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## A SURVEY OF ADULT MENTALLY ILL RESIDENTS OF MINNESOTA'S REGIONAL TREATMENT CENTERS

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MINNESOTA DEPARTMENT OF HUMAN SERVICES

Consultant's Report prepared for the Human SErvices Dept by Policy Research Associates, inc.

# A SURVEY OF ADULT MENTALLY ILL RESIDENTS OF MINNESOTA'S REGIONAL TREATMENT CENTERS: JUNE, 1989

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#### EXECUTIVE SUMMARY

#### Background

In May 1989, Policy Research Associates, Inc. (PRA) entered into a contract with Minnesota Department of Human Services (DHS) to conduct a survey of all adult mentally ill residents in the Minnesota Regional Treatment Centers in June, 1989.

The core goal of the proposed work was the development of a clinical profile of the estimated 1,800 residents in Minnesota's Regional Treatment Centers (RTCs) who have a primary or concurrent mental illness diagnosis for the purpose of providing sufficient functional data to classify these persons into groups that were meaningful for planning treatment interventions at the state and facility level.

The survey group consisted of all adult inpatients receiving treatment for mental illness as well as those adult inpatients in chemical dependency (CD) and developmental disability (DD) programs who had a concurrent diagnosis of mental illness (N=1,826). Of these, 45 patients were part of the Sex Offender Program and, as such, were removed from this segment of the study. The resulting number of patients surveyed for this report is 1,781. The patients were rated by staff members who were familiar with their behavior and had access to their ward chart.

The data were collected between June 19 and 30, 1989. All persons with a diagnosis of mental illness in residence for at least three days during the two week survey period had a form completed for them.

#### **Major Findings**

- There are considerable differences across programs in the demographic profiles of the patients. While the Adult Mental Health (MH), DD and CD programs have a moderate majority of male patients, the vast majority of Forensic patients (91.5%) are males and a slight minority (46.2%) of the Geriatric MH patients are males.
- The two noteworthy age differences are the older age, by definition, of the Geriatric patients (73.7 years of age on the average) and the younger age (31.5) of the 22 CD patients.
- Forensic programs contain proportionally more minority patients (17.5%) than any other program. The three major minority groups, American Indian, Hispanics and Blacks, scored significantly higher than Whites for alcohol or drug problems. Fully three-quarters (75.0%) of the American Indian patients had either an alcohol or drug problem, as did 60% of the Hispanic patients and 47.0% of the Black patients. These contrasted with 34.5% of the White patients.
- The majority of Adult MH Program patients are Schizophrenic (66.3%) followed by Affective Psychosis (20.1%). The Forensic patients, also, are heavily schizophrenic (62.1%), but have many more Personality Disorders (32.2%), Drug Abuse (22.6%) and Alcohol Abuse diagnoses (18.6%) than Affective Psychosis (7.3%). Geriatric patients are predominantly Schizophrenic (51.1%) also, but have many patients with Organic Brain Syndrome (OBS) (31.9%) as well as with Affective Psychosis (14.3%). Of the patients in DD Programs 21.8% are diagnosed as Schizophrenia and 14.1% with Affective Psychosis. The residual category of Other, which includes 45.9% of the DD patients, contains 17 other diagnoses with the most prominent being Organic Personality Syndrome (N=15) and Pedophelia (N=5).

- Our classification approach produces the following number of patients in each program type who we would see as appropriate for some type of community placement: Adult MH 208; Geriatric MH 32; Forensic 23; DD 69; and CD 6. These groups total 338 patients (19.0% of the 1,781 patients surveyed) who were inpatients in June, 1989 who could be placed in the community, if the appropriate settings were available.
- Obviously, there is no classification approach that is always the correct one. The comparison of the clinical assessments with our statistical recommendations means that 35 of the 338 cases our algorithm would place in the community would require special clinical review and, probably, specialized support services. In addition, there are 47 persons who the staff is confident could be placed in the community, although they were not identified by our statistical determinations. These patients, too, would require detailed reviews and could be appropriate for community placement, raising the number of patients that should be placed in the community to as high as 385.
- Removing the exclusionary criteria for community placement of having been "otherwise violent" or having had a verbal suicide threat in the last 30 days plus including patients the staff thought definitely could be placed on the community increases the total number of Adult and Geriatric MH RTC patients who are appropriate for community placement to 460 (25.8%). By group, these 460 patients are: Adult MH - 268; Geriatric MH - 39, Forensic - 32; DD - 114 and CD - 7.
  - For the purpose of planning inpatient services in the RTC a fourfold partitioning of the RTC patients based on length of stay and clinical characteristics is suggested: (1) Admission Assessment (N=106); (2) Admission Treatment (N=247); (3) Hospital Rehabilitative (N=420); and (4) Hospital Supportive (Special Populations (N=307)).

#### **INTRODUCTION**

In May 1989, Policy Research Associates, Inc. (PRA) entered into a contract with Minnesota Department of Human Services (DHS) to conduct a survey of all adult residents with a diagnoses of mental illness in the Minnesota Regional Treatment Centers in June, 1989.

The core goal of the proposed work was the development of a clinical profile of the estimated 1,800 residents in Minnesota's Regional Treatment Centers (RTCs) who have a mental illness diagnosis for the purpose of providing sufficient functional data to classify these persons into groups that were meaningful for planning treatment interventions at the state and facility level.

That goal required a comprehensive study of the physical and mental health of every person in the regional treatment centers who had a diagnosis of mental illness. It had to provide detailed clinical profiles as well as a means to classify each patient according to his/her level of need. The data also had to allow comparisons of patients, wards, units, hospitals, and programs. Moreover, when combined with demographic, legal, and financial information, the data had to be able to substantially assist the management of clinical programs.

The approach taken was built upon the assumption that measures of an individual's physical and mental health can be used to estimate the kind (or level) of care he/she requires. These measures are not built upon diagnosis alone, or the mere presence of symptoms. Instead the measures incorporate the traits, behavior, and degree of symptoms which clinically bear upon decisions to provide particular levels of care. For example, an individual's ability to bathe, dress, and groom is a primary consideration in determining the physical level of care which he/she requires; the presence of dangerous behavior, or the degree of psychotic symptoms, depression, or agitation, all have a bearing on the level of psychiatric care required.

Simply stated, the database needed to provide an estimate of the most appropriate care for the patient based upon his/her physical health, behavior, functional abilities, and projected ability to perform key tasks in the community.

The survey that was designed was accomplished through the dedicated work of hundreds of Minnesota DHS employees. The survey data will be used in this report to profile all patients by type of program and by facility rather than to report on any single individual's condition. The assumption here is that the patients who were surveyed over the two-week survey period are representative of those who would usually be found in the Minnesota RTCs. While there are seasonal variations in admission patterns in most public sector inpatient facilities, these are passing and not sufficient to bias a complete enumeration as was done here. Thus, these data can be taken as fully representative of the residents in Minnesota's RTCs throughout 1989 and, probably, 1990.

In addition to Minnesota DHS and PRA staff who worked on this survey, Michael Popkin, M.D., of the Department of Psychiatry of the University of Minnesota's School of Medicine provided clinical insights to the material in this report.

#### SURVEY METHODS

#### 1. Sample and Instrumentation

The survey group consisted of all adult inpatients receiving treatment for mental illness as well as those adult inpatients in chemical dependency (CD) and developmental disability (DD) programs who had a concurrent diagnosis of mental illness (N=1,826). This represents a total of 905 adult MH patients, 185 geriatric (65 years of age and older) MH patients, 495 MR/DD patients, 177 forensic patients, and 22 CD patients. Of these, 45 patients were part of the Sex Offender Program and were removed from this segment of the study since they were seen as a unique treatment group. The resulting number of patients surveyed for this report is 1781. The patients were rated by staff members who were familiar with their behavior and had access to their ward chart.

The survey instrument (attached in Appendix A) was an adaptation of the New York State Office of Mental Health Level of Care Survey revised to specifically fit the needs of the Minnesota DHS Project. The strategy and content for the survey were reviewed at a meeting at the Department of Human Services with Dr. Thomas Malueg and his staff on May 15, 1989. Following the previously developed mechanics for the survey, it was decided to use hospital staff with the best knowledge of each patient's recent behavior and physical status for data collection.

One person from each ward, typically the supervising nurse, was assigned the task of overseeing the conduct of the survey on the ward. They were responsible for keeping track of the survey forms, screening the forms for completeness and accuracy, and assisting the surveyors as necessary. A Facility Survey Coordinator was selected to oversee all survey activities at their Regional Treatment Center. Their responsibility was to see that all patients had been surveyed and all forms were complete and accurate. The forms were then forwarded to Ms. Fran Bly in DHS Central Office. Ms. Bly, along with other DHS staff including Sue Allen and Kay Ehrhart, visually screened each form for errors, recontacted the facility for incomplete and inconsistent entries and, upon completion, mailed them to PRA for data entry.

#### 2. <u>Training and Data Reliability</u>

Training was conducted on June 13, 1989 in St. Cloud and on June 14, 1989 in Minneapolis. It covered: (1) the background and importance of the project; (2) logistics for completing the survey; and (3) and a detailed review of the survey form itself. Several representatives from each RTC were trained. They were trained not only to understand the form and logistics, but also to serve as the local experts for those surveyors who were unable to attend the regional training. In addition, the regional training served as a team building effort; those who came to the training shared in the understanding that this would be an important effort, one for which they were uniquely qualified.

The method of training used in Minnesota was virtually identical to that used in all other states and provinces across the US and Canada where the survey has been conducted. Any variations in training have reflected site-specific details of the survey (e.g., the official name given to the survey) or size and geographic isolation of the hospital in question.

In 1975, when the Survey was first designed, the form was different from that used today, as were the method of survey conduct, and the training. We used then what might be likened to a utilization review method, that is, independent surveyors were trained to go from ward to ward making an independent assessment of each patient, and recording the results on what was then the survey form. On the face of it, that approach seemed ideal, offering both consistency in the mental set of the surveyors as well as independence of assessment. It had, however, three serious shortcomings. <u>First</u>, as a practical matter, at any site, the survey took months rather than weeks to complete. <u>Second</u>, we found that surveyors' level of enthusiasm and assiduity in conducting the survey diminished rapidly after more than fifteen or twenty surveys. <u>Third</u>, and most important, the results of the survey were not very reliable; coefficients for most scales were in the .30 - .50 range.

We discovered another fact about the survey. Despite the call for independence of assessment, it was virtually impossible for the survey team to make their judgments independently of the ward staff who worked with the patients. The reason was that for the surveyors to get as complete an account of the patients as possible, they still relied upon ward staff's behavioral descriptions of the patients.

With those facts in mind, we revamped the survey to be both more practical to administer and more reliable in results. In essence, the trick was to design a form which was tailored as precisely as possible to be completed by ward staff who must work with the patient on a day to day basis.

The result of that effort was essentially the prototype of the survey form used in Minnesota. The terminology on the survey form was revised to include behavioral descriptions of the patients that are commonly used by ward level staff. Moreover, we included a modified version on the NIMH's highly respected and widely used <u>Nurses' Observation Scale for</u> <u>Inpatient Evaluation</u> (our modifications were designed to improve the robustness of the depression factor in the scale).

The results of our modifications were substantial. Reliability of the New York scales jumped to the .75 - .96 range. Moreover, in factor analyses of the data using different years' data we have consistently gotten the same factor structures -- clearly an indication that a consistent image of the patients is being measured. We have also found that the survey discriminates well among patients actually residing in different levels of care: Medicalsurgical and nursing home patients look like nursing home patients according to the survey; patients in family (foster) care look appropriate for the community. Patients in acute admissions wards break down essentially into two groups, those in psychiatric crisis and in need of continued hospitalization, and those now stabilized and ready for the community.

Clearly, it is difficult to accurately assess the intended and unintended effects of training. We feel in the case of this survey, however, the design of survey form is sufficiently robust to withstand any shortcoming of training or peculiarities of individual rater's mental set.

#### 3. Data Collection

The data were collected between June 19 and 30, 1989. All persons with a diagnosis of mental illness in residence for at least three days during the two week survey period had a form completed for them. A total of 1,826 residents were assessed.

After a second stage visual review of the forms at PRA and their final cleaning, data entry began on July 17, 1989. It consisted of keying the forms using an SPSS-PC data entry program. All forms were double-keyed to insure accuracy. Cleaning procedures were continually applied throughout the processing through internal logic checks in the data entry program. When missing or invalid/inconsistent responses were discovered during either the initial screening or the data entry program, the forms were set aside and copies of the form were returned to DHS. They, in turn, sent them to the Survey Coordinator at each facility for correction or clarification. Upon completion, the forms were returned to PRA and entered in to the database.

#### 4. Data Analysis

The major part of our data analysis was the development of demographic, physical health, and psychiatric status profiles of all patients with a diagnosis of mental illness in the eight RTCs. These data were the basis for the computation of the level of care for each patient. Previously developed, theoretically-based scales and indices were computed from responses to a wide range of questions covering the individual's physical and mental health, the skilled nursing procedures which he/she may be receiving, and his/her ability to complete a variety of specific activities. Then, a statistical algorithm was used to compute the patients Physical and Psychiatric Levels of Care.

The Physical Level of Care (PLC) has four distinct levels:

- I. Independent the individual is physically healthy, generally independent in activities of daily living, does not require skilled nursing procedures.
- II. Supervised the individual requires supervision in activities of daily living, but is generally healthy and does not need skilled nursing procedures. This individual would require the kind of supervision available in a domiciliary care setting.
- III. Health Related the individual has more serious problems in activities of daily living, perhaps requiring some physical assistance, is physically less healthy or more disabled, and may required one or more skilled nursing procedures. This individual looks like the kind of person one might find in a health related facility, the entry level of a skilled nursing environment.
- IV. Skilled Nursing this individual is seriously or totally disabled in activities of daily living, has many or serious physical health problems, and probably requires one or more skilled nursing procedures. This individual has the same kind of physical health profile as someone in a skilled nursing facility.

The Psychiatric Level of Care (PSYCH) has two distinct levels:

- I. **Community** the individual may have continuing psychiatric problems but is not dangerous, not very psychotic, or not functionally disabled and probably could be treated in community aftercare programs.
- II. Hopital the individual may or may not be dangerous, but is clearly symptomatic and chronically mentally disabled. He/she may be extremely psychotic, agitated, or depressed. He/she requires structured programs, support, and residential care.

When combined in a matrix, the Physical and Psychiatric Levels of Care determine the overall Level of Care (LOC). There are four main considerations that must be kept in mind when using level of care estimates:

- The physical level of care estimate may be affected by the individual's psychiatric problems; the individual's psychiatric levels may be influenced by existing physical problems.
- Practical distinctions between physical and psychiatric levels become blurred when looking at elderly populations.
- Level of Care estimate is most useful and accurate when used to reflect the aggregate needs of those served by a facility.

The survey's concept of levels of care may not directly correspond with a particular agency's or staff member's philosophy.

#### 5. Data Reporting

The presentation of results in this report groups findings by five types of programs:

- Adult Mental Health (Adult MH) Programs,
- Geriatric Mental Health Patients,
- Developmental Disabilities (DD) Programs,
- Forensic Programs, and
- Chemical Dependency (CD) Programs.

The DD and CD patients were all persons on units categorized as DD or CD units who also had mental illness diagnoses. Forensic patients were comprised of patients on designated forensic units at St. Peter RTCS. All other surveyed patients were considered as being generic Adult MH Patients. Geriatric Patients included all survey patients from the Adult MH Programs 65 years of age and older regardless of whether they were on a designated geriatric unit.

#### **RESULTS**

#### **1. PATIENT PROFILES**

#### a. <u>Demographics</u>

As seen in Table 1, there are considerable differences across programs in the demographic profiles of the patients. While the Adult MH, DD and CD programs have a moderate majority of male patients, the vast majority of Forensic patients (91.5%) are males and a slight minority (46.2%) of the Geriatric MH patients are males.

The two noteworthy age differences are the older age, by definition, of the Geriatric patients (73.7 years of age on the average) and the younger age (31.5) of the 22 CD patients.

Forensic programs contain proportionally more minority patients (17.5%) than any other program.

The legal statuses of patients, as would be expected, vary greatly by type of program. Just about one quarter (24.2%) of both Adult MH and Geriatric programs are Voluntary status and just over half (54.5%) of the CD patients are Voluntary, compared to only 1.4% of the DD patients and 0.6% of the Forensic patients.

In reviewing Tables 1A to 1G, it is apparent that there are some noticeable differences across facilities in the characteristics of patients within the same programs.

For example, the mean age of the patients in Adult MH programs statewide ranges from 36.0 years of age in Anoka-Metro RTC to 44.0 in Moose Lake RTC. Similarly, there is wide disparity in the proportion of the patients in the Adult MH Programs who are Voluntary legal status with fully 40.0% of Fergus Falls RTC Voluntary compared to only 10.3% of Brainerd's Adult MH program patients. The one other area of substantial demographic difference is in Anoka-Metro RTC which has more minority patients in their Adult MH Program (15.9%) than the statewide average of 8.1%. On all other demographics, the programs are quite similar across facilities.

#### b. <u>Physical Health</u>

There is no baseline against which to easily compare the information on physical health contained in Tables 2 through 2G. The individual items are probably most useful as they are used later in this report to calculate the level of care each person needs. Nonetheless, they are useful in offering a gross picture of who the people in the RTCs are and how the various facilities may differ on the physical health needs of their residents.

The physical health profiles of the RTC patient are very much as expected. The Geriatric MH patients average 2 1/2 times as many physical health prolems as the next highest group. Only 4.4% of the Geriatrics have no physical health problem compared to 43.5% of patients in the other Adult MH Programs. The one area of slight inconsistency is the large number of patients in Adult MH programs (56.5%) who require at least one skilled nursing procedure. This figure is much closer to the geriatric patients (72.0%) than any other measure of physical health.

As expected, the particular types of physical health problems noted were quite variable across program type. The most frequent problem reported for Geriatric patients was circulatory disorders (29.7%) which was reported in only 5.5% of the Adult MH Program patients. Reciprocally, the top problem among Adult MH Program patients was obesity (12.2%), as it was among Forensic patients (10.7%). Yet it was very low on the list for Geriatric patients.

There are a few points of note in the facility tables (Tables 2A - 2G). Anoka-Metro RTC's Adult MH Program patients seem to be the healthiest of any RTC with 60.1% reported as having no physical health problem compared to the statewide average of 43.5%. Nonetheless, its proportion of Adult MH Program patients who require at least one skilled nursing procedure (47.6%) is very close to the statewide average (56.5%).

#### c. <u>Psychiatric Disability Levels</u>

Each of the five program types has a distinct distribution of diagnoses among its patients.

The Adult MH Program patients are heavily Schizophrenic (66.3%) followed by Affective Psychosis (20.1%). The Forensic patients, also, are heavily schizophrenic (62.1%), but have many more Personality Disorders (32.2%), Drug Abuse (22.6%) and Alcohol Abuse diagnoses (18.6%) than Affective Psychosis (7.3%). Geriatric patients are predominantly Schizophrenic (51.1%) also, but have many patients with Organic Brain Syndrome (OBS) (31.9%) as well as with Affective Psychosis (14.3%). Fully 91.3% of the patients in DD Programs are diagnosed as MR - DD with Schizophrenia (21.8%) and Affective Psychosis (14.1%) sometimes present. The residual category of Other, which includes 45.9% of the DD patients, contains 17 other diagnoses with the most prominent being Organic Personality Disorder (N=15) and Pedophilia (N=5).

The three summary scales of patient functioning reported are most easily interpreted by turning to the bottom portion of Table 3. In that Table the Minnesota RTC residents are compared to each other and to the New York State Psychiatric Center patients surveyed in November, 1988. These groups allow some calibrating of the current RTC residents.

The results of these comparisons are not surprising. The PSYSUM scale of psychiatric disability of the Adult, Geriatric and DD patients is almost exactly the same as the NYS inpatients.

There are no notable differences within program type across facility.

## Overall, these data indicate that the Minnesota RTC patients are probably quite similar to persons in state mental health inpatient facilities throughout the United States.

#### d. Violent Behavior Patterns

Clearly the program group with the highest proportion of its patients who were violent in some way in the past 30 days is the DD group (50.3%). This is nearly twice the proportion of Forensic patients (26.6%), although 67.8% of the Forensic patients were considered currently dangerous by the staff compared to but 25.5% of the DD patients. These disjunctures simply highlight the difference between actual past behavior and current clinical perceptions. The Geriatric patients and the Adult MH Patients were quite similar in the proportion violent in the past 30 days (33.5% and 29.9%, respectively). The CD patients were by far the least violent (13.6%).

In looking at this table, it should be noted that the Been Otherwise Violent category, which included 13.9% of the Adult MH patients and 14.7% of the DD patients, included for the most part verbally threatening behaviors.

By contrast the CD patients were the highest on violence to self in the past 30 days (40.9%) compared to the Geriatric patients the lowest at 3.8%. Consistent with their behavioral histories, the CD patients were highest of the five program now considered a suicide risk (18.2%).

Among the Adult MH Program patients there is considerable difference across facility in the proportion who were violent to others in the past 30 days. The range is from 20.1% in St. Peter RTC to 41.4% at Brainerd RHSC. These two facilities also are at the edge of the range of patients exhibiting violence to self in the past 30 days with St. Peter having 12.9% of its Adult MH patients compared to 28.7% of Brainerd's.

There are similar differences among Geriatric patients. Fully 46.2% of Moose Lake RTC Geriatric patients were reported as having been violent to others in the past 30 days as compared to 16.3% of Willmar's Geriatric patients (Brainerd had 66.7% of its Geriatric patients violent to others, but that is only two of three patients). There was very little difference across facility on the proportion of Geriatric patients who were violent towards self in the past 30 days.

#### 2. FACILITY PROFILES

#### a. Use of Emergency Interventions

As seen in Table 5, the vast majority of patients in all programs had no emergency interventions in the past 30 days. Among Geriatric and CD Programs, 90.1% and 90.9% had none with 77.9% of DD Program patients, 73.4% of Adult MH Program patients and 71.7% of Forensic patients having had no emergency interventions.

Where some type of intervention was used, there were only slight differences across programs. One-to-one supervision was most often used in Adult MH Programs along with seclusion or restraint. Emergency medications were more often used in Geriatric and Forensic programs than in other programs.

There is only minor variations across facilities in their use of emergency interventions in the various programs. Overall, Moose Lake RTC and St. Peter RTC Adult MH patients had a higher proportion with no emergency interventions in the prior 30 days (83.3% and 85.0%) than the other four RTCs (Anoka-Metro, 68.3%; Brainerd, 66.7%; Fergus Falls, 68.2%; Willmar, 70.3%).

#### b. Medication Patterns

As evidenced in Table 6 and as would be expected, only a minority of patients were not receiving psychotropic medications. By far the largest group in this category were the DD Program patients (29.3%) followed by Forensic patients (15.3%), CD patients (13.6%), Geriatric patients (10.4%), and Adult MH patients (8.0%).

The vast majority of Adult MH patients are on neuroleptics (83.0%), as is the case among Forensic patients (76.8%) and Geriatric patients (69.2%). Geriatric patients also frequently are on anticonvulsants (38.5%), as are a quarter to a third of the other non-CD inpatients.

The legal circumstances under which psychotropic medications are used vary in expected ways by program. The majority of Adult MH patients (70.1%), Geriatric patients (65.0%) and CD patients (94.7%) do so voluntarily. By contrast, 83.7% of the DD program

patients take medications under consent of a guardian and 41.1% of Forensic patients receive medication under a court order.

Tables 6A-6G show that there are some differences in the use of psychotropic medications in the same programs across facilities. For example, the percentage of Adult MH patients who receive neuroleptics varies from 69.0% in Brainerd RHSC to 90.8% in Willmar RTC. The dispersion for Geriatric patients is narrower being from 64.0% at Fergus Falls RTC to 79.1% at Willmar RTC, which again has the highest proportion.

There are vast differences in the proportion of Adult MH patients who receive medication voluntarily. At Fergus Falls RTC, 83.5% of the Adult MH receive medications voluntarily compared to 38.1% at Brainerd RHSC. Not very dissimilar is the difference among Geriatric patients where 47.6% of St. Peter Geriatric patients take medication on Voluntary status compared to Fergus Falls RTC at 90.0% and Anoka-Metro RTC at 80.0%.

#### c. <u>Case Management Status</u>

There is substantial difference between the MH and DD Programs in the proportion of residents who have been assigned a case manager (see Table 7). Most (81.4%) of the DD patients were reported to have been assigned a case manager compared to just over half (57.3%) of the Adult MH patients 51.1% of the Geriatric patients, and 48.0% of the Forensic Patient. Once assigned case managers, in all types of programs, case managers almost always do meet with the staff about their clients (between 98.8% in DD Programs and 85.0% in Adult MH Programs).

These general trends mask some huge facility differences. Brainerd RHSC has only 6.9% of its Adult MH patients with a case manager and Willmar reported 78.6% as Unknown as to whether they had a case manager. For Geriatric patients the discrepancies are even larger. At Willmar 97.7% of its Geriatric patients were recorded as Unknown while 92.0% of Fergus Falls Geriatric patients has a case manager. For those with assigned case managers there were only moderate differences across facility in how many had actually met with the staff about their clients.

### 3. PATIENT GROUPINGS FOR RTC PROGRAMMING

Based on the actual characteristics of the Minnesota RTC patients in June, 1989 and a model for inpatient mental health services drawn from our experience with LOC surveys in 17 U.S. states and 3 Canadian provinces, we present an array of services for adult, mentally ill, RTC patients in Figure 1. This model is based upon two major assumptions:

- 1. Regardless of how many persons are ultimately deemed appropriate for community placement and for whom community-based services are actually developed, some portion of residents of the State of Minnesota who require inpatient mental health services will continue to depend upon the state mental health system for them.
- 2. The RTC system always will have a heterogenous group of patients requiring a broad range of services for widely different periods of time.

The array of services proposed in Figure 1 starts with length of stay (LOS) as a major defining factor. Our experience indicates that the first two weeks of most hospitalizations are focused primarily on assessment, stabilization and behavioral management whether for first-time or repeat admissions. These activities are geared at one and the same time to rapidly returning to the community those persons whose conditions (psychiatric, medical, and social)

#### FIGURE 1

#### INPATIENT ARRAY OF SERVICES

#### UNIT TYPE

	Admission <u>Assessment</u>	Admission <u>Treatment</u>	Hospital <u>Rehabilitative</u>	Hospital Supportive <u>(Special Populations)</u>
Length of Stay	< 14 days	15-90 days	> 91 days	> 91 days
Patient Characteristics	All patients meeting LOS requirement	All patients (N=254) minus 7 persons requiring skilled nursing for serious medical problems and having severe psychiatri symptoms	All patients minus special populations included in hospital maintenance units c	<pre>Psycho-Organic with PSYSUM &gt; 70 and ADLS &gt; 25 (N=35) Serious medical problems plus serious mental disorder (N=102) Treatment refractory (LOS &gt; 2 years and PSYSUM &gt; 70) (N=143) Persistently and Seriously assaultive (NA)**</pre>
Number of Adult MH and Geriatric MH Patients 6/30/89*	106	247	447	307
Primary Services	Assessment Stabilization Behavioral Management	Discharge Planning Case Management Medication Continued Stabilization Behavioral Management	Discharge Planning Case Management Medication Verbal Therapies Vocational ADL Skills Educational Social Interaction	Targeted Services, e.g. Secure Care Units Social Skills Self-Care Skills Medication Management Skilled Nursing Care

Does not include forensic, DD or CD patients
Not identifiable from survey data

can be rapidly stabilized and to identifying the proper treatment regimen and residential unit for those persons who will require intermediate or longer-term care. This phase is very resource intensive as medication types and doseages are tested and retested and as a whole range of assessment activities are conducted. Treatment is primarily in the form of medication. Discharge planning may also begin in this phase. Medical services for physical conditions can be very important in this phase.

Once the first phase (Admission Assessment) is completed, the group of persons who will remain in the RTC for intermediate periods has been identified. We have chosen up to 90 days as a key juncture for limiting the Admission Treatment phase based upon both conceptual and empirical grounds. Conceptually, we feel that up to three months gives the treatment staff a reasonably long period to make breakthroughs with most any condition. Empirically, we have found in the New York State system for many years that 90 days is a key point after which time patients who have not been discharged have a very high probability of remaining for very long periods. We see no reason why this demarcation would not be applicable to the Minnesota RTC system based on its patients' lengths of stay reported on the survey forms.

Within the Admission Treatment group there is a wide range of patients. Some will leave after two or three weeks and by the fifteenth day are already stabilized and are just awaiting a community residential opening. At the same time, some portion of this group will have some of the same needs as those we have included in the Special Populations within the Hospital Supportive category. We did not separate them here, because usually any special medical or behavioral problems and treatment are still geared to short-term treatment and discharge, although the specter of longer-term treatment will sometimes already be apparent. Certainly, most of the services listed in Figure 2 under Hospital Rehabilitation could be applicable to these intermediate length of stay patients, but realistically they usually are not. Medication still usually takes primacy but may be complemented by some verbal therapies and behavioral management. Discharge planning and case management are crucial to insuring the briefest possible stay and successful community placement. Brief incursions into some other areas may occur, but they usually will be secondary across the total number of cases in this category.

All patients whose lengths of stay exceed 90 days are divided into Hospital Supportive Special Populations and Hospital Rehabilitative. The latter label belies the fact that for most of the patients included in Special Populations rehabilitation is expected. Conversely, the category label is meant to indicate clearly that there are some patients in every state hospital system who can be expected to be maintained for extended periods of time and who may not be able to return to the community. To plan for a system that makes no accommodation for this group is to pretend about reality. Based on our June, 1989 survey we estimate that this would be about 307 (28.4%) of Minnesota's adult mentally ill RTC population. This group includes patients: (1) whose problems are primarily organic in nature (an OBS diagnosis) and whose functioning level is low (PSYSUM > 70 and ADLS > 25); (2) who need skilled nursing care and who also have serious psychiatric disorder (PSYSUM > 70); (3) who we have called Treatment Refractory because of long lengths of stay (> 2 years) and who still display serious psychiatric disorder (PSYSUM > 70); (4) who carry a MH/MR dual diagnosis; or (5) who are persistently and seriously assaultive. The fifth group cannot be identified from the survey data which only asked for whether any assault occurred in the past 30 days.

The Hospital Rehabilitative group includes all persons with a LOS over 90 days who do not have conditions or lengths of stay that by definition would suggest extended inpatient treatment. More positively, they are patients who would most often carry a schizophrenia diagnosis, are infrequently assaultive to others or to self and have had many prior RTC admissions. These are patients whose social support networks may be more intact than the Hospital Supportive groups. This overview is intended to demonstrate one way in which the entire adult mentally ill RTC patient population could be grouped meaningfully for inpatient program planning and staffing. The categories offered here are meaningful both conceptually based on the role of the state mental hospital in the contemporary mental health services system and empirically based on real data generated by our June 1989 survey of all adult mentally ill persons in Minnesota RTC's. The exact application of these categories for actual program components and staffing levels goes well beyond this survey's data. It requires the interplay of incisive clinical ideas and informed, creative program analysts employing these data to check their ideas about actual levels of need and the geographic distribution of patients for whom services would be targeted.

#### 4. **PATIENT COMMUNITY APPROPRIATENESS DETERMINATIONS**

#### a. <u>Procedures</u>

In order to compute the overall recommended level of care for each patient, six scales and eight indices were used following a scoring algorithm applied annually in the NYS OMH Level of Care Survey. That these scales apply equally well to the Minnesota data was shown by the very high reliability scores attained. The following scales, when applied to the Minnesota data set, showed a reliability Alpha  $\geq$  .90: Community Activities Dysfunction Scale (CADS), Activities of Daily Living Scale (ADLS), and the Psychiatric Factors Composed Score (PSYSUM). The remaining scales, Disruptive-Agitated-Irritated Scale (DAIS), Social Affect and Interest Scale (SAIS), Psychiatric Symptom Scale (PSYS), Confusion Scale (CONS), and Depression Scale (DEPS), had a reliability Alpha  $\geq$  .80.

Once the scales and indices were computed, certain exclusionary criteria were implemented to compute the recommended Physical and the Psychiatric Levels of Care. When these are combined in a matrix, the overall level of care can be determined. The exclusionary items were those developed over the past decade by clinical and program staff in the NYS OMH. Future analyses of the Minnesota data could adjust these criteria, if that were deemed appropriate.

The scales used to compute the Physical Level of Care are the Activities of Daily Living Scale (ADLS) and the Community Activities Dysfunction Scale (CADS). The indices are Risk of Skilled Nursing (RISKN), Number of Physical Problems (PPI), Blind-Deaf-Severe Functional Disability (BDF), and Skilled Nursing Procedures Required (SNI).

The Activities of Daily Living Scale (ADLS) (Range = 8-49) is computed by adding the responses to the following questions about the patients personal care activities:

3a. Bathing (1 = Fully Independent to 6 = Needs Total Care)

3b. Dressing (1 = Fully Independent to 6 = Needs Total Care)

3c. Grooming (1 = Fully Independent to 6 = Needs Total Care)

3d. Eating (1 = Fully Independent to 6 = Needs Total Care)

3e. Using Toilet (1 = Fully Independent to 6 = Needs Total Care)

4. Incontinence of Urine (1 = Never to 6 = Uses Catheter)

5. Ability to Walk (1 = Fully Independent to 8 = Bed fast)

6. Incontinence of Feces (1 = Never to 5 = Has Colostomy)

The Community Activity Dysfunction Scale (CADS) (Range = 10-50) is computed by adding the responses to the following items about the patients projected ability to perform certain functions outside of the facility setting:

- 24a. Take his medication independently (1 = Definitely Yes to 5 = Definitely No)
- 24b. Keep appointments for clinics and other Mental Health services (1 = Definitely Yes to 5 = Definitely No)

- 24c. Use money correctly to purchase whatever he needs (1 = Definitely Yes to 5 = Definitely No)
- 24d. Hold on to a paying job (1 = Definitely Yes to 5 = Definitely No)
- 24e. Perform activities necessary to maintain a home or apartment (1 = Definitely Yes to 5 = Definitely No)
- 24f. Use public transportation (1 = Definitely Yes to 5 = Definitely No)
- 24g. Maintain an adequate diet (1 = Definitely Yes to 5 = Definitely No)
- 24h. Take initiative or seek assistance with own problems (1 = Definitely Yes to 5 = Definitely No)
- 24i. Abuse drugs (1 = Definitely No to 5 = Definitely Yes)
- 24j. Abuse alcohol (1 = Definitely No to 5 = Definitely Yes)

Blind-Hearing Impaired-Severe Functional Disability (BDF) is scored if Blind (Question 1n) or Hearing Impaired (Question 10) is checked or if CADS is greater than 28.

Number of Physical Health Problems (PPI) is simply the number of physical problems indicated on the "Physical Health Problems of the Patient" part of the form excluding questions about blindness, speech impairment, or hearing impairment (Range = 0-22).

Risk of Skilled Nursing (RISKN) is scored if the response to Incontinence of Urine (Question 4) is greater than 2, the response to Ability to Walk (Question 5) is greater than 4, the response to Incontinence of Feces (Question 6) is greater than 2, or PPI is greater than 5.

Need for Skilled Nursing Procedures (SNI) were indicated 1 if the rater reported that any skilled nursing procedures (Questions 2a to 2q) were required (Range = 0-17).

The computation of Physical Level of Care is as follows:

Physical LOC = Independent if ADLS = 8

Physical LOC = Supervised if  $9 \le ADLS \le 18$ 

Physical LOC = Health Related Care if  $19 \le ADLS \le 24$ 

Physical LOC = Skilled Nursing Care if  $25 \le ADLS$ .

Exclusionary Criteria:

- If Physical LOC = Independent and BDF = 1, Physical LOC is recalculated to Supervised.
- If Physical LOC = Supervised and SNI = 1 or RISKN = 1, Physical LOC is recalculated to Health Related Care.
- If Physical LOC = Health Care Related and SNI = 1 or RISKN = 1, Physical LOC is recalculated to Skilled Nursing Care.

The scale used to compute the Psychiatric Level of Care is the Psychiatric Factors Composite Score (PSYSUM) which is computed by adding the scores of the following subscales: the Disruptive - Agitated - Irritated Scale (DAIS), the Psychotic Symptom Sale (PSYS), the Depression Scale (DEPS), the Confusion Scale (CONS), the Social Affect and Interest Scale (SAIS), and the Personal Appearance and Neatness Scale (PANS). The indices are Dangerous to Others in Last 30 days (DOI), Dangerous to Self in Last 30 Days (DSI), Sociopathic Behavior in Last 30 Days (SBI), Dangerousness in Last 30 Days (RISKD), and Severe Psychiatric Symptoms in Last 30 Days (RISKP). The Disruptive - Agitated - Irritated Scale (DAIS) (Range = 7-35) is computed by adding the responses to the following seven questions about the patients behavior in the last 30 days:

- 16b. Is impatient (1 = Never-Rarely to 5 = Always)
- 16d. Gets angry or annoyed easily (1 = Never-Rarely to 5 = Always)
- 16h. Becomes easily upset if something doesn't suit him (1 = Never-Rarely to 5 = Always)
- 16i. Is irritable or grouchy (1 = Never-Rarely to 5 = Always)
- 16w. Quick to fly off the handle (1 = Never-Rarely to 5 = Always)
- 16bb. Verbally abuses others (1 = Never-Rarely to 5 = Always)
- 16dd. Is disruptive (1 = Never-Rarely to 5 = Always)

The Psychotic Symptom Scale (PSYS) (Range = 6-30) is computed by adding the responses to the following six questions about the patients behavior in the last 30 days:

- 16c. Hears things that are not there (1 = Never-Rarely to 5 = Always)
- 16q. Sees things that are not there (1 = Never-Rarely to 5 = Always)
- 16t. Talk, mutters, mumbles to himself (1 = Never-Rarely to 5 = Always)
- 16v. Giggles or smiles to himself without any apparent reason (1 = Never-Rarely to 5 = Always)
- 16z. Has strange ideas, says strange things (1 = Never-Rarely to 5 = Always)
- 16cc. Has bizarre habits, rituals or behavior (1 = Never-Rarely to 5 = Always)

The Depression Scale (DEPS) (Range = 4-20) is also based on responses about the patients behavior in the past 30 days. It is computed by adding the responses to the following questions:

- 160. Says he feels blue or depressed (1 = Rarely-Never to 5 = Always)
- 16r. Says that he is no good (1 = Rarely-Never to 5 = Always)
- 16u. Says he feels hopeless, useless or unwanted (1 = Rarely-Never to 5 = Always)
- 16y. Talks of killing himself, wishes he were dead (1 = Rarely-Never to 5 = Always)

The Confusion Scale (CONS) (Range = 5-25) is based on responses about the patients behavior in the past 30 days. It is computed by adding the responses to the following questions:

- 16j. Has trouble remembering (1 = Rarely-Never to 5 = Always)
- 16s. Has difficulty completing even simple tasks on his own (1 = Rarely-Never to 5 = Always)
- 16aa. Gets confused (1 = Rarely-Never to 5 = Always)
- 16ff. Has to be reminded of what to do (1 = Rarely-Never to 5 = Always)
- 16gg. Has to be told to follow hospital routine (1 = Rarely-Never to 5 = Always)

The Social Affect and Interest Scale (SAIS) (Range = 5-25) is computed by adding responses to the following questions about the patients behavior in the last 30 days:

- 16c. Shows interest in activities around him (1 = Always to 5 = Rarely-Never)
- 16g. Tries to be friendly with others (1 = Always to 5 = Rarely-Never)
- 16k. Laughs or smiles at funny comments or events (1 = Always to 5 = Rarely-Never)
- 16n. Starts up conversation with others (1 = Always to 5 = Rarely-Never)
- 16p. Talks about his interests (1 = Always to 5 = Rarely-Never)

Personal Appearance and Neatness Scale (PANS) (Range = 4-20) is based on responses to the following questions about the patients behavior in the last 30 days:

- 16a. Is sloppy (1 = Rarely-Never to 5 = Always)
- 16f. Keeps his clothes neat (1 = Always to 5 = Never Rarely)
- 161. Is messy in eating habits (1 = Rarely-Never to 5 = Always)
- 16x. Keeps self clean (1 = Always to 5 = Never Rarely)

PSYSUM (Range = 32-160) is the patients overall psychiatric composite score computed by adding the responses to the following items:

DAIS (7 = Rarely-Never to 35 = Always)

PSYS (6 = Rarely-Never to 30 = Always)

DEPS (4 = Rarely-Never to 20 = Always)

CONS (5 = Rarely-Never to 25 = Always)

SAIS (5 = Always to 25 = Rarely-Never)

PANS (4 = Always to 20 = Rarely-Never)

16m. Steals or hoards things (1 = Rarely-Never to 5 = Always)

Dangerous to Others (DOI) was scored as equal to 1, if the rater answered yes to any of the following items in the last 30 days:

- 8a. Psychiatric medication initiated on an emergency basis
- 8b. Physical restraint or seclusion to control violent behavior
- 8c. 1-1 Supervision for single periods of 30 minutes or more to monitor or control for dangerous or violent behavior to self or others
- 9c. Physically assaulted someone
- 9e. Destroyed furniture or property
- 91. Is otherwise violent
- 13. Is patient now considered dangerous to others

Dangerous to self (DSI) was scored as equal to 1, if the rater answered yes to any of the following items concerning the patients behavior in the last 30 days:

- 9a. Attempted suicide
- 9b. Talked about killing self
- 9h. Deliberately injured self
- 9i. Been on suicide precaution
- 14. Is the patient now considered a suicide risk

Sociopathic Behavior (SBI) was scored as equal to 1 if the rater answered yes to any of the following items concerning the patients behavior in the last 30 days:

- 9d. Tried to kill someone
- 9j. Sexually assaulted someone
- 9k. Set a fire

Overall risk (RISKD) was scored as equal to 1 if DOI = 1, SBI = 1 or DSI = 1. RISKP is a dummy variable equal to 1 if DAIS  $\geq$  18, PSYS  $\geq$  15, or DEPS  $\geq$  7.

The computation of psychiatric level of care is as follows:

Psychiatric LOC = Community Appropriate if  $PSYSUM \le 69$ 

Psychiatric LOC = Hospital-Appropriate if  $PSYSUM \ge 70$ 

Exclusionary criteria:

If RISKD = 1 or RISKP = 1 the Psychiatric LOC is computed as Hospital Appropriate

#### b. <u>Results</u>

As shown in Tables 8 and 9, the classification approach described below produces the following number of persons in each program type who we would see as appropriate for some type of community placement: Adult MH - 208; Geriatric MH - 32; Forensic - 23; DD - 69; and CD - 6. These programs total 338 patients (19.0% of the 1,781 patients surveyed) who were inpatients in June, 1989 who could be placed in the community if the appropriate settings were available.

#### c. Comparing Statistical and Clinical Assessments of Community Appropriateness

A remaining question about our classification approach was in what ways our categorization of patients using a statistical algorithm differed from the assessment of the hospital staff who completed the survey form. On that form there was an item that asked, "Is patient now appropriate for placement in the community?" The staff could rate them on a five point scale from Definitely Yes to Definitely No.

Examining Table 9 shows that there was a total of 35 cases across the programs that we scored as community-appropriate, but whom the staff said Definitely No. The vast majority of the cases (27 of the 35) were persons who were blind or deaf, but who we scored as not requiring psychiatric care and, therefore, as belonging in the community. Three had a Mentally III - Dangerous commitment status, but who had no behavioral reasons for hospitalization. Three had suicide attempts and one had a homicide attempt before admission, but had no current condition requiring psychiatric hospitalization. The other one of the 35 cases had many physical problems only.

Reciprocally, there were 47 cases that our algorithm scored as belonging in hospital while staff scored them as Definitely Yes for community placement. Of these 47, the algorithm kept 32 in hospital because the staff scored the patient as currently dangerous to self or others, which is an exclusionary item for community placement in the algorithm. In addition, 8 of these 32 persons scored as also having severe psychiatric symptoms. Twenty-six of the 47 had severe psychiatric symptoms in the last three days and six were eliminated for community placement because their summary scale on psychiatric disability exceeded the acceptable cut point.

Obviously, there is no classification approach that is always the correct one. The comparison of the clinical assessments with our statistical ones does mean that 35 of the 338 cases our algorithm would place in the community would require special clinical review and, probably, specialized support services. In addition, there are 47 persons who the staff is confident could be placed in the community, despite our statistical determinations. These patients, too, would require detailed reviews and could be appropriate for community placement raising the number of patients that should be placed in the community to as high as 385.

#### d. Further Refinements

The statistical algorithm presented above is the one that we feel best reflects the real world in which there are certain types of patients whom most program operators are willing and prepared to serve in the community. Clearly, less conservative criteria could be used in those areas where the state mental health authority either runs community residential programs or can mandate that program operators accept assaultive, disruptive or threatening persons who would not be accepted into most community-based programs throughout the U.S. Using criteria less stringent than those we used would increase the number of patients who would be considered appropriate for community placement.

During the course of this contract, a number of changes to make our algorithm less restrictive were suggested. The most frequently mentioned are reflected in Figure 1. In this model, the first modification was dropping as an exclusionary criterion for community placement anyone who was scored as having been "otherwise violent" in the past 30 days. Based on the RTC staff's written comments on the survey forms, most of the behaviors included in the category were verbally threatening incidents. For Adult and Geriatric MH patients, if this criterion did not exclude patients who otherwise would have been scored as community appropriate, 24 patients beyond the 240 originally identified would have been community appropriate bringing the total to 264 or 24.3% of the total of adult mentally ill RTC patients.

The second criterion reviewers thought overly restrictive was a verbal threat of suicide. If that criterion were dropped as one which automatically excluded someone from being community appropriate, another 15 patients would be added, moving the total number of community appropriate patients up to 279 or 25.7% of adult mentally ill RTC patients.

The next three adjustments reflected in Figure 2 centered on the staff's answers to the question of whether they thought the patient was now appropriate for placement in the community. They answered on a five-point range from "Definitely Yes" to "Definitely No." Reviewers of our prior draft suggested that the 28 patients rated "Definitely Yes" by the staff, but not identified by the statistical algorithm or the other two changes, should be included. Further, including patients for whom the staff said "Probably Yes" but not selected by the original statistical algorithm, nor included by either of the three prior adjustments, would add another 92 patients as community appropriate. If the patients the staff scored as "Possibly" were included, 132 patients not previously identified who would be identified as community appropriate.

It should be readily apparent from the prior paragraphs that our original algorithm that identified 22.1% of the Adult and Geriatric MH patients as community appropriate can be easily adjusted by selecting factors logically derived from any conceptual framework. We continue to feel that our original estimate is the most realistic identification of which patients will actually be able to be maintained in the community. Certainly, a broader array of community programming would warrant expanding criteria such as has been done in this section. Without radical expansion of community-based options, we believe it is most unrealistic to go beyond the 36.7% figure in the next to last iteration of this model. Even to reach that figure, however, would require a rapid and multifaceted expansion of existing programs throughout Minnesota.

Clearly, 36.7% and 48.9%, and even higher proportions, are figures to work towards as public sector mental health patients create and manage more community programs. Nonetheless, to manage the existing systems of care rationally, it would be unrealistic to expect such high percentages to be community-appropriate today, given current residential and treatment options. In the end, then, we stand by a 22.1% figure as a realistic, sound proportion of patients who should now be in the community but would grant that up to about 28% might be possible, currently, in a best case scenario. However, beyond that, more innovative, risktaking programs than currently exist would be required.



#### 5. SPECIAL ISSUES

When the DHS Advisory Committee reviewed the initial draft of this report in October, 1989, a number of questions, beyond those reflected in the prior sections, were raised that are addressed below.

#### a. <u>Age and Length of Stay</u>

A number of questions were raised about the age distribution and Length of Stay (LOS) of persons 65 years of age and older. Table 10A breaks Adult MH and Geriatric MH patients into six age categories. Clearly, there is a strong relationship between older age and longer lengths of stay. Just over two thirds of patients aged 18-20 had been hospitalized less than 90 days compared to about one fifth of patients 75 years of age and older.

Only about one quarter of all MH patients over 65 years of age (24.7%) have been hospitalized during the current admission over 10 years. Indeed, 35 of 182 Geriatric MH patients (19.2%) have been in less than 90 days. The relatively even distribution of Geriatric patients over the five LOS categories suggests that the RTCs do not serve only the long-term, chronic geriatric patients as is the case in many states, but may be treating them for relatively short periods of time before returning them to the community.

#### b. Assignment of Case Managers

Tables 10B-10B-8 report how each of the 87 Minnesota counties has done in assigning case managers to those patients for whom they are the designated county of financial responsibility. The tables display these figures by program type.

It is clear that there is a huge variation by county from 12 counties where no clients have case managers to five smaller counties where all clients have been assigned case managers. More relevant are the counties in between these extremes who have large numbers of patients for whom they are responsible. Some of these counties do extremely well in assigning case managers (e.g., Blue Earth County with 85.7% of its 42 patients, St. Louis County with 79.2% of its 120 patients) and others do poorly (e.g., Stearns County with 14.6% of its 41 patients). The largest counties fall into the middle. Hennepin County has 504 patients, 69.4% of whom have assigned case managers and Ramsey County has 203 patients, 62.6% of whom have assigned case managers.

### c. <u>Cultural or Racial Differences</u>

The survey data contain only one variable related to the question of possible differences across cultural or racial groups. That item was race. It is at best a gross measure of the core issues that seem to be of concern. Table 10C reports how race, as reported, was related to reported drug and alcohol problems and Table 10D to the three major psychiatric and functional summary scales.

The three major minority groups, American Indian, Hispanics and Blacks scored significantly higher than Whites on having alcohol or drug problem. Fully three-quarters (75.0%) of the American Indian patient had either an alcohol or drug problem, as did 60% of the Hispanic patients and 47.0% of the Black patients. These compared with 34.5% of the White patients.

The inverse relationship between race and levels of psychiatric and functional disability were found, i.e., white patients tended to have the highest levels of disability of the four major ethnic groups.

## TABLES

### TABLE 1

### Demographic Profile of Residents in Minnesota Regional Centers

	Programs					
	Adult MH <u>Programs</u> (N=905)	Geriatric MH <u>Patients</u> (N=182)	DD <u>Programs</u> (N=495)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=22)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Sex						
Male	56.8	46.2	60.4	91.5	54.5	
Female	43.2	53.8	39.6	8.5	45.5	
Age						
18 - 20 years	2.5	0.0	2.9	1.2	4.6	
21 - 34 years	39.4	0.0	34.7	44.6	68.2	
35 - 44 years	27.6	0.0	31.9	37.3	22.7	
45 - 64 years	30.5	0.0	22.6	15.8	4.5	
65 years or more	0.0	100.0	7.9	1.1	0.0	
Mean Age	38.8	73.7	40.7	36.6	31.5	
Race						
White	91.9	98.9	95.6	82.5	95.5	
Black	3.8	0.6	2.6	9.6	4.5	
Hispanic	0.4	0.0	0.2	2.8	0.0	
American Indian	2.7	0.5	1.4	4.5	0.0	
Asian / Pacific Island	1.0	0.0	0.2	0.0	0.0	
Other	0.2	0.0	0.0	0.6	0.0	
Languages Spoken	*					
English Only	95 2	95.6	913	97 2	95 5	
Snanish Only	0.3	0.0	0.0	0.0	0.0	
English and Other	3.4	3.4	1.0	2.8	0.0	
Spanish and Other	0.1	0.4	0.0	0.0	0.0	
Other	0.0	0.5	1 2	0.0	0.0	
Unknown	0.1	0.5	6.5	0.0	4.5	
Any Prior Minnesota RTC Admissions	79.3	68.9	55.4	81.4	72.7	
Legal Status						
Committed - MI	60.2	67.1	0.6	26.5	13.7	
Committed - MI & D	6.3	2.7	0.0	63.8	4.5	
Committed - MR	0.0	0.0	88.3	1.1	0.0	
Committed - CD	0.1	1.1	0.0	0.0	27.3	
Committed - MI & MR	0.1	0.0	9.1	0.6	0.0	
Committed - MI & CD	4.8	0.0	0.0	0.6	0.0	
Committed - MI & D & MR	0.0	0.0	0.0	0.6	0.0	
Committed - MI & D & CD	0.0	0.0	0.0	0.6	0.0	
Voluntary	24.2	24.2	1.4	0.6	54.5	
Hold Order	4.3	10	0.6	5.6	0.0	

### TABLE 1A

### Demographic Profile of Residents in Anoka-Metro RTC

	Programs				
	Adult MH <u>Programs</u> (N=233)	Geriatric MH <u>Patients</u> (N=11)	CD <u>Programs</u> (N=4)		
	<u>%</u>	<u>%</u>	<u>%</u>		
Sex					
Male Female	57.1 42.9	45.5 54.5	75.0 25.0		
Age					
18 - 20 years	2.1	0.0	25.0		
21 - 34 years	46.4	0.0	25.0		
35 - 44 vears	33.0	0.0	50.0		
45 - 64 years	18.5	0.0	0.0		
65 years or more	0.0	100.0	0.0		
Mean Age	36.0	69.5	30.0		
Race					
White	84.1	90.9	75.0		
Black	8.2	9.1	25.0		
Hispanic	0.9	0.0	0.0		
American Indian	4.3	0.0	0.0		
Asian / Pacific Island	2.1	0.0	0.0		
Other	0.4	0.0	0.0		
Languages Spoken					
English Only	95.4	81.8	100.0		
Spanish Only	0.4	0.0	0.0		
English and Other	3.0	9.1	0.0		
Spanish and Other	0.4	00	0.0		
Other	0.1	0.0	0.0		
Unknown	0.4	9.1	0.0		
Any Prior Minnesota RTC Admissions	74.8	54.5	50.0		
<u>Legal Status</u>					
Committed - MI	69.1	72.7	50.0		
Committed - MI & D	7.3	27.3	0.0		
Committed - MR	0.0	0.0	0.0		
Committed - CD	0.4	0.0	50.0		
Committed - MI & MR	0.0	0.0	0.0		
Committed - MI & CD	9.9	0.0	0.0		
Committed - MI & D & MR	0.0	0.0	0.0		
Committed - MI & D & CD	0.0	0.0	0.0		
Voluntary	12.0	0.0	0.0		
Hold Order	1.3	0.0	0.0		

### TABLE 1B

## Demographic Profile of Residents in Brainerd RHSC

	Programs			
	Adult MH <u>Programs</u> (N=87)	Geriatric MH <u>Patients</u> (N=3)	DD <u>Programs</u> (N=67)	
	<u>%</u>	<u>%</u>	<u>%</u>	
Sex				
Male	57.5	66.7	44.8	
Female	42.5	33.3	55.2	
Age				
18 - 20 years	3.4	0.0	3.0	
21 - 34 years	42.6	0.0	40.3	
35 - 44 years	26.4	0.0	20.9	
45 - 64 years	27.6	0.0	23.9	
65 years or more	0.0	100.0	11.9	
Mean Age	37.1	74.3	41.4	
Race				
White	93.2	100.0	95.5	
Black	0.0	0.0	0.0	
Hispanic	1.1	0.0	0.0	
American Indian	4.6	0.0	4.5	
Asian / Pacific Island	1.1	0.0	0.0	
Other	0.0	0.0	0.0	
Languages Spoken				
English Only	94.4	100.0	95.5	
Spanish Only	1.1	0.0	0.0	
English and Other	4.6	0.0	0.0	
Spanish and Other	0.0	0.0	0.0	
Other	0.0	0.0	4.5	
Unknown	0.0	0.0	0.0	
Any Prior Minnesota RTC Admission	84.9	50.0	72.7	
Legal Status				
Committed - MI	62.2	33.4	3.0	
Committed - MI & D	10.3	0.0	0.0	
Committed - MR	0.0	0.0	82.1	
Committed - CD	0.0	0.0	0.0	
Committed - MI & MR	0.0	0.0	14.9	
Committed - MI & CD	2.3	0.0	0.0	
Committed - MI & D & MR	0.0	0.0	0.0	
Committed - MI & D & CD	0.0	0.0	0.0	
Voluntary	10.3	33.3	0.0	
Hold Order	14.9	33.3	0.0	

### TABLE 1C

### Demographic Profile of Residents in Fergus Falls RTC

### by Programs - June 1989

<u>Programs</u>

ا<sub>ندھما</sub> ...

	Adult	Geriatric		
	MH	MH	DD	CD
-	(N-85)	$\frac{Patients}{(N-25)}$	$\frac{\text{Programs}}{(N-26)}$	$\frac{\text{Programs}}{(N-7)}$
	(14-05)	(14-25)	(11-20)	(14=7)
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Sex				
Male	55.3	40.0	65.4	42.9
Female	44.7	60.0	34.6	57.1
Age				
18 - 20 years	2.3	0.0	0.0	0.0
21 - 34 years	35.3	0.0	19.2	85.7
35 - 44 years	22.4	0.0	42.3	0.0
45 - 64 years	40.0	0.0	30.8	14.3
by years or more	0.0	100.0	/./	0.0
Mean Age	40.9	/2.0	43./	32.0
Race	05.0	100.0	100.0	100.0
White	95.3	100.0	100.0	100.0
Black	0.0	0.0	0.0	0.0
American Indian	0.0	0.0	0.0	0.0
Asian / Pacific Island	3.5	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Language Spoken	02.0	0(0	100.0	100.0
English Only Speciel Only	92.9	96.0	100.0	100.0
Spanish only English and Other	0.0	0.0	0.0	0.0
English and Other	7.1	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Unknown	0.0	0.0	0.0	0.0
Any Prior Minnesota RTC Admission	ns 847	64.0	88.5	85 7
	<u>15</u> 04.7	04.0	00.5	00.7
Legal Status				
Committed - MI	50.6	60.0	0.0	14.2
Committed - MI & D	0.0	0.0	0.0	0.0
Committed - MR	0.0	0.0	100.0	0.0
Committed - CD	0.0	0.0	0.0	42.9
Committed - MI & MK	0.0	0.0	0.0	0.0
Committed - MI & CD Committed MI & D & MP	1.2	0.0	0.0	0.0
Committed = MI & D & MIK	0.0	0.0	0.0	0.0
Voluntary	<u>40</u> 0	20.0	0.0	<u></u> ⊿2 0
Hold Order	8 2	20.0	0.0	-12.5
	0.2	20.0	0.0	0.0

### TABLE 1D

## Demographic Profile of Residents in Moose Lake RTC

### by Programs - June 1989

Programs 1 4 1

	Adult MH <u>Programs</u> (N=132)	Geriatric MH <u>Patients</u> (N=78)	DD <u>Programs</u> (N=10)	CD <u>Programs</u> (N=9)
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Sex				
Male	56.1	47.4	70.0	55.6
Female	43.9	52.6	30.0	44.4
Age				
18 - 20 years	0.8	0.0	0.0	0.0
21 - 34 years	27.3	0.0	20.0	77.8
35 - 44 years	26.5	0.0	60.0	22.2
45 - 64 years	45.5	0.0	10.0	0.0
65 years or more	0.0	100.0	10.0	0.0
Mean Age	44.0	74.4	42.0	31.0
Race				
White	95.5	100.0	100.0	100.0
Black	1.5	0.0	0.0	0.0
Hispanic	0.0	0.0	0.0	0.0
American Indian	3.0	0.0	0.0	0.0
Asian / Pacific Island	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Languages Spoken				
English Only	977	94 9	100.0	100.0
Spanish Only	00	0.0	0.0	0.0
English and Other	23	5.1	0.0	0.0
Snanish and Other	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Unknown	0.0	0.0	0.0	0.0
Any Prior Minnesota RTC Admissio	<u>n</u> 80.2	73.1	80.0	77.8
Legal Status				
Committed - MI	57.6	79.5	0.0	0.0
Committed - MI & D	6.8	1.3	0.0	0.0
Committed - MR	0.0	0.0	90.0	0.0
Committed - CD	0.0	2.6	0.0	11.1
Committed - MI & MR	0.0	0.0	10.0	0.0
Committed - MI & CD	1.5	0.0	0.0	0.0
Committed - MI & D & MR	0.0	0.0	0.0	0.0
Committed - MI & D & CD	0.0	0.0	0.0	0.0
Voluntary	29.5	16.7	0.0	88.9
Hold Order	4.5	0.0	0.0	0.0

### TABLE 1E

## Demographic Profile of Residents in St. Peter RTC

### by Program - June 1989

	Adult MH <u>Programs</u> (N=139)	Geriatric MH <u>Patients</u> (N=22)	DD <u>Programs</u> (N=114)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=2)
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Sex				• · -	
Male Female	61.9 38.1	40.9 59.1	64.0 36.0	91.5 8.5	50.0 50.0
Age					
18 - 20 years	3.6	0.0	6.1	1.1	0.0
21 - 34 years	37.4	0.0	37.7	44.7	50.0
35 - 44 years	27.3	0.0	28.1	37.3	50.0
45 - 64 years	31.7	0.0	16.7	15.8	0.0
65 years or more	0.0	100.0	11.4	1.1	0.0
Mean Age	39.0	73.4	40.3	36.6	35.5
Race	04.5			00 F	100.0
white Dia ala	96.5	100.0	98.2	82.5	100.0
	0.7	0.0	0.9	9.0	0.0
Hispanic American Indian	0.7	0.0	0.0	2.8	0.0
American Indian	1.4	0.0	0.9	4.5	0.0
Asian / Pacific Island	0.7	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.6	0.0
Languages Spoken					
English Only	87.8	100.0	97.3	97.2	50.0
Spanish Only	0.7	0.0	0.0	0.0	0.0
English and Other	6.5	0.0	1.8	2.8	0.0
Spanish and Other	0.0	0.0	0.0	0.0	0.0
Other	5.0	0.0	0.9	0.0	0.0
Unknown	0.0	0.0	0.0	0.0	50.0
Any Prior Minnesota RTC Admissions	82.6	68.2	71.1	81.4	50.0
<u>Legal Status</u>					
Committed - MI	43.9	54.5	0.8	26.6	0.0
Committed - MI & D	10.8	0.0	0.0	63.8	50.0
Committed - MR	0.0	0.0	71.9	1.0	0.0
Committed - CD	0.0	0.0	0.0	0.0	0.0
Committed - MI & MR	0.6	0.0	22.8	0.6	0.0
Committed - MI & CD	6.5	0.0	0.0	0.6	0.0
Committed - MI & D & MR	0.0	0.0	0.0	0.6	0.0
Committed - MI & D & CD	0.0	0.0	0.0	0.6	0.0
Voluntary	36.0	45.5	3.5	0.6	50.0
Hold Order	2.2	0.0	0.9	5.6	0.0

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Programs

### TABLE 1F

## Demographic Profile of Residents in Willmar RTC

	Programs				
	Adult MH <u>Programs</u> (N=229)	Geriatric MH <u>Patients</u> (N=43)	DD <u>Programs</u> (N=11)		
	<u>%</u>	<u>%</u>	<u>%</u>		
Sex					
Male Female	54.1	48.8	81.8		
remaie	43.7	J1.2	10.2		
Age					
18 - 20 years	2.6	0.0	0.0		
21 - 34 years	41.0	0.0	18.2		
35 - 44 years	25.3	0.0	36.4		
45 - 64 years	31.0	0.0	45.5		
65 years or more	0.0	100.0	0.0		
Mean Age	38.5	74.3	45.5		
Race					
White	93.4	97.7	100.0		
Black	5.2	0.0	0.0		
Hispanic	0.0	0.0	0.0		
American Indian	0.4	2.3	0.0		
Asian / Pacific Island	0.4	0.0	0.0		
Other	0.4	0.0	0.0		
Languages Snoken					
English Only	00.1	077	100.0		
Spanish Only	99.1	97.7	100.0		
English and Other	0.0	0.0	0.0		
Snanish and Other	0.9	2.5	0.0		
Other	0.0	0.0	0.0		
Unknown	0.0	0.0	0.0		
Any Prior Minnesota RTC Admissions	77.4	69.0	80.0		
Legal Status					
Committed - MI	65.5	55.8	0.0		
Committed - MI & D	3.1	2.3	0.0		
Committed - MR	0.0	0.0	100.0		
Committed - CD	0.0	0.0	0.0		
Committed - MI & MR	0.0	0.0	0.0		
Committed - MI & CD	2.6	0.0	0.0		
Committed - MI & D & MR	0.0	0.0	0.0		
Committed - MI & D & CD	0.0	0.0	0.0		
Voluntary	25.8	34.9	0.0		
Hold Order	3.1	7.0	0.0		

### TABLE 1G

### Demographic Profile of Residents in Cambridge RHSC

	Programs
	DD <u>Programs</u> (N=61)
	<u>%</u>
<u>Sex</u>	( 9 0
Male Female	31.1
Age	
21 - 34 years	45.9
35 - 44 years	36.1
35 - 44 years	0.0
45 - 64 years	18.0
65 years or more	0.0
Mean Age	37.6
Race	
White	91.8
Black	6.6
Hispanic	1.6
American Indian	0.0
Asian / Pacific Island	0.0
Other	0.0
Languages Spoken	
English Only	98.4
Spanish Only	0.0
English and Other	1.6
Spanish and Other	0.0
Other	0.0
Unknown	0.0
Any Prior Minnesota RTC Admissions	55.2
Legal Status	
Committed - MI	0.0
Committed - MI & D	0.0
Committed - MR	82.0
Committed - CD	0.0
Committed - MI & MR	13.1
Committed - MI & CD	0.0
Committed - MI & D & MR	0.0
Committed - MI & D & CD	0.0
voluntary	3.3
nola Uraer	0.1

### TABLE 1H

### Demographic Profile of Residents in Faribault RC

	<u>Programs</u>
	DD <u>Programs</u>
	(N=206)
	<u>%</u>
Sex	
Male	58.7
Female	41.3
A ne	
$\frac{\Lambda EC}{21 - 34}$ years	24
35 - 44 years	31.6
35 - 44 years	33.5
45 - 64 years	25.2
65 years or more	7.3
Mean Age	41.0
Race	
White	94.2
Black	3.9
Hispanic	0.0
American Indian	1.5
Asian / Pacific Island	0.5
Other	0.0
Languages Spoken	
English Only	82.5
Spanish Only	0.0
English and Other	1.0
Spanish and Other	0.0
Other	1.0
Unknown	15.5
Any Prior Minnesota RTC Admissions	33.8
Legal Status	
Committed - MI	0.0
Committed - MI & D	0.0
Committed - MR	99.0
Committed - CD	0.0
Committed - MI & MK	0.0
Committed - MI & D & MR	0.0
Committed - MI & D & MK Committed - MI & D & CD	0.0
Voluntary	0.0
Hold Order	0.5

### TABLE 2

### Physical Health Profile of Residents in Minnesota Regional Centers

### by Program - June 1989

	Programs					
	Adult MH <u>Programs</u>	Geriatric MH <u>Patients</u>	DD <u>Programs</u>	Forensic <u>Programs</u>	CD <u>Programs</u>	
	(N=905)	(N=182)	(N=495)	(N=177)	(N=22)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Mean # of Physical Health Problems	1.0	2.7	1.2	0.7	0.5	
Range of Physical Health Problems Range = 0-25	0-9	0-8	0-7	0-4	0-4	
Patients With No Physical Health Problems	43.5	4.4	17.6	53.1	68.2	
Blind or Hearing Impaired	4.8	22.0	11.5	2.8	0.0	
Incontinence - Urine or Feces	10.1	39.6	27.5	6.2	4.5	
Requiring Mobility Assistance	2.9	29.1	11.7	0.0	0.0	
Skilled Nursing Required	56.5	72.0	50.7	43.5	36.4	

### Most Frequent Physical Problems

<u>Adult MH</u>		<u>%</u>	Geriatric MH		<u>%</u>
a. b. c. d. e.	Obesity Tardive Dyskinesia Seizure Disorders Limited Vision Hypertension	12.2 11.7 9.3 7.7 6.0	a. b. c. d. c.	Other Circulatory Disorder Limited Vision Arthritis Hearing Impaired Organic Brain Syndrome	29.7 25.3 21.4 20.3 19.8
DD	-	<u>%</u>	For	rensic	<u>%</u>
a. b. c. d. e.	Speech Impaired Seizure Disorders Limited Vision Other Circulatory Disorder Tardive Dyskinesia	33.7 32.9 15.4 11.9 11.3	a. b. c. d. e.	Obesity Organic Brain Syndrome Limited Vision Other Circulatory Disorder Seizure Disorders	10.7 9.0 8.5 5.6 5.6
CD					

a.	Gastro-Intestinal Disorder	9.1
b.	Urogenital Disorder	9.1

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### TABLE 2A

### Physical Health Profile of Residents in Anoka-Metro RTC

### by Programs - June 1989

		<u>Programs</u>	
	Adult MH <u>Programs</u> (N=233)	Geriatric MH <u>Patients</u> (N=11)	CD <u>Programs</u> (N=4)
	<u>%</u>	<u>%</u>	<u>%</u>
Mean # of Physical Health Problems	0.5	1.7	0.5
Range of Physical Health Problems (Range = 0-25)	0-4	0-6	0-1
Patients With No Physical Health Problems	60.1	18.2	50.0
Blind or Hearing Impaired	2.6	0.0	0.0
Incontinence - Urine or Feces	7.3	36.4	0.0
Mobility Assistance Required	1.3	36.4	0.0
Skilled Nursing Required	47.6	72.7	50.0

### Most Frequent Physical Problems

<u>Adult MH</u>		<u>%</u>	<u>% Geriatric MH</u>		<u>%</u>	
a. b. c. d. e.	Pathological Water Drinking Tardive Dyskinesia Seizure Disorder Obesity Chronic Respiratory Disorder	8.6 7.7 5.6 5.2 4.3	a. b. c. d. e.	Diabetes Hypertension CVA - Stroke Other Circulatory Disorders Chronic Respiratory Dis.	27.3 27.3 18.2 18.2 18.2	
<u>CD</u>		<u>%</u>		ς.		
a. b.	Fracture, Current Huntingtons Disease	25.0 25.0				

#### Huntingtons Disease b. 25.0
#### TABLE 2B

## Physical Health Profile of Residents in Brainerd RHSC

## by Programs - June 1989

		Programs	
,	Adult MH <u>Programs</u> (N=87)	Geriatric MH <u>Patients</u> (N=3)	DD <u>Programs</u> (N=67)
	<u>%</u>	<u>%</u>	<u>%</u>
Mean # of Physical Health Problems	1.0	3.0	1.3
Range of Physical Health Problems (Range = 0-25)	0-4	0-5	0-3
Patients With No Physical Health Problems	35.6	33.3	7.5
Blind or Hearing Impaired	1.1	33.3	13.4
Incontinence - Urine or Feces	6.9	33.3	14.9
Mobility Assistance Required	0.0	66.7	9.0
Skilled Nursing Required	62.1	100.0	35.8

# Most Frequent Physical Problems

<u>Ad</u>	ult MH	<u>%</u>	<u>Geriatric MH</u>	
a.	Tardive Dyskinesia	21.8	a. Other Circulatory Disorders	66.7
b.	Obesity	17.2	b. Urogenital Disorder	66.7
c.	Seizure Disorder	5.7	-	
d.	Pathological Water		DD	<u>%</u>
	Drinking	5.7		
e.	Limited Vision	5.7	a. Speech Impairment	43.3
			b. Tardive Dyskensia	32.8
			c. Seizure Disorder	28.4
			d. Limited Vision	23.9
			c. Obesity	19.4

c. Obesity

### TABLE 2C

## Physical Health Profile of Residents in Fergus Falls RTC

# by Programs - June 1989

	Programs				
	Adult MH <u>Programs</u> (N=85)	Geriatric MH <u>Patients</u> (N=25)	DD <u>Programs</u> (N=26)	CD <u>Programs</u> (N=7)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Mean # of Physical Health Problems	1.2	3.0	0.7	0.1	
Range of Physical Health Problems Range = 0-25	0-9	0-8	0-2	0-1	
Patients With No Physical Health Problems	44.7	4.0	26.9	85.7	
Blind or Hearing Impaired	3.5	16.0	11.5	0.0	
Incontinence - Urine or Feces	8.2	48.0	38.5	0.0	
Mobility Assistance Required	8.2	32.0	7.7	0.0	
Skilled Nursing Procedures	56.5	80.0	50.0	42.9	

### Most Frequent Physical Problems

<u>Adult MH</u>	<u>%</u>	<u>Geriatric MH</u>	<u>%</u>
<ul> <li>a. Obesity</li> <li>b. Hypertension</li> <li>c. Seizure Disorder</li> <li>d. Tardive Dyskinesia</li> <li>e. Urogenital Disorder</li> </ul>	14.1 12.9 11.8 11.8 9.4	<ul> <li>a. Other Circulatory Disorders</li> <li>b. Tardive Dyskinesia</li> <li>c. Organic Brain Syndrome</li> <li>d. Seizure Disorder</li> <li>e. Hypertension</li> </ul>	36.0 32.0 32.0 24.0 24.0
DD	<u>%</u>	CD	<u>%</u>
<ul> <li>a. Speech Impaired</li> <li>b. Seizure Disorder</li> <li>c. Limited Vision</li> <li>d. Other Circulatory Dis.</li> <li>e. Obesity</li> </ul>	34.6 15.4 15.4 11.5 11.5	a. Hypertension	14.3

### TABLE 2D

## Physical Health Profile of Residents in Moose Lake RTC

# by Programs - June 1989

	Programs				
	Adult MH <u>Programs</u> (N=132)	Geriatric MH <u>Patients</u> (N=78)	DD <u>Programs</u> (N=10)	CD <u>Programs</u> (N=9)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Mean # of Physical Health Problems	1.3	2.9	1.7	0.6	
Range of Physical Health Problems Range = 0-25	0-9	0-7	0-4	0-4	
Patients With No Physical Health Problems	33.3	1.3	10.0	77.8	
Blind or Hearing Impaired	7.6	33.3	10.0	0.0	
Incontinence - Urine or Feces	18.2	42.3	30.0	11.1	
Mobility Assistance Required	7.6	32.1	10.0	0.0	
Skilled Nursing Required	58.3	67.9	90.0	22.2	

## Most Frequent Physical Problems

<u>Adu</u>	<u>lt_MH</u>	<u>%</u>	<u>Geriatric MH</u>	<u>%</u>
a.	Seizure Disorder	18.9	<ul> <li>a. Hearing Impaired</li> <li>b. Other Circulatory Disorder</li> <li>c. Arthritis</li> <li>d. Organic Brain Syndrome</li> <li>e. Seizure Disorder</li> </ul>	32.1
b.	Obesity	12.9		30.8
c.	Tardive Dyskinesia	12.9		28.2
d.	Limited Vision	10.6		26.9
e.	Other Circulatory Dis.	9.8		24.4
<u>DD</u>		<u>%</u>	<u>CD</u>	<u>%</u>
a.	Gastro-Intestinal Dis.	40.0	<ul> <li>a. Urogenital Disorder</li> <li>b. Arthritis</li> <li>c. Gastro-Intestinal Dis.</li> <li>d. Coronary Heart Disease</li> </ul>	22.2
b.	Hypertension	30.0		11.1
c.	Limited Vision	20.0		11.1
d.	Speech Impaired	20.0		11.1

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#### TABLE 2E

# Physical Health Profile of Residents in St. Peter RTC

# by Program - June 1989

			<u>Programs</u>		
	AdultGeriatricMHMHDDForentProgramsPatientsProgramsProgra(N=139)(N=22)(N=114)(N=114)				s CD <u>Programs</u> (N=2)
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Mean # of Physical Health Problems	0.7	2.1	1.0	0.7	1.5
Range of Physical Health Problems Range = 0-25	0-5	0-5	0-4	0-4	0-2
Patients With No Physical Health Problems	46.8	4.5	21.9	53.1	0.0
Blind or Hearing Impaired	10.1	13.6	7.9	2.8	0.0
Incontinence - Urine or Feces	7.9	36.4	13.2	6.2	0.0
Requiring Mobility Assistance	2.9	9.1	1.8	0.0	0.0
Skilled Nursing Required	42.4	81.8	50.0	43.5	50.0

### Most Frequent Physical Problems

<u>Adult MH</u>	<u>%</u>	<u>Geriatric MH</u>	<u>%</u>
<ul> <li>a. Pathological Water Drinking</li> <li>b. Obesity</li> <li>c. Gastro-Intestinal Disorder</li> <li>d. Tardive Dyskinesia</li> <li>e. Organic Brain Syndrome</li> </ul>	11.5 10.8 6.5 6.5 5.8	<ul> <li>a. Limited Vision</li> <li>b. Other Circulatory Disorders</li> <li>c. Diabetes</li> <li>d. Organic Brain Syndrome</li> <li>e. Hypertension</li> </ul>	40.9 22.7 18.2 18.2 13.6
DD	<u>%</u>	Forensic	<u>%</u>
<ul> <li>a. Seizure Disorder</li> <li>b. Limited Vision</li> <li>c. Other Circulatory Disorders</li> <li>d. Obesity</li> <li>e. Tardive Dyskinesia</li> </ul>	22.8 15.8 9.6 8.8 7.9	<ul> <li>a. Obesity</li> <li>b. Organic Brain Syndrome</li> <li>c. Limited Vision</li> <li>d. Other Circulatory Disorders</li> <li>e. Seizure Disorder</li> </ul>	10.7 9.0 8.5 5.6 5.6
CD			

a.	Diabetes	50.0
b.	Obesity	50.0
c.	Gastro-Intestinal Disorder	50.0

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### TABLE 2F

# Physical Health Profile of Residents in Willmar RTC

### by Programs - June 1989

		Programs	
	Adult MH <u>Programs</u> (N=229)	Geriatric MH <u>Patients</u> (N=43)	CD <u>Programs</u> (N=11)
	<u>%</u>	<u>%</u>	<u>%</u>
Mean # of Physical Health Problems	1.2	2.6	1.3
Range of Physical Health Problems (Range = 0-25)	0-6	0-6	0-3
Patients With No Physical Health Problems	33.2	4.7	27.3
Blind or Hearing Impaired	3.9	14.0	0.0
Incontinence - Urine or Feces	11.4	32.6	27.3
Mobility Assistance Required	0.9	27.9	0.0
Skilled Nursing Required	70.7	67.4	27.3

## Most Frequent Physical Problems

<u>Adu</u>	<u>lt MH</u>	<u>%</u>	<u>Ger</u>	iatric MH	<u>%</u>
a. b. c. d. c.	Obesity Limited Vision Tardive Dyskinesia Seizure Disorder Urogenital Disorder	17.0 15.3 14.4 11.4 9.2	a. b. c. d. e.	Limited Vision Other Circulatory Disorder Arthritis Hypertension Seizure Disorder	37.2 27.9 25.6 23.3 18.6
DD		<u>%</u>			
a. b. c. d.	Seizure Disorder Gastro-Intestinal Dis. Urogenital Disorder Tardive Dyskinesia	36.4 18.2 18.2 18.2			

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# TABLE 2G

# Physical Health Profile of Residents in Cambridge RHSC

# by Programs - June 1989

	<u>Programs</u>
	DD <u>Programs</u> (N=61)
	<u>%</u>
Mean # of Physical Health Problems	1.1
Range of Physical Health Problems (Range = 0-25)	0-3
Patients With No Physical Health Problems	26.2
Blind or Hearing Impaired	4.9
Incontinence - Urine or Feces	31.1
Mobility Assistance Required	1.6
Skilled Nursing Required	52.5

## Most Frequent Physical Problems

a.	Seizure Disorder	45.9
b.	Speech Impaired	19.7
c.	Tardive Dyskinesia	19.7
d.	Limited Vision	9.8
e.	Chronic Respiratory Disorder	6.6

## TABLE 2G

# Physical Health Profile of Residents in Cambridge RHSC

# by Programs - June 1989

	Programs
	DD <u>Programs</u> (N=61)
	<u>%</u>
Mean # of Physical Health Problems	1.1
Range of Physical Health Problems (Range = 0-25)	0-3
Patients With No Physical Health Problems	26.2
Blind or Hearing Impaired	4.9
Incontinence - Urine or Feces	31.1
Mobility Assistance Required	1.6
Skilled Nursing Required	52.5

### Most Frequent Physical Problems

a.	Seizure Disorder	45.9
b.	Speech Impaired	19.7
c.	Tardive Dyskinesia	19.7
d.	Limited Vision	9.8
e.	Chronic Respiratory Disorder	6.6

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## TABLE 2H

# Physical Health Profile of Residents in Faribault RC

# by Programs - June 1989

	<u>Programs</u>
	DD <u>Programs</u> (N=206)
	<u>%</u>
Mean # of Physical Health Problems	1.3
Range of Physical Health Problems (Range = 0-25)	0-7
Patients With No Physical Health Problems	14.6
Blind or Hearing Impaired	15.5
Incontinence - Urine or Feces	36.9
Mobility Assistance Required	22.3
Skilled Nursing Required	54.9

### Most Frequent Physical Problems

a.	Speech Impaired	39.8
b.	Seizure Disorder	39.8
c.	Other Circulatory Disorders	18.4
d.	Limited Vision	14.6
e.	Gastro-Intestinal Disorder	13.1

### TABLE 3

### Psychiatric Disability Profile of Residents in Minnesota Regional Centers by Program - June 1989

		~ • •	<u>Programs</u>			
	Adult MH <u>Programs</u> (N=905) <u>%</u>	Geriatric MH <u>Patients</u> (N=182) <u>%</u>	DD <u>Programs</u> (N=495) <u>%</u>	Forensic <u>Programs</u> (N=177) <u>%</u>	CD <u>Programs</u> (N=22) <u>%</u>	
Diagnosis						
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 0.6 0.3 6.2 66.3 20.1 3.0 12.4 11.5 2.9 11.7 0.8 0.9 11.2	0.0 2.2 0.5 31.9 51.1 14.3 3.3 7.7 0.5 4.4 4.4 0.0 1.1 11.5	0.0 0.2 2.2 21.8 14.1 8.7 0.8 0.2 91.3 10.1 2.8 4.0 45.9	0.6 0.0 4.0 6.8 62.1 7.3 1.7 18.6 22.6 4.5 32.2 0.6 1.7 28.2	$\begin{array}{c} 0.0\\ 0.0\\ 0.0\\ 22.7\\ 45.5\\ 0.0\\ 77.3\\ 36.4\\ 0.0\\ 18.2\\ 0.0\\ 0.0\\ 13.6\end{array}$	
Summary Scales						NYS Psychiatric <u>Centers</u>
Mean PSYSUM (Psychiatric Symptom Scale)	73.4	80.1	76.3	69.5	63.1	77.7
Range = 32-160 (≥ 70 = Hospital Appropriate)	33-134	41-127	40-122	39-123	34-86	32-160
Mean ADLS (Activities of Daily Living Scale)	12.0	23.3	20.5	9.9	8.6	16.7
Range = 8-49 (≥ 25 = Serious Disability)	8-46	8-46	8-46	8-22	8-13	8-48
Mean CADS (Community Activities Dysfunction Scale)	28.9	36.4	37.0	27.8	18.9	32.6
Range = 8-40 (≥ 28 = Serious Disability)	8-40	17-40	13-40	8-40	8-30	8-40

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### TABLE 3A

# Psychiatric Disability Profile of Residents in Anoka-Metro RTC

		<u>Programs</u>	
	Adult MH <u>Programs</u> (N=233)	Geriatric MH <u>Patients</u> (N=11)	CD <u>Programs</u> (N=4)
	<u>%</u>	<u>%</u>	<u>%</u>
Diagnosis			
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 0.0 0.4 4.7 67.0 24.5 1.7 15.9 27.9 1.3 9.9 0.0 1.7 9.0	0.0 0.0 18.2 72.7 9.1 0.0 9.1 0.0 0.0 0.0 0.0 0.0 0.0 9.1	$\begin{array}{c} 0.0\\ 0.0\\ 0.0\\ 0.0\\ 25.0\\ 0.0\\ 25.0\\ 0.0\\ 25.0\\ 0.0\\ 0.0\\ 0.0\\ 0.0\\ 75.0\\ \end{array}$
Summary Scales			
Mean PSYSUM (Psychiatric Symptom Scale) Range = 32-160	72.7 33-134	75.4 51-118	63.0 50-85
(≥ 70 = Hospital Appropriate)			
Mean ADLS (Activities of Daily Living Scale)	10.0	22.1	8.8
Range = 8-49 (≥ 25 = Serious Disability)	8-38	8-46	8-10
Mean CADS (Community Activities Dysfunction Scale)	27.4	33.6	18.0
Range = 8-40 (≥ 28 = Serious Disability)	8-40	20-40	12-29

## TABLE 3B

# Psychiatric Disability Profile of Residents in Brainerd RHSC

# by Programs - June 1989

		<u>Programs</u>	
	Adult MH <u>Programs</u> (N=87)	Geriatric MH <u>Patients</u> (N=3)	DD <u>Programs</u> (N=67)
	<u>%</u>	<u>%</u>	<u>%</u>
Diagnosis			
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 0.0 5.7 50.6 29.9 3.4 9.2 8.0 5.7 11.5 0.0 0.0 13.8	$\begin{array}{c} 0.0\\ 0.0\\ 0.0\\ 33.3\\ 0.0\\ 33.3\\ 33.3\\ 0.0\\ 0.0$	$\begin{array}{c} 0.0\\ 0.0\\ 0.0\\ 17.9\\ 6.0\\ 0.0\\ 0.0\\ 0.0\\ 97.0\\ 3.0\\ 1.5\\ 3.0\\ 74.6\end{array}$
Summary Scales			
Mean PSYSUM (Psychiatric Symptom Scale) Range = 32-160 (≥ 70 = Hospital Appropriate)	68.6 38-113	72.3 51-104	75.1 50-97
Mean ADLS (Activities of Daily Living Scale)	10.8	25.7	18.3
Range = 8-49 (≥ 25 = Serious Disability)	8-28	8-44	8-43
Mean CADS (Community Activities Dysfunction Scale)	26.9	34.7	37.3
Rang <b>e = 8-40</b> (≥ 28 = Serious Disability)	12-40	29-40	23-40

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## TABLE 3C

# Psychiatric Disability Profile of Residents in Fergus Falls RTC

	Programs				
	Adult MH <u>Programs</u> (N=85)	Geriatric MH <u>Patients</u> (N=25)	DD <u>Programs</u> (N=26)	CD <u>Programs</u> (N=7)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
<u>Diagnosis</u>					
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 1.2 0.0 9.4 52.9 25.9 3.5 8.2 5.9 2.4 18.8 0.0 2.4 14.1	$\begin{array}{c} 0.0\\ 0.0\\ 4.0\\ 24.0\\ 40.0\\ 20.0\\ 12.0\\ 0.0\\ 12.0\\ 8.0\\ 0.0\\ 0.0\\ 20.0\\ \end{array}$	0.0 0.0 3.8 26.9 26.9 15.4 0.0 0.0 0.0 3.8 0.0 7.7 19.2	$\begin{array}{c} 0.0\\ 0.0\\ 0.0\\ 14.3\\ 42.9\\ 0.0\\ 85.7\\ 71.4\\ 0.0\\ 42.9\\ 0.0\\ 0.0\\ 0.0\\ 0.0\\ 0.0\\ \end{array}$	
Summary Scales					
Mean PSYSUM (Psychiatric Symptom Scale) Range = 32-160 (> 70 = Hospital Appropriat	73.9 41-113 te)	80.2 47-108	75.7 44-115	70.6 59-86	
Mean ADLS (Activities of Daily Living Scale)	14.1	27.4	22.3	8.0	
Range = 8-49 (≥ 25 = Serious Disability)	8-41	8-46	8-45	8-8	
Mean CADS (Community Activ Dysfunction Scale)	vities 29.1	36.9	37.9	19.1	
Range = 8-40 (≥ 28 = Serious Disability)	15-40	19-40	24-40	8-30	

#### TABLE 3D

### Psychiatric Disability Profile of Residents in Moose Lake RTC

	<u>Programs</u>				
	Adult MH <u>Programs</u> (N=132)	Geriatric MH <u>Patients</u> (N=78)	DD <u>Programs</u> (N=10)	CD <u>Programs</u> (N=9)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Diagnosis					
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 0.0 15.2 70.5 18.2 3.8 15.2 3.8 15.2 3.8 3.8 6.8 0.0 0.0 11.4	0.0 2.6 0.0 38.5 53.8 14.1 1.3 12.8 0.0 3.8 1.3 0.0 0.0 6.4	0.0 0.0 0.0 80.0 40.0 10.0 10.0 10.0 10.0 0.0 0.0 0.0 0.0	$\begin{array}{c} 0.0\\ 0.0\\ 0.0\\ 44.4\\ 55.6\\ 0.0\\ 100.0\\ 22.2\\ 0.0\\ 0.0\\ 0.0\\ 0.0\\ 0.0\\ 0.0$	
Summary Scales					
Mean PSYSUM (Psychiatric Symptom Scale) Range = 32-160 (≥ 70 = Hospital Appropria	71.0 37-110 te)	81.2 41-127	80.7 58-112	60.2 45-82	
Mean ADLS (Activities of Daily Living Scale)	13.6	23.1	18.9	9.2	
Range = 8-49 (≥ 25 = Serious Disability)	8-46	8-46	11-43	8-13	
Mean CADS (Community Acti Dysfunction Scale)	vities 30.2	37.3	31.5	19.2	
Range = 8-40 (≥ 28 = Serious Disability)	14-40	17-40	23-40	11-29	

### TABLE 3F

# Psychiatric Disability Profile of Residents in Willmar RTC

		Programs	
	Adult MH <u>Programs</u> (N=229)	Geriatric MH <u>Patients</u> (N=43)	DD <u>Programs</u> (N=11)
	<u>%</u>	<u>%</u>	<u>%</u>
Diagnosis			
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 1.7 0.9 3.1 69.9 16.6 3.1 11.4 5.7 2.6 16.2 0.9 0.4 10.9	0.0 2.3 0.0 32.6 53.5 16.3 0.0 4.7 2.3 4.7 7.0 0.0 2.3 16.3	$\begin{array}{c} 0.0\\ 0.0\\ 9.1\\ 0.0\\ 45.5\\ 27.3\\ 18.2\\ 0.0\\ 0.0\\ 100.0\\ 0.0\\ 0.0\\ 0.0\\ 0.0\\ 0$
Summary Scales			
Mean PSYSUM (Psychiatric Symptom Scale Range = 32-160 (> 70 = Hospital Appropriate)	77.4 34-130	79.9 51-115	74.5 57-103
Mean ADLS (Activities of Daily Living Scale)	12.8	21.8	18.3
Range = 8-49 (≥ 25 = Serious Disability)	8-37	8-41	11-29
Mean CADS (Community Activities Dysfunction Scale)	31.4	36.7	37.5
Range = 8-40 (> 28 = Serious Disability)	8-40	19-40	28-40

# TABLE 3G

# Psychiatric Disability Profile of Residents in Cambridge RHSC

	<u>Programs</u>
	DD <u>Programs</u> (N=61)
	<u>%</u>
Diagnosis	
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 0.0 1.6 23.0 44.3 6.6 0.0 0.0 98.4 8.2 3.3 6.6 24.6
Summary Scales	ι.
Mean PSYSUM (Psychiatric Symptom Scale)	71.3
Range = 32-160 (≥ 70 = Hospital Appropriate)	47-99
Mean ADLS (Activities of Daily Living Scale)	19.8
Range = 8-49 (≥ 25 = Serious Disability)	8-42
Mean CADS (Community Activities Dysfunction Scale)	38.0
Range = 8-40 (> 28 = Serious Disability)	23-40

## TABLE 3H

# Psychiatric Disability Profile of Residents in Faribault RC

	Programs
	DD <u>Programs</u> (N=206)
	<u>%</u>
<u>Diagnosis</u>	
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - Other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 0.0 2.4 18.9 4.9 12.1 0.0 0.0 99.0 3.4 1.5 3.9 60.7
Summary Scales	
Mean PSYSUM (Psychiatric Symptom Scale)	78.7
Range = 32-160 (≥ 70 = Hospital Appropriate)	45-122
Mean ADLS (Activities of Daily Living Scale)	24.3
Range = 8-49 (≥ 25 = Serious Disability)	8-46
Mean CADS (Community Activities Dysfunction Scale)	38.1
Range = 8-40 (≥ 28 = Serious Disability)	13-40

#### TABLE 3E

## Psychiatric Disability Profile of Residents in St. Peter RTC

## by Program - June 1989

	A .J., 14	Casiataia	<u>Programs</u>		
	MH <u>Programs</u> (N=139) <u>%</u>	MH <u>Patients</u> (N=22) <u>%</u>	DD <u>Programs</u> (N=114) <u>%</u>	Forensic <u>Programs</u> (N=177) <u>%</u>	CD <u>Programs</u> (N=2) <u>%</u>
Diagnosis					
None or Deferred OBS - SUBS - Alcohol OBS - SUBS - Drugs OBS - other Schizophrenia Affective Psychosis Other Psychosis Alcohol Abuse Drug Abuse MR - DD Personality Disorder Impulse Condition Disorder Anxiety Disorder Other	0.0 0.0 3.6 73.4 10.8 3.6 10.1 6.5 3.6 7.9 3.6 0.7 11.5	0.0 4.5 0.0 22.7 45.5 4.5 4.5 4.5 0.0 0.0 4.5 0.0 4.5 13.6	0.0 0.0 3.5 20.2 13.2 6.1 2.6 0.0 89.5 30.7 7.0 3.5 27.2	0.6 0.0 4.0 6.8 62.1 7.3 1.7 18.6 22.6 4.5 32.2 0.6 1.7 28.2	$\begin{array}{c} 0.0\\ 0.0\\ 0.0\\ 0.0\\ 0.0\\ 50.0\\ 0.0\\ 0.0$
Summary Scales					
Mean PSYSUM (Psychiatric Symptom Scale)	72.8	80.5	75.2	69.5	50.5
Range = 32-160 (≥ 70 = Hospital Appropriate)	39-121	47-121	40-112	39-123	34-67
Mean ADLS (Activities of Daily Living Scale)	11.6	22.2	15.3	9.9	8.0
Range = 8-49 (≥ 25 = Serious Disability)	8-44	8-43	8-39	8-22	8-8
Mean CADS (Community Activities Dysfunction Scale)	27.5	34.0	34.6	27.8	18.5
Range = 8-40 (≥ 28 = Serious Disability)	8-40	26-40	17-40	8-40	18-19

## TABLE 4

# Violent Behavior Profile of Residents in Minnesota Regional Centers

			<u>Programs</u>		
	Adult MH <u>Programs</u> (N=905)	Geriatric MH <u>Patients</u> (N=182)	DD <u>Programs</u> (N=495)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=22)
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Violence to Others in Past 30 Days					
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	0.3 1.1 1.4 16.8 8.2	0.0 0.0 24.7 1.1	0.6 1.0 0.4 35.6 21.6	0.6 3.4 0.6 18.6 7.3	0.0 0.0 4.5 4.5 13.6
Any of the above violence to others in past 30 days	22.8	25.3	43.8	22.0	13.6
Been Otherwise Violent in past 30 days	13.9	9.9	14.7	10.2	0.0
Now Dangerous to Others	20.1	20.9	25.5	67.8	0.0
Violence to Self in Past 30 Days					
Attempted Suicide Talked About Killing Himself Deliberately Injured Self Been on Suicide Precaution	2.4 13.8 7.2 8.1	0.0 1.6 2.2 0.5	0.4 5.9 25.9 1.0	2.8 7.9 6.2 6.2	13.6 22.7 9.1 31.8
Any of the above violence to self in past 30 days	18.5	3.8	29.7	11.9	40.9
Now a Suicide Risk	10.2	0.5	4.0	6.2	18.2

#### TABLE 4A

## Violent Behavior Profile of Residents in Anoka-Metro RTC

	<u>Programs</u>					
	Adult MH <u>Programs</u> (N=233)	Geriatric MH <u>Patients</u> (N=11)	CD <u>Programs</u> (N=4)			
	<u>%</u>	<u>%</u>	<u>%</u>			
Violence to Others in Past 30 Days						
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	0.4 0.9 3.0 18.0 7.7	0.0 0.0 0.0 18.2 0.0	0.0 0.0 0.0 0.0 0.0			
Any of the above violence to others in past 30 days	24.5	18.2	0.0			
Been Otherwise Violent in past 30 days	11.2	0.0	0.0			
Now Dangerous to Others	19.7	9.1	0.0			
Violence to Self in Past 30 Days						
Attempted Suicide Talked About Killing Self Deliberately Injured Self Been on Suicide Precaution	2.1 11.2 7.7 5.2	0.0 0.0 9.1 0.0	0.0 0.0 0.0 0.0			
Any of the above violence to self in past 30 days	15.9	9.1	0.0			
Now a Suicide Risk	9.0	0.0	0.0			

### TABLE 4B

# Violent Behavior Profile of Residents in Brainerd RHSC

	Programs				
	Adult MH <u>Programs</u> (N=87)	Geriatric MH <u>Patients</u> (N=3)	DD <u>Programs</u> (N=67)		
	<u>%</u>	<u>%</u>	<u>%</u>		
Violence to Others in Past 30 Days					
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	0.0 0.0 0.0 24.1 9.2	0.0 0.0 0.0 33.3 0.0	3.0 0.0 1.5 20.9 29.9		
Any of the above violence to others in past 30 days	26.4	33.3	43.3		
Been Otherwise Violent in past 30 days	26.4	66.7	14.9		
Now Dangerous to Others	12.6	33.3	25.4		
Violence to Self in Past 30 Days					
Attempted Suicide Talked About Killing Self Deliberately Injured Self Been on Suicide Precaution	1.1 19.5 10.3 19.5	0.0 0.0 0.0 0.0	3.0 7.5 34.3 4.5		
Any to the above violence to self in past 30 days	28.7	0.0	38.8		
Now a Suicide Risk	11.5	0.0	7.5		

### TABLE 4C

## Violent Behavior Profile of Residents in Fergus Falls RTC

## by Programs - June 1989

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	Programs					
	Adult MH <u>Programs</u> (N=85)	Geriatric MH <u>Patients</u> (N=25)	DD <u>Programs</u> (N=26)	CD <u>Programs</u> (N=7)		
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>		
Violence to Others in Past 30 Days						
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	0.0 2.4 0.0 21.2 12.9	0.0 0.0 0.0 28.0 0.0	0.0 0.0 0.0 19.2 19.2	0.0 0.0 0.0 0.0 28.6		
Any of the above violence to others in past 30 days	30.6	28.0	30.8	28.6		
Been Otherwise Violent in past 30 days	14.1	8.0	3.8	0.0		
Now Dangerous to Others	20.0	20.0	3.8	0.0		
Violence to Self in Past 30 Days						
Attempted Suicide Talked About Killing Self Deliberately Injured Self Been on Suicide Precaution	3.5 16.5 4.7 14.1	0.0 4.0 0.0 4.0	0.0 3.8 19.2 0.0	28.6 14.3 14.3 28.6		
Any of the above violence to self in past 30 days	21.2	4.0	19.2	42.9		
Now a Suicide Risk	4.7	0.0	0.0	14.3		

## TABLE 4D

### Violent Behavior Profile of Residents in Moose Lake RTC

	Programs						
	Adult MH <u>Programs</u> (N=132)	Geriatric MH <u>Patients</u> (N=78)	DD <u>Programs</u> (N=10)	CD <u>Programs</u> (N=9)			
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>			
Violence to Others in Past 30 Days							
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	0.0 1.5 2.3 15.9 3.8	0.0 0.0 0.0 32.1 1.3	0.0 0.0 0.0 40.0 40.0	0.0 0.0 11.1 11.1 11.1			
Any of the above violence to others in past 30 days	18.9	32.1	60.0	11.1			
Been Otherwise Violent in past 30 days	12.9	15.4	20.0	0.0			
Now Dangerous to Others	24.2	20.5	30.0	0.0			
Violence to Self in Past 30 Days							
Attempted Suicide Talked About Killing Self Deliberately Injured Self Been on Suicide Precaution	1.5 11.4 4.5 6.8	0.0 2.6 1.3 0.0	0.0 0.0 50.0 0.0	11.1 33.3 11.1 55.6			
Any of the above violence to self in past 30 days	14.4	3.8	50.0	55.6			
Now a Suicide Risk	4.5	1.3	0.0	33.3			

### TABLE 4E

# Violent Behavior Profile of Residents in St. Peter RTC

## by Program - June 1989

	<u>Programs</u>					
	Adult MH <u>Programs</u> (N=139)	Geriatric MH <u>Patients</u> (N=22)	DD <u>Programs</u> (N=114)	DD Forensic <u>Programs</u> <u>Programs</u> (N=114) (N=177)		
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Violence to Others in Past 30 Days						
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	1.4 1.4 0.0 12.2 6.5	0.0 0.0 27.3 0.0	0.0 0.9 0.0 40.4 8.8	0.6 3.4 0.6 18.6 7.3	0.0 0.0 0.0 0.0 0.0	
Any of the above violence to others in past 30 days	17.3	27.3	43.9	22.0	0.0	
Been Otherwise Violent in past 30 days	8.6	0.0	14.9	10.2	0.0	
Now Dangerous to Others	14.4	9.1	43.9	67.8	0.0	
Violence to Self in Past 30 Days						
Attempted Suicide Talked About Killing Self Deliberately Injured Self Been on Suicide Precaution	1.4 10.8 5.0 3.6	0.0 0.0 0.0 0.0	0.0 13.2 12.3 1.8	2.8 7.9 6.2 6.2	0.0 50.0 0.0 0.0	
Any of the above violence to self in past 30 days		12.9	0.0	21.9	11.9	
Now a Suicide Risk	3.6	0.0	6.1	6.2	0.0	

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## TABLE 4F

# Violent Behavior Profile of Residents in Willmar RTC

	Programs					
	Adult MH <u>Programs</u> (N=229)	Geriatric MH <u>Patients</u> (N=43)	DD <u>Programs</u> (N=11)			
	<u>%</u>	<u>%</u>	<u>%</u>			
Violence to Others in Past 30 Days						
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	0.0 0.9 1.3 14.4 10.0	0.0 0.0 9.3 2.3	0.0 0.0 0.0 45.5 9.1			
Any of the above violence to others in past 30 days	22.3	11.6	45.5			
Been Otherwise Violent in past 30 days	15.7	4.7	9.1			
Now Dangerous to Others	24.5	30.2	0.0			
Violence to Self in Past 30 Days						
Attempted Suicide Talked About Killing Self Deliberately Injured Self Been on Suicide Precaution	3.9 16.6 9.2 7.9	0.0 0.0 4.7 0.0	0.0 0.0 27.3 0.0			
Any of the above violence to self in past 30 days	21.8	4.7	27.3			
Now a Suicide Risk	20.1	0.0	0.0			

## TABLE 4G

# Violent Behavior Profile of Residents in Cambridge RHSC

## by Programs - June 1989

	<u>Programs</u>
	DD <u>Programs</u> (N=61)
	<u>%</u>
Violence to Others in Past 30 Days	
Tried to Kill Someone Sexually Assaulted Someone Set a Fire Physically Assaulted Someone Destroyed Furniture / Property	0.0 0.0 0.0 37.7 21.3
Any of the above violence to others in past 30 days	44.3
Been Otherwise Violent in past 30 days	21.3
Now Dangerous to Others	3.3
Violence to Self in Past 30 Days	
Attempted Suicide Talked About Killing Self Deliberately Injured Self Been on Suicide Precaution	0.0 0.0 39.3 0.0
Any of the above violence to self in past 30 days	39.3
Now a Suicide Risk	0.0

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## TABLE 5

# Use of Emergency Interventions in Minnesota Regional Centers

	Programs				
	Adult MH <u>Programs</u> (N=905)	Geriatric MH <u>Patients</u> (N=182)	DD <u>Programs</u> (N=495)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=22)
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
In Last 30 Days:					
Emergency Psychiatric Meds Only	2.2	5.5	0.2	7.9	0.0
Seclusion or Restraint Only	8.3	3.3	9.5	9.0	0.0
1-1 Supervision Only	8.4	1.1	6.1	3.4	9.1
Emergency Meds and Seclusion/ Restraint	1.7	0.0	0.0	3.4	0.0
Emergency Meds and 1-1 Supervision	0.8	0.0	0.4	0.6	0.0
Seclusion/Restraint and 1-1 Supervision	4.0	0.0	5.7	4.0	0.0
Emergency Meds, 1-1 Supervision, and Seclusion/Restraint	1.2	0.0	0.2	0.0	0.0
None	73.4	90.1	77. <del>9</del>	71.7	90.9
TOTAL	100.0	100.0	100.0	100.0	100.0

### TABLE 5A

## Use of Emergency Interventions in Anoka-Metro RTC

### by Programs - June 1989

	Programs				
	Adult MH <u>Programs</u> (N=233)	Geriatric MH <u>Patients</u> (N=11)	CD <u>Programs</u> (N=4)		
	<u>%</u>	<u>%</u>	<u>%</u>		
<u>In Last 30 Days</u> :					
Emergency Psychiatric Meds Only	2.1	0.0	0.0		
Seclusion or Restraint Only	10.7	9.1	0.0		
1-1 Supervision Only	7.3	0.0	0.0		
Emergency Meds and Seclusion Restraint	3.4	0.0	0.0		
Emergency Meds and 1-1 Supervision	0.9	0.0	0.0		
Seclusion/Restraint and 1-1 Supervision	5.6	0.0	0.0		
Emergency Meds, 1-1 Supervision, and Seclusion/Restraint	1.7	0.0	0.0		
None	68.3	90.9	100.0		
TOTAL	100.0	100.0	100.0		

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### TABLE 5B

## Use of Emergency Interventions in Brainerd RHSC

	Programs					
	Adult MH <u>Programs</u> (N=87)	Geriatric MH <u>Patients</u> (N=3)	DD <u>Programs</u> (N=67)			
	<u>%</u>	<u>%</u>	<u>%</u>			
In Last 30 Days:						
Emergency Psychiatric Meds Only	1.1	0.0	0.0			
Seclusion or Restraint Only	13.8	33.4	13.4			
1-1 Supervision Only	6.9	33.3	7.5			
Emergency Meds and Seclusion Restraint	4.6	0.0	0.0			
Emergency Meds and 1-1 Supervision	0.0	0.0	0.0			
Seclusion/Restraint and 1-1 Supervision	4.6	0.0	14.9			
Emergency Meds, 1-1 Supervision, and Seclusion/Restraint	2.3	0.0	0.0			
None	66.7	33.3	64.2			
TOTAL	100.0	100.0	100.0			

### TABLE 5C

# Use of Emergency Interventions in Fergus Falls RTC

	Programs					
	Adult MH <u>Programs</u> (N=85)	Geriatric MH <u>Patients</u> (N=25)	DD <u>Programs</u> (N=26)	CD <u>Programs</u> (N=7)		
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>		
<u>In Last 30 Days</u> :		•				
Emergency Psychiatric Meds Only	2.4	4.0	0.0	0.0		
Seclusion or Restraint Only	17.6	8.0	0.0	0.0		
1-1 Supervision Only	5.9	4.0	3.8	28.6		
Emergency Meds and Seclusion/ Restraint	0.0	0.0	0.0	0.0		
Emergency Meds and 1-1 Supervision	2.4	0.0	0.0	0.0		
Seclusion/Restraint and 1-1 Supervision	1.1	0.0	0.0	0.0		
Emergency Meds, 1-1 Supervision, and Seclusion/Restraint	2.4	0.0	0.0	0.0		
None	68.2	84.0	96.2	71.4		
TOTAL	100.0	100.0	100.0	100.0		

### TABLE 5D

# Use of Emergency Interventions in Moose Lake RTC

# by Programs - June 1989

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	Programs					
	Adult MH <u>Programs</u> (N=132)	Geriatric MH <u>Patients</u> (N=78)	DD <u>Programs</u> (N=10)	CD <u>Programs</u> (N=9)		
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>		
<u>In Last 30 Days</u> :						
Emergency Psychiatric Meds Only	6.1	10.3	0.0	0.0		
Seclusion or Restraint Only	5.3	2.6	0.0	0.0		
1-1 Supervision Only	3.0	0.0	10.0	0.0		
Emergency Meds and Seclusion/ Restraint	1.5	0.0	0.0	0.0		
Emergency Meds and 1-1 Supervision	0.0	0.0	0.0	0.0		
Seclusion/Restraint and 1-1 Supervision	0.0	0.0	10.0	0.0		
Emergency Meds, 1-1 Supervision, and Seclusion/Restraint	0.8	0.0	0.0	0.0		
None	83.3	87.2	80.0	100.0		
TOTAL	100.0	100.0	100.0	100.0		

## TABLE 5E

# Use of Emergency Interventions in St. Peter RTC

	Programs				
	Adult MH <u>Programs</u> (N=139)	Geriatric MH <u>Patients</u> (N=22)	DD <u>Programs</u> (N=114)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=2)
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
<u>In Last 30 Days</u> :					
Emergency Psychiatric Meds Only	1.4	0.0	0.0	7.9	0.0
Seclusion or Restraint Only	5.0	0.0	14.0	9.0	0.0
1-1 Supervision Only	2.9	0.0	7.0	3.4	0.0
Emergency Meds and Seclusion/ Restraint	0.0	0.0	0.0	3.4	0.0
Emergency Meds and 1-1 Supervision	0.7	0.0	0.0	0.5	0.0
Seclusion/Restraint and 1-1 Supervision	0.0	0.0	0.0	0.0	0.0
Emergency Meds, 1-1 Supervision, and Seclusion/Restraint	5.0	0.0	7.0	4.0	0.0
None	85.0	100.0	72.0	71.8	100.0
TOTAL	100.0	100.0	100.0	100.0	100.0

## TABLE 5F

# Use of Emergency Interventions in Willmar RTC

	Programs					
	Adult MH <u>Programs</u> (N=229)	Geriatric MH <u>Patients</u> (N=43)	DD <u>Programs</u> (N=11)			
	<u>%</u>	<u>%</u>	<u>%</u>			
In Last 30 Days:						
Emergency Psychiatric Meds Only	0.9	2.3	0.0			
Seclusion or Restraint Only	3.9	0.0	27.3			
1-1 Supervision Only	17.9	0.0	0.0			
Emergency Meds and Seclusion/ Restraint	0.4	0.0	0.0			
Emergency Meds and 1-1 Supervision	0.9	0.0	0.0			
Seclusion/Restraint and 1-1 Supervision	4.8	0.0	0.0			
Emergency Meds, 1-1 Supervision, and Seclusion/Restraint	0.9	0.0	0.0			
None	70.3	97.7	72.7			
TOTAL	100.0	100.0	100.0			

## TABLE 5G

# Use of Emergency Interventions

# in Cambridge RHSC

# by Programs - June 1989

	<u>Programs</u>
	DD <u>Programs</u> (N=61)
	<u>%</u>
In Last 30 Days:	
Emergency Psychiatric Meds Only	0.0
Seclusion or Restraint Only	11.5
1-1 Supervision Only	0.0
Emergency Meds and Seclusion/Restraint	0.0
Emergency Meds and 1-1 Supervision	0.0
Seclusion/Restraint and 1-1 Supervision	1.6
Emergency Meds, 1-1 Supervision and Seclusion/Restraint	1.6
None	85.3

TOTAL

100.0

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# TABLE 5H

## Use of Emergency Interventions

# of Residents in Faribault RC

	<u>Programs</u>
	DD <u>Programs</u> (N=206)
	<u>%</u>
In Last 30 Days:	
Emergency Psychiatric Meds Only	0.5
Seclusion or Restraint Only	5.8
1-1 Supervision Only	7.3
Emergency Meds and Seclusion/Restraint	0.0
Emergency Meds and 1-1 Supervision	1.0
Seclusion/Restraint and 1-1 Supervision	3.9
Emergency Meds, 1-1 Supervision and Seclusion/Restraint	0.0
None	81.6
TOTAL	100.0

### TABLE 6

## Psychiatric Medications Profile of Residents in Minnesota Regional Centers

#### by Program - June 1989

	Programs				
,	Adult MH <u>Programs</u> (N=905)	Geriatric MH <u>Patients</u> (N=182)	DD <u>Programs</u> (N=495)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=22)
Current Medication*	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Anticonvulsants	25.5	38.5	25.0	33.0	0.0
	23.5	50.5	23.9	55.7	0.0
Antidepressants	16.6	17.6	8.5	15.8	31.8
Antianxiety	19.9	25.3	10.5	9.0	13.6
Neuroleptics	83.0	69.2	53.1	76.8	50.0
Sedatives / Hypnotics	2.3	1.1	1.0	0.0	0.0
None of these	8.0	10.4	29.3	15.3	13.6
<u>Circumstance of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>					
Voluntarily	70.1	65.0	35.9	42.5	94.7
Under Consent of Guardian	13.8	28.8	83.7	20.5	0.0
Under Emergency TRP Approval	3.5	0.6	0.0	3.4	0.0
Under Court Order	19.8	22.5	0.3	41.1	0.0
Refusing Meds Pending Court Review	2.2	0.0	0.3	0.0	5.3
Judicial / Administrative Roles					
Request for Jarvis Hearing	29.9	30.8	0.4	42.9	. 0.0
Request to Appoint Guardian Ad Litem	25.6	38.5	1.8	32.2	0.0
Request for TRP	32.4	41.2	0.8	46.3	0.0

\* Patients may have been receiving more than one type of medication under more than one legal circumstance, so percentages add to more than 100%.

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#### TABLE 6

# Psychiatric Medications Profile of Residents in Minnesota Regional Centers

#### by Program - June 1989

	Programs				
	Adult MH <u>Programs</u> (N=905)	Geriatric MH <u>Patients</u> (N=182)	DD <u>Programs</u> (N=495)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=22)
Current Medication*	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Anticonvulsants	25.5	38.5	25.9	33.9	0.0
Antidepressants	16.6	17.6	8.5	15.8	31.8
Antianxiety	19.9	25.3	10.5	9.0	13.6
Neuroleptics	83.0	69.2	53.1	76.8	50.0
Sedatives / Hypnotics	2.3	1.1	1.0	0.0	0.0
None of these	8.0	10.4	29.3	15.3	13.6
<u>Circumstance of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>					
Voluntarily	70.1	65.0	35.9	42.5	94.7
Under Consent of Guardian	13.8	28.8	83.7	20.5	0.0
Under Emergency TRP Approval	3.5	0.6	0.0	3.4	0.0
Under Court Order	19.8	22.5	0.3	41.1	0.0
Refusing Meds Pending Court Review	2.2	0.0	0.3	0.0	5.3
<u>Judicial / Administrative Roles</u>					
Request for Jarvis Hearing	29.9	30.8	0.4	42.9	. 0.0
Request to Appoint Guardian Ad Litem	25.6	38.5	1.8	32.2	0.0
Request for TRP	32.4	41.2	0.8	46.3	0.0

\* Patients may have been receiving more than one type of medication under more than one legal circumstance, so percentages add to more than 100%.
#### TABLE 6A

# Psychiatric Medications Profile of Residents in Anoka-Metro RTC

	Programs			
	Adult MH <u>Programs</u> (N=233)	Geriatric MH <u>Patients</u> (N=11)	CD <u>Programs</u> (N=4)	
	<u>%</u>	<u>%</u>	<u>%</u>	
Current Medication				
Anticonvulsants	27.0	18.2	0.0	
Antidepressants	13.3	9.1	25.0	
Antianxiety	25.3	9.1	25.0	
Neuroleptics	85.8	72.7	50.0	
Sedatives / Hypnotics	3.9	0.0	0.0	
None of these	5.2	9.1	25.0	
<u>Circumstances of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>				
Voluntarily	70.9	80.0	100.0	
Under Consent of Guardian	13.2	10.0	0.0	
Under Emergency TRP Approval	4.1	0.0	0.0	
Under Court Order	18.6	10.0	0.0	
Refusing Meds Pending Court Review	1.8	0.0	0.0	
Judicial / Administrative Roles				
Request for Jarvis Hearing	30.5	45.5	0.0	
Request to Appoint Guardian Ad Litem	35.2	54.5	0.0	
Request for TRP	36.5	18.2	0.0	

# TABLE 6B

# Psychiatric Medications Profile of Residents in Brainerd RHSC

	Programs			
	Adult MH <u>Programs</u> (N=87)	Geriatric MH <u>Patients</u> (N=3)	DD <u>Programs</u> (N=67)	
	<u>%</u>	<u>%</u>	<u>%</u>	
Current Medication				
Anticonvulsants	10.3	0.0	19.4	
Antidepressants	6.9	33.3	6.0	
Antianxiety	8.0	33.3	9.0	
Neuroleptics	69.0	0.0	41.8	
Sedatives / Hypnotics	1.1	0.0	0.0	
None of these	26.4	66.7	40.3	
<u>Circumstances of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>				
Voluntarily	38.1	100.0	19.4	
Under Consent of Guardian	20.6	0.0	77.8	
Under Emergency TRP Approval	6.3	0.0	0.0	
Under Court Order	38.1	0.0	2.8	
Refusing Meds Pending Court Review	0.0	0.0	0.0	
Judicial / Administrative Roles				
Request for Jarvis Hearing	47.1	33.3	3.0	
Request to Appoint Guardian Ad Litem	35.6	33.3	6.0	
Request for TRP	42.5	33.3	4.5	

# TABLE 6C

# Psychiatric Medications Profile of Residents in Fergus Falls RTC

	Programs				
	Adult MH <u>Programs</u> (N=85)	Geriatric MH <u>Patients</u> (N=25)	DD <u>Programs</u> (N=26)	CD <u>Programs</u> (N=7)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Current Medication		٠			
Anticonvulsants	25.9	48.0	15.4	0.0	
Antidepressants	30.6	12.0	15.4	42.9	
Antianxiety	10.6	12.0	3.8	28.6	
Neuroleptics	77.6	64.0	80.8	28.6	
Sedatives / Hypnotics	1.2	0.0	0.0	0.0	
None of these	5.9	20.0	7.7	14.3	
<u>Circumstances of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>					
Voluntarily	83.5	90.0	91.7	100.0	
Under Consent of Guardian	17.7	10.0	100.0	0.0	
Under Emergency TRP Approva	6.3	0.0	0.0	0.0	
Under Court Order	13.9	20.0	0.0	0.0	
Refusing Meds Pending Court Review	1.3	0.0	0.0	0.0	
Judicial / Administrative Roles					
Request for Jarvis Hearing	24.7	36.0	0.0	0.0	
Request for Appoint Guardian Ad Litem	40.0	60.0	0.0	0.0	
Request for TRP	32.9	32.0	0.0	0.0	

# TABLE 6D

# Psychiatric Medications Profile of Residents in Moose Lake RTC

	Programs				
	AdultGeriatricMHMHDDProgramsPatientsPrograms(N=132)(N=78)(N=10)		DD <u>Programs</u> (N=10)	CD <u>ms Programs</u> ) (N=9)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Current Medication					
Anticonvulsants	42.4	48.7	10.0	0.0	
Antidepressants	15.2	15.4	10.0	22.2	
Antianxiety	24.2	30.8	0.0	0.0	
Neuroleptics	78.0	66.7	80.0	77,8	
Sedatives / Hypnotics	4.5	2.6	0.0	0.0	
None of these	4.5	6.4	20.0	0.0	
<u>Circumstances of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>					
Voluntarily	79.7	61.4	0.0	88.9	
Under Consent of Guardian	20.3	35.7	100.0	0.0	
Under Emergency TRP Approva	1 2.4	1.4	0.0	. 0.0	
Under Court Order	8.9	21.4	0.0	0.0	
Refusing Meds Pending Court Review	2.4	0.0	0.0	11.1	
Judicial / Administrative Roles					
Request for Jarvis Hearing	16.7	32.1	0.0	0.0	
Request for Appoint Guardian Ad Litem	23.5	46.2	0.0	0.0	
Request for TRP	28.8	50.0	0.0	0.0	

#### TABLE 6E

# Psychiatric Medications Profile of Residents in St. Peter RTC

		<u>Programs</u>		
Adult MH <u>Programs</u> (N=139)	Geriatric MH <u>Patients</u> (N=22)	DD <u>Programs</u> (N=114)	Forensic <u>Programs</u> (N=177)	CD <u>Programs</u> (N=2)
<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
16.5	13.6	23.7	33.9	0.0
10.8	18.2	15.8	15.8	50.0
29.5	31.8	20.2	9.0	0.0
82.0	72.7	57.9	76.8	0.0
1.4	0.0	2.6	0.0	0.0
12.9	4.5	22.8	15.3	50.0
58.9	47.6	20.2	42.5	100.0
13.7	33.3	78.7	20.5	0.0
4.8	0.0	0.0	3.4	0.0
25.0	23.8	0.0	41.1	0.0
2.4	0.0	1.1	0.0	0.0
36.0	18.2	0.0	42.9	0.0
18.0	22.7	1.8	32.2	0.0
20.1	18.2	0.9	46.3	0.0
	Adult MH Programs (N=139) % 16.5 10.8 29.5 82.0 1.4 12.9 58.9 13.7 4.8 25.0 2.4 36.0 18.0 20.1	Adult MH Programs (N=139)Geriatric MH Patients (N=22)	Adult MH ProgramsGeriatric MH Patients (N=139)DD Programs (N=114)%%%16.513.623.710.818.215.829.531.820.282.072.757.91.40.02.612.94.522.858.947.620.213.733.378.74.80.00.025.023.80.02.40.01.136.018.20.018.022.71.820.118.20.9	Adult MH Programs (N=139) Geriatric MH Patients (N=22) DD programs (N=114) Forensic Programs (N=177)   % % % %   16.5 13.6 23.7 33.9   10.8 18.2 15.8 15.8   29.5 31.8 20.2 9.0   82.0 72.7 57.9 76.8   1.4 0.0 2.6 0.0   12.9 4.5 22.8 15.3   58.9 47.6 20.2 42.5   13.7 33.3 78.7 20.5   4.8 0.0 0.0 3.4   25.0 23.8 0.0 41.1   2.4 0.0 1.1 0.0   36.0 18.2 0.0 42.9   18.0 22.7 1.8 32.2   20.1 18.2 0.9 46.3

# TABLE 6F

# Psychiatric Medications Profile of Residents in Willmar RTC

	Programs			
	Adult MH <u>Programs</u> (N=229)	Geriatric MH <u>Patients</u> (N=43)	DD <u>Programs</u> (N=11)	
	<u>%</u>	<u>%</u>	<u>%</u>	
Current Medication				
Anticonvulsants	25.3	34.9	27.3	
Antidepressants	22.7	25.6	27.3	
Antianxiety	14.0	23.3	9.1	
Neuroleptics	90. <b>8</b>	79.1	81.8	
Sedatives / Hypnotics	0.9	0.0	0.0	
None of these	3.5	11.6	0.0	
<u>Circumstances of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>				
Voluntarily	74.5	63.2	0.0	
Under Consent of Guardian	7.3	28.9	100.0	
Under Emergency TRP Approval	0.9	0.0	0.0	
Under Court Order	20.9	28.9	0.0	
Refusing Meds Pending Court Review	3.2	0.0	0.0	
Judicial / Administrative Roles				
Request for Jarvis Hearing	28.8	27.9	0.0	
Request to Appoint Guardian Ad Litem	12.7	16.3	0.0	
Request for TRP	33.6	48.8	0.0	

# TABLE 6G

# Psychiatric Medications Profile of Residents in Cambridge RHSC

# by Programs - June 1989

	Programs
	DD <u>Programs</u> (N=61)
	<u>%</u>
Current Medication	
Anticonvulsants	49.2
Antidepressants	6.6
Antianxiety	4.9
Neuroleptics	77.0
Sedatives / Hypnotics	0.0
None of these	13.1
<u>Circumstances of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>	
Voluntarily	94.3
Under Consent of Guardian	90.6
Under Emergency TRP Approval	0.0
Under Court Order	0.0
Refusing Meds Pending Court Review	0.0
Judicial / Administrative Roles	
Request for Jarvis Hearing	0.0
Request to Appoint Guardian Ad Litem	4.9
Request for TRP	0.0

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# TABLE 6H

# Psychiatric Medications Profile of Residents in Fariabult RC

	<u>Programs</u>
	DD <u>Programs</u> (N=206)
	<u>%</u>
Current Medication	
Anticonvulsants	24.3
Antidepressants	3.9
Antianxiety	8.7
Neuroleptics	40.8
Sedatives / Hypnotics	1.0
None of these	38.8
<u>Circumstances of Psychiatric</u> <u>Med Use of Those Currently</u> <u>Receiving Medication</u>	
Voluntarily	21.1
Under Consent of Guardian	80.5
Under Emergency TRP Approval	0.0
Under Court Order	0.0
Refusing Meds Pending Court Review	0.0
Judicial / Administrative Roles	
Request for Jarvis Hearing	0.0
Request to Appoint Guardian Ad Litem	0.0
Request for TRP	0.0

# TABLE 7

# Case Management Status of Residents in Minnesota Regional Centers

# by Program - June 1989

	Programs				
	Adult MH <u>Programs</u> (N=905)	Geriatric MH <u>Patients</u> (N=182)	DD <u>Programs</u> (N=495)	Forensic <u>Programs</u> (N=177)	
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	
Does the client currently have a county mental health or mental retardation case manager?					
Yes	57.3	51.1	81.4	48.0	
No	12.4	10.4	18.4	28.8	
No Information	30.3	38.5	0.2	23.2	
Total	100.0	100.0	100.0	100.0	
If Yes, has the case manager met with the staff about the client?	(N=519)	(N=93)	(N=403)	(N=85)	
Yes	85.0	88.2	98.8	91.8	
No	9.6	4.3	0.7	8.2	
No Information	5.4	7.5	0.5	0.0	
Total	100.0	100.0	100.0	100.0	

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# TABLE 7A

# Case Management Status of Residents in Anoka-Metro RTC

Programs		
Adult MH <u>Programs</u> (N=233)	Geriatric MH <u>Patients</u> (N=11)	
<u>%</u>	<u>%</u>	
90.1	54.5	
6.0	36.4	
3.9	9.1	
100.0	100.0	
(N=202)	(N=6)	
86.7	50.0	
6.2	0.0	
7.1	50.0	
100.0	100.0	
	Progr Adult MH Programs (N=233) % 90.1 6.0 3.9 100.0 (N=202) 86.7 6.2 7.1 100.0	

#### TABLE 7B

# Case Management Status of Residents in Brainerd RHSC

# by Programs - June 1989

		Programs	
	Adult MH <u>Programs</u> (N=87)	Geriatric MH <u>Patients</u> (N=3)	DD <u>Programs</u> (N=67)
	<u>%</u>	<u>%</u>	<u>%</u>
Does the client currently have a county mental health or mental retardation case manager?			
Yes	6.9	0.0	11.9
No	64.4	66.7	86.6
No Information	28.7	33.3	1.5
Total	100.0	100.0	100.0
If Yes, has the case manager met with the staff about the client?	(N=6)	(N=0)	(N=8)
Yes	66.7	0.0	100.0
No	16.7	0.0	0.0
No Information	16.7	0.0	0.0
Total	100.0	0.0	100.0

# TABLE 7C

# Case Management Status of Residents in Fergus Falls RTC

	Programs			
	Adult MH <u>Programs</u> (N=85)	Geriatric MH <u>Patients</u> (N=25)	DD <u>Programs</u> (N=26)	
	<u>%</u>	<u>%</u>	<u>%</u>	
Does the client currently have a county mental health or mental retardation case manager?				
Yes	88.2	92.0	0.0	
No	4.7	4.0	100.0	
No Information	7.1	4.0	0.0	
Total	100.0	100.0	100.0	
If Yes, has the case manager met with the staff about the client?	(N=75)	(N=23)	(N=0)	
Yes	86.7	95.7	0.0	
No	12.0	4.3	0.0	
No Information	1.3	0.0	0.0	
Total	100.0	100.0	0.0	

#### TABLE 7D

#### Case Management Status of Residents in Moose Lake RTC

#### by Programs - June 1989

	Adult MH <u>Programs</u> (N=132)	Geriatric MH <u>Patients</u> (N=78)	DD <u>Programs</u> (N=10)
	<u>%</u>	<u>%</u>	<u>%</u>
Does the client currently have a county mental health or mental retardation case manager	?		
Yes	77.3	59.0	100.0
No	3.0	12.8	0.0
No Information	19.7	28.2	0.0
Total	100.0	100.0	100.0
If Yes, has the case manager met with the staff about the client?	(N=102)	(N=46)	(N=10)
Yes	92.2	89.1	100.0
No	6.9	4.3	0.0
No Information	1.0	6.5	0.0
Total	100.0	100.0	100.0

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# TABLE 7E

# Case Management Status of Residents in St. Peter RTC

# by Program - June 1989

	Programs							
	Adult MH <u>Programs</u> (N=139)	Geriatric MH <u>Patients</u> (N=22)	DD <u>Programs</u> (N=114)	Forensic <u>Programs</u> (N=177)				
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>				
Does the client currently have a county mental health or mental retardation case manager?		·						
Yes	76.3	77.3	100.0	48.0				
No	3.6	9.1	0.0	28.8				
No Information	20.1	13.6	0.0	23.2				
Total	100.0	100.0	100.0	100.0				
If Yes, has the case manager met with the staff about the client?	(N=106)	(N=17)	(N=114)	(N=85)				
Yes	72.6	88.2	97.4	91.8				
No	17.9	5.9	0.0	8.2				
No Information	9.4	5.9	2.6	0.0				
Total	100.0	100.0	100.0	100.0				

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# TABLE 7F

# Case Management Status of Residents in Willmar RTC

# by Programs - June 1989

	Programs						
	Adult MH <u>Programs</u> (N=229)	Geriatric MH <u>Patients</u> (N=43)	DD <u>Programs</u> (N=11)				
	<u>%</u>	<u>%</u>	<u>%</u>				
Does the client currently have a county mental health or mental retardation case manager?							
Yes	8.7	2.3	100.0				
No	12.7	0.0	0.0				
No Information	78.6	97.7	0.0				
Total	100.0	100.0	100.0				
If Yes, has the case manager met with the staff about the client?	(N=20)	(N=1)	(N=11)				
Yes	95.0	100.0	100.0				
No	5.0	0.0	0.0				
No Information	0.0	0.0	0.0				
Total	100.0	100.0	100.0				

# TABLE 7G

# Case Management Status of Residents in Cambridge RHSC

# by Programs - June 1989

	<u>Programs</u>
	DD <u>Programs</u> (N=61)
	<u>%</u>
Does the client currently have a county mental health or mental retardation case manager?	
Yes	95.1
No	4.9
No Information	0.0
Total	100.0
If Yes, has the case manager met with the staff about the client?	(N=58)
Yes	100.0
No	0.0
No Information	0.0
Total	100.0

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# TABLE 7H

# Case Management Status of Residents in Faribault RC

	Programs
	DD <u>Programs</u> (N=206)
	<u>%</u>
Does the client currently have a county mental health or mental retardation case manager?	
Yes	98.1
No	1.9
No Information	0.0
Total	100.0
If Yes, has the case manager met with the staff about the client?	(N=202)
Yes	99.0
No	0.0
No Information	1.0
Total	100.0

# Table 8

### Statistical Determination of Community - Appropriate RTC Patients by Facility - June 1989

	<u>Community - Appropriate</u>		<u>Hospital - Appropriate</u>		
Anoka - Metro RTC Brainerd RHSC	67 31	19.8 9.2	181 126	12.5 8.7	
Fergus Falls RTC Moose Lake RTC St. Peter RTC	23 42 90	6.8 12.4 26.6	120 187 364	8.3 13.0 25.2	
Willmar RTC Cambridge RHSC Fanbault RC	47 8 30	13.9 2.4 8.9	236 53	16.4 3.7	
Total	338	100.0	1443	100.0	

#### TABLE 9

# Community Appropriateness: Statistical Determinations Compared to Clinical Assessments for Residents in Minnesota Regional Treatment Center

#### by Programs - June 1989

### ADULT MH PROGRAMS

#### Statistical Determinations

	Staff	<b>A</b>			u <del>yy</del> usur <sup>a</sup> yo y soo			
Is patient now appropriate for placement into community?	Assessment	<u>Comr</u> N	<u>nunity</u> <u>%</u>	<u>Hos</u> <u>N</u>	<u>%</u>			
Definitely Yes	83	57	27.4	26	3.7			
Probably Yes	156	60	28.8	96	13.8			
Possibly	154	39	18.8	115	16.5			
Probably No	181	33	15.9	148	21.2			
Definitely No	331	19	9.1	312	44.8			
Total	905	208	100.0	697	100.0			

#### **GERIATRIC MH PATIENTS**

		Statistical Determinations					
Is patient now appropriate for placement into community	Staff <u>AssessmentCommunity</u>	<u>Hos</u> N	<u>pital</u> <u>%</u>	N	<u>%</u>		
Definitely Yes	12	5	15.6	7	4.7		
Probably Yes	13	4	12.5	9	6.0		
Possibly	31	8	25.0	23	15.5		
Probably No	49	11	34.4	38	25.5		
Definitely No	76	4	12.5	72	48.3		
Total	181	32	100.0	149	100.0		

# TABLE 9 (continued)

# Community Appropriateness: Statistical Determinations Compared to Clinical Assessments

# for Residents in Minnesota Regional Treatment Center

#### by Programs - June 1989

### DD PROGRAMS

Statistical Determinations

	Staff <u>Assessment</u>	Comr	<u>nunity</u>	<u>Hospital</u>		
Is patient now appropriate for placement into community?		<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	
Definitely Yes	22	9	13.0	13	3.1	
Probably Yes	72	17	24.6	55	12.9	
Possibly	190	22	31.9	168	39.4	
Probably No	124	12	17.4	112	26.3	
Definitely No	87	9	13.1	78	18.3	
Total	495	69	100.0	426	100.0	

#### FORENSIC PATIENTS

		Statistical Determinations						
Is patient now appropriate for placement into community?	Staff <u>Assessment</u>	<u>Comr</u> <u>N</u>	<u>nunity</u> <u>%</u>	<u>Hos</u> N	<u>pital</u> <u>%</u>			
Definitely Yes	2	2	8.7	0	0.0			
Probably Yes	12	3	13.0	8	5.2			
Possibly	22	5	21.8	17	11.0			
Probably No	46	10	43.5	36	23.4			
Definitely No	96	3	13.0	93	60.4			
Total	177	23	100.0	154	100.0			

# TABLE 9 (continued)

# Community Appropriateness: Statistical Determinations Compared to Clinical Assessment for Residents in Minnesota Regional Treatment Center

# by Programs - June 1989

#### CD PROGRAMS

# Statistical Determinations

	Staff	Com		Homital		
Is patient now appropriate for placement into community?	Assessment	<u>Com</u>	<u>%</u>	<u>N</u>	<u>%</u>	
Definitely Yes	5	4	66.6	1	6.3	
Probably Yes	5	0	0.0	5	31.3	
Possibly	5	1	16.7	4	25.0	
Probably No	4	1	16.7	3	18.7	
Definitely No	3	0	0.0	3	18.7	
Total	22	6	100.0	16	100.0	

#### TABLE 10 A

#### Length of Stay of Adult MH & Geriatric MH Patients

#### in Minnesota Regional Treatment Centers by Age: June 1989

							AGE								
Length of Stay	<u>18</u>	<u>- 20</u>	<u>21</u>	- 34	<u>35</u>	- 44	<u>45</u>	- 64	<u>6</u>	<u>5 - 74</u>	<u>75</u>	or More	Ī	otal	
	N	x	N	ž	N	X	N	X	N	X	N	x	N	X	
< 90 day <b>s</b>	15	68.2	152	42.6	92	36.8	64	23.2	19	17.4	16	21.9	35	19.2	
90 days - 2 years	7	31.8	148	41.5	100	40.0	109	39.5	32	29.4	11	15.1	43	23.6	
2 - 5 years	0	0.0	44	12.3	29	11.6	43	15.6	11	10.1	8	11.0	19	10.4	68
6 - 10 <del>yea</del> rs	0	0.0	12	3.4	21	8.4	29	10.5	24	22.0	16	21.9	40	22.0	
11 years or more	0	0.0	1	0.2	9	3.2	31	11.2	23	21.1	22	30.1	45	24.8	
Total	22	100.0	357	100.0	250	100.0	276	100.0	109	100.0	73	100.0	182	100.0	

#### TABLE 10B

#### Number of Patients and Proportion With Case Managers for Each County

#### by Program

	PROGRAMS Adult Mu Conjectio Mu DD Expensio CD Total												
	<u>Adul t</u>	MH	Geriatr	ic MH	Ĩ	<u>ac</u>	For	ensic		CD	<u>To</u>	<u>Total</u>	
County of Financial <u>Responsibili</u>	N EY	X	N	X	N	<u>x</u>	N	X	. <u>N</u>	X	N	X	
Aitkin	5	0.0	0	0.0	2	0.0	0	0.0	0	0.0	7	0.0	
Anoka	30	66.7	1	0.0	8	87.5	8	25.0	0	0.0	47	61.7	
Becker	10	80.0	0	0.0	0	0.0	1	0.0	0	0.0	11	72.7	
Beltrami	3	0.0	1	100.0	6	33.3	4	75.0	0	0.0	14	42.9	
Benton	9	11.1	2	0.0	1	0.0	1	100.0	1	0.0	14	14.3	
Big Stone	2	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	0.0	
Blue Earth	23	82.6	3	33.3	12	100.0	4	100.0	0	0.0	42	85.7	
Brown	7	85.7	6	66.7	11	100.0	3	33.3	0	0.0	27	81.5	
Carlton	8	62.5	7	57.1	3	66.7	0	0.0	0	0.0	18	61.1	
Carver	4	50.0	0	0.0	6	100.0	0	0.0	0	0.0	10	80.0	
Cass	10	30.0	0	0.0	6	16.7	1	100.0	0	0.0	17	29.4	
Chippewa	1	0.0	1	0.0	0	0.0	0	0.0	0	0.0	2	0.0	
Chisago	6	83.3	2	50.0	1	100.0	0	0.0	0	0.0	9	77.8	
Clay	14	92.9	2	100.0	2	50.0	0	0.0	2	100.0	20	90.0	
Clearwater	2	50.0	0	0.0	1	0.0	0.0	0	0.0	3	33.3		

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#### Number of Patients and Proportion With Case Managers for Each County

#### by Program

	PROGRAMS												
	<u>Adult</u> N	<u>MH</u> %	<u>Geriatr</u> N	<u>ic MH</u>	<u>DI</u> N	<u>×</u>	<u>For</u> e	ensic X	<u>9</u> <u>N</u>	<u>.D</u> <u>x</u>	<u>To</u> <u>N</u>	<u>ital</u>	
County of Financial <u>Responsibilit</u>	_ <u>ty</u>	-	-	-	_	_							
Cook	2	50.0	0	0.0	2	100.0	0	0.0	0	0.0	4	75.0	
Cottonwood	4	25.0	4	0.0	3	100.0	1	100.0	0	0.0	12	41.7	
Crow Wing	19	15.8	5	20.0	5	0.0	3	0.0	0	0.0	32	12.5	
Dakota	9	66.7	2	50.0	17	100.0	7	28.6	4	50.0	39	71.8	
Dodge	2	50.0	0	0.0	1	100.0	0	0.0	0	0.0	3	66.7	
Douglas	11	54.5	3	100.0	3	0.0	1	100.0	0	0.0	18	55.6	
Faribault	2	100.0	2	100.0	5	100.0	0	0.0	0	0.0	9	100.0	
Fillmore	1	0.0	0	0.0	7	85.7	0	0.0	0	0.0	8	75.0	
Freeborn	2	50.0	3	66.7	7	100.0	2	50.0	0	0.0	14	78.6	
Goodhue	2	100.0	1	100.0	5	100.0	2	50.0	1	0.0	11	81.8	
Grant	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	
Hennepin	225	62.4	20	40.0	162	93.8	63	46.0	4	50.0	504	69.4	
Houston	3	0.0	1	0.0	3	100.0	0	0.0	0	0.0	7	42.9	
Hubbard	6	0.0	0	0.0	1	0.0	0	0.0	0	0.0	7	0.0	
Isanti	3	66.7	0	0.0	0	0.0	0	0.0	1	0.0	4	50.0	
Itaska	9	77.8	5	20.0	3	33.3	5	60.0	0	0.0	22	54.5	

#### Number of Patients and Proportion With Case Managers for Each County

#### by Program

	PROGRAMS Achilt MH Geniatric MH DD Forensic CD Total													
	<u>Adult</u>	<u>MH</u>	Geriat	ric MH	D	D	For	ensic	<u>0</u>	<u>.D</u>	Ic	otal		
	N	X	N	<u>×</u>	N	<u>×</u>	<u>N</u>	<u>×</u>	<u>N</u> .	<u>×</u>	<u>N</u>	x		
County of Fina <u>Responsibility</u>	ncial													
Jackson	0	0.0	4	0.0	0	0.0	0	0.0	0	0.0	4	0.0		
Kanabec	1	100.0	1	0.0	1	100.0	0	0.0	0	0.0	3	66.7		
Kandiyohi	17	35.3	2	0.0	0	0.0	0	0.0	0	0.0	19	31.6		
Kittson	0	0.0	0	0.0	1	0.0	0	0.0	0	0.0	1	0.0		
Koochiching	3	100.0	2	50.0	2	0.0	0	0.0	0	0.0	7	57.1		
Lac qui Parle	3	0.0	2	0.0	0	0.0	0	0.0	0	0.0	5	0.0		
Lake	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0	1	100.0		
Lake of the Woods	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0		
LeSeuer	6	83.3	1	100.0	6	100.0	1	100.0	1	0.0	15	86.7		
Lincoln	1	100.0	1	0.0	0	0.0	0	0.0	0	0.0	2	50.0		
Lyon	3	0.0	2	0.0	1	100.0	0	0.0	0	0.0	6	16.7		
McLeod	6	50.0	3	0.0	2	100.0	1	0.0	0	0.0	12	41.7		
Mahnomen	1	100.0	0	0.0	1	0.0	0	0.0	0	0.0	2	50.0		
Marshall	3	100.0	0	0.0	0	0.0	0	0.0	0	0.0	3	100.0		
Martin	2	50.0	4	50.0	7	100.0	1	100.0	0	0.0	14	78.6		
Meeker	5	0.0	1	0.0	2	100.0	1	100.0	0	0.0	9	33.3		

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#### Number of Patients and Proportion With Case Managers for Each County

#### by Program

	<u>PROGRAMS</u> Actult MH Geriatric MH DD Forensic <u>CD Total</u>													
	<u>Adul t</u>	: MH	<u>Geriatr</u>	ic MH	DD	•	Fore	nsic	<u>CD</u>		Tot	tal		
County of Financial <u>Responsibilit</u>	N N	X	N	X	N	<u>x</u>	N	X	N	X	N	<u>×</u>		
Mille Lacs	4	75.0	0	0.0	0	0.0	0	0.0	0	0.0	4	75.0		
Morrison	7	0.0	0	0.0	8	25.0	0	0.0	0	0.0	15	13.3		
Mower	7	57.1	0	0.0	8	100.0	0	0.0	0	0.0	15	80.0		
Murray	3	33.3	1	0.0	1	100.0	0	0.0	0	0.0	5	40.0		
Nicollet	10	90.0	2	100.0	5	100.0	2	0.0	0	0.0	19	84.2		
Nobles	3	0.0	1	0.0	1	100.0	0	0.0	0	0.0	5	20.0		
Norman	3	66.7	2	50.0	0	0.0	1	100.0	0	0.0	6	66.7		
Olmsted	26	61.5	7	42.9	9	88.9	3	66.7	0	0.0	45	64.4		
Otter Tail	18	88.9	12	91.7	7	14.3	1	0.0	2	0.0	40	70.0		
Pennington	2	100.0	1	100.0	1	0.0	0	0.0	0	0.0	4	75.0		
Pine	4	75.0	4	25.0	1	100.0	1	0.0	1	0.0	11	45.5		
Pipestone	1	0.0	0	0.0	1	100.0	0	0.0	0	0.0	2	50.0		
Polk	6	83.3	2	100.0	2	0.0	1	0.0	1	0.0	12	58.3		
Роре	1	100.0	2	100.0	2	0.0	0	0.0	0	0.0	5	66.0		
Ramsey	112	51.8	9	44.4	56	92.9	25	52.0	1	0.0	203	62.6		
Red Lake	1	100.0	0	0.0	1	0.0	0	0.0	0	0.0	2	50.0		

#### Number of Patients and Proportion With Case Managers for Each County

#### by Program

	PROGRAMS													
	<u>Adul t</u>	<u>t MH</u>	Geriatr	ic MH	DD	2	Fore	ensic	<u>CD</u>		Tota	al		
County of Financial Responsibili	<u>N</u>	<u>x</u>	N	X	N	X	N	ž	N	<u>×</u>	N	X		
Redwood	7	0.0	1	0.0	2	50.0	0	0.0	0	0.0	10	10.0		
Renville	7	14.3	1	0.0	0	0.0	0	0.0	0	0.0	8	12.5		
Rice	7	57.1	1	0.0	9	100.0	2	0.0	0	0.0	19	68.4		
Rock	2	0.0	1	0.0	1	100.0	0	0.0	0	0.0	4	25.0		
Roseau	1	100.0	0	0.0	4	0.0	0	0.0	0	0.0	5	20.0		
St. Louis	64	87.5	29	96.6	16	50.0	9	33.3	2	0.0	120	79.2		
Scott	8	12.5	0	0.0	8	100.0	0	0.0	0	0.0	16	56.3		
Sherburne	5	60.0	0	0.0	2	100.0	2	100.0	0	0.0	9	77.8		
Sibley	3	0.0	0	0.0	2	100.0	0	0.0	0	0.0	5	40.0		
Stearns	28	14.3	2	0.0	7	14.3	4	25.0	0	0.0	41	14.6		
Steele	7	85.7	0	0.0	5	100.0	1	100.0	0	0.0	13	92.3		
Stevens	2	100.0	0	0.0	0	0.0	0	0.0	0	0.0	2	100.0		
Swift	2	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	0.0		
Todd	1	100.Q	0	0.0	3	0.0	0	0.0	0	0.0	4	25.0		
Traverse	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0	1	0.0		
Wabasha	2	100.0	1	0.0	1	100.0	0	0.0	0	0.0	4	75.0		

#### Number of Patients and Proportion With Case Managers for Each County

#### by Program

	PROGRAMS													
	<u>Adul 1</u>	t MH	<u>Geriatr</u>	ic MH	DD	!	Foren	sic	CD	,	<u>Total</u>			
County of Financial <u>Responsibilit</u>	N Y	ž	<u>N</u>	×	<u>N</u>	X	N	X	<u>N</u>	<u>×</u>	N	<u>×</u>		
Wadena	3	0.0	0	0.0	2	0.0	0	0.0	1	0.0	6	0.0		
Waseca	2	100.0	1	0.0	0	0.0	0	0.0	0	0.0	3	66.7		
Washington	6	100.0	0	0.0	7	85.7	9	77.8	0	0.0	22	86.4		
Watonwan	2	100.0	1	100.0	2	100.0	0	0.0	0	0.0	5	100.0		
Wilkin	5	100.0	1	100.0	2	0.0	3	66.7	0	0.0	11	72.7		
Winona	6	50.0	1	0.0	9	100.0	2	0.0	0	0.0	18	66.7		
Wright	9	11.1	1	0.0	3	100.0	0	0.0	0	0.0	13	30.8		
Yellow Medicine	1	0.0	3	0.0	0	0.0	0	0.0	0	0.0	4	0.0		

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#### TABLE 10B-1

#### County of Financial Responsibility for Anoka-Metro RTC

#### by Program - June 1989

#### PROGRAMS

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County of Financial Responsibility	Adul	Adult MH		<u>Geriatric MH</u>		CD		
Responsibility	N	<u>×</u>	N	<u>×</u>	N	x	N	X
Anoka	23	9.9	1	9.1	0	0.0	24	9.7
Benton	1	0.4	0	0.0	0	0.0	1	0.4
Dakota	7	3.0	1	9.1	2	50.0	10	4.0
Hennepin	141	60.5	7	63.6	2	50.0	150	60.5
Ramsey	53	22.7	2	18.2	0	0.0	55	22.2
Sherburne	3	1.3	0	0.0	0	0.0	3	1.2
Stearns	2	0.9	0	0.0	0	0.0	2	0.8
Washington	3	1.3	0	0.0	0	0.0	3	1.2
Total	233	100.0	11	100.0	4	100.0	248	100.0

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#### TABLE 10B-2

#### County of Financial Responsibility for Brainerd RHSC

#### by Program - June 1989

#### PROGRAMS

County of Financial	Adul	t MH	<u>Geriat</u>	ric MH	DD		<u>Tota</u>	<u>ı</u>
Financial <u>Responsibility</u>	N	<u>x</u>	N	<u>×</u>	<u>N</u>	<u>x</u>	N	x
Aitkin	5	5.7	0	0.0	2	3.0	7	4.5
Anoka	1	1.1	0	0.0	1	1.5	2	1.3
Beltrami	2	2.4	0	0.0	5	7.5	7	4.5
Benton	6	6.9	0	0.0	1	1.5	7	4.5
Carlton	0	0.0	0	0.0	1	1.5	1	0.6
Cass	8	9.2	0	0.0	6	8.9	14	8.9
Clay	0	0.0	0	0.0	1	1.5	1	0.6
Clearwater	1	1.1	0	0.0	1	1.5	2	1.3
Cook	0	0.0	0	0.0	2	3.0	2	1.3
Crow Wing	18	20.7	3	100.0	5	7.5	26	16.6
Dakota	1	1.1	0	0.0	0	0.0	1	0.6
Fillmore	0	0.0	0	0.0	1	1.5	1	0.6
Hennepin	16	18.4	0	0.0	8	11.9	24	15.3
Hubbard	6	6.9	0	0.0	1	1.5	7	4.5
Itaska	0	0.0	0	0.0	2	3.0	2	1.3
Koochiching	0	0.0	0	0.0	2	3.0	2	1.3

#### County of Financial Responsibility for Brainerd RHSC

#### by Program - June 1989

#### PROGRAMS

<b>County</b> of Financial	Adul	Adult MH		ric MH	DD	•	<u>Total</u>		
Responsibility	N	<u>×</u>	N	<u>×</u>	N	X	<u>N</u>	<u>x</u>	
Lake of the Woods	1	1.1	0	0.0	0	0.0	1	0.6	
Morrison	7	8.0	0	0.0	6	8.9	13	8.3	
Pine	1	1.1	0	0.0	0	0.0	1	0.6	
Ramsey	5	5.7	0	0.0	3	4.5	8	5.0	
St. Louis	2	2.4	0	0.0	8	11.9	10	6.4	
Sherburne	2	2.4	0	0.0	0	0.0	2	1.3	
\$tearns	2	2.4	0	0.0	6	8.9	8	5.0	
Todd	0	0.0	0	0.0	3	4.5	3	1.9	
Wadena	3	3.4	0	0.0	2	3.0	5	3.2	
Tabal	67	100.0	7	100.0	47	100.0	157	100.0	
IULAL	0/	100.0	2	100.0	07	100.0	זכו	100.0	

#### TABLE 10B-3

#### County of Financial Responsibility for Fergus Falls RTC

#### by Program - June 1989

PROGRAMS

County of	Adul	<u>: MH</u>	<u>Geriatr</u>	ic MH	DI	<u>D</u>	<u> </u>	D	<u>1</u> 0	otal
Financial <u>Responsibility</u>	N	X	N	X	N	<u>×</u>	N	<u>×</u>	<u>N</u>	X
Anoka	1	1.2	0	0.0	0	0.0	0	0.0	1	0.7
Becker	10	11.8	0	0.0	0	0.0	0	0.0	10	7.0
Clay	14	16.4	2	8.0	1	3.8	2	28.6	19	13.3
Clearwater	1	1.2	0	0.0	0	0.0	0	0.0	1	0.7
Douglas	8	9.4	3	12.0	3	11.5	0	0.0	14	9.8
Hennepin	4	4.6	0	0.0	1	3.8	0	0.0	5	3.5
Isanti	0	0.0	0	0.0	0	0.0	1	14.3	1	0.7
Kittson	0	0.0	0	0.0	1	3.8	0	0.0	1	0.7
Mahnomen	1	1.2	0	0.0	1	3.8	0	0.0	2	1.4
Marshall	3	3.5	0	0.0	0	0.0	0	0.0	3	2.1
Norman	3	3.5	2	8.0	0	0.0	0	0.0	5	3.5
Otter Tail	17	20.0	12	48.0	6	23.1	2	28.6	37	25.9
Pennington	2	2.4	1	4.0	1	3.8	0	0.0	4	2.8
Polk	6	7.1	2	8.0	2	7.8	1	14.3	11	7.7
Pone	1	1.2	2	8.0	2	7.8	0	0.0	5	3.5
Ramsev	4	4.6	0	0.0	0	0.0	0	0.0	4	2.8

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#### County of Financial Responsibility for Fergus Falls RTC

#### by Program - June 1989

	PROGRAMS										
County of	<u>Adul t</u>	мн	<u>Geriatr</u>	ic MH	DD	<u>!</u>	CD		Tota	al	
Responsibility	N	X	N	X	N	X	N	X	N	X	
Red Lake	1	1.2	0	0.0	1	3.8	0	0.0	2	1.4	
Redwood	0	0.0	0	0.0	1	3.8	0	0.0	1	0.7	
Roseau	1	1.2	0	0.0	4	15.4	0	0.0	5	3.5	
Stevens	2	2.4	0	0.0	0	0.0	0	0.0	2	1.4	
Todd	1	1.2	0	0.0	0	0.0	0	0.0	1	0.7	
Wadena	0	0.0	0	0.0	0	0.0	1	14.3	1	0.7	
Wilkin	5	5.9	1	4.0	2	7.8	0	0.0	8	5.8	
Total	85	100.0	z	100.0	26	100.0	7	100.0	143	100.0	

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#### TABLE 108-4

#### County of Financial Responsibility for Moose Lake RTC

					PROGR	AMS				
County of Financial <u>Responsibility</u>	<u>Adul t</u>	MH	<u>Geriatri</u>	c MH	DD		CD		Tota	<u>it</u>
Financial <u>Responsibility</u>	N	X	<u>N</u>	<u>×</u>	N	X	N	<u>×</u>	N	X
Beltrami	1	0.8	1	1.3	0	0.0	0	0.0	2	0.9
Benton	0	0.0	0	0.0	0	0.0	1	11.1	1	0.4
Brown	0	0.0	1	1.3	0	0.0	0	0.0	1	0.4
Carlton	8	6.1	7	9.0	1	10.0	0	0.0	16	7.0
Cass	2	1.5	0	0.0	0	0.0	0	0.0	2	0.9
Chisago	6	4.4	2	2.6	0	0.0	0	0.0	8	3.6
Cook	2	1.5	0	0.0	0	0.0	0	0.0	2	0.9
Crow Wing	1	0.8	2	2.6	0	0.0	0	0.0	3	1.3
Dakota	0	0.0	1	1.3	0	0.0	2	22.2	3	1.3
Freeborn	0	0.0	2	2.6	0	0.0	0	0.0	2	0.9
Goodhue	1	0.8	0	0.0	0	0.0	0	0.0	1	0.4
Hennepin	18	13.6	6	7.7	0	0.0	2	22.2	26	11.4
Houston	0	0.0	1	1.3	0	0.0	0	0.0	1	0.4
Isanti	3	2.3	0	0.0	0	0.0	0	0.0	3	1.3
Itaska	, 9	6.8	5	6.3	0	0.0	0	0.0	14	6.1
Kanabec	1	0.8	1	1.3	0	0.0	0	0.0	2	0.9

#### County of Financial Responsibility for Moose Lake RTC

#### by Program - June 1989

PROGRAMS

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County of	Adult MH		<u>Geriatric MH</u>		DI	DD		CD		<u>Total</u>	
Responsibility	N	X	N	X	<u>N</u>	<u>×</u>	<u>N</u>	<u>×</u>	N	X	
Koochiching	3	2.3	2	2.6	0	0.0	0	0.0	5	2.2	
Lake	0	0.0	0	0.0	1	10.0	0	0.0	1	0.4	
Martin	0	0.0	1	1.3	0	0.0	0	0.0	1	0.4	
Mille Lacs	3	2.3	0	0.0	0	0.0	0	0.0	3	1.3	
Olmsted	2	1.5	5	6.3	0	0.0	0	0.0	7	3.1	
Pine	3	2.3	4	5.1	0	0.0	1	11.1	8	3.6	
Ramsey	6	4.4	5	6.3	0	0.0	1	11.1	12	5.2	
Rice	0	0.0	1	1.3	0	0.0	0	0.0	1	0.4	
St. Louis	61	46.2	29	37.2	8	80.0	2	22.2	100	43.7	
Wabasha	0	0.0	1	1.3	0	0.0	0	0.0	1	0.4	
Waseca	0	0.0	1	1.3	0	0.0	0	0.0	1	0.4	
Washington	1	0.8	0	0.0	0	0.0	0	0.0	1	0.4	
Winona	1	0.8	0	0.0	0	0.0	0	0.0	1	0.4	
Total	132	100.0	78	100.0	10	100.0	9	100.0	229	100.0	

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#### TABLE 10B-5

#### County of Financial Responsibility for St. Peter RTC

#### by Program - June 1989

#### PROGRAMS

County of Financial <u>Responsib.</u>	Adult MH		<u>Geriatric MH</u>		DD	DD		Forensic		CD		<u>Total</u>	
	<u>N</u>	X	<u>N</u>	X	<u>N</u>	X	<u>N</u>	X	N	X	N	X	
Anoka	1	0.7	0	0.0	3	2.6	8	4.5	0	0.0	12	2.6	
Becker	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	
Beltrami	0	0.0	0	0.0	0	0.0	4	2.3	0	0.0	4	0.9	
Benton	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	
Blue Earth	23	16.5	2	9.5	10	8.8	4	2.3	0	0.0	39	8.6	
Brown	7	5.1	4	18.9	7	6.1	3	1.7	0	0.0	21	4.6	
Carver	2	1.4	0	0.0	3	2.6	0	0.0	0	0.0	5	1.1	
Cass	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	
Cottonwood	1	0.7	0	0.0	1	0.9	1	0.6	0	0.0	3	0.7	
Crow Wing	0	0.0	0	0.0	0	0.0	3	1.7	0	0.0	3	0.7	
Dakota	0	0.0	0	0.0	1	0.9	7	4.0	0	0.0	8	1.9	
Dodge	2	1.4	0	0.0	0	0.0	0	0.0	0	0.0	2	0.4	
Douglas	1	0.7	0	0.0	0	0.0	1	0.6	0	0.0	2	0.4	
Faribault	2	1.4	2	9.5	5	4.3	0	0.0	0	0.0	9	2.0	
Fillmore	1	0.7	0	0.0	0	0.0	0	0.0	0	0.0	1	0.2	
Freeborn	2	1.4	1	4.8	5	4.3	2	1.0	0	0.0	10	2.2	
### TABLE 108-5 (continued)

# County of Financial Responsibility for St. Peter RTC

### by Program - June 1989

#### PROGRAMS

County of	Adult MH		<u>Geriatric MH</u>		DD		Forens	Forensic		<u>CD</u>		<u>Total</u>	
Responsib.	N	X	<u>N</u>	X	N	X	N	X	N	X	N	X	
Goodhue	1	0.7	1	4.8	3	2.6	2	1.0	1	50.0	8	1.9	
Hennepin	9	6.5	0	0.0	24	21.1	63	35.6	0	0.0	96	21.2	
Houston	3	2.2	0	0.0	0	0.0	0	0.0	0	0.0	3	0.7	
Itaska	0	0.0	0	0.0	1	0.9	5	2.8	0	0.0	6	1.3	
LeSeuer	6	4.4	1	4.8	5	4.3	1	0.6	1	50.0	14	3.1	
McLeod	0	0.0	0	0.0	1	0.9	1	0.6	0	0.0	2	0.4	
Martin	2	1.4	3	14.3	6	5.3	1	0.6	0	0.0	12	2.6	
Neeker	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	
Mille Lacs	1	0.7	0	0.0	0	0.0	0	0.0	0	0.0	1	0.2	
Mower	7	5.1	0	0.0	3	2.6	0	0.0	0	0.0	10	2.2	
Nicollet	10	7.2	2	9.5	3	2.6	2	1.0	0	0.0	17	3.8	
Nobles	1	0.7	0	0.0	0	0.0	0	0.0	0	0.0	1	0.2	
Norman	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	
Olmsted	21	15.1	2	9.5	2	1.8	3	1.7	0	0.0	28	6.2	
Otter Tail	1	0.7	0	0.0	1	0.9	1	0.6	0	0.0	3	0.7	
Pine	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	

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### TABLE 10B-5 (continued)

# County of Financial Responsibility for St. Peter RTC

#### by Program - June 1989

#### PROGRAMS

County of	Adult MH		<u>Geriatr</u>	<u>Geriatric MH</u>		DD		Forensic		CD		<u>Total</u>	
Financial <u>Responsib.</u>	N	<u>x</u>	N	X	N	X	N	<u>x</u>	<u>N</u>	X	<u>N</u>	X	
Polk	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	
Ramsey	5	3.7	1	4.8	14	12.3	25	14.1	0	0.0	45	9.9	
Rice	7	5.1	0	0.0	1	0.9	2	1.0	0	0.0	10	2.2	
St. Louis	1	0.7	0	0.0	0	0.0	9	5.1	0	0.0	10	2.2	
Scott	1	0.7	0	0.0	7	6.1	0	0.0	0	0.0	8	1.9	
Sherburne	0	0.0	0	0.0	0	0.0	2	1.1	0	0.0	2	0.4	
Sibley	0	0.0	0	0.0	2	1.8	0	0.0	0	0.0	2	0.4	
Stearns	0	0.0	0	0.0	0	0.0	4	2.3	0	0.0	4	0.9	
Steele	7	5.1	0	0.0	1	0.9	1	0.6	0	0.0	9	2.0	
Traverse	0	0.0	0	0.0	0	0.0	1	0.6	0	0.0	1	0.2	
Wabasha	2	1.4	0	0.0	1	0.9	0	0.0	0	0.0	3	0.7	
Waseca	2	1.4	0	0.0	0	0.0	0	0.0	0	0.0	2	0.4	
Washington	2	1.4	0	0.0	1	0.9	9	5.1	0	0.0	12	2.6	
Watonwan	2	1.4	1	4.8	2	1.8	0	0.0	0	0.0	5	1.1	
Wilkin	0	0.0	0	0.0	0	0.0	3	1.7	0	0.0	3	0.7	
Winona	5	3.7	1	4.8	1	0.9	2	1.0	0	0.0	9	2.0	
Yellow Medicin	e 1	0.7	0	0.0	0	0.0	0	0.0	0	0.0	1	0.2	
Total	139	100.0	21	100.0	114	100.0	177	100.0	2	100.0	453	100.0	

### TABLE 108-6

# County of Financial Responsibility for Willmar RTC

#### by Program - June 1989

#### PROGRAMS

County of		Adult MH	<u>Geria</u>	tric MH	DD			<u>Total</u>
Responsibility	N	<u>×</u>	N	<u>x</u>	N	<u>×</u>	· !	<u> </u>
Anoka	4	1.7	0	0.0	0	0.0		<b>4</b> 1.4
Benton	2	0.9	2	4.7	0	0.0	4	4 1.4
Big Stone	2	0.9	0	0.0	0	0.0	:	2 0.7
Blue Earth	0	0.0	1	2.3	0	0.0		1 0.4
Brown	0	0.0	1	2.3	0	0.0		1 0.4
Carver	2	0.9	0	0.0	0	0.0	:	2 0.7
Chippewa	1	0.4	1	2.3	0	0.0	:	2 0.7
Cottonwood	3	1.3	4	9.3	1	9.1	ł	3 2.7
Dakota	1	0.4	0	0.0	0	0.0	:	1 0.4
Douglas	2	0.9	0	0.0	0	0.0	:	2 0.7
Grant	1	0.4	0	0.0	0	0.0		1 0.4
Hennepin	67	29.3	7	16.3	1	9.1	7	5 26.5
Jackson	0	0.0	4	9.3	0	0.0		4 1.4
Kandiyohi	17	7.4	2	4.7	0	0.0	1	9 6.7
Lac qui Parle	3	1.3	2	4.7	0	0.0	:	5 1.8
Lincoln	1	0.4	1	2.3	0	0.0	:	2 0.7

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### TABLE 10B-6 (continued)

# County of Financial Responsibility for Willmar RTC

# by Program - June 1989

#### PROGRAMS

County of	Adul	t MH	Geriat	tric MH	DD		<u>Tota</u>	<u>.t</u>
Financial <u>Responnsibility</u>	N	<u>×</u>	<u>N</u>	<u>×</u>	N	<u>×</u>	N	x
Lyon	3	1.3	2	4.7	1	9.1	6	2.1
McLeod	6	2.6	3	7.0	1	9.1	10	3.5
Meeker	5	2.2	1	2.3	1	9.1	7	2.5
Murray	3	1.3	1	2.3	1	9.1	5	1.8
Nobles	2	0.9	1	2.3	1	9.1	4	1.4
Olmsted	3	1.3	0	0.0	0	0.0	3	1.1
Pipestone	1	0.4	0	0.0	1	9.1	2	0.7
Ramsey	39	17.0	1	2.3	0	0.0	40	14.1
Redwood	7	3.1	1	2.3	1	9.1	9	3.2
Renville	7	3.1	1	2.3	0	0.0	8	2.7
Rock	2	0.9	1	2.3	1	9.1	4	1.4
Scott	7	3.1	0	0.0	0	0.0	7	2.5
Sibley	3	1.3	0	0.0	0	0.0	3	1.1
Stearns	24	10.5	2	4.7	0	0.0	26	9.2
Swift	2	0.9	0	0.0	0	0.0	2	0.7
Wright	9	3.9	1	2.3	1	9.1	11	3.9
Yellow Medicine	0	0.0	3	7.0	0	0.0	3	1.1
Total	229	100.0	43	100.0	11	100.0	283	100.0

#### TABLE 10B-7

# County of Financial Responsibility for Cambridge RHSC

# by Program - June 1989

	PROGRAM				
		DD			
County of Financial Responsibility	<u>N</u>	<u>×</u>			
Anoka	4	6.7			
Beltrami	1	1.6			
Chisago	1	1.6			
Hennepin	8	13.1			
Kanabec	1	1.6			
Meeker	1	1.6			
Mower	1	1.6			
Olmsted	1	1.6			
Pine	1	1.6			
Ramsey	31	50.8			
Sherburne	2	3.4			
Stearns	1	1.6			
Washington	5	8.2			
Winona	2	3.4			
Wright	1	1.6			
Total	61	100.0			

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### TABLE 10B-8

# County of Financial Responsibility for Faribault RC

#### by Program - June 1989

		PROGRAM
		DD
County of Financial Responsibility	<u>N</u>	<u>×</u>
Blue Earth	2	1.0
Brown	4	1.8
Carlton	1	0.5
Carver	3	1.5
Cottonwood	1	0.5
Dakota	16	7.8
Dodge	1	0.5
Fillmore	6	2.9
Freeborn	2	1.0
Goodhue	2	1.0
Hennepin	120	58.3
Houston	3	1.5
LeSeuer	1	0.5
Martin	1	0.5
Morrison	2	1.0
Mower	4	1.8

# TABLE 10B-8 (continued)

### County of Financial Responsibility for Cambridge RHSC

### by Program - June 1989

	PR	PROGRAM		
		DD		
County of Financial Responsibility	N	<u>x</u>		
Nicollet	2	1.0		
Olmsted	6	2.9		
Ramsey	8	3.9		
Rice	8	3.9		
Scott	1	0.5		
Steele	4	1.8		
Washington	1	0.5		
Winona	6	2.9		
Wright	1	0.5		
Total	206	100.0		

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### TABLE 10C

Proportion of Residents in Winnesota Regional Treatment Centers

with Reported Drug or Alcohol Problems by Race: June 1989

	<u>White</u> (N=1652)		<u>Mhite Black</u> (N=1652) (N=66)		<u>(</u> )	<u>Hispanic</u> (N=10)		American <u>Indian</u> (N=40)		Asian / Pacific <u>Island</u> (N=10)		<u>Oth</u> (N=	<u>Other</u> (N=3)	
	N	<u>×</u>	<u>N</u>	X	N	<u>×</u>	<u>N</u>	<u>%</u>	N	<u>%</u>	<u>N</u>	<u>%</u>		
Alcohol Problem	500	30.3	26	39.4	5	50.0	27	67.5	1	10.0	2	66.7		
Drug Problem	420	25.4	24	36.4	5	50.0	22	55.0	2	20.0	2	66.7		
Alcohol or Drug Problem	570	34.5	31	47.0	6	60.0	30	75.0	2	20.0	2	66.7		

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#### TABLE 10D

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# Levels of Disability by Race

### of Residents in Ninnesota Regional Treatment Centers: June 1989

	<u>White</u> (N=1652)	<u>Black</u> (N=66)	<u>Hispanic</u> (N=10)	American <u>Indian</u> (N=40)	Asian / Pacific <u>Island</u> (N=10)	<u>Other</u> (N=3)
	<u>×</u>	<u>×</u>	<u>×</u>	<u>×</u>	<u>×</u>	<u>x</u>
Mean PSYSYM	74.8	66.8	67.7	73.8	71.9	65.0
Range = 32-160	33-134	38-112	50-82	40-109	48-124	44-85
Mean ADLS	15.6	11.3	8.7	11.7	11.1	10.3
Range = 8-49	8-46	8-27	8-11	8-24	8-26	8-15
Mean CADS	31.9	29.5	28.5	30.8	28.3	27.3
Range = 8-40	8-40	15-40	24-37	9-40	20-39	18-36