Public Information and Education
- Public Affairs
- Program

Note: The evaluation can be carried out by the entire Board of Directors or by an Ad Hoc Evaluation Committee of sufficient size to fulfill its charge effectively. All records, minutes, publications, and reports should be made available to it. The Committee should also feel free to interview any group or individual whose opinions and judgment as to the effectiveness of the organization might be helpful.

The Evaluation Committee should also feel free -- indeed, be urged -- to make recommendations and suggestions of ways to bring about improvements in the future activities of the organization. They should also feel free to be honestly critical in those areas it finds appropriate.

The final report of the Evaluation Committee should be furnished to each Board Member; in the case of a chapter, to its Division; and in the case of a Division, a copy should be sent to the Organization Committee of NAMH.

REFERENCE: Report of the Task Force on Five Year Goals

OTHER HEALTH AND WELFARE ORGANIZATIONS

Affiliates Use Same Name	Affiliates Use Localized Name
HEALTH COUNCIL MEMBERS	
American Cancer Society	National Association for Retarded Children
American Diabetes Association	National Council on Alcoholism
American Social Health Association	National Society for Crippled Children and Adults
Arthritis Foundation	National Tuberculosis Association
Epilepsy Association of America	
Muscular Dystrophy Association of America	
National Cystic Fibrosis Research Foundation	
National Kidney Foundation	
National Society for Prevention of Blindness	
United Cerebral Palsy	
NATIONAL ASSEMBLY MEMBERS	
American Red Cross	Family Service Association
Camp Fire Girls	National Association of Hearing and Speech Agencies
Big Brothers	National Council for Homemaker-Health Aide Services
Junior League	National Council on Crime and Delinquency
Child Study Association	
Child Welfare League	
Florence Crittendon	
Girl Scouts	
Girls Club	
Goodwill Industries	
Catholic Charities	
Y.M.C.A.	
Y.W.C.A.	
U.S.O.	
Volunteers of America	
Salvation Army	

COMPARISON OF NATIONAL VOLUNTARY AGENCY POLICIES AND PRACTICES REGARDING STANDARDS OF PERFORMANCE, EVALUATION OF PERFORMANCE AND REISSUANCE OF CHARTERS OF AFFILIATION

1. Responding Agencies:

   American Heart Association
   Girl Scouts of the USA
   National Association for Retarded Children
   National Board of the YWCA
   National Council of the YMCA
   National Easter Seal Society
   National Tuberculosis & Respiratory Disease Association

2. Do you formally or officially charter your affiliates? Yes 7 No ____

3. Do you have written criteria for affiliation? Yes 7 No ____

4. Do you provide a written charter of affiliation? Yes 7 No ____

5. Is the charter in effect indefinitely or for a specified time limit? Indefinitely 2 Time Limit 4

6. Do you do a regular periodic evaluation of affiliate performance? Yes 5 No 1

   How often? 1 - 2 - 3 - 5 (years)

7. Do you have policy standards of performance other than those contained in the written charter for affiliation? Yes 5 No 1

8. If you do a periodic evaluation of affiliate performance, who does the evaluation?

   1. Staff
   2. Vice Presidents & Staff
   3. Regional Committee & Staff
   4. Self, National Board & Staff
   5. Other Volunteer Units
   6. National Board & Staff

9. Are there standards of performance for your National operations? Yes 2 No 5

10. Is there a routine periodic evaluation of your National operation?

Yes____ No 7

Most agencies reported informal evaluations by Board or special study committees, making evaluations on an irregular basis.

11. Do you have any advice for NAMH as it undertakes to develop an evaluation process and rechartering procedure?

American Heart Association

Recommend peer review by volunteers of other affiliates.

National Tuberculosis and Respiratory Disease Association

(1) Evaluation requirements for affiliates should be no higher than those for National.

(2) By establishing a satisfactory annual routine reporting system for affiliates as part of charter or agreement provisions, the National Office will have access to adequate information for a continuous monitoring of performance of affiliates.

(3) Depending on the structural and legal relationship of the affiliates to NAMH, it might be well to consider a recovery of assets clause in a charter or contract.

National Board, Y.W.C.A. of the USA

We are convinced of the value of having the local unit carry a major portion of its own evaluation and having as many as possible of its responsible leaders and members (clients) appropriately involved as possible. We are also convinced of the value of shared national/local responsibility; by-products are strengthened by national/local relationships and a better informed National Board.

COMPARISON OF NATIONAL VOLUNTARY AGENCY POLICIES AND PRACTICES REGARDING STANDARDS OF PERFORMANCE, EVALUATION OF PERFORMANCE AND REISSUANCE OF CHARTERS OF AFFILIATION

1.	Agency: NATIONAL ASSOCIATION FOR MENTAL HEALTH	
2.	Do you formally or officially charter your affiliates?	YES
3.	Do you have written criteria for affiliation?	YES
4.	Do you provide a written charter of affiliation?	YES
5.	Is the charter in effect indefinitely or for a specified time limit?	Indefinitely
6.	Do you do a regular periodic evaluation of affiliate performance?	NO
7.	Do you have policy standards of performance other than those contained in the written charter for affiliation?	YES
8.	If you do a periodic evaluation of affiliate performance, who does the evaluation?	
9.	Are there standards of performance for your National operations?	NO
10.	Is there a routine periodic evaluation of your National operation?	NO

NAME CHANGE - FIELD SURVEY

Are you in favor of a name change?

YES ----- 97

NO ----- 43

COMMENTS:

In favor of name change to: National Mental Health Association, Name of State Mental Health Association, Name of County or City Mental Health Association.

"Mental Health" should come first in any list of names people use, if for no other reason than convenience and the saving of time and effort.

I feel that the MH name should be similar on a national, state and local level -- Mental Health Association of National, Mental Health Association of State, Mental Health Association of County.

NAMH is too close to NIMH. Also, when speaking of our units without specifying any one, we use the term Mental Health Association. Therefore, I suggest the specific unit (National, State or County) to be followed by MHA.

I am in favor of uniformity of name which might require name change.

All units should be called "Mental Health Association."

State Division, Mental Health Association; County Chapter, Mental Health Association. Almost everyone uses the name "The Mental Health Association" now. Phone and other directory listings would be simplified. The name would have a unifying influence. People at the chapter level would be more apt to identify with National.

Uniform identity nationwide.

I believe we have reached the point where our name does not have to "sell" mental health but rather just let the public know that we are the people to turn to on all matters of mental health.

"Mental Health Association" would be preferable.

I like it as is and think each Division should be the same. NAMH has strong identity now.

What is wrong with the present name?

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

SPECIAL COMMITTEE ON NAMING THE ORGANIZATION

(From Minutes November 1964
Meeting of Board of Directors)

Mr. Joseph Brown, committee member, presented the report of this Special Committee on behalf of Mr. S. Heagan Bayles, chairman as here carried:

The Special Committee on Naming the Organization was appointed by the President following approval by the NAMH Board on June 20, 1964 of a recommendation by the Organization Committee that an ad hoc committee be appointed to study the advisability of changing the name of the organization.

The Organization Committee identified the following as some of the reasons for consideration of a name change:

-- "National Association for Mental Health" has come to be identified principally with the national office, since the Divisions and Chapters have different names.

-- There is resistance to the word "national" with the implications of a remote, controlling authority.

-- As a name, NAMH is somewhat cumbersome, not lending itself to easy use.

-- NAMH is frequently confused with National Institute of Mental Health.

-- A name beginning with "Mental Health Association", for example, would be more in line with the term used by the general public.

-- A name common to the three levels would make for greater utilization of the umbrella of publicity through the communication media and would have a salutary effect on fund-raising.

-- If the three levels used a name beginning with "Mental Health Association" there could be uniform telephone listing, making associations easy to locate by persons seeking assistance.

Your ad hoc committee reviewed the background relating to the name of the organization, as summarized in the attached June 8, staff memorandum from Mr. Ryan, and agreed that many of the objections to the present name, and particularly to the word "national", are valid. It was also felt that a shorter name would: intensify the public relations impact; be easier to use and more prominent in publications, posters, and letterheads; be less likely to be abbreviated into meaningless alphabetical combinations.

The committee also considered the advantages of greater uniformity in the use of an organizational name that would contribute to greater effectiveness as an organization and to increased impact in public relations, legislative efforts, and fund-raising. They agreed that the words that should be emphasized are "mental health association."

The committee felt that consideration should be given to changing the name to one that would encourage uniform use of a name and symbol that could be used at all three levels of the organization throughout the country. After considering a number of designations, some of which are not available because other organizations already have the legal rights to them, the name "The Mental Health Association" was unanimously agreed on. Use of this name by the national organization would mke it easy and appropriate for the state organization to add "in (name of state)", and the Chapter further to add "and (name of locality)". There was agreement that in Chapter literature and publicity the words "in (name of state)" would be in smaller letters than the other parts of the name, thus giving greater prominence to the Chapter.

Adoption of a uniform generic name such as this would make it possible for National to furnish standard mats or cuts of the name and the symbol of Divisions and for Divisions to provide them to their Chapters.

The committee recognized that such change should not be made precipitously but that Divisions and Chapters should be given an opportunity to review the proposals and communicate their reactions before final action is taken by the Board. The committee further recognizes that if a new name is adopted, it should be before the 1966 campaign materials are produced so that they can reflect the change.

It is therefore the recommendation of your ad hoc committee;

-- That the Board of Directors approve in principle the proposal that the name of the National Association for Mental Health, Inc., be changed to "The Mental Health Association" with consistent name changes at Division and Chapter levels, such as "The Mental Health Association'in (name of state)' and ' (name of locality)'"; and

-- that the proposed name change be submitted as soon as possible to the Divisions for reaction in sufficient time to allow the Board of Directors to consider final adoption of a name change at the mid-year 1965 meeting of the Board.

Following a discussion in which the Board recognized the convincing arguments presented for the change in name but recognized also that there had not been sufficient time for the Board to study carefully the staff memorandum giving background information relating to the name of the organization and the committee report.

A motion that the present name of the Association be changed to some other name that would be found more agreeable and more satisfactory as we strive to gain our objectives resulted in twenty-five negative and twenty-one affirmative votes being cast.

Recognizing the close vote, the seriousness of the matter of a name change and the lack of adequate time to study the information provided a motion to refer the matter back to appropriate committee or committees with an opportunity provided for discussion with Divisions, and with sufficient advance information to Board, with a report to be presented at the next meeting of the Board was moved, seconded and voted.

From Minutes, May 4-5, 1965
Meeting of Board of Directors

As background material for the discussion of the change of name, copies of the Report of the Special Committee on Naming the Organization and the Staff Memorandum on Background Information Relating to the Name of the Organization were sent to Board Members.

Relevant points brought out in discussion were -- we do not yet have what we are looking for, a name that gives us national identity without using the word national; the need for a simple name; the possibility of change to National Mental Health Association, thus eliminating confusion with NIMH but maintaining national identity; the possibility of change to "Mental Health Association", eliminating the word "national", and thus avoiding any confusion with the Federal Government; the image value inherent in a name that has been used for a number of years.

Following lengthy discussion, a motion that the Board approve in principle the change of name to "Mental Health Association", with Divisions asked to react to suggested change and with the Executive Committee authorized to take action in September, depending on the reaction of the Divisions, was defeated.

The attention of the Board was called to the fact that at the November 1964 meeting of the Board a motion to change the name to "Mental Health Association" was defeated (25 negative - 21 affirmative). Recognizing the close vote, a subsequent motion to refer the matter back to appropriate committee and an opportunity provided for Divisions to discuss, with report to Board at next meeting, was passed.

A motion to table the discussion pending the report of the management consultation firm was moved, seconded and voted.

It was suggested that Divisions may want to refrain from amending their articles of incorporation as a result of action taken earlier in the meeting on Charter Standard II until final action is taken on the matter of change in name, thus avoiding the possibility of making two changes in close succession.

GLOSSARY

Activities

Methods for achieving stated objectives (see Programs)

Advocacy

The act of representing a group or cause

Affiliate

Unit of a larger organization

Affiliation

The interrelationship between units of the organization

Affiliation Document

The instrument by which different units evaluate their relationship

Common

Belonging to or shared by all members of a group

Codification

A summary by category of existing standards

Evaluation Process

The modus by which separate units of the Association examine their reciprocal relationships

Federation

A single Association of separate units, each retaining the management and control of its own local affairs under principles agreed upon mutually

Focus

A center of activity, attraction or attention

Function

The action for which a person or thing is specifically fitted or used or for which a thing exists

Guidelines

A way to assist another unit of the Association to function more effectively in achieving common purposes

Image

A mental conception held in common by members of a group and its publics

Interrelationship

Interaction between the three units of the Association

Member

One who belongs to all three units of the Association

Peer Evaluation

Review of program and performance by colleagues

Programs

Methods for achieving objectives (see Activities)

Social Action

Supporting the welfare of human beings through change

Standards

Basic: Minimum requirements essential to continued affiliation

Excellence: Performance which exceeds minimum requirements and merits special recognition

Unit

Chapter, Division or National component of the Association

RELATIVE ROLES AND RESPONSIBILITIES OF THE THREE UNITS

UNIT FUNCTIONS	NATIONAL	DIVISION	CHAPTER
RESEARCH	Federal Legislation, Litigation, Grants; Assist Selected Divisions with State Research Studies	State and Federal Legislation	State & Federal Legislation
SOCIAL ACTION	Advocacy Relating to Federal Legislation & Regulations--Information to Divisions & Chapters, Litigation, Public Affairs Network	Advocacy Relating to Federal & State Legislation, Information to Chapters; Observation, Evaluation & Assistance to State Government Affecting Mental Health	Advocacy Relating to Local, State & Federal Legislation; Influence & Cooperation with CMHCs; Observation, Evaluation & Assistance to Local Government Affecting Mental Health
PUBLIC INFORMATION	Consultation & Training for Divisions & Chapters; Development of Publications & P.I. Materials, Newsletters, Journals, Audiovisuals, Information to National News Media, Consultation to Writers, Producers	Consultation & Training for Chapters, Development of Special State-wide Publications, Newsletters, Press Releases, Work with Radio/TV	Local News Media Materials, Chapter Newsletters
NATIONAL GUIDELINES & POLICIES	Development & Presentation to Appropriate Governing Body	Development of State-wide Issues	Development of Local Issues
LIAISON WITH OTHER ORGANIZATIONS	National Organizations with an Interest in Mental Health	State Organizations with an Interest in Mental Health	Local Organizations with an Interest in Mental Health
TRAINING MEETINGS	Annual Meeting; Division & Metro Presidents & Executives; Assist with Staff Council Institute, Regional Meetings; Board Orientation	Annual Meetings, Chapter Executives, Volunteers, Board Orientations	Annual Meetings, Board Orientations, Volunteers
PERSONNEL RECRUITMENT & DEVELOPMENT	Assist Divisions & Metro Chapters in Staff Recruitment & Training	Assist Chapters in Staff Recruitment & Training	Encourage Staff Training at State & Natl. Meetings & Staff Council Institute
FINANCIAL DEVELOPMENT & LEADERSHIP CULTIVATION	Consultation & Training for Divisions & Metro Chapters, F.R. Loans for Divisions, Cultivate Foundations, Develop F.R. & Membership Materials for Divisions & Chapters, Leadership Recruitment, Bequest Cultivation, Work with United Way	Consultation & Training for Local Leadership, Bequest Cultivation, Assist Chapters with United Fund Negotiations, Fund Raising & Membership Recruitment	Fund Raising, Bequest Cultivation, United Fund Enrichment, Membership Recruitment
INFORMATION & REFERRAL	Assistance to National Organizations & Individuals	Assistance to State Organizations & Individuals	Assistance to Individuals & Their Families & Local Organizations
VOLUNTEER PATIENT SERVICES		Development of Programs, Coordination, Training for Chapters	Volunteer Services, Rehabilitation, Adopt-a-Patient, Social Clubs, Special Activities
EDUCATION	(See Public Information)	Provide Educational Booklets to Chapters, Maintain Film Library, Assist Chapters with Workshops	Provide Literature, Create Speakers Bureau, Provide Films, Workshops, Specialized Training for Clergy, Educators, Industry, Law Enforcement Agencies, Parent Groups

CODIFICATION OF EXISTING ACTIONS RELATING TO ORGANIZATION, FINANCE AND PROGRAM

Compiled by Unity and Standards Committee
of The National Association for Mental Health, Inc.

A. ORGANIZATION

1. Basic Documents

a. Division affiliation may be granted to a state mental health association upon:

(1) Acceptance of the purposes, standards, policies and procedures, and the Financial Support Plan of NAMH.

(2) Incorporation within the state as a non-profit organization and receipt of tax exemption certificate from the Bureau of Internal Revenue for the state Division, its current Chapters and any Chapters that may be established in the future.

(3) Adoption of By-Laws.

(Policies & Procedures for Divisions)

b. A constitution and by-laws which conform to the Association's regulations in regard thereto.

(Art. III, Sec. 1 of Nat'l. By-Laws)

c. By-laws which clearly outline the general purposes of the organization, provide standing committees and define their duties. Specific by-law provisions for tenure of office and responsibilities of officers and directors, operational procedures, basic program and standards for Chapters.

(Charter Standards for Divisions)

d. Agreement to provisions that in case of dissolution the Division will surrender the NAMH charter and will transfer, subject to the provisions of any state law, title to its net assets, including the right to its corporate name, to NAMH or to such other qualified tax-exempt organization as NAMH may designate.

(Charter Standards for Divisions)

2. Name of Association

A mental health association which becomes a Division of NAMH shall adopt a name that insures identification with NAMH at all three levels as a coordinated national organization, or include with its name an explanatory phrase that insures identification, such as "a Division of The National Association for Mental Health, Inc." This statement should appear on letterheads, forms, bulletins and newsletters, and all other printed material which bears the Division's name.

(Policies & Procedures for Divisions)

3. Use of Symbols

Upon acceptance as a Division or a Provisional Division of NAMH, the affiliate shall use as its symbol the mental health bell on its letterhead, publications, and other material where appropriate. This symbol is registered by NAMH, and authorization of its use will be withdrawn if the Division disaffiliates or is disaffiliated.

(Policies & Procedures for Divisions)

4. Membership

Composition of the voting membership and the Board of Directors of the Division in accordance with a pattern approved by NAMH.

(Charter Standards for Divisions)

5. Board of Directors

a. Composition of the voting membership and the Board of Directors of the Division in accordance with a pattern approved by NAMH.

(Charter Standards for Divisions)

b. Any person who is employed by a public agency or institution which is engaged primarily in mental health work . . . shall not be eligible as a member of the Board or as an employee of any Division or Chapter.

(General Policies for Divs. & Chapters)

6. Standing Committees

Formation and activation of basic standing committees and other committees which afford the means of carrying out the responsibilities of the Corporation.

(Policies & Procedures for Divisions)

7. Officers

The Charter Standards call for "specific by-law provisions for tenure of office and responsibilities of officers . . . "

The prohibition on election of Board Members "employed by a public agency or institution which is engaged primarily in mental health work" would obviously apply to officers also.

(Charter Standards for Divisions)

8. Representation of Ethnic Minorities and the Poor

The national membership and Board adopt as the membership goal for all three levels of the Association (National, Division and Chapter) and its committees a substantial and appropriate proportion of the ethnic minorities and the poor themselves approximately in the same proportion as they exist in the community served.

The Association actively strive to immediately build substantial representation of the ethnic minorities and the poor in the general membership as a means of enlarging its own pool of resources for community support and for leadership development.

Divisions and Chapters establish a separate Committee on the Ethnic Minorities and the Poor or, when this is impractical, designate a single Board Member to take responsibility for seeing that priority is given to the mental health needs of these groups. Such a committee or individual would also act as liaison to our own national level Committee on the Ethnic Minorities and the Poor.

The Association launch an intensive program to achieve representation of Ethnic Monorities and the Poor who are qualified in the professional and non-professional staffing of the National, State and local offices, as a means of enhancing the effectiveness of the Association's efforts to achieve its service goals, while at the same time enlarging the opportunities for career development for larger segments of the ethnic minorities and the poor.

(Membership Action 1970)

9. Non-Discrimination Policy

No person shall be denied or excluded from any of the programs of the National Association for Mental health, including receipt of

services, because of race, color, or creed; and that recipients of these benefits shall not be discriminated against because of race, color or creed.

It will be a continuing policy of the National Association for Mental Health, Inc., to afford all persons the opportunity to serve in any capacity as a volunteer without regard to race, color or creed.

It shall be the continuing policy of the Association to afford equal employment opportunity for all persons in the filling of staff positions, and there shall be no discrimination on the basis of race, creed or color with regard to employment, assignment, promotion or other conditions of staff employment.

(Approved by Executive Committee 7/21/68)

10. Relationship with Other Organizations

Divisions are encouraged to cooperate with and maintain effective liaison with other important health agencies, public and private. However, Divisions and their Chapters shall not be combined with other voluntary or professional agencies in their organizational structure.

(Policy on Mergers - approved in 1965 & reaffirmed by the Membership in 1969)

11. Structure and Staffing of Divisions

There must be minimum income and staffing requirements for all the associations:

a. There should be adequate staffing for the Division and all size Chapters.

b. If there is only enough money to have one executive director in one office, this should be at the Division level.

c. In a Division which is large enough to have both a Division executive director and one or more local executive directors, local executive directors should be hired only when the Chapter can afford such an arrangement including support of effective local program and full State and National obligations.

(Report of Committee on Relating Income to Structure and Staffing - approved by the Membership in 1969)

B. FINANCIAL SUPPORT

1. Financial Responsibility

Each Division shall provide its share of the approved national budget authorization level. A Division's share is determined by the state's position in the country's purchasing power as calculated under the Effective Buying Income (EBI) formula of Sales Management.

(Financial Support Policy - Rev. 1972)

2. Transmittal of Funds

Divisions shall submit monthly support payments unless a different payment schedule has been authorized by the National Organization Committee.

(Financial Policies adopted by the National Board - 1963)

3. Division-Chapter Relationships

A single principle should obtain in arrangements between Divisions and Chapters, and this should be the principle of equitable sharing of an agreed-upon financial authorization. The National Board should support each state's officially adopted formula as long as it is consistent with the principle and is otherwise a reasonable means of distributing to each local Chapter the fair share of Chapter responsibility for the state and National budgets.

(Financial Support Policy - Rev. 1972)

4. Sharing of Bequest Income

Bequests received without restriction or limitation by Chapters or Divisions shall be used by them, as to 20% thereof, for activities of the National Office serving the general purposes for which such unit exists, and shall be paid over to NAMH for that purpose.

(Financial Support Policy - Rev. 1972)

5. Division Sharing of Non-Designated Gifts and Bequests Received or Solicited by the National Office

It is expected that state financial support plans will spell out a formula for sharing or assigning to the Chapter from which the non-designated gift and/or bequest was derived the largest share of the contribution. If, however, the Division provides basic staffing and other budgeting for the Chapter, this should be taken

into consideration in the final disbursement of non-designated gifts or bequest income. Also, if assignment to the Chapter will result in loss of money because of local circumstances, the Division and Chapter should arrange for effective assignment of the money with proper credit to the Chapter concerned.

(Financial Support Policy - Rev. 1972)

C. FINANCIAL ADMINISTRATION

1. Fiscal Year

a. Establishment of a fiscal year for the Division which coincides with the fiscal year of NAMH.

(Charter Standards)

b. Divisions and Chapters shall establish their fiscal year from January 1 to December 31 to conform to the fiscal year of the National Association for Mental Health.

(Financial Policies approved by the Board - 1963)

2. Annual Budget

a. Preparation of an annual budget and forwarding a copy to NAMH.

(Charter Standards)

b. Divisions shall prepare annually a campaign goal budget and shall submit such budget, as well as the actual operating budget for the following year, to the Division, on request, by December 31 of each year.

Chapters shall prepare annually a campaign goal budget and shall submit such budget, as well as the actual operating budget for the following year, to the Division, on request, by December 31 of each year.

(Financial Policies - 1963)

3. Internal Controls

a. Maintenance of a bookkeeping system using forms and procedures outlined in an accounting manual furnished by NAMH.

(Charter Standards)

b. The funds of the Division or Chapter, including securities, shall be deposited in such banks or other financial institutions as may be designated by its Board of Directors.

(Financial Policies - 1963)

c. Checks, drafts and orders for payment of money shall require two signatures, of such officers or agents as the Board of Directors may designate.

(Financial Policies - 1963)

4. Compliance with Uniform Standards of Accounting

The Association shall be bound by the Uniform Accounting Standards for Voluntary Health and Welfare Associations.

(Approved by the Nat'l Board - Nov 1966)

5. Bonding

Appropriate persons shall be bonded.

(Charter Standards)

6. Annual Audit

a. An annual audit of Division books by an independent public accountant with a copy of the audit sent to NAMH and a consolidated audit including all affiliated Chapter audits shall be accomplished.

(Charter Standards)

b. The accounts of the Division or Chapter shall be audited annually by an independent public accountant selected by the Board of Directors.

Divisions with annual income of $5,000 or less may submit the annual treasurer's report to NAMH, in lieu of audit. Chapters with annual assets of $5,000 or less may, with the approval of the Division, submit an annual treasurer's report to the Division in lieu of an audit.

(Financial Policies - 1963)

7. Financial Reports

a. Divisions and Chapters shall maintain a bookkeeping system using forms and procedures outlined in an accounting manual furnished by NAMH.

Chapters shall submit annually to the Division two copies of an income and expenditure report, on forms provided by NAMH, together with two copies of their audit report.

Divisions will produce and transmit annually to NAMH an income and expenditure report, on forms provided by NAMH, together

with a consolidated income and expenditure report for the entire state, including a copy of both the Division audit and a consolidated audit (using the same format as on the forms).

(Financial Policies - 1963)

8. Investment Policies

Common stocks or similar marketable securities received as a bequest by any unit of the Association shall be divided with the other two units on the same formula for sharing cash bequests. National strongly discourages the speculation inherent in retention of such volatile assets as common stocks and similar securities and therefore strongly advises that they be immediately offered for sale on the day of their receipt and disposed of for cash as promptly as the market will accept the offer of sale. The cash receipts from such sale shall be promptly shared with the two other units on the Association's formula for such division. If, however, the unit receiving the original bequest elects to retain these securities and not to sell them as herein advised, it shall not speculate with those portions of such securities as are to become the property of the two other units of the Association, but shall distribute to them promptly either their pro rate share of the certificates of these securities or, preferably, their shares in cash of the market value of these securities on the day they were first received by the original recipient of the bequest.

(Policies on Investments - approved by Nat'l Board - June 1973)

D. PROGRAM

It shall be the policy of the National Association for Mental Health and its affiliates to provide community and patient services, with the exception of direct medical treatment services, to help the mentally ill, their families and others in the community, in accordance with standards adopted by the NAMH Board of Directors upon recommendation of the appropriate Board committees and councils.

The operation of a facility that provides direct medical treatment to the patient as part of its essential function may be established and supported by mental health associations on a demonstration basis only. This direct medical treatment service may be undertaken for a limited period of time with the specific purpose of transferring its operation to appropriate community agencies. This policy shall not prevent a mental health association from making a grant or recurring grants to direct medical treatment facilities within the limits of this policy.

(The Service Policy - adopted by the Membership & Board of Directors - 1963)

NCMHA CHAPTER SELF-EVALUATION FORM

CHAPTER_____ DATE_____

I. BOARD

a. Size of Board - Within Minimum No. (20)_____
- Within Maximum No. (40)_____

b. Required number of officers?_____

President_____ President-Elect_____
Secretary_____ Treasurer_____

c. Elected NCMHA delegate?_____
Elected alternate NCMHA delegate?_____

d. Is the Board made up of county geographic representatives?_____

e. Are all Board members assigned to the various structure Committees?_____

f. Is Board attendance good?_____

g. Did Board members (committee chairmen and committee members) receive a copy of the "committee charges" and a list of on-going activities of the committee, and responsibilities of the committee chairman?_____

h. When your potential board members were approached - did they receive in writing -

1. A personal letter of request?_____
2. A history of the local chapter?_____
3. A fact sheet (chapter and NCMHA)?_____
4. The functions and objectives of the various committees?_____

i. Did your Nominating Committee use the membership list as a resource for the recruitment of new members?_____

j. Do you involve your membership (non-board members) in any of your activities?_____

k. Do you have any specific criteria for the selection of board members?_____

l. Do you have the required number of yearly board meetings(4)?_____

II. COMMITTEES

a. Do you have the required (under affiliation standards) number of committees?_____

1. Program Committee (with four sub-committees)
   a. Hospital Patients Sub-Committee?_____
   b. Aftercare and Rehabilitation Sub-Committee?_____
   c. Childhood Mental Illness Sub-Committee?_____
   d. Community Services Sub-Committee?_____

2. Financial Development Committee?_____
3. Publicity Committee?_____
4. Membership Committee?_____
5. Public Affairs Committee?_____
6. Annual Meeting Committee?_____
7. Nominating Committee?_____

b. Do you use ad-hoc committees for special functions when needed?_____

c. Are your committee chairmen and officers, carefully selected using this criteria as a guide?_____

1. Time and interest to give to the program.
2. Leadership ability.
3. Ability to recruit and work with volunteers.
4. Organization ability.
5. Ability to evaluate
6. Knowledge of community and possible needs.

d. Do your committees meet on a regular basis?_____

e. Do your committee chairmen occasionally meet together to determine how they can support the functions of the various committees?_____
(i.e., membership committee working with nominating committee;publicity committee working with other committees, etc.)

f. Do your committees submit, annually, a "budget" to the finance committee?_____

g. Is recognition for work given to committee members?_____

h. Are your committee members given the opportunity to serve on a committee of their choice?_____

III. PROGRAM

a. Are your programs covered in the standard "4" program emphases?_____

b. Do your programs meet any of the community needs?_____

c. Do you evaluate your programs annually?_____

d. Is the community aware of your organization and its activities?_____

e. Do you work with other community agencies in your program activities?_____

f. Do you have an "information and referral" program or a brochure of resource information for distribution to the public?_____
If so, is this material shared with other agencies for distribution?_____

g. Do you use effectively, materials sent from NCMHA and the NAMH Monthly Memo?_____

IV. FUNDING

a. Does your funding method provide ADEQUATE FINANCING FOR YOUR ENTIRE PROGRAM?_____

b. Does your funding method provide VISIBILITY for the Association?_____

c. Is your fund-raising activity carried out at a specific time, annually?_____

d. Does your entire Board (if independent fund-raising) assist in the fund raising project?_____

e. Do you plan your funding needs on projected future needs (2 to 5 years in advance)?_____

f. What is your most effective method of fund-raising?

1. BellRinger_____ 3. Mail Appeal_____ 5. Special Events?_____
2. Membership_____ 4. United Fund_____

V. PUBLICITY

a. Have you developed a sound total public relations program?_____

b. Do you have at least one monthly news release?_____

c. Do you take advantage of free radio and TV time available under FCC community service requirements?_____

d. Do you have a newsletter?_____

e. Do you have a Speaker's Bureau?_____

VI. MEMBERSHIP

a. Do you conduct an annual membership campaign?_____

b. Is your membership informed of the activities of the Association?_____

c. Is your membership invited to attend board meetings, workshops, special programs, NCMHA board meetings, NAMH meetings?_____

d. Do you use your membership as "volunteer manpower" for special occasions?_____

VII. STAFFING

a. Is the role of the staff person clearly defined and understood by the board and staff?_____

b. Does staff keep committee chairmen and entire board well informed of the business of the Association?_____

c. Does staff work well with volunteers and other community agencies?

_____

d. Does Board accept staff recommendations for program activities and other functions of the Association?_____

e. Does staff receive adequate compensation for services rendered?_____

f. Is your staff person a member of NAMH Staff Council?_____
(National staff organization for annual training of chapter staff. An in-put organization for chapter staff).

VIII. NCMHA AND NAMH AFFILIATION

a. Do you invite NCMHA President and Regional Vice Presidents to visit with your chapter?_____

b. Do you call on NCMHA committee chairmen for assistance with your related committees?_____

c. Does your voting delegate attend NCMHA meetings and report back to your board?_____

d. Does your chapter send a representative to the NAMH Annual Meeting?_____

e. Does your chapter meet its support sharing obligations to NCMHA and NAMH?_____

f. Do you promptly send required operational information and forms to NCMHA? (reference to list in President's Manual, tax forms, a board list, delegates names, etc.).

IX. SUMMARY

a. Under Items I - VIII - list the weak areas_____

b. Under Items I - VIII - list the strong areas_____

c. List unmet needs of chapter_____

d. Are you pleased with your evaluation?_____

e. List areas in which NCMHA and NAMH could provide assistance to your chapter?_____

X. SUGGESTION

a. Share this evaluation with your entire Board of Directors.

_____
(Signature/Person Submitting Report)
Date:_____

MENTAL HEALTH ASSOCIATION EVALUATION FORM

Note: The evaluation can be carried out by the entire Board of Directors or by an Ad Hoc Evaluation Committee of sufficient size to fulfill its charge effectively. All records, minutes, publications, and reports should be made available to it. The Committee should also feel free to interview any group or individual whose opinions and judgment as to the effectiveness of the organization might be helpful.

The Evaluation Committee should also feel free--indeed, be urged--to make recommendations and suggestions of ways to bring about improvements in the future activities of the organization. They should also feel free to be honestly critical in those areas it finds appropriate.

The final report of the Evaluation Committee should be furnished to each Board Member; in the case of a chapter, to its Division; and in the case of a Division, a copy should be sent to the Organization Committee of NAMH.

STATISTICAL DATA

Name of Unit: _____

_____
Address/City/State/Zip Code

Is Unit Incorporated? _____Yes _____No Date of Incorporation_____

Is most recent set of corporate charter documents on file at the Division Office?_____/National Office?_____

Is there an Internal Revenue Service Tax Exempt Ruling letter currently in effect? _____Yes _____No

Date of IRS Tax Exempt Ruling letter _____

Is this letter on file at the Division Office?_____/National Office?_____

Officers:

_____
Name/Address/City/State/Zip Code

_____
Name/Address/City/State/Zip Code

_____
Name/Address/City/State/Zip Code

List other authorized staff positions (include vacant positions):

_____ _____

_____ _____

_____ _____

Population Served:_____ Area served (sq. miles):_____

Percentage Income Breakdown of Area Served:

Under $5,000 _____ $15,000-25,000 _____

$5,000-10,000 _____ Over $25,000 _____

$10,000-15,000 _____

In completing the rest of this evaluation, keep in mind the stated purpose of the Association:

Role of the Association

The original and continuing role of the Association is:

a) to improve attitudes toward mental illness and the mentally ill

b) to improve services for the mentally ill

c) to work for the prevention of mental illness and promotion of mental health

The unique function of the mental health association is to promote citizen interest and relevant activity on behalf of the mentally ill and the cause of mental health. In other words, the Association's job is to help determine what needs to be done and then to see that whatever needs doing is in fact accomplished by whomever can do it best.

The areas of the Association's immediate interest and function have been defined as follows:

1. Research into the causes, prevention, treatment and cure of mental illness.
2. Social action to bring about humane legislation, sound administrative policy, adequate facilities and sufficient financing to offer the best possible prevention, detection, treatment and rehabilitation programs.

Volunteer Activity

The Association is people--volunteers who are sufficiently interested, informed and active to form a true special interest group. The organization functions at each level by involving several constellations of interested people studying and improving services for children, hospitalized patients, the discharged patient and community mental health services. To be effective, the Association must be populated at all three levels with knowledgeable, active volunteers with considerable influence on government, professionals, organizations, and the general public so that prevention, identification, diagnosis, care and rehabilitation of mental illness are achieved.

Staffing

The basic program force of our organization is the volunteer time and energy which moves legislation, regulations, attitudes and professional practices in the direction of effective services for the prevention, identification, diagnosis, care and rehabilitation of mental illness. In order to keep this many interests vibrantly alive and this many volunteers maximally effective requires staff back-up.

ORGANIZATIONAL AND ADMINISTRATIVE DATA

	Yes	No
Do you have a Board of Directors or Trustees? How many members?_____	____	____
Are members of the Board selected on a geographical basis so they truly represent the area served?	____	____
Are minority groups represented on your Board in an appropriate manner?	____	____
Is your Board adequately balanced with nonprofessional members?	____	____
Is there a provision in your By-Laws limiting the number of years a Board Member may serve? If yes, limitation: _____	____	____

	Yes	No
Is there provision for general membership in your Mental Health Association?	____	____
Is there a continuous program of membership recruitment?	____	____
Is there a concerted effort to involve members in the work of the Association?	____	____
Do you keep your members informed of Mental Health Association activities through		
- Newsletters	____	____
- Membership Meetings	____	____
- Other (list)		
_____		
_____		
_____		
Do you have the following committees:		
- Public Affairs	____	____
- Nominating	____	____
- Finance	____	____
- Public Information and Education	____	____
- Organization and Structure (for Divisions and large Chapters)	____	____
Are your tax returns filed on time?	____	____
Do you provide an orientation and training program for volunteers?	____	____
In other training areas, do you:		

	Yes	No
- have staff attend the Staff Council Institute?	____	____
- provide other types of staff training?	____	____

Describe: _____

_____

_____

	Yes	No
Does your unit participate in Division/National meetings?		
Annual Meetings?	____	____
Training Sessions?	____	____
Others?	____	____

Describe: _____

_____

_____

How many Board Members from your unit attended:

Unit's Annual Meeting? _____

NAMH Annual Meeting? _____

How many representatives from your unit participate in Division Committee activities? _____

How many representatives from your unit participate in National Committee activities? _____

How many representatives from your unit participate in legislative hearings for your Division? _____

Does your unit maintain its own office?	____	____
Is your salary scale adequate and competitive for what you expect from your		
professional staff?	____	____
clerical staff?	____	____

	Yes	No
Do you provide fringe benefits for your employees?		
hospitalization?	____	____
major medical?	____	____
travel accident coverage?	____	____
retirement plan?	____	____
sick benefits?	____	____
paid vacation?	____	____
Do you have bonding insurance coverage on your staff?	____	____
Do you have an annual evaluation of staff performance and discuss the results with them?	____	____

FINANCE AND FUND RAISING

Do you have a specific program for financial development?	____	____
Has your unit set income goals? How much? _____	____	____
If yours is a United Fund unit, did the members appear at a hearing before that organization's allocation committee last year?	____	____
Did they include a presentation in behalf of the Division and/or National?	____	____
Does your United Fund include a sufficient amount for Division and National Support?	____	____

Report on Your Sources of Income for the Last Calendar Year

United Fund Unit:

Per Capita Income _____

United Fund Allocation _____

Membership _____

Special Gifts _____

Special Events _____

Foundations _____

Bequests _____

Yes No

United Fund Unit Subtotal: _____

Other Income: _____

Describe: _____

_____

_____

Total _____

Independent Campaign Unit:

Per Capita Income _____

Bellringer _____

Membership _____

Direct Mail _____

Special Events _____

Commerce & Industry _____

Foundations _____

Bequests _____

Independent Campaign _____

Unit Subtotal _____

Other Income: _____

Describe: _____

_____

_____

Total _____

Are you considering a change in fund raising methods in the future? ___ ___

Comment on any significant changes in fund raising results since last year:

_____

_____

_____

Yes No

Give a concise statement of fund raising goals for next year:

_____

_____

_____

PUBLIC INFORMATION AND EDUCATION

If you have separate Public Information and Education Committees, comment on both:

_____

_____

_____

Does it have a chairman? ____ ____

Do they meet regularly? ____ ____

Does your unit produce a newsletter? ____ ____

If so, what is circulation? _____

Does your unit distribute the NAMH Reporter regularly . . .

To Board Members? ____ ____

To Committee Members? ____ ____

To General Members? ____ ____

How many pieces of literature did you distribute last year? _____

List titles of five most popular:

_____

_____

_____

_____

_____

Do you publish and/or provide a directory of facilities and services available in your area? ____ ____

	Yes	No
Do you maintain a speakers bureau?	____	____

How many speakers available? _____

How many appearances did they make on your behalf last year? _____

What was the approximate total audience? _____

Do you maintain a film library?	____	____

How many films in it? _____

How many showings last year? _____

What was approximate total audience? _____

How many newspaper stories about MHA activities in your area last year? _____

How many radio features on mental health did you generate last year? _____

How many TV public spots in your area last year? _____

How many TV features on MH did you generate last year? _____

How many public meetings did the Association sponsor or participate in last year? _____

State briefly the basic messages relating to mental illness and mental health covered by the above activities:

_____

_____

_____

_____

_____

How many of your Board Members subscribe to Mental Hygiene? _____

	Yes	No

PUBLIC AFFAIRS

Do you have active programs in these areas:

Legislation?	____	____
Hospitalized patients?	____	____
Children's Services (including education)?	____	____
Community Mental Health Centers?	____	____
Prevention?	____	____
Rehabilitation and Aftercare?	____	____
Working with the Disadvantaged?	____	____

List any other programs and state briefly what you did in each:

_____

_____

_____

_____

Does the Association maintain active fact finding groups to determine needs in these areas in your community? ____ ____

Does the Association conduct pilot projects in any areas? ____ ____

If so, describe: _____

_____

_____

_____

Does the Association support or conduct any direct service programs? ____ ____

If so, describe: _____

_____

_____

OPTIONAL

If a chapter, comment on the performance of your Division:

_____

_____

_____

_____

_____

_____

If a Division, comment on the performance of your affiliated Chapter:

_____

_____

_____

_____

_____

_____

If a Division, comment on the performance of National:

_____

_____

_____

_____

_____

Add a paragraph on how the results of this form should be used. Do so many "no" answers in each category indicate a unit is under-performing? Should there then be sanctions imposed? If so, what and by whom?