Explanation of Mental Health Program Requests

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL BUILDING
ST. PAUL

Dr Vail.

TO: THE LEGISLATURE OF THE STATE OF MINNESOTA,
1963 Session

FROM: David J. Vail, M. D.
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SUBJECT: Report on past biennium and explanation of requests.

This report is divided into three main portions: a review of accomplishments during the past two years, a report on the new hospital administration plan, and an explanation of requests, together with program plans for the next biennium.

I. Review of accomplishments.

This covers the period roughly from August 1, 1960, when I became Medical Director, until the opening of the 1963 legislative session. A partial listing is given, with explanatory notes where appropriate.

1. Hospital administration plan implemented.

Listed first because it has aroused so much interest. More on this below.

2. Hospitals accredited.

Anoka and Rochester State Hospitals received full Accreditation by the Joint Commission on Accreditation of Hospitals. Careful work has been done with all hospitals in preparation for inspections.

3. Open Hospital Program inaugurated.

This approach to mental hospital programming, although not totally free of liabilities, has tremendous treatment power in terms of patient care and social restoration.

An index of progress for hospitals for the mentally ill:

	Wards totally open
Nov. 1960 Average 52%	(Range, 22-79%)
Nov. 1962 " 76%	(" 58-100%)

Hospitals for the mentally retarded have also, with appropriate modifications, adopted the open hospital philosophy.

4. Voluntary admissions increased.

Another indication of a progressive program based on concepts of treatment:

Sept. 1960 average:	25%	(Range, 3.3-64%)
Nov. 1962 "	48%	(" 13-75%)

5. Community mental health program expanded.

	No. Centers	No. Prof. Staff	% State Pop. Served
Jan. 1960	14	42*	45%
Jan. 1962	17	77*	80%

*Including 10 psychiatrists, 1960; 22 psychiatrists, 1962.

6. Regional coordinating plan inaugurated.

Developed in early 1962. By year's end, two regional committees are operational. Two are in active formation stages. Ultimately we expect seven or eight.

7. Mental hospital population decline hastened.

This has been striking. It is not an end in itself, or the ultimate measure of effectiveness. Nonetheless, it is an indicator of program activity and public acceptance. The acquisition of Glen Lake and conversion of the Ah-Gwah-Ching facility have also figured significantly. This decline in population requires a new approach to

staffing ratios in mental hospitals, described below.

Total number resident patients		
Nov. 30, 1960:	10,019	
Nov. 30, 1962:	8,240	
Reduction:	1,779	or 17%

8. Children's Mental Health Services Organized.

Dr. Richard Bartman, a psychiatrist, was recruited from California and joined us in October, 1961. He is in charge of programs for emotionally disturbed and mentally ill children, and for the mentally retarded. There has been a massive job to be done in both fields, and in the broad area of overlap. Among concrete results so far are: Survey of mental retardation institution populations. Refinement of staff ratio analyses and differentiation of special programs for special problem areas. Development of staffing pattern and program plans for Lino Lakes, including improved community evaluation and referral procedures.

9. Mental Health Study and Planning Program established.

This enterprise, undertaken in July, 1962, on the basis of a federal mental health project grant, is probably the first of its kind in the country. It aims at a broad evaluation and self-examining operation throughout all branches of the state program. It includes stating program goals, measuring the means by which goals are approached, and continual planning of future developments. In other words, a systematic, scientific method of "getting from here to there."

10. Research Program Reorganized.

We have brought about a closer control and higher accountability of research methods and procedures aimed at improving the quality, relevance, and significance of mental health research. This was done by the September, 1961, appointment of Dr. Howard Davis as research coordinator and designation of a special subcommittee of the Mental Health Medical Policy Committee to review all research project requests in detail. A more complete report on research is appended.

11. Information and volunteer services consolidated.

This brings all aspects of public involvement in the program under one highly organized section headed by Mrs. Miriam Karlins. This has attracted favorable attention nationally. Another "first" in this area is the establishment of a position for coordinating volunteer services at the community level.

12. Medical recruitment continued.

The splendid action of the 1961 Legislature in allowing expansion of the community mental health program and in passing the "ABC" salary law have been instrumental here. The gain in psychiatric recruitment in the community program has been touched on above. At the institution level, we see, for example, an improvement for the seven mental hospitals from 51 to 59 medical staff positions from January 1, 1960, to January 9, 1963. In relation to population, this is an improvement of some 40-50%. As of January 9, 1963, a second top psychiatric job has been filled in central office. The

recruitment of Dr. Bartman has been mentioned. The hospitals for the mentally retarded have shown a significant increase in medical staff. There will be a full-time psychiatrist at Brainerd by April, 1963, for the first time in that institution's history. The number of psychiatric residents has increased from three in October, 1960, to six currently. There has been a continuing net gain in medical staff since July, 1960. The period July-December, 1962, showed the biggest gain in two years. The fine collaboration of the Board of Medical Examiners has also been a great help.

The above tabulation does not include definite and tentative recruitment prospects currently in negotiation. Nor does it give any indication of the increased power to be derived from the consulting staff under the new administration Plan.

II. The Hospital Administration Plan.

The background and history of this, up until December, 1961, is shown in the essay appended. Here I will try briefly to give an evaluation of this plan as of today, some two and one-half years after it was first begun at Brainerd, and one and one-half years after developed intensively in hospitals for the mentally ill.

Progress: Brainerd, September, 1960. Willmar, September, 1961.
Hastings, December, 1961. Fergus Falls, January, 1962.
Anoka, September, 1962.

Experience has been varied, interesting, and encouraging. The virulent opposition by the American Psychiatric Association (despite official exhortations to attempt "bold experimentation in administrative patterns") has been unpleasant and a nuisance, but not insurmountable. The most

important finding so far, despite dire predictions, is that there is no impediment to the care and social rehabilitation of patients, no regression from opening wards and eliminating restraints, and no interference with clinical programs. If anything, there is facilitation in all areas. There have been no instances of disagreement requiring intervention from central office. It seems to me that these facts give us leisure and security to continue with the trial.

In my honest opinion, there are no significant impediments to recruitment and retention of medical staff, certainly no more than those brought about by strict licensure laws and geographical disadvantages. Instances of turnover have been dramatic. But on close individual analysis they have possessed other, more compelling reasons. The new arrangement has a screening effect. There is evidence to suggest that it may have positive appeal to the younger men in the field.

Other effects:

A. Negative.

1. Confusion as to "headship" or "who's boss?" This is a problem because of deep traditions as to roles and images shared by hospital staff, patients, and to some extent, the public.

2. Status problems. This appears to be an individual matter.

3. Occasional ambiguity and duplication of effort in day-by-day decisions.

B. Positive.

1. Vast increase in the efficiency and professional quality of hospital management. This does not refer simply to "tighter

economy" but to the broader concepts of managerial skill and address. This is especially evident in personnel relations, public relations, and systematic planning of programs and facilities.

2. Attraction of top talent in the hospital management field.

3. Mutual stimulation and assistance between clinical and administrative teams toward the benefit of the hospital program.

4. Greater stability of the organization, in the sense of continuity and survival through the normal ups and downs of hospital experience.

5. More concentration of medical and treatment matters, research and teaching by top medical staff. (In my experience, this has been the only way to ensure that such concentration on medical issues and delegation of administative details does actually occur.)

6. Better organization and discipline within the medical staff. Strengthening and improvement of medical staff, where basic strength exists. A surprise effect is a seemingly fantastic improvement in "mileage" from consultant or part-time staff, especially psychiatric.

7. Better coordination in the general state program, and closer adherence to department policies. It lends itself better than the traditional approach to the "unified and continuous development of program," called for in law.

In summary, the advantages well outweigh the disadvantages. The problems which have arisen are the result of a new constitution which in some ways deviates sharply from the traditional. Some analogies can be seen in the history and development of the U.S. Constitution. We feel that the areas of ambiguity will become clear as tests are made and precedents established.

The plan seems to have reached two basic objectives: (1) it appears to be at least as effective as the traditional system, and (2) it does give top physicians more time to concentrate in medicine while at the same time improving the overall administrative level.

We recommend no change in present laws or legislatively-determined policies. We feel this approach has deep potential significance for mental hospital program operation in this country. We desire to continue with it during an extended period of several years' evaluation.

III. Explanation of requests.

1. Staffing ratios.

We have approached this complex problem in terms of two strategic levels. The most basic level is that of having enough staff in the institution to provide an acceptable level of custodial care. A more advanced level obtains when one has reached the first objective, and then strengthens his resources to deal effectively with the intensive demands of the work load, with the aim of rapid social restoration and return to the community.

The first level is related to resident population, the second to admission and discharge rates. A rough analogy in military action

would be the differing requirements of an army of occupation as against a mobile striking force for conquering new territory.

In 1961 all institution requests were based on formulas related to resident population.

In 1963 the requests for mental retardation institutions are based on resident population. This is not to say that the admission, intensive treatment and discharge functions are not important. For the present, however, they are overshadowed by the bitter need for staff to provide a decent and adequate level of basic mental health and nursing care. On the basis of formulas so devised, our department request for positions in the mental retardation institutions for the first time exceeds those for the mental illness hospitals.

The latter group, because of declining populations, has reasonably well achieved the first level (although resident population-custodial considerations cannot be abandoned) and is at the more advanced level. Our current request takes into account to a significant degree the "striking force" concept, based on precise, if conservative, studies of admission and discharge trends. (Increasing voluntaries will tend to raise the admission rate.) This is not to be interpreted as a down-grading or write-off of the continued active treatment needs of the resident and chronic population.

The entire rationale and formulas for the mental hospitals, together with the district changes, are shown in Appendix III.

Staffing for the children's facility at Lino Lakes is based on the "striking force" concept.

Implied throughout is the reasonably valid supposition that with adequate staff to meet the admission-discharge demand, one can maintain a treatment and restoration level and prevent a degeneration to custodial levels and a rise in resident population.

2. District changes.

To present this meaningfully one requires a map showing the present status of hospitals and their relation to community mental health center areas. The regional concept also enters in.

With slight changes in receiving districts, we have been able to align precisely the counties served by state hospitals and the areas served by community mental health centers. With this base we have then moved to establish coordinating committees comprised of principal mental health agencies in the region. Thus, the "district" idea goes beyond simply a geographical spread of counties. It embraces an interaction of professionals with mental health responsibilities. We thus aim to bring about a better coordination of hospital and community efforts, to make the mental hospital truly a community resource, and to implement the concept of continuity of care through an organized network of services.

Our next big move will be to rearrange the metropolitan area by dividing Hennepin County admissions between Anoka and Hastings. This will have the effect of making hospital treatment available to 840,000 people within an hour's drive from their homes. Simultaneously, it will relieve St. Peter from this heavy burden, and allow for a more realistic local area to be served by St. Peter. Since this will involve pulling into St. Peter four counties now served by Rochester, we will thus be able to make the admission-staff ratio at Rochester more realistic.

The overall results show roughly a doubling of the Anoka and Hastings intake (assuming Hennepin County is divided between them) and a significant reduction for St. Peter and Rochester.

Thus the stategy of our request is based primarily on intensive buildup of staff at Anoka and Hastings.

Once this is accomplished, we can complete the regional plan by establishing committees for the north central, west metropolitan, south central, and southeast regions.

3. Community mental health program expansion.

Briefly, we desire by the end of this next biennium to see 100% coverage of state population by community mental health centers. Furthermore, our request is based on consolidating existing centers to the extent allowed by law. This is especially important in the metropolitan centers of Hennepin and Ramsey Counties.

4. Training.

One cannot over-emphasize the strategic importance of training programs. We have good basic mechanisms developed for psychiatric training at the University of Minnesota and Mayo Foundation, and a reasonable chance of setting up our own psychiatric residency at Rochester. Other training areas need for continuing support through stipends; in particular, social work and professional nursing.

5. Research.

There is no need to reiterate what has already been said about research in the Governor's Committee report and elsewhere. The effect on staff morale is tremendous. We feel that through research,

through our improved research procedures, we can learn more to help us understand the clinical and social problems with which we deal and thereby improve the program.

IV. Summary.

We feel that we have conducted the Minnesota program in a way to merit your confidence. The nation is watching with admiration and interest, not only the hospital administration experiment, but other aspects. We want to see continued growth and advancement. We aim to increase to the fullest extent possible the social usefulness of the Minnesota mental health program as a service to the public good.

SUMMARY*

A REPORT ON MINNESOTA'S MENTAL HEALTH RESEARCH PROGRAM
1949-1962

PURPOSE

Legislative support and Departmental facilitation of mental health research have been extended largely on faith. The Medical Policy Committee has assurance, through its own actions, that appropriations have been allocated with care, but even the Committee has had available somewhat less than comforting feed-back reflecting research pay-off.

This report is an attempt to: (1) Provide an accounting of the investment of research appropriations over the Program's 13-year history, (2) Answer the question What ever happens to all the projects making up the Program at a given period? and (3) Respond to the most often-asked question: What, from an investment of nearly one million dollars, has been learned that benefits the State of Minnesota?

CONTENT OF REPORT

Section I. Appropriations: An accounting of the investment.

STATE APPROPRIATIONS for mental health research over the last 13 years total $951,204, beginning at $100,000 each biennium to the mid-fifties and at or near $200,000 per biennium since 1957-59. State funds have been joined by federal and private grants, bringing the total research support to approximately $1½ million.

INVESTMENT of the state funds has shifted markedly over the years. While less than 15% of the first year's allocation was for research personnel, by 1961-62 this had grown to 90%. Though equipment allocations have decreased proportionately, these may need to rise in the near future to allow increased use of electronic data processing and advanced laboratory apparatuses.

Section II. Follow-up Evaluation: What ever happens to all the projects launched each year?

A SAMPLE YEAR (1958-59) was selected for follow-up of all projects formally reported at its start as under way or ready for launching. (A 4-year elapsed time period was selected to allow for completion, reporting, and application of results.) 100% of the projects were accounted for. Of the 73 projects reported for that year:

7 could not get under way (largely because all investigators accepted other employment or funds were not allocated);

4 were dropped (2 only after providing usable findings);

*Copies of the full report may be obtained by calling 221-2673, the Department of Public Welfare

11 remain active (9 of these have yielded early findings which have been formally reported); and

51 have been completed.

OF THE 62 PROJECTS completed or continuing:

68% have been presented to professional audiences, by being read at meetings, published in journals or both;

84% are judged by researchers and administrators to have yielded findings usable in the service program of the facility where they were conducted;

81% provided information applicable to other facilities;

61% contributed to basic knowledge; and

45% helped retain or recruit professional staff.

In some instances, research indicated what would not work in service programs, as well as pointing to new techniques.

It has also been found that many patients involved in research showed an improvement in behavior, even when serving as "no-treatment controls".

TOPICS STUDIED in the sample year range from biochemistry through studies of specific disorders, assessment tools, in-hospital treatment and follow-up.

FINDINGS range, similarly, from increased knowledge of the relation of 24-hour neurophysiological cycles and drug reactions to information that a special group therapy technique would cut in half the number of a certain kind of patient returning to the hospital.

Section III. What has been learned of benefit to Minnesota?

Approximately 140 examples of research yields are presented in the full Report. A sample of these is presented below, according to topic areas.

STUDIES OF BIOCHEMISTRY AND THE NERVOUS SYSTEM.

+ New wave have been found to accurately locate brain damage in order to make much safer decisions regarding brain surgery. (Rochester)

+ Cholesteral associated with everyday behavior of patients, was reduced when foods like dried beans were added to the diet in place of sugar or flour. (Hastings)

+ Measurement of certain body rythms throughout the 24-hour daily period were found to be of important use in diagnosis, treatment and control of a type of nervous disease. (Cambridge)

+ Information gained about an inherited disease, Huntington's Chorea, has been made available to those directly involved - the families affected. (Rochester).

+ Which Antibiotics Treat Infections of the nervous system has been learned. (Rochester).

+ Male Patients at Opposite Extremes in serum cholesteral level are different also in their behavior. (Hastings)

STUDIES IN GERIATRICS

+ The More Rest Home Beds there are in a community, the fewer its commitments to mental hospitals of people over age 65. (Anoka)

+ When Many Kinds of Treatment are offered (medical, occupational and recreational therapy, personal attention from aides and volunteers) elderly patients improve in their thinking and actions. (Fergus Falls)

+ Many Talents and Interests among older patients were tapped by a survey and made a part of recreational planning. (Fergus Falls)

+ Older Patients Improved with the drug Procaine. (St. Peter)

EVALUATION OF TREATMENT METHODS

+ Patients can Learn to Do Many Things for themselves, with training based on modern learning principles. (Willmar)

+ Intensive Electro-Shock Treatment was dropped from the treatment program as it was found to be ineffective. (Hastings)

+ Many Patients Now Walk as a result of studies of a drug to remove edema fluid from their legs. (Rochester)

+ Disturbances On The Ward are fewer when cooler water is used for swimming therapy. (Anoka)

+ The Brain Operation, lobotomy, can now be used only on patients for whom great improvement can be expected. (Fergus Falls)

+ On Both A State-Wide and national basis, effective drugs could be selected and others discarded on the basis of controlled studies of their effects. (Fergus Falls)

+ Savings of Staff Time and of inconvenience to patients result from the finding that some drugs can be given once a day as effectively as several times. (Anoka)

+ The Finding That Smaller Doses of perphenazine are as helpful as a larger amount of the drug results in more economical use. (Fergus Falls)

+ Undesirable and Dangerous side effects of drug treatment now seldom develop, as a result of studies. (Rochester)

+ Broadcasts of Music and News help brain-damaged patients keep in touch and remember better. (Rochester)

+ Shock Treatments Reviewed: From 42 to 47 of patients given insulin, metrazol or electric shock treatments have not had to return to the hospital within the next five years. (St. Peter)

+ Sunburn need no longer be a side-effect of tranquilizing drugs, when a new spray for the skin is used. (Hastings)

+ An Aftercare Worker attached to both the community and the hospital was found much more affective than one attached to either alone. (Moose Lake)

+ Attitudes held toward a discharged patient have more to do with how well he'll get along than diagnosis or even length of illness. (Moose Lake)

+ Pulling Community Agencies Together in the service of a patient results in a better adjustment at home and less likelihood of re-hospitalization. (Moose Lake)

+ The Amount of Understanding a relative has of the patient's illness influences the length of hospital stay. Social service interviews were found to increase understanding and thus shorten stay. (Anoka)

+ Tranquilizer Drugs can be withdrawn at planned intervals from certain patients who show no ill effects if drugs aren't held back too long. Such patients can be identified by testing so drugs needn't be withdrawn from the wrong persons. Considerable savings in the drug budget results. (Anoka)

+ Patients who expect to have interpersonal difficulties on the job after discharge tend not to leave the hospital. This knowledge provides for better prediction and better help in planning to handle anticipated problems. (Anoka)

+ It was found that a specially devised training program for psychiatric practical nurses resulted in far better job performance and effective care of patients. (St. Peter and Anoka)

+ A very promising program of assigning selected aides to work with selected patients was proved not to be effective, thus avoiding fruitless expenditures. (Anoka)

+ A new drug was found to be much more effective than the one in favorite use in helping over-active patients. (Fergus Falls)

+ A special type of Aftercare which included direct work with the patient and with community agencies cut almost in half the number of patients returning to the hospital. (Hastings)

+ A New Drug claimed to be effective with patients who had been mentally ill long periods was found not to be of value, and therefore could be dropped. (St. Peter)

+ Group Therapy and Drugs used in combination helped patients far more than either used alone. (St. Peter)

DEVELOPMENT AND ASSESSMENT OF PSYCHOLOGICAL TESTS, RATING SCALES AND OTHER PSYCHODIAGNOSTIC METHODS

+ Comparison of The Patient's Behavior when he enters the hospital and at various times during his hospital stay can be made with use of a newly developed scale. (Anoka)

+ Intelligence can be estimated adequately with a brief test which can be given and scored by a clerk, thus relieving the professional person for other duties. (Fergus Falls)

+ Survey with a Commonly-used Personality Test reflects the number and variety of personality types entering the hospital. The results have a bearing on what treatments should be available. (Hastings)

+ A Group Form of a frequently used test was found to be just as useful, with mental patients, as a more time-consuming individual test. (Hastings)

+ Differences of Considerable Importance in the meaning of IQ scores of the mentally retarded on two commly used tests were found.(Faribault)

+ Reading Disability, mental retardation and personality disorder can be differentiated quickly by use of a test developed here. (Willmar)

+ A Hitherto Unknown Relationship between drawing behavior and personality tests was observed, adding to methods available for personality evaluation. (Hastings)

+ A Scale for Rating Social Behavior was developed, and has gained world-wide use as one of the major tools of its kind. (Fergus Falls)

STUDIES OF MENTAL RETARDATION

+ Screening Programs in Well-Baby Clinics in Minneapolis, St. Paul and the Fergus Falls area are the result of findings that mental retardation can be presented among persons with a certain chemical found in the urine only if treatment starts in infancy. (Faribault)

+ Many Clues for development of better training programs came from the finding that present use of patient help is not geared to progressive development of the patient. (Brainerd)

STUDIES OF MENTAL RETARDATION (continued)

+ Retarded Children are found to be more limited in the area of social concepts than in some other skills. (Faribault)

+ Patient Helpers are from 55% to 90% as productive as employees in laundry jobs, and 40% to 97% as productive on sewing garments. (Faribault)

+ Bad Practices in using patient help are revealed: some patients work three split shifts, and some work seven days a week for insignificant pay. (Brainerd)

+ 55% of Former Residents at the Owatonna State School made long-range community adjustment. (Owatonna)

STUDIES OF ALCOHOLISM

+ Returns to the Hospital were cut in half, among alcoholic patients offered one special form of group therapy. (Willmar)

+ Considerable Savings result from the finding that newly-admitted alcoholic patients do not routinely require the massive doses of vitamins which used to be thought necessary. (Willmar)

+ A Varied Treatment Program resulted from study to find what is the best hospital-centered treatment for alcoholics. (Willmar)

STUDIES OF LAW VIOLATORS

+ Parole Prediction studies reveal that only a small number of former prisoners are likely to commit new crimes and can be identified while they are in prison. (Prison)

+ 40 Percent of male sex offenders seen for pre-sentence investigation were under the influence of alcohol when they committed their crimes. (St. Peter)

+ Prisoners Who Will Do Well on parole if treated with group psycho-therapy can be selected out of the prison population, and also those who will do better as a result of incarceration without such treatment. (Prison)

+ Selection of Prisoners for the Farm Colony (minimum security) is improved with use of findings from inmate classification studies. (Prison)

STUDIES OF ATTITUDES AND THE COMMUNICATION OF INFORMATION

+ Need for Better Staff Training and communication was revealed in a survey of employee's attitudes toward rehabilitation therapies. (Faribault)

+ The Value of Information Programs was shown in study of a workshop with relatives, who proved to be eager for information about the hospital, mental illness, and their particular patient. (Fergus Falls)

+ Ministers involved in a 12-week program on mental health improved considerably in their ability to help others. (Anoka)

+ Staff Members Are Communicating Better with patients as a result of a study of causes of poor communications within the hospital.(Fergus Falls)

+ A Course In Abnormal Psychology helped 98% of employees taking it to be more effective in their work. (St. Peter)

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PRESENT PROGRAM

Since the sample year (1958-59) considerable progress has been achieved in the State Mental Health Research Program.

A Research Section has been developed for the purpose of coordinating the Program.

The Medical Policy Committee has formed a Research Subcommittee to which proposals for all researches in Medical Services facilities are submitted by the Research Section. Each proposal is reviewed from the standpoints of (1) patients' welfare, (2) relevance to the State's needs, (3) scientific rigor, and (4) coordination with similar projects under way. Consultation is available on each. Follow-through supports completion, utilization of findings, and dissemination of results. Applications for grants are processed according to ratings on several criteria predicting value to be obtained.

A periodical, Current Conclusions, is published bi-monthly to help State researchers and staff members remain abreast of the relevant emerging literature.

Annual research conferences have been invigorated with consequent doubling of attendance.

Sixty-seven percent more projects are currently under way than in 1958-59 largely attributable to time donated by State staff members, an often unrecognized contribution to the total State Research Program.

FUTURE DEVELOPMENT

There is evidence that Minnesota's leading effectiveness in mental health program services has been influenced by the findings of its research program. But attacking mental disturbance is still spearing fish in murky waters. If the attack is to grow more precise, more deliberate, and more effective, clarification through research will continue to be a necessary companion of creative leadership, staff training, service dedication, and community participation.

THE MINNESOTA HOSPITAL ADMINISTRATION PLAN

- by David J. Vail, M.D.
Medical Director
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As word has gotten around about hospital administration changes in Minnesota, it seems important and timely to issue this description of what we are doing. Thus this statement is for the purposes only of providing information. A more detailed consideration of theoretical background and argumentation will be submitted after we have had a chance to evaluate the program and learn something of its advantages and disadvantages.

The basic law we are using is this:

> "Sec. 8. HOSPITAL ADMINISTRATOR. Notwithstanding any provision of law to the contrary, the Commissioner of Welfare may appoint, as the chief executive officer of any state hospital, a hospital administrator. Such hospital administrator shall be a graduate of an accredited college giving a course leading to a degree in hospital administration and the Commissioner of Welfare, by rule or regulation, shall establish such colleges which in his opinion give an accredited course in hospital administration. The provisions of this section shall not apply to any chief executive officer now appointed to that position who on the effective date of this section is neither a physician and surgeon nor a graduate of a college giving a degree in hospital administration. In addition to a chief executive officer, the Commissioner of Welfare may appoint a licensed doctor of medicine as chief of the medical staff and he shall be in charge of all medical care, treatment, rehabilitation and research."

This law was originally enacted in 1959 as a rider to the appropriation act for the Department of Public Welfare. Essentially the same bill was re-enacted using the same mechanism in 1961, with the additional insertion, at our recommendation, of the word rehabilitation in the final sentence, thus attempting to resolve the issue of responsibility for industrial assignments and other related aspects of environmental therapy.

Simultaneously the legislature enacted two salary laws, one limiting the salary of the chief executive officer (medical or non-medical) to $15,000. The other allows for salaries for board-certified medical specialists up to $22,500. By clear intent of the legislature and the governmental committee which administers this latter law, medical superintendents were excluded from placement in the higher salary brackets.

We made our first appointment under the appropriation rider in September, 1960 when a non-medical administrator was appointed chief executive officer, with the title of Administrator, at the Brainerd State School and Hospital (for the mentally retarded). This was done in order to clarify the authority of the administrator, who had been acting under the title of Assistant Hospital Superintendent. The quest for a medical superintendent there began in 1955. The quest now for a Medical Director still continues.

The next appointment was made at the Willmar State Hospital (for the mentally ill) in September, 1961. At that time, acting voluntarily, Dr. Vera Behrendt, who had been superintendent, resigned from that position and was appointed Medical Director. Mr. Lester Johnson, who had been Assistant Hospital Superintendent, was appointed Administrator. A similar transposition will take effect at the Fergus Falls State Hospital (for the mentally ill) on January 1, 1962. This again was done on the voluntary action of Dr. William Patterson, who will become Medical Director and Mr. Robert Hoffmann who will become Administrator. Both Mr. Johnson and Mr. Hoffmann are qualified, professionally trained hospital administrators in the meaning of the law, and each has had upward of 5 years of experience at his respective hospital. Our part in this was to point out the feasibility of such a move and invite consideration to participating in this administrative pattern. In each case, the principals involved and their respective department heads, have established their own organization charts and delineated the lines of authority and responsibility that are the most comfortable for them and their own personnel. In other words, we are not issuing any blueprint, but leaving wide option for local determinations.

It would be well at this point to quote from a memorandum issued to the individuals at that time contemplating this step.

> "The medical chief, like any other department head, has line authority over the staff in his own department. His staff authority extends throughout the clinical departments and into any other departments insofar as the basic mission of the hospital is involved.
>
> "The administrator is 'responsible to the Governing Body (i.e., myself) for the conduct of the hospital'. His function is to establish and maintain a proper climate or milieu in which the proper mission of the hospital can be carried out.
>
> "The medical chief, by law, is 'in charge of all medical care, treatment, rehabilitation, and research.' This to me refers to services and programs rather than departments as such. Paradoxically, the authority of the medical chief is clearer than that of the administrator. The latter, although vested with line authority, actually has none which by law cannot be removed from him in a contest by the Commissioner. The authority of the medical chief, although in the nature of staff rather than line authority, is more nearly absolute and inviolate. The mode of his authority is by persuasion and counsel rather than directive. The medical chief also reports directly to myself.
>
> "A desirable development in this plan, it seems to me, is a decentralization of line authority from the center to the periphery. This gives increased autonomy to the department heads in effecting the treatment and rehabilitation program policies set forth by the medical chief. Staff coordination of the activities of the clinical departments is the prerogative of the medical chief.
>
> "Under this plan, a further specification of duties would be as follows:
>
> A. For the administrator

1. Administrative program analysis.

2. Cost-accounting and budget analysis.

3. Fiscal management and budget allocations.

4. Overall responsibility for personnel practices and procedures, including hiring and firing (exception: medical staff).

5. Facilitation and implementation of training programs.

6. Facilitation of communications at all levels and in all directions throughout the hospital.

7. Public relations and public information.

8. Any and all unspecified activities aimed at accomplishing the treatment and rehabilitation mission of the hospital in facilitation of and accordance with the prescriptions of the medical staff.

B. For the medical chief

1. Development and guidance of the treatment and rehabilitation program of the hospital.

2. Organization of medical staff, including appointments and instructions to appropriate committees.

3. Psychiatric inservice training and development beginning with medical staff, through all clinical departments, and extending as appropriate to non-clinical departments.

4. Continuing review and analysis of the clinical program of the hospital, beginning with but not limited to the work of the medical staff.

5. Improvement of psychiatric histories and examinations and of medical (including non-psychiatric) histories generally.

6. Development and supervision of research programs.

7. Continuing attention to the general issues of rehabilitation and environmental therapy, with the development of the therapeutic community as facilitated through the administrator.

8. Establishment and maintenance, through the offices of the administrator, of admission, release and discharge policies.

Generally I think we should aim at the continuing development, in a public mental hospital setting, of the triangular relationship

of the Governing Body - Medical Staff - Hospital Administrator pattern called for by the Joint Commission on Accreditation of Hospitals. It hardly needs stressing that there must be absolute confidence, freedom of communication, and compatibility of personality among all the members of this triumvirate."

Some of the control features are:

(1) Appointments and salary determination for both the Medical Director and the Administrator are made upon the recommendation of a statutory medical policy advisory committee. This committee is composed of non-governmental medical and basic science specialists.

(2) Both the Medical Director and the Administrator report to this office. At this point this means, in effect, myself. Hopefully in the future this would be a psychiatrist Director of Hospital Services, working out of this office: we are trying to recruit such a person.

(3) Policy statements have been issued as necessary from time to time as matters are brought to our attention. For example, the following memo on legal issues dated July 10, 1961:

"All documents, forms, legally required notices and reports, etc., called for in law as emanating from the 'Superintendent' must bear the signature of the Superintendent or Chief Executive Officer, regardless of the working title (such as Administrator) which he uses. Any such documents pertaining to medical matters or decisions must also for policy purposes bear the signature of the medical chief of staff.

"The main sections of MS 1957 involving medical decisions are the following:

246.10	Surgical operations
246.101	Discharge of Epileptic Inmates
246.43	Sex offenders
253.15	Patients may be paroled in certain cases
253.16	Discharge of Inmates
253.17	Feebleminded children transferred to school for feebleminded
253.21	Commitment; Proceedings; Restoration to Sanity
254.10	Hearings; Orders
256.07	Sterilization of feebleminded persons; Consent to operation
256.08	Insane persons in state hospitals; Consent to operation
525.749 through 525.79	Commitments

NOTE: Subdivision 1 of 525.753 refers to the 'chief medical officer'. I interpret this to mean the chief of the medical staff. I think, however, that appropriate documents in this connection, so as to be consistent with the rest, should bear a double signature.

631.19 Acquittal on Ground of Insanity; Commitment; Release

"It is clear as a matter of policy that the significant decisions in regard to these statutes are to be made by the medical chief of staff and are definitely within his province, as determined by law, of 'all medical care, treatment, rehabilitation, and research.' As a matter of program policy I would consider any such decisions invalid unless authorized by the medical chief. At the same time, the full intent of the law would not be complied with unless the chief executive officer also sign any relevant documents. In any contest of judgment between the medical chief of staff and the chief executive officer in these instances (which I do not anticipate) I would be prepared to rule in favor of the medical chief.

"The above listing of statutes is presumed to be complete. Any others of a similar nature which may have been omitted would be interpreted in like manner. I hope that you will bring any such statutes to my attention.

"This memorandum constitutes an amendment to the Constitution of the Minnesota State Hospitals, and at some suitable time appropriate wording will be inserted or appended to the Constitution."

(4) A formal Constitution for the Minnesota State Hospitals, comprising the key laws and policy statements pertaining to hospital and medical staff organization, developed with appropriate modifications along lines recommended by the Joint Commission on Accreditation of Hospitals.

(5) Legislative vigilance over the program, with the promise of further specific legislation to clarify unresolved issues, or authority to determine rules and regulations which will have the force of law, if policy statements such as the above do not prove to be sufficient.

The next such set of appointments will be made at the Hastings State Hospital early in 1962, following the resignation of the present (medical) superintendent. In discussing the appointment of a chief executive officer at Hastings, our Policy Committee had no hesitation in recommending that he be a non-medical hospital administrator.

One of the misconceptions that has arisen, is that we are "asking" present medical superintendents to resign in favor of a non-medical administrator. This is not true. We are insisting that medical superintendents utilize the civil service classification of Assistant Hospital Superintendent for the appointment of suitable administrators in a secondary role. There are no strings attached in such an instance as to any future adjustments or change in the organization. Actually we have discouraged any attempt at a mass "switchover" until we have a better basis for evaluating and understanding the program and all its implications. On the other hand, as vacancies may arise, we would proceed with this (for us) new pattern.

Whether this move is consistent with the recommendations of the Joint Commission on Mental Illness and Health, and whether it is a step forward of a step backward (both have been alleged) will not be argued here. We ask for a reasonable and fair trial period and a chance at some later time to debate the issues and results. We would also welcome evaluations by whatever groups or resources are qualified to make them.

DEPARTMENT OF PUBLIC WELFARE

To: Commissioner Norris Hursh November 23, 1962

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

Subject: Personnel requests for hospitals for mentally ill
(Based on a memo to Superintendents, dated April 2, 1962)

I have devised a different approach to the proble of personnel requests for the 1963-65 biennium.

It gets away from the concept of staff in relation to a static resident population. It is based primarily on admission rates, more specifically narrowing down on the intake of first admissions below age 65 as the most reliable basic indicator. An adjustment is then made on the basis of a formula, to take into account the existing population.

The attached chart 1 shows how this concept is applied and then results in a figure of 531 as the total need for personnel at a modest level. (This does not include the special services -- alcoholism, surgery, tuberculosis, and maximum security, which should be treated separately, again on a work-load basis).

The plan also takes into account a change in receiving districts as follows:

Hennepin County divided between Anoka and Hastings.
LeSueur, Scott, Faribault and Freeborn out of Rochester into St. Peter.

The figure for positions (Chart 1, Column 8) is converted into dollars, using a figure of $9,500. as the average per position.

The total dollar figure is then apportioned according to need (Chart 1, Column 11; Chart 2).

Working back from the total dollar figure, each hospital has the option of devising its own additional personnel requests according to the needs as determined locally. The total dollar figures must not be exceeded, and the number of positions should coincide generally with the position allotment (Chart 1, Column 8).

Finally, to convert dollars back to jobs, make proper selections from the guides shown in Chart 3, with a suitable balance of high-, medium-, and low-expense jobs.

The total N of 531, together with the additional requirements of special services, will approximate about one-third of the total arrived at through the Anoka plan, and in the same order of magnitude as the 585 requested in 1961.

(The Appendix Chart shows in detail the pattern of admissions in the seven hospitals for the mentally ill from 1955 - 1961.)

DJV:ms

CHART 1

To achieve two staff per psychiatric admission

as based on proposed receiving district changes[1]

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	Present			Proposed, Unadjusted			S required	Need	% of	Round-	Adjust-
	S	A	S:A	S	A	S:A	When S:A=2 (5) x2	(7)-(1)	T	ed	ed 7
Anoka	310[2]	180	1.72	310	265	1.17	530	220	41.5	40	29
Hastings	276	160	1.73	276	245	1.13	490	214	40	40	29
Rochester	420[3]	270	1.56	420	215	1.86	430	10	1.89	2	7
Willmar	296[4]	160	1.85	296	160	1.85	320	24	4.5	5	7
Fergus Falls	477	260	1.83	477	260	1.83	520	43	8.1	8	11
Moose Lake	280[5]	150	1.87	280	150	1.87	300	20	3.8	4	7
St. Peter	540[6]	223	2.4	540	118	4.6	-0-	-0-		1	10
								T: 531			

Legend S=Total staff complement
A=Psychiatric admissions (yearly first admissions, under age 65)

1 Hennepin Co., divided between Anoka and Hastings
Faribault, Freeborn, LeSueur, Scott to St. Peter

2 Based on overhead of 21 positions for surgery, 80 for TB

3 " " " " 32 " " "

4 " " " " 48 " " alcohol services

5 " " " " 14 " " " "

6 " " " " 72 " " maximum security

7 Takes into account the existing population.

CHART 2

CF. Chart 1, Column 10

	ADJUSTED PROPORTION OF STAFF INCREASE	$/hospital/year for new personnel
Anoka	29%	$692,955
Hastings	29%	692,955
Rochester	7%	167,265
Willmar	7%	167,265
Fergus Falls	11%	262,845
Moose Lake	7%	167,265
St. Peter	10%	238,950

N = 531 positions

at $4500 per position

= $2,389,500 p.a.

CHART 3

Conversion of dollars to jobs.

Priorities

High Expense	1. Psychiatrist
Medium Expense	1. Registered Nurse 2. Social Worker 3. Other (Psychologist, pharmacist, etc.)
Low Expense	1. Psychiatric aide 2. Custodial, food service 3. Other (Laundry, clerical, farm, etc.)

In calculating, use $14,000 as the average figure for psychiatrist.

Use the minimum of the salary range for others.

Appendix Chart

MINNESOTA STATE MENTAL HOSPITALS
MENTALLY ILL FIRST ADMISSIONS - AGE DISTRIBUTION BY HOSPITAL
FISCAL YEARS 1955-56 THROUGH 1960-61

	Total	Total Under Age 65	Under Age 25	Ages 25-44	Ages 45-64	Ages 65-84	Age 85 and Older	Not Reported
ALL MENTALLY ILL								
1955-56	2,453	1,419	243	573	603	878	156	-
1956-57	2,360	1,350	222	580	548	851	159	-
1957-58	2,374	1,384	227	566	591	851	139	-
1958-59	2,356	1,476	262	633	581	743	120	19
1959-60	2,243	1,392	272	595	525	735	114	2
1960-61	2,184	1,418	318	585	515	668	97	1
ANOKA								
1955-56	295	189	26	87	76	95	11	-
1956-57	318	198	27	88	83	106	14	-
1957-58	303	184	29	83	72	99	20	-
1958-59	268	177	34	76	67	81	9	-
1959-60	248	175	34	76	65	67	6	-
1960-61	261	187	59	72	56	63	11	-
FERGUS FALLS								
1955-56	383	229	27	91	111	135	19	-
1956-57	372	235	32	97	106	120	17	-
1957-58	425	255	38	99	118	149	21	-
1958-59	392	259	53	116	90	112	21	-
1959-60	403	284	59	122	103	102	16	1
1960-61	372	252	60	102	90	102	18	-
HASTINGS								
1955-56	270	156	39	58	59	94	20	-
1956-57	294	161	40	68	53	112	21	-
1957-58	297	168	34	60	74	106	23	-
1958-59	263	167	29	67	71	86	9	1
1959-60	278	158	28	64	66	103	17	-
1960-61	278	168	53	66	49	97	12	1
MOOSE LAKE								
1955-56	344	163	41	56	66	156	25	-
1956-57	320	140	33	50	57	144	36	-
1957-58	312	142	27	62	53	153	17	-
1958-59	300	149	21	61	67	133	16	2
1959-60	273	137	21	56	60	117	19	-
1960-61	265	152	16	66	70	98	15	-
ROCHESTER								
1955-56	462	292	63	114	115	137	33	-
1956-57	426	262	46	119	97	141	23	-
1957-58	429	272	47	105	120	135	22	-
1958-59	433	286	63	123	100	112	34	11
1959-60	394	244	53	104	87	122	27	1
1960-61	405	275	60	121	94	110	20	-

Appendix Chart

MINNESOTA STATE MENTAL HOSPITALS
MENTALLY ILL FIRST ADMISSIONS - AGE DISTRIBUTION BY HOSPITAL
FISCAL YEARS 1955-56 THROUGH 1960-61
(Continued)

	Total	Total Under Age 65	Under Age 25	Ages 25-44	Ages 45-64	Ages 65-84	Age 85 and Older	Not Reported
ST. PETER								
1955-56	432	215	19	101	95	178	39	-
1956-57	390	200	28	96	77	153	36	-
1957-58	378	211	29	92	90	142	25	-
1958-59	466	286	41	129	116	159	21	-
1959-60	422	246	46	106	94	158	18	-
1960-61	354	203	42	82	79	136	15	-
WILLMAR								
1955-56	238	147	19	55	73	82	9	-
1956-57	216	129	14	48	67	75	12	-
1957-58	208	131	18	52	61	66	11	-
1958-59	217	146	22	56	68	59	10	2
1959-60	210	133	25	62	46	66	11	-
1960-61	226	161	24	65	72	59	6	-
MINNESOTA SECURITY HOSPITAL								
1955-56	25	23	6	10	7	2	-	-
1956-57	20	20	1	13	6	-	-	-
1957-58	14	14	1	11	2	-	-	-
1958-59	11	10	3	5	2	1	-	-
1959-60	15	15	6	5	4	-	-	-
1960-61	23	20	4	11	5	3	-	-

Total includes a few first admissions to Sandstone 1956-59 not shown separately.

INSTITUTIONS AND CENTRAL OFFICE MEDICAL RECRUITMENT AND TURNOVER

July 1, 1962 - December 31, 1962

	No. In	(Trans. In)	No. Out	(Trans Out)	Reasons In	Reasons Out
Anoka	1.58	(1)	3.08		4, 1	4, 1, 8
Fergus Falls	1	(1)	1*		8	1
Hastings	2.5	(1)	2**		4	4, 1
Moose Lake	0		0	(1)		
Rochester	4.5		2	(1)	4, 5, 5.1	8.1
St. Peter	1		1		8	7.2
Willmar	1		0	(2)#	4	
Brainerd	0		0			
Cambridge	0		0			
Faribault	0		0			
Central Office	0		0			
	11.58		9.00	Net gain 2.5		

(Shows superintendents and C. S. only)

Notes: * Entering state psychiatric residency career program
** Includes Dr. Sletten (last day 1-2-63)
# Includes transfer to Glen Lake

LEGEND:

Reasons In		Reasons Out	
0	Not stated	0	Not stated
1	Await fellowship or residency	1	Begin residency or other education
1.1	Spouse in training		
2	Await military service	2	Enter military service
4	Interest in program	4	Disaffection
5	Career Advancement	5	Career advancement
5.1	Obligation		
6	Financial	6	Financial
7	Health	7	Health
7.1	Retirement	7.1	Retirement
		7.2	Death
8	Personal	8	Personal
		8.1	Leaving Area
9	Other	9	Other

SYNOPSIS:

Period	In	Out	Gain	Cum. Gain (since 7/60)
7/59 - 12/59	16	11	5	
1/60 - 6/60	13	20	-7	
7/60 - 12/60	10.58	6.33	4.25	4.25
1/61 - 6/61	11.25	10.78	0.47	4.72
7/61 - 12/61	11.05	10.33	0.72	5.44
1/62 - 6/62	13.75	12.67	1.08	6.52
7/62 - 12/62	11.58	9.08	2.5	10.02