NESOTA'S Comprehensive, Community Based Mental Health - Mental Retardation Program

A Two-Year Review

July 1966 - June 1968

Medical Services Division
Minnesota Department of Public Welfare
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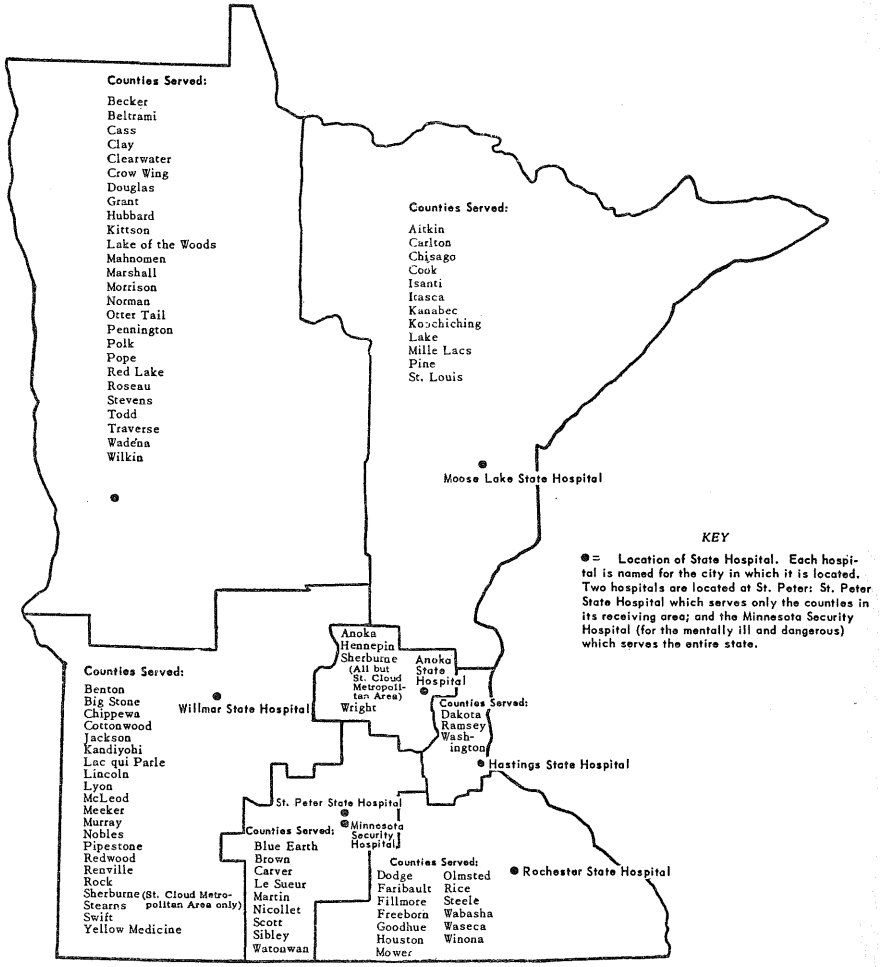
MINNESOTA'S RECEIVING AREAS
HOSPITALS FOR THE MENTALLY ILL



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Introduction

MINNESOTA'S COMPREHENSIVE, community-based program has been designed to integrate the department's three systems of services—state hospitals, county welfare departments and area programs—with an emphasis on greater local responsibility and participation in reducing and preventing mental illness, mental retardation, and inebriacy. The foundation is the concept that no single agency or system holds the key to meeting the problems of mental disorder: only by close coordination of programs, joint planning and action, and a concentration on prevention at the source—in the community—can results be achieved.

The programs' components form a network of services linking the hospital system with the community. The hospitals serve as care and treatment resources to residents of counties in their specific receiving districts. They also share responsibility with the counties, area programs, and other community groups in planning and carrying out a comprehensive program in their particular region of the state. The county welfare departments provide direct family and social services, including mental health services, and also participate in local program development. The area mental health - mental retardation programs provide both direct and consultative services, and also have the responsibiliy for planning, developing, implementing and evaluating a total area program to reduce the incidence of specific mental health and mental retardation problems.

The Medical Services division has administrative responsibility for the treatment and rehabilitation programs of the state hospitals, supervisory responsibility for the mental health - mental retardation programs of county welfare departments, and for contracted agreements with the area mental health - mental retardation program boards and day activity center boards.

The division also is responsible for program planning and development of resources, a state-wide research program, education and manpower development which includes personnel training programs, public information and mental health-mental retardation education, consultation and administration of state funds to community agencies.

Developments in the State Program

State Hospital System

All of the state hospitals for the mentally ill are fully accredited by the Joint Commission on Accreditation of Hospitals. Two facilities for the mentally retarded—Brainerd and Cambridge—received provisional accreditation in 1967 and 1968.

The hospitals maintain the "open door" policy which, except for rare exceptions, eliminates locked doors or other physical restraints which inhibit patient movement. This policy is a symbol of the treatment programs, demonstrating respect for the dignity of the individual and emphasizing the patient's role as a responsible citizen in the community.

Other hospital programs—independent living units, patient councils, work assignments with pay—also emphasize the dignity and rights of patients.

Many of the hospitals have instituted the "unit system" in which the treatment program is carried out in autonomous units. This geographical unit system is based on the counties served by the area mental health - mental retardation programs in the hospital's receiving district. Each operates as part of the community mental health team in coordination and aftercare planning with the area program, the county welfare department, and other local rehabilitative agencies and facilities.

As directed by the 1967 Legislature in a move to alleviate overcrowding at the state facilities for the mentally retarded, special units have been opened at the Hastings and St. Peter mental hospitals for patients transferred from Faribault. Other residential treatment centers for mentally retarded patients are planned at the Fergus Falls and Rochester facilities.

A new unit for alcoholics and drug addicts was opened at the Hastings state hospital, an addition to the treatment and rehabilitation programs offered at the Moose Lake and Willmar hospitals.

In addition to providing specialized treatment programs for adult psychiatric, adolescent, psycho-geriatric, mentally retarded, inebriate and addicted patients, some of the facilities now offer day hospital and outpatient treatment services.

Further integration of the state hospitals into the community is being accomplished through the increased participation of volunteers, sponsorship of seminars and conferences, utilization of the hospitals as training centers for professional personnel, involvement of hospital personnel

in community affairs concerning health and welfare programs, assistance to local agencies in planning and programming, and the development of closer working relationships with service agencies and other community treatment and educational facilities.

Community Programs

The number of area mental health - mental retardation programs has increased to 24, serving both the urban and rural population in 85 counties. These are supported on a 50-50 basis with counties through the Community Mental Health Services Act.

Through federal legislation which provides for construction and staffing grants to the area programs for community facilities, such services now are available in some localities: the psychiatric day hospital at the Hibbing general hospital, and the inpatient and partial hospitalization service at the St. Cloud hospital.

The daytime activity centers program has expanded, now available in 49 counties. The centers are a major training and care resource for mentally retarded persons of a broad range of ages and functional levels. The state also matches local funds for these community facilities through the Daytime Activity Centers Act.

Central Office

In 1968, a new staff office was established to design, organize, and execute a state-wide program for mentally retarded persons. Its responsibilities include hospital and community programs, coordination with other state agencies, and with private and voluntary groups in developing local services and facilities. The division's guardianship service is part of this program office.

With the enactment of the Minnesota Hospitalization and Commitment Act, hospital review boards have been organized for each facility to evaluate admission and retention of patients. The boards, which meet at least every six months, may interview patients and examine their medical records in determining the needs for continued hospitalization, proper hospitalization, or commitment procedures.

The division's staff educational program concerning humane practices continues. In addition to the state committee, composed of representatives of the state hospitals and central office personnel, humane practices committees function within each facility. This program, aimed at

eliminating dehumanizing practices which affect the dignity and rights of patients, was given one of three key achievement awards at the American Psychiatric Association's 1967 Mental Hospital Institute in Minneapolis. *Dehumanization and the Total Institution,* a film used in the staff training program, also received a major award at the 1967 International Film and Television Festival in New York.

Division Administration

The division structure consists of program offices, currently two—a division program office and a mental retardation program office; and sections—community programs, mental health - mental retardation research, education and manpower development.

Central office personnel also includes a staff of consultants who assist the three systems—state hospitals, county welfare departments, and area mental health - mental retardation programs—in developing programs and services.

These consultants function as advisors in the practices related to chaplaincy services, nursing services, psychological services, rehabilitation therapy services, social services and volunteer services.

Division Program Office

This office, while it was supported under a federal research grant, was known as the mental health study and planning office.

It is responsible for the initial design and continuing revisions in the design of the division's over-all mental health - mental retardation - inebriacy program as one part of the program of the Minnesota Department of Public Welfare.

Through individual contacts and committees, the staff works closely with the division director and with all units of the division in an effort to assure the development of common goals derived from the Department of Public Welfare's family rehabilitation policies, and to promote close working relationships among units of the division at state and local levels, and between the Medical Services division and other departmental divisions, and other agencies and organizations.

Specifically, these have included: (1) major central office responsibilities for the implementation of the Minnesota Hospitalization and Commitment Act; (2) the development of revised policies governing

county welfare programs, community mental health - mental retardation programs, and state hospitals; (3) participation in the design of a unified information system for the department; (4) assistance to counties, community programs and hospitals in developing their programs in keeping with state policies.

Mental Retardation Program Office

This biennium has been a period in which major work has been accomplished in the following areas:

- **Establishment of the Mental Retardation Program Office within the Medical Services division in October, 1967.**
- **Establishment of a public mental health - mental retardation program on a state, regional, area and county-wide basis.**
- **Implementation of Minnesota's Hospitalization and Commitment Act.**
- **Establishment of review boards for each state hospital, including the mentally retarded.**
- **Increased voluntary admissions to state facilities.**
- **Unit programs for small groups of patients, with emphasis on individualized programs. A unit director position established to accomplish this with all staff working with the patients.**
- **Establishment of special program units for the mentally retarded in state hospitals for the mentally ill: Hastings, Fergus Falls, Moose Lake.**
- **Establishment of the Minnesota Valley Social Adaptation Center at St. Peter.**
- **Continued work in cooperation with the Child Welfare division and the state Department of Health on establishment of program standards for private residential facilities.**
- **Preliminary work with the Child Welfare division toward the establishment of a permanent foster home program for mentally retarded children.**
- **Increased emphasis and participation in surveys of county welfare department programming and provision of services for the mentally retarded.**
- **Continued development of a variety of resources to meet individual needs.**
- **The number of state grant-in-aid daytime activity centers increased from 40 to 68.**
- **Continued evaluation of cases for determination of eligibility for Interstate Mental Health Compact negotiations.**
- **Completion of work of the Mental Retardation Planning Council in December, 1967. Implementation of the recommendations of the Council were assumed by the Mental Retardation Program Office.**

Guardianship Program

Emphasis during this biennium has focused upon evaluation of the programs and services furnished by county welfare departments for mentally retarded persons. This unit has participated in surveys of nine county welfare department programs.

The number of persons under guardianship as mentally deficient or epileptic dropped 379 from 10,783 to 10,404. This was due to: (1) court actions for restoration to capacity; (2) court action for discharge of guardianship; and (3) deaths. In addition, the number of new commitments was only 40% of that of the previous biennium. This was due to continuing emphasis on accessibility of programs for all retarded and the encouragement of more selective use of guardianship.

Some trends in the guardianship program may be seen from the following table:

	1958-60	1960-62	1962-64	1964-66	1966-68
Number under Guardianship	10,054	10,895	10,885	10,783	10,404
Number of Commitments	1,234	1,113	929	566	228
Number Restored to Capacity	——	24	80	67	66
Number Discharged from Guardianship	——	229	456	295	286

The shift in emphasis from guardianship to the development of programs appropriate for individual needs has resulted in a drop in the number of commitments from 51.4 per month in the 1958-60 biennium to 9.5 per month in the 1966-68 biennium.

Trends in the use of foster care for mentally retarded children are shown in the following tables:

Foster Care Cost	**1965-66**	**$765,996.81**
Foster Care Cost	**1966-67**	**870,797.98**

	1962-63	1963-64	1964-65	1965-66	1966-67
Absolute Trend in Cost of Foster Care					
MR under guardiansnip (including a few epileptic)	$459,169	$638,250	$662,032	$765,997	$870,798
Absolute Trend in Number of Children					
MR under guardianship (including a few epileptic)	528	641	646	682	716
Absolute Trend in Number of Days of Care					
MR under guardianship (including a few epileptic)	117,988	160,356	162,260	180,653	191,454
Trend in Average Cost per Child					
MR under guardianship (including a few epileptic)	$869.64	$995.71	$1,024.82	$1,123.16	$1,216.20
Trend in Average Daily Cost of Board and Room					
(Under guardianship)	$3.63	$3.70	$5.77	$3.97	$4.20

The unit participated with the Child Welfare division in developing criteria for a permanent foster home program for mentally retarded children.

During this biennium two large private residential facilities for the adult retarded with a capacity of approximately 260 opened—The Nor-Haven Home for women in St. Paul, and the Robert Milton Home for men, in Redwood Falls.

Institutional Programs for the Mentally Retarded

During the last biennium, populations at the state hospitals for the mentally retarded were reduced from 6,066 on June 30, 1966, to 5,565 on June 30, 1968. Overcrowding continued mainly at Faribault state hospital, where population has been reduced from 2,762 on June 30, 1966, to 2,498 on June 30, 1968.

Since there has been a large decrease in the populations in the hospitals for the mentally ill, efforts were made to determine whether some mentally retarded could be integrated into programs for the mentally ill or whether separate programs could be established for them within hospitals for the mentally ill. The Cambridge-Moose Lake Project was established in the fall of 1965 to determine whether patients with certain behavior problems at Cambridge state hospital could profit by placement at Moose Lake state hospital: 26 patients were transferred from Cambridge to Moose Lake and the project established that mentally retarded patients with behavioral problems could be integrated successfully into the psychiatric program for the mentally ill.

Concurrently with the latter stages of the Cambridge-Moose Lake Project, planning towards utilization of available space in hospitals for the mentally ill for programs for the mentally retarded proceeded. As a result of this planning, a new facility for the retarded—the Minnesota Valley Social Adaptation Center—was established on the St. Peter hospital campus on January 1, 1968. This facility will initially serve adult transfers from Faribault state hospital up to a capacity of 382. Its residents will be from the 22 southwestern counties.

In the fall of 1967, 10 patients with behavioral problems were transferred from Faribault state hospital into the population of Hastings state hospital. Planning for a segregated or specialized program for 90 additional mentally retarded was initiated in March, 1968.

Plans were formulated for Fergus Falls state hospital to accept transferees on an integrated approach, based on the Cambridge-Moose Lake method. Planning for other MR units was in progress.

Planning was initiated toward development of a program for the mentally retarded at Rochester state hospital.

Admissions to state facilities for the retarded has remained relatively stable for the past three bienniums as shown by the following numbers:

	1962-64	1964-66	1966-68
Number of Admissions	**561**	**502**	**498 plus 49 temporary placements**

Temporary placements are generally for less than 90 days and for the purpose of providing relief for parents for vacations, illness, or family emergencies.

Discharges from the facilities have greatly increased as shown by these figures:

1962-64	1964-66	1966-68
601	**654**	**1,051**

The number of voluntary admissions has continued to increase.

Intensive work was initiated in each facility towards organization of units with program responsibility and with responsibility of program design appropriate to meet the needs of each patient as an individual rather than on a group basis. This includes increased use of community resources and services to carry out a program more realistically related to community life.

Education and Manpower Development

On January 1, 1968, the section formerly known as Information, Mental Health Education and Volunteer Services, was changed to the section on Education and Manpower Development. Its responsibilities were enlarged to include the coordination of training programs in the state facilities for the mentally ill and mentally retarded, staff development programs, manpower development (including recruitment, careers, and projects under OEO) and humane practices, in addition to public information, and mental health - mental retardation education.

During the past two years, a number of educational workshops and meetings were held in connection with the Minnesota Hospitalization and Commitment Act which was passed by 1967 Legislature. A new booklet entitled *Patient's Rights under Minnesota's Hospitalization and Commitment Act* was produced, explaining patients' civil and general rights guaranteed under the new act, and an informational packet was prepared for members of the Review Boards of each state hospital to acquaint them with the facets of the law. A supplement, *Rights of Mentally Retarded or Mentally Deficient Patients under Minnesota's Hospitalization and Commitment Act,* also was published and distributed to

hospital staff, relatives of patients and to appropriate agencies.

The annual Humane Practices Institute is held each spring. An assessment of problem areas covered during the previous year, recommendations, plans and goals for the coming year are formulated at this conference.

A series of workshops on programs for retarded persons in the state hospitals was held, focusing on the needs of four particular groups: (1) severely retarded ambulatory adults, (2) delinquent and acting-out adolescents, (3) emotionally disturbed children, and (4) multiply-handicapped retarded persons. These workshops were followed up by hospital committees working on program developments for each of the four groups.

The annual Teachers' Mental Health Workshop held each summer at one of Minnesota's colleges, sponsored jointly by the state departments of Health, Education, and Public Welfare, continues to be one of the highlights of the mental health - mental retardation education program. The mental health educator continues to work with the state departments of Health and Education in the summer health workshops for teachers, school superintendents, and principals. In addition, the educator served as a member of a committee to develop family life education materials for the University of Minnesota's extension division. Work with community organizations, church groups and youth organizations are on-going and expanding in the mental health - mental retardation education area.

Two new films were produced during the past two years—one on the problem of dehumanization, *Dehumanization and the Total Institution,* and another on mental retardation, *A World of the Right Size.*

A series of workshops was held on "The Learning Process" and "Behavior Modification as Related to Developing Self-Help Skills for Severely Retarded Children." Also, a number of meetings were held to develop training materials on mental retardation for the staff of the hospitals for the mentally ill who will work with mentally retarded patients.

Mental Health - Mental Retardation Training

The training program is an important one, not only to keep present staff abreast of recent treatment developments and improve their knowledge and efficiency, but also to insure the availability of future professional workers for the state program.

The training section is concerned with the development of adequate mental health - mental retardation training programs, and the administra-

tion of state funds for this purpose. The latter are used mainly for stipends in various hard-to-recruit professions. The responsibilities include coordination with other divisions on policy issues and the selection of candidates for training stipends. The Medical Services division's training section works closely with the Department of Public Welfare's counterpart section in coordinating programs and combining resources where appropriate.

The section also has worked cooperatively with the Governor's Office of Economic Opportunity in the Career Opportunities program. Training funds are used to support workshops and seminars on pertinent topics; federal funds together with state monies have been used for these purposes.

Volunteer Services

The volunteer services program, formerly part of the section, continues to concern itself with both hospital and community services. The regular meetings of the volunteer services coordinators are being used more for staff development purposes. There is a continued effort to re-evaluate the various programs and services in the light of today's knowledge, and changing concepts and needs.

Areas of emphasis in volunteer services in the last two years included:

- **The one-to-one program**
- **Volunteers taking patients into the community rather than all volunteer activities taking place within the hospital**
- **Resident volunteers—young people of college age living on wards and offering their friendship to patients**
- **Use of volunteers to help develop camping programs for patients in some hospitals.**
- **Opportunity in some hospitals for patients to conduct volunteer projects for other patients in their own hospital or in another hospital**
- **Increased involvement of young people as volunteers.**

Research Program

Divisional interest in promoting careful scrutiny of questions relevant to its responsibilities was again supported by the Legislature with an appropriation of $280,000 for the biennium. Available funds now support research personnel in three state facilities, and the central office research section. In addition, many staff persons in the hospitals are involved in conducting research projects along with other responsibilities. Research funds also provide for the use of specialized consultants and computer services, the purchase of research equipment and supplies, and assistance to state researchers in disseminating results of completed studies through publication.

During the biennium ending June, 1968, 42 studies were completed by state researchers. Cooperative research with the University of Minnesota continued.

On-going projects include studies of such diverse areas as basic metabolic and physiological functioning, discharge readiness and post-discharge follow-up of psychiatric patients, evaluation of a Hospital Improvement Program, alcoholic treatment programs; and the assessment of different types of hospital treatments and therapies, including work in such fields as drug use and vocational rehabilitation. Many studies are being carried out directly by, or under the coordination of, the central office research section. Included among these are studies related to living conditions on the hospital wards, variables responsible for admissions to state hospitals, the effects on mentally retarded patients of large scale transfers to hospitals for the mentally ill, suicide attempts in four representative types of counties in Minnesota, and self-injurious behavior of the mentally retarded.

Research, whether under state funds or conducted without such grants, continues to be coordinated through the central office research section. Consultation is provided in research design and procedures.

A committee on cooperative research has been established to stimulate increased participation in research endeavors and to provide a mechanism for joint efforts among researchers in the various state facilities.

The section continues to coordinate the review of all project proposals by the Mental Health Medical Policy committee which serves to assure that all research is technically competent, ethically humane, and relevant to the department's program.

Regional Coordinating Committees

For purposes of coordinated regional program development, and effective utilization of mental health and mental retardation resources, coordinating committees have been developed in some parts of the state. Regions correspond with the receiving districts of the seven state hospitals for the mentally ill. In 1968, four committees were functioning, and preliminary planning was under way in two other regions.

Memberships on these committees includes representation from state hospitals for both the mentally ill and the mentally retarded, area mental health - mental retardation boards (most of which operate community mental health centers), county welfare departments, and other agencies with related responsibilities.

Examples of their efforts include, in one region, a study of future utilization of the state hospital, and in another, the need for a coordinated adolescent treatment program.

State Hospital Service

Statistics

Mental Hospital Population Changes

During the 1966-68 biennium the number of resident patients in Minnesota state mental hospitals dropped from 5,906 to 4,244, with 3,981 mentally ill and 263 inebriates in residence on June 30, 1968. The mental hospitals have shown a continuing decrease in population since 1954-55 when a daily average of 11,505 patients (11,297 mentally ill and 208 inebriates) were in residence. For every 100 mentally ill patients hospitalized in 1954-55 there were 52 in residence on June 30, 1966 and only 35 on June 30, 1968.

An increasing number of patients entering and leaving the mental hospitals has accompanied the decrease in resident patients. During fiscal year 1967-68, more than 7,100 patients entered the hospitals by admission or return from provisional discharge (200 more than in 1966-67 and 2,200 more than in 1954-55, when the resident population was at its highest point). The increase in releases has been even greater: almost 7,800 patients were released by direct or provisional discharge in 1967-68 (500 more than in 1966-67 and 3,900 more than were released in 1954-55). Deaths in the hospitals have dropped: 378 patients died in state hospitals in 1967-68 compared with 418 in 1966-67 and 1,006 in 1954-55.

The above figures on turnover in population include 2,600 inebriates entering and leaving the hospitals in 1967-68, double the number in 1954-55. Among the mentally ill the more than 4,500 patients entering in 1967-68 represented a 25% increase over 1954-55, while the nearly 5,200 patients released in 1967-68 was almost twice the number released in 1954-55. The increase in mentally ill patients entering represents an increase in readmissions and returns proportionate to the greatly increased number of releases. During 1967-68 there were fewer than 2,000 mentally ill first admissions to state mental hospitals, about 400 less than in 1954-55. The number of first admissions leveled off at about 2,200

per year during the period 1962-63 through 1965-66 and decreased to about 2,000 in 1966-67.

The greatest decrease in resident population has been among patients 65 or older. In 1954-55 there were more than 4,000 of these elderly patients in state hospitals and the number increased to over 4,300 in 1956-57, accounting for 40% of the mental hospital population. By June 30, 1966 there were fewer than 1,700 patients 65 or older in state hospitals and on June 30, 1968 less than 1,000, representing about one-fourth of all mentally ill patients in residence. During the 1966-68 biennium, the number of hospitalized mentally ill dropped one-third, with a 29% decrease in patients under age 65 and a 41% decrease in older patients.

The Minnesota Hospitalization and Commitment Act, which became effective January 1, 1968, made it possible for mentally ill patients to be admitted on an informal basis, whereas prior to that date they had to sign an agreement for voluntary hospitalization. During January - June 1968, a total of 1,157 mentally ill patients, 570 first admissions and 587 readmissions were admitted on an informal basis. The change to informal admission brought about a small increase in total first admissions of mentally ill patients to state hospitals but very little change in the number of readmissions. About two-thirds of all mentally ill readmissions were informal after January 1, 1968, about the same proportion as were voluntary during the previous three quarters of the biennium. Among first admissions, however, 57% were informal after January 1, 1968 compared with 47 % voluntary in the three quarters of the biennium prior to that date. Mentally ill first admissions averaged 170 per month during January-June, 1968 compared with 160 per month during July-December, 1967 and 167 per month during fiscal year 1966-1967.

The new law also made provision of day care and out-patient services an official part of the services provided by state hospitals. As of June 30, 1968, there were 67 mentally ill patients in day care at Rochester and Hastings and 160 were enrolled as out-patients at four hospitals. Of the 160 a total of 89 were residents of other state facilities receiving out-patient medical care at Rochester, 62 were former mental hospital patients and 9 were persons from the community who had never been residents of a state institution. During the period January-June 1968, a monthly average of 366 days of day care and 293 out-patient visits were reported by state mental hospitals. Out-patient visits include patients enrolled and single visi contacts, with a monthly average of 151 visits re-

ported for residents of other state facilities, 105 for former mental patients and 37 for other persons from the community during January-June, 1968.

Patient Transfers

During the first year of this biennium, 84 nonresident patients were admitted to Minnesota's state hospitals, 19 were voluntary admissions with fairly short-term hospitalizations. The second year, 1967-1968, reveals a total of 85 nonresident patients admitted, with 23 being informal admissions.

During the biennium, 47 patients were transferred to other states for hospitalization. Of this total, 14 were mentally retarded patients; and 2 were mentally ill aliens who were returned to their native countries—Poland and Norway. The mentally retarded were transferred, at the request of relatives to other Compact states and California, which now recognizes the residence of the minor child as following that of the parents.

A breakdown for each year discloses that 20 patients were moved the first year of the biennium and 27 the second year. Fourteen Compact states were involved in the transfer of 35 patients while the two foreign countries, named above, and three other states were involved under settlement laws in the transfer of the other 12 patients.

The total costs of these transfers amounted to $6,852.51 with $2,577.85 paid by relatives or guardians, and the balance of $4,274.66 paid by the state.

In addition, 5 nonresident patients were transferred to Veterans' Administration facilities; 9 died; and 5 were transferred to nursing homes.

Three additional states became members of the Interstate Mental Health Compact during the past two years, thus bringing the total number of states to 35.

During this same period, authorizations were given for the return of 72 patients to Minnesota for state hospital care. Thirty-four were accepted as having legal settlement in Minnesota, and 38 were transferred here under Compact terms. Returns were denied on 23 cases: 15 were not considered as proper referrals under the Compact, and 8 were denied because of lack of legal settlement.

Arrangements were completed for the release of 56 patients to relatives in other states with after-care supervision provided by those states. Permission was denied Minnesota on 8 other cases. Of 34 requests for patients to come to Minnesota for after-care supervision, 31 were approved and 3 denied.

At the end date of this report period, 16 mentally retarded patients were on the waiting lists of other Compact states with 6 on Minnesota's waiting lists.

Hospital Services

Chaplaincy Services

Full and part-time staff chaplains continue to provide religious counseling and religious services within the state hospitals. Several facilities also have the services of chaplains sponsored by faith groups. The chaplaincy advisory committee, composed of representatives of the major religious groups, meets quarterly. It screens applicants for vacancies, establishes and maintains standards. Programs designed to acquaint local clergy with early signs of mental illness, and to assist them in counseling emotionally disturbed persons before and after hospitalization, are scheduled at several of the state facilities. All hospital chaplains meet twice yearly to exchange views as to how the religious needs of their patients can be better served.

Nursing Services

Nursing services consist of providing more meaningful life experiences, assuring health and well-being, and developing interactional and social skills of residents within institutional and community based settings.

With the passage of the Minnesota Hospitalization and Commitment Act, the office of nursing services is providing consultation in the implementation of Section 10 (place of temporary hospitalization), Section 15:8 (public health nurse in after-care planning), and Section 2:16 (utilization of public health and psychiatric nurses as health officers).

This biennium has brought about the introduction of the "licensed practical nurse" and the "senior psychiatric technician" Civil Service classifications. It is now possible for the psychiatric technician to pursue the administrative avenue of the job as hospital services assistant or a patient programmer as a senior psychiatric technician. An advanced course of 200 hours is now being provided for appointment as a senior psychiatric technician. In addition, the utilization of the "hospital aide" Civil Service classification has been broadened in the facilities in order to lessen turnover and vacancies.

The need for continuing education for the nursing staff to maximize their skills is recognized. Several conferences were held on Rehabilitation

Nursing, Nursing in Mental Retardation, Behavior Modification, Self-Help Skills, Psychiatric Nursing, and Developing Referral Criteria for public health nurses.

These were offered by consultants from outstanding programs both within and outside the state. With the transfer of residents from the hospitals for the mentally retarded to facilities for the mentally ill, the nursing education departments have been developing courses for the nursing staff in the nursing aspects of the mentally retarded patient.

With shifting emphasis from the disease process to essential therapeutic nursing action, the nursing personnel are now more actively engaged with groups of residents. This has been facilitated by the decentralization of the institutions by unit/program areas.

Cooperative efforts of the nursing staff have occurred on cottage areas through establishment of daytime activity centers, and in the Project Teach and Foster Grandparent programs in the hospitals for the mentally retarded.

There has been very substantial increase in the number of applicants among the psychiatric technicians for Department of Public Welfare nursing stipends to further their education in practical and professional schools of nursing.

Psychological Services

Psychological services are provided in all the state hospitals. These services are composed of a wide variety of functions which include: the use of psychological tests and techniques for the diagnosis and understanding of individual patients, the assessment of their ability in areas of deficiency, their habitual modes of response to situations, the presence or absence of specific disabilities, and for other information which will enable the hospital staff treatment team to be of maximum assistance to the patient; the conduct of individual and group therapies for patients; consultation with other staff with regard to treatment and management of patients; assistance with the selection and training of personnel; participation in planning and coordination of hospital treatment programs; and organization, development, and conduct of research projects designed to acquire a greater understanding of the problems of mental illness and mental retardation, as well as the development of improvement in skills, techniques, and manners of approach used in treatment and planning for patients.

The number of psychologists employed in the state facilities remains approximately the same as during the previous biennium (50). The department continues to have difficulty in recruiting a sufficient number of psychologists, and vacancies exist in most of the state facilities. Nevertheless, there has been an increase in the over-all qualifications of psychologists who have received state certification.

In-service training programs for psychologists continue to be provided in the hospitals. Several facilities have developed internship and traineeship programs in conjunction with colleges which enable students to become familiar at first hand with the duties and responsibilities of psychologists.

Rehabilitation Therapy Services

Rehabilitation therapy consists of three main education-for-living programs that are conducted in all facilities for the mentally ill and mentally retarded.

Educational Services Significant advancement in program size and quality has been made. Educational programs are planned jointly with hospital staff teachers and therapists, and coordinated by the special education section of the state Department of Education.

In addition to this joint effort between public school and hospital staff, the education program in the state facilities is augmented by the provisions of the federal Elementary and Secondary Education Act (Title 1 Public Law 89-10, as amended by P. L. 89-313). Patients under 21 years of age in both the hospitals for the mentally ill and the mentally retarded are eligible for educational and educationally-related services beyond those which the public schools and the state hospitals can provide. The first projects were started in May, 1966, and have been renewed yearly since that time.

"Project Teach," which is funded through Title 1 Public Law 89-313, has produced most dramatic results in the hospitals for the mentally retarded. There has been a change in the basic orientation to the mentally retarded individual. Progress can and is being made educationally with every person in Project Teach. The key has been more staff and equipment; an optimistic attitude; plus the realization that education is more than books and classrooms, but includes total adaptation to environment.

Because further improvement is desirable, a study currently is underway by the Minnesota National Laboratory to assess the education pro-

grams in the hospitals for the mentally retarded. This study is financed through funds made available through Public Law 89-313.

Vocational Services Industrial therapists, vocational counselors and nonprofessional assistants are employed to assist patients in developing and retaining sound work skills which, in turn, help them to secure and hold adequate jobs when discharged.

Patients are given vocational evaluation and opportunities to learn work habits and social skills, and are placed in hospital industries to accomplish these ends. The therapy of work as an outlet and release is considered an important facet of this program. Placement of patients in this type of hospital setting is done on the basis of therapeutic ends desired, the patient's abilities and need to learn work skills.

Patients also are given the opportunity to work in the community under an extramural work program. This affords them the opportunity to commute to the community, work, and earn money while still under treatment at the hospital. This also gives them a financial reward for work performed.

A special program has been continued during the last year under the Manpower Development and Training Act to train potentially employable mentally retarded patients in three different types of service work occupations. This shows an increasing use of community and agency facilities and services by hospital staff. Cooperating agencies are the vocational education and vocational rehabilitation divisions of the Department of Education, the Department of Employment Security and local employment offices, hospital personnel, and central office staff. Area vocational schools located near the hospitals hire instructors and supervise the training programs.

A pilot program for paying patients for work within the hospital has been developed at Hastings state hospital. Another new pilot program, Industrial Therapy Enterprises, which is a type of sheltered workshop within the hospital setting, also has been established. In this project, patients are referred to Industrial Therapy Enterprises by the psychiatric team and are provided the opportunity to learn various types of industrial work in actual production situations. This program pays graduated wages for work performed and deals with industry on a standard business basis. Patients begin by working in the hospital industries for a token pay and are promoted, in a sense, into Industrial Therapy Enterprises. Following this period of training while receiving therapy in the hospital, patients are either placed into sheltered workshops in the community or into full-time jobs in competitive employment.

In addition to the above, vocational programs have been established in six facilities for the mentally ill and two hospitals for the mentally retarded as a result of the federal Vocational Rehabilitation Act. These cooperative vocational rehabilitation programs are a joint effort of the Department of Education's division of vocational rehabilitation, and the Medical Services division. The projects are supported by one-fourth state money, usually in the form of salaries, and three-fourths federal matching funds, most of which is used for case services involving job placement in the community. The cooperative programs are not intended to replace but to augment existing hospital programs.

Therapeutic Services Professionally trained occupational, recreation, and music therapists, and nonprofessional assistants are employed to conduct this program. Personnel assist in planning treatment programs, and work with patients prescribed for specific kinds of therapeutic activities. Therapists participate in treatment team meetings and carry out, together with other personnel and volunteers, a variety of activities for groups and for individual patients. Reports are made to assist medical, psychological, and social service staff to evaluate patients' progress.

Nearly all personnel in the rehabilitation therapy programs are employed through state appropriations to the hospitals. During the past two years, several positions were added through provisions of various state and federal programs previously mentioned. These programs are beginning to have an influence on the kinds and quality of services provided to patients, warranting great optimism about future development in all areas of education-for-living.

Approximately 250 therapists and teachers are employed to carry out the educational, vocational, and therapeutic services in the state facilities. These activities should not be interpreted as generally available to all patients, but do indicate that such programs are needed for more patients.

As a prelude to a hospital-wide physical fitness program, a survey of current programs in this area is underway.

Hospital Programs

Anoka State Hospital

Anoka state hospital, reaccredited in 1967 by the Joint Commission on Accreditation of Hospitals, is now organized in three major independent units: the psychiatric hospital, the medical-surgical hospital, and the adolescent hospital. This pattern, fully developed in the biennium just

closed, has enabled the facility to serve its expanding receiving area—a population of more than a million, and growing—with increasing usefulness.

The hospital, 70 years old in 1969, reached its peak population, some 1,500 patients, in the mid-1950's. Though more than 100 patients from St. Peter hospital have been assigned to it, under the Department of Public Welfare policy that places mental patients close to their homes (more are expected to come), the population in June, 1968, was under 600. Some of the decline came when, because of the eradication of tuberculosis among patients in mental institutions, the tuberculosis hospital was closed (July 1, 1967); but much of it stems from the continuing surplus of patient discharges over admissions. This trend is expected to continue (even though admissions grow annually in number), due to shorter lengths of stay, fewer commitments, and such external influences as development of community resources for early detection and treatment of mental illness, the need of some patients for more intensive psychiatric rehabilitation than short-term treatment can provide, and the expansion of federal and state aid to the hospital. (A change in the size of receiving area, the development of new programs such as assignment of nursing-home-type patients, or mass transfers from other hospitals might reverse the trend.)

Under Anoka's three-hospital organization, planning, budgeting, and definition of responsibilities have been refined. Review and realignment of several hospital committees and their functions have been made. Decentralization has increased individual unit responsibility and accountability in problem-solving. Treatment programs under the unit system promise to yield improved patient care as well as improved efficiency.

Use of the American Hospital association cost accounting program has been valuable to the business manager and his staff in the reorganizational process.

The medical-surgical hospital continues to be a costly operation, in part because it works with grossly inadequate facilities. The future of this program is under study by the Department of Public Welfare, the Department of Administration, and legislative committees. It expects guidance from special committees and consultants who are examining national trends in costs, staff compensation, reimbursement, availability of staff, levels of patient care, and future needs and objectives. The program has helped the Department of Corrections at Stillwater to narrow a gap in patient care and has provided surgery for 11 other institutions. The

University of Minnesota has given indication that it will continue support of teaching programs for surgeons and interns at Anoka.

The importance of strengthening community interrelationships at all levels led to the establishment of the West Metropolitan Mental Health-Mental Retardation Coordinating committee to undertake area-wide planning. Its linking of community agencies in mutually-helpful services has led to a program at Anoka-Ramsey Junior college and another at the Anoka-Hennepin Area Vocational Technical school. Mercy hospital, the general hospital in Anoka, is working productively with the state hospital in pathology, nursing training, laboratory work, and other areas.

A careers program has been initiated at Anoka in collaboration with the Department of Public Welfare and the Minnesota Civil Service department, under the approval of the state Department of Administration. Nine Anoka employees are participating in a special half-time school or university training project with Office of Economic Opportunity support to serve persons with behavior or underprivilege problems.

The volunteer program has been redesigned to fit the three-unit pattern of hospital organization and, in keeping with modern thinking, has directed much of its energy into one-to-one patient-volunteer relationships rather than the former group activities.

In the year ending June 30, 1968, hospital staff turnover, under the Civil Service plan of 1967, decreased 28% from the 43% of the preceding year. Location of the hospital near the Twin Cities offers opportunities for recruitment of professional staff; but unskilled labor sources do not meet hospital needs. Regardless of turnover, dedicated long-term employees form the backbone of hospital operation.

Among building, plant, and other capital projects completed during the biennium:

- **100 acres of surplus land were sold to Anoka Independent School No. 11 as a site for a new Anoka senior high school.**
- **An area of 303 acres of surplus land is being examined by city, county, and state planners for use for park and recreation facilities.**
- **Library facilities were constructed on the ground floor of the auditorium.**
- **A building linking Cottages 6 and 7 on all floors made possible establishment of the adult psychiatric center.**
- **Rehabilitation services were centralized in Cottage 8.**
- **Cottage 1 was demolished.**
- **Adolescent units were remodeled.**
- **Roads, parking facilities, lighting and other hospital grounds features were improved.**
- **The outdoor recreation area west of the Miller building came into full use. Two baseball diamonds, with the cooperation of the city of Anoka, were provided.**

- **Refurnishing of cottages helped to provide extended patient areas.**
- **The sewage system was improved following a state grant of $30,000 to the City of Anoka.**

Brainerd State Hospital

During the past two years, there have been significant developments at the hospital. The major improvement has been a greater emphasis upon programming and a continuing improvement in the level of care on all units. This increase in effort of programming has been as a result of the new positions granted by the 1967 Legislature, the federal funds available for special programming, and the increased effort in the direction of individual program for residents. During this period, the teams have had a chance to work more closely with patient programming and planning, and as more services have become available, these have been effectively utilized. The hospital has continued to function on a four-program unit basis as follows:

Program 1-4: This unit is designed for patients who are physically handicapped as well as being severely mentally retarded. Programming for these patients consists of an attempt to develop to greatest possible individual capacity such self-care skills as assisting in dressing themselves, ambulation, and toileting. To promote recognition of surroundings, multiple stimuli are used. Many patients were formerly thought to be permanently bedfast, but experience has demonstrated that it is possible to have many of these at least up and about in a wheel chair. Present concentration is heavy on physical therapy but there are also programs in recreation, handicrafts, and some work training. For those who have the ability, some training in reading and related accomplishments is programmed.

Program 2-3: This is a unit designed for the ambulant mentally retarded child, 16 years of age and under. During the child's early years, the program centers on self-care in dressing, feeding, toileting, and on the development of pre-school learning activities. The children in this unit are then involved in a wide range of programs in school, recreation, handicrafts, and music for the development of sensory capabilities and dexterity. Those who show the necessary capabilities are involved in a limited reading program with development of other learning areas and preparation for future job training.

Program 5: This unit deals with the adult retarded, the majority of whom are in the profound and severely mentally retarded classifications. Concentration is on the development of self-care through the use of oper-

ant conditioning with an attempt to develop good social habits. Initial efforts deal with toilet training, self-feeding, self-dressing, and preparation for eventual involvement in the institutional work training program and in sheltered workshops when these are developed.

Program 6: This unit serves adult patients who are moderately or mildly retarded, who are capable of working, and who are being trained to be competent in relatively simple kinds of work. Emphasis in this program is on the continuation of training for the development of good work habits and necessary social attitudes. The social and vocational training programs are aimed at the return of the patient to the community at some functional level.

Along with the development of programs has been increased emphasis on in-service training. This training has been both at the departmental level and hospital-wide. A number of consultants have been brought in to help with specific problems such as programming for the severely physically disabled patient in Program 1-4, consultants in behavior modification and operant learning for patients primarily in Program 5, and training for supervisory staff. A workshop in vocational assessment was jointly sponsored by the division of Vocational Rehabilitation and the hospital.

The services of the rehabilitation department have been more than doubled through positions provided by the Legislature, and the federal Elementary-Secondary Education Act. Programming within the school and rehabilitation center has been expanded, and services from this department now have been provided in the patient buildings. The provision of staffing for the patient building units has helped to reach more individuals. One of the significant developments of this program has been the project to move some bedfast children from beds, to sit, and to begin training in the self-care areas, and sensory stimulation. Sufficient progress was made with these children to warrant further programming.

The hospital has been reviewed by the Joint Commission on Accreditation of Hospitals and currently has a one-year provisional accreditation. It also was reviewed by the American Association on Mental Deficiency with the hospital meeting 74% of the AAMD standards, with 19% partially met, and 7% not met.

Probably one of the more venturesome programs has been the cooperative program between the hospital and the division of Vocational Rehabilitation, in which a unit for social and vocational training and evaluation was established. This, in part, is staffed by some of the per-

sonnel from the hospital, with additional staffing coming from DVR through federal funds. In the early stages of this particular program as it is developing, there have been significant results in evaluation and training and placement of residents into the community.

The hospital has participated in the Foster Grandparent program which, while providing services to the patients at the hospital, also provides significant services to the senior citizens from the area. The hospital also has worked closely with the Iron Range Resource and Development Corps in the National Youth Corps program which has provided work situations for drop-outs. One of the significant results has been that several of the students returned to school. The hospital has cooperated with the Junior college in providing an experience program for the child development teacher technician training program, and has cooperated with them in the work-study program for some college students needing employment.

The development of these various programs has assisted the community in meeting some of its needs, while at the same time providing the services necessary for caring for the retarded.

Another significant community development came about as an outgrowth of the Manpower Development and Training program that was conducted at the hospital. When the federal funds for the MDTA training program were no longer available, the experience gained from the program by the hospital, the county welfare departments, the area vocational school, and the division of Vocational Rehabilitation made it possible to continue this program. This was accomplished by the area vocational school providing the service at the school for individuals needing this particular type of training, such as nursing aide training, and custodial worker training. The division of Vocational Rehabilitation provides screening services for the area vocational school and uses this as a resource for services for their clients.

Significant gains have been made in the living conditions of the patients, and evaluation of this has shown significant improvements.

The program of operant training for the severely retarded adult has started to show some interesting results. While there were problems, there were enough significant gains to continue this particular program. Historically this group of patients have, in a sense, been the forgotten, rejected patient, but their life—at least in the hospital—can be made more meaningful and many can be trained to care for themselves.

Probably the most significant development at the hospital has been—with additional staff and program development—the emergence of a hopeful attitude of "can do." While this attitude has always existed at Brainerd, staff and material shortages of the past have made it very frustrating to "get on with the doing." However, with recent developments, this spirit of "can do" has begun to quicken and placements to the community have been successful.

Cambridge State Hospital

Cambridge continues its efforts to bring "new hope" to its patient-residents with its continual search for new and better ideas to help each develop to his highest potential. It has been very encouraging and most heartening to see the increasingly productive results of these efforts. Attitudes of all staff—nonprofessional and professional alike—have played a very significant part. Questioning present methods and practices make for easy and quick changes. Thus, progress is not stifled by tradition.

The staff is attempting to program each patient so he may become a well-rounded individual—an individual with an active mind and body that will enable him to prepare for responsibilities in varied degrees. Some of the activities and programs to help the various handicapped patients reach the highest potential are Project Teach, daily living center, camping, Foster Grandparents, Girl Scouts, Boy Scouts, 4-H, independent living, continued use of apartment settings, room living settings, and regular religious instruction by volunteers. Volunteers provide one-to-one relationships to patients, and others work with small groups.

Camping has become an integral part of the over-all hospital program. It has grown from 364 participants in 1966 to 797 in 1968. For the mentally retarded, camping is an experience in group living in a natural environment. It is a sustained experience under the supervision of trained leadership. The patient-residents usually spend a week at various camps throughout the state. This past summer Cambridge conducted a day camp experiment which was considered very successful.

Project Teach is a program funded through a federal grant. The residents involved are severely and profoundly retarded adolescents under the age of 21. The range of abilities vary from some who can care for themselves to those who cannot speak, cannot dress themselves, or cannot eat by themselves. Objectives are different for each resident involved, but the one main goal is to improve their level of functioning from what it is at present, so that residents can become more independent and increase both

their social and self-help skills. There are 60 residents involved in this program. Progress has been substantial.

The Foster Grandparent program has been of tremendous value. Forty were assigned to Cambridge. Each grandparent had two assigned children, spending two hours with each patient weekdays. The foster grandparents give personal attention, and in doing so, bring out the personalities of the patients. The children have shown improvement in toilet training, eating habits, and appear happier, perhaps because they have a feeling of belonging to someone. The children have an opportunity to be away from the wards and to enjoy other surroundings. There is no doubt as to the benefit gained mutually. The grandparents, as well as the children, gain as their lives become more meaningful, with greater security.

Religion is also a part of a well-rounded individual. The Protestant and the Catholic chaplains both have religious instruction conducted by volunteers. This has grown tremendously. For the Protestants, from 20 volunteers for 100 residents in 1965 to 68 volunteers for 450 residents in 1967-68; for Catholics, from 10 volunteers for 80 residents in 1965 to 60 volunteers for 250 residents in 1967-68. Besides these instructions, the chaplains conduct services, special classes, confirmation, etc. The Protestant chaplain has also involved patients in religious chancel dramas, which were given at the hospital as well as in many churches in the community. In the religious program, the residents also learn to do for others rather than just for self.

Volunteers of all ages (330 regular and 500 occasional at the hospital plus countless numbers of others who help through donations, etc.) play an important part in the total program of the hospital. Some participate in the one-to-one program, others in group projects, others present entertainment programs. The past two summers Cambridge has had young people as full-time volunteers. This year, 60 young adults gave two weeks of their time. Seven Catholic nuns also volunteered for five weeks full-time. All the volunteers enjoyed structured assignments for 12 hours per day, six days each week. The mornings and part of the afternoons were spent working under the supervision of the nursing department. In the afternoon and evening, they were assigned to the Project Teach and recreation areas. In all the assignments, the volunteers worked with patients. Many of the volunteers have returned since their two-week experience. Comments indicate that young people accept the mentally retarded as individuals, and are willing to help them.

Faribault State Hospital

During the past two years there have been a number of major developments at the hospital. Of major importance has been the refinement of the unit structure which has allowed the establishment of independent and group treatment and training programs for many residents. This progress has resulted from increased staff granted by the last Legislature, as well as reductions in inpatient population due to community placement and transfer to other hospitals.

Programs for Residents: Project Teach has made a great impact upon the lives of 250 profoundly and severely retarded school age children. Seventy-five project "mothers" have been hired on a part-time basis to teach basic self-help skills in feeding, toileting, and ambulations. Many youngsters formerly confined to wheel chairs and beds are gaining skills in ambulation which allow them to become more involved in their environment. A physical therapist, speech therapists, occupational therapists, and child development specialists provide consultation and direction to this project.

Other education programs are offered youngsters within the hospital, and during the past year the education department has expanded the services offered to adult residents. Other developments include audiological screening of the residents and the development of speech and hearing services.

The hospital has been fortunate in having been provided a Foster Grandparent program, sponsored by the Minnesota Association for Retarded Children and financed by the U. S. Office of Economic Opportunity. Under this program, 40 elderly men and women of low income are employed to furnish personal attention and service to 80 children. Although one of the objectives of this program is to provide both the children and the foster grandparents with close personal relationships, there has been a notable improvement in function on the part of many of the children who have participated. As an example of what can be accomplished with the mentally retarded through close patient relationship, this program has been of inestimable value.

Improvements in medical service include consultants in surgery, internal medicine, orthopedics, neurology, dermatology, radiology, podiatry, and psychiatry. These consultants plus the hospital medical staff have allowed for continued improvement in medical services. The consulting psychiatrists have developed treatment programs for emotionally disturbed residents.

Hospital personnel have completed the following research projects:

- **Continuation of diet studies on PKU patients.**
- **Aminoacid metabolism in PKU, in cooperation with the staff of the University of Minnesota pediatric department.**
- **Behavior and blood phenylalanine level in PKU, in cooperation with Dight Institute, University of Minnesota.**
- **Genetic PKU family study, in cooperation with the Minnesota Department of Health.**
- **The evaluation of the Guthrie "Inhibition Assays" in cooperation with researchers at the University of Minnesota.**
- **Dermatologlyphics in microcephaly, in cooperation with the Veterans' hospital's department of neurology.**

In addition, the psychology department has done much work in program evaluation by developing behavior rating instruments. These ratings are proving extremely useful in developing and classifying residents by their needs and measuring their progress. This project has been assisted by funds from the U. S. Public Health Service funds for Hospital Improvement Project programs.

The Hospital In-Service training grant has aided immeasurably in the development of the training programs for nurses, aides and technicians, allowing the hospital to supplement the nursing education staff as well as bring in experts in treatment and programming for the mentally retarded.

During the past biennium, the hospital has broadened considerably its community contacts. One example is the developing parent-staff group meetings. These groups have provided a means for greater involvement of parents with their children, their children's programs and the hospital. Parents are better informed on their children's activities, what the staff is doing and planning, and what their own role is expected to be. They have given valuable service and advice to the hospital. Parent groups have provided funds and labor to refurnish a ward, develop and equip a playground, and reorganize clothing facilities. A decided improvement in parent-staff relationships, and sometimes in parent-child relationships, has been the result.

Another example of increased participation in community programs is the hospital's involvement in regional MH-MR planning groups.

As the hospital's population decreases, more specialized treatment and training programs for severely and profoundly retarded multiply handicapped residents are being developed. The staff is enthusiastic and determined to improve the services provided the mentally retarded in the hospital's receiving district.

Fergus Falls State Hospital

Since June 30, 1966, the hospital has undergone many changes of a dramatic nature. The geographic units have become solidified into four units, each relating to a mental health - mental retardation program in the area, and each developing its own distinctive program for the treatment of mentally ill through involvement of county welfare departments, area programs, the hospital, and other helping agents as available. The medical-rehabilitation unit has developed meaningful programs for the more severely handicapped of the population, including a physical therapy unit that has demonstrated outstanding success with some of the physically handicapped patients. The adolescent unit has continued to solidify its treatment program, and has gained considerable acceptance throughout the area as one of the very few resources for this kind of treatment. The independent living unit has decreased its population, through placement of residents by continued work with the sheltered workshop and other resources, to the point where plans for disbanding this unit are presently under way.

This hospital has been heavily involved in a community-hospital-area program development of area committees whose goal is to provide some organization of mental health and mental retardation programming, as well as assessment of needs for the use of the resources of the hospital by the various communities. The hospital has been flexible, unit by unit, in response to the distinctive demands of the various communities served.

Another development has been the involvement of psychiatric technicians in the treatment process. Along with a very clear delegation of responsibility and line authority to unit program directors, has come a clear delegation for the technician's responsibility in the area of planning with residents the treatment process that would be the most meaningful to each individual. The ability of many technicians to perform in this area has been demonstrated far beyond expectations.

This past year the Junior college housed on the grounds of the hospital has provided an opportunity to expose an educational institution to a mental hospital and vice versa. Thirty students from the college lived on the wards in adjoining rooms to residents, in return for which these students have given the program their youthfulness and enthusiasm and many very close, personal relationships to residents.

The hospital has begun work with the mentally retarded; first, by working with Brainerd and Cambridge state hospitals concerning placement of patients through the county welfare departments in the region.

A few mentally retarded patients have been admitted directly from the community—an experience meaningful for both the staff and the mentally retarded resident.

This past year has seen the development of the nurses' cottage to house an entire geographic unit. This building has been minimally used to house students and guests of the hospital while at the same time being a warm family life kind of facility that was remodeled sufficiently to provide an ideal living situation for residents. Some of the former staff homes are now used for residents on an independent-living, activities-of-daily-life training basis. This has expanded the hospital's ability to provide a nonclinical sort of setting for living and learning, the basis for the hospital's program.

Hastings State Hospital

For its receiving district of Ramsey, Dakota, and Washington counties, the hospital continues a treatment program for the mentally ill and for the aged, and recently has established units for the mentally retarded, for alcoholics, and for the physically handicapped.

During the past few years, dramatic improvements in the treatment programs have enabled the hospital to reduce its in-patient population to the present level of slightly more than 300 patients, while experiencing an increasing rate of admissions. Average resident population declined; releases from the hospital as well as admissions have increased. Average length of stay also continues to decline.

Three psychiatric wards house adult psychiatric patients according to their county of residence. An especially sharp drop of the number of geriatric patients in the hospital shows a decrease of two-thirds during the past two years. Geriatric patients now are living in two wards.

Near the end of 1967, a day treatment center was opened in a building previously used as a patient ward building. Persons who do not require full hospitalization now may live in the community and receive appropriate treament during the day.

The establishment of the Cooperative Vocational Rehabilitation project has increased patient use of community vocational and rehabilitative services. The sheltered workshop at the hospital, formerly known as Industrial Therapies Enterprises, has been incorporated into the CVRP program, and so has the independent living unit for women. Volunteers supported the opening of a new independent unit for men.

Staff development included a new curriculum and training program for senior psychiatric technicians, and a series of training seminars for per-

sons working with geriatric patients, the mentally retarded, or the alcoholic. A one-week intensive hospital staff evaluation with two consultants provided a catalyst for the program in training and development for the entire hospital complement.

Hastings state hospital is accredited by the Joint Commission on Accreditation of Hospitals, and has a staff of 292. It employs 8 other persons through federally-supported programs.

Through the encouragement of the East Metropolitan Regional Coordinating Committee, an accelerated treatment program for adolescents was begun. This includes both organized treatment, special activities and special education.

Lake Owasso Children's Home

Established as an annex to Faribault state hospital in 1955, Lake Owasso has operated as an annex to the Cambridge hospital since 1961.

The majority of the residents were admitted by transfer from Cambridge with only an occasional direct admission. The population continues to be 130. The present employee complement is 49. During the past two years, the direct patient care staff has increased from 21 to 23 technicians.

A program entitled Goals for Home Living was established two years ago. The specific purpose was to help residents become less dependent on staff and more capable of making their own decisions. A high percentage of the residents who originally were in this program have been discharged to community facilities.

A new home economics department has been a successful addition. All residents are included in the summer camping program, and each resident attends two sessions per year.

Space created by discharge of residents has been used for children and teenagers who were transferred from Cambridge. The staff of Davis hall was challenged by the changes necessary to accommodate and program for almost a complete turnover of residents. Dedication and good morale of the employees contributed to the successful changeover.

The rehabilitation department contributes actively to an on-going recreation, socialization, and vocational program. During the past two years, the greatest change has been in the amount of community involvement. YWCA, Girl Scouts, activity clubs with former residents now in residential facilities, community church services, and a variety of one-to-one volunteer services, are a few of the added activities.

Success of a therapeutic program with individualized care plans is less

difficult to achieve in a small institutional setting. The goal is to give therapeutic training for all residents, to assist each resident to obtain the maximum benefit of her potential, and to provide as home-like an environment as possible. Every technician is assigned a small group of residents to teach and counsel on an individual basis or in a group. Many skills have been developed with this special attention and training. All employees work as one team with close cooperation and ready communication.

Minnesota Residential Treatment Center

During the past two years, the center has been undergoing various organizational and programming changes while continuing to provide a full program of in-patient treatment for emotionally disturbed children and intensive child-centered work with their parents.

Perhaps the most significant change made was the discontinuance of adolescent admissions and the instituting of a policy of admitting children age 5 to 12. During the fiscal year July, 1967, to July, 1968, approximately 97 children were processed in admissions and discharges. This figure represents a total approximately equal to that processed for the center since its opening June, 1963.

The changes allowed for the instituting of a part-time medical director/chief psychiatric consultant with a program coordinator acting as program administrator under the medical director's supervision. Other changes included the separation of various major departments with different functions, which were formerly one under a supervisor, into separate units each with its own director or supervisor.

The center continues to serve as a training resource for trainees in the various disciplines associated with the treatment of the emotionally disturbed child. Because of the wide range of psychiatric problems treated, it continues to offer an excellent training experience to these and other disciplines.

The social services department has started a parent group counseling service. This was a needed addition to the already existing individual parent counseling.

The rehabilitation therapies department continues to supplement the physical education and recreation program through federal funding. Volunteer services is being expanded to include a librarian and aides in music and occupational therapies. Cooperative work pertaining to developing a set of procedures for identifying and correcting problems of physi-

cal coordination continues between the rehabilitation and psychology departments.

Child care personnel continue to participate in an on-going in-service training program that is designed to assist them in better understanding themselves as well as understanding the behavior of the children.

Minnesota Security Hospital

The hospital serves the state by providing care and treatment for male patients who are at the same time mentally disordered and have a severe behavior problem.

Most of the patients are transferred from other state hospitals, although some come directly from the courts or from the correctional system.

The program is based on the patients' critical needs, and resembles a rehabilitation program more than a classical treatment program. Once the mental disorder is modified to an acceptable degree, the focus is on learning socially acceptable behavior. The hospital's over-all program includes therapy programs, and a broad group activity program with extensive off-campus educational and recreational activities.

For the more able patient, there is a varied vocational program including a sheltered workshop, furniture refinishing, auto reconditioning, janitorial training, and in the near future, food service training. Some of the patients work full time in the community, returning to the hospital evenings.

The school program utilizes programmed learning techniques.

Treatment efforts concerning the sexual deviate and the "dangerous" individual has been intensified in the hopes of learning more about these disorders for future programs.

Moose Lake State Hospital

The hospital continues to maintain its total "open hospital" status which originated in 1961. The open hospital philosophy sets the tone for acceptance of patient behavior and requires staff to learn more about the patient, find solutions to his problems, and modify his behavior.

It is the specialized rehabilitation facility for mentally ill, senile, and inebriate patients from 12 northeastern counties, and serves an area encompassing about one-fourth of the state's total land area and includes slightly more than 400,000 people. The population is primarily rural except for Duluth.

A considerable reduction in patient population has occurred during the past two years, primarily as the result of expanded community facilities in northeastern Minnesota, principally nursing homes. A review of patient population indicates that at present approximately 38% are adult mentally ill, 3% adolescent, 8% inebriate, 42% geriatric and 9% mentally deficient. The admission rate continues to increase.

The total hospital complement is 346.42 employees, which is an increase over the preceding biennium. These additional employees have been used to improve the hospital environment and to build its treatment program.

The treatment program is organized on the basis of six teams: four psychiatric, one inebriate, and one geriatric team. Each team has assigned to it specific professional and nursing staff, has its own physical plant facilities and specific patient load. Mentally ill patients are on an "integrated" basis, which does not segregate patients' categories, and leads to an improved milieu.

The hospital pioneered the Cambridge-Moose Lake Project, which involved the transfer of selected retarded patients to the open integrated mental hospital. The program has been successful.

Treatment is based on the concept of education for daily living, i.e., teaching or re-teaching the patient how to work and play, with a multitude of functions involved. In conjunction with this, patient living areas are designed and equipped to resemble "home," and activities areas are similarly designed and equipped to resemble "communities."

Heavy emphasis is placed on the community aspects of the hospital operation. Working relationships with county welfare departments and four area mental health - mental retardation programs in the receiving district are maintained through regular liaison committee meetings.

According to acceptable present standards for physical plant space, the hospital has now reached a point where the population of the hospital equals the physical plant facilities available.

Owatonna State School

The school had its beginning in 1945 when the State Public School for dependent and neglected children was changed by law to a school for educable or mildly retarded children. The 1967 law describes the current function of the school:

The Owatonna state school shall be used as a state institution to provide educational, vocational, and social training and such related therapeutic and rehabilitative services as are necessary to achieve the same for mentally deficient persons under age 21.

The following are descriptions of the types of children who may be admitted to Owatonna state school:

- **Mentally retarded children who are unable to function in a community setting. This includes those children who are unable to adjust to their own family setting, boarding homes, private residential facilities, and special classes, and also those who for some reason cannot adjust to the demands of the community.**
- **Children who need special services which the ordinary community cannot be expected to provide. This group would include those children who have some very special psychological, rehabilitative, or educational needs that the school can provide but which are too specialized to be dealt with in a normal community setting.**

The goal of the institution is to provide the necessary services to help students to make acceptable personal adjustments and to acquire the necessary basic skills for returning to community living in the shortest possible time.

Three programs are utilized:

CORE program. Students attend academic and pre-vocational classes, are assigned to on-campus work assignments, participate in campus and community recreation, and receive therapeutic services in accordance with their needs. Students in this program usually have behavioral and emotional problems that periodically have to be dealt with on an individual basis. When such emotional and behavior handicaps require a more concentrated group of therapeutic services, the student may be temporarily placed in one of the Intensive Treatment programs.

INTENSIVE TREATMENT program. This provides a highly individualized service with emphasis on the behavioral and emotional handicaps. It is a small coeducational unit in which a variety of therapeutic services is provided including psychiatric consultation, academic education, vocational and social training, recreation, etc.

INDEPENDENT LIVING program. This program is designed to develop and promote independence on the part of older students preparatory to return to the community. Emphasis is placed on vocational training and experience. Students are expected to manage their time and money, and also are encouraged to assume responsibility for the care of their appearance, personal effects and living quarters.

In summary, the school admits boys and girls, age 8 to 19, who are mildly mentally retarded and who, by reason of emotional, social and/or personal handicapping conditions, are unable to take advantage of facilities that are ordinarily available in the community. Criteria for admission through the appropriate county welfare department includes: (1) determination that the individual's needs cannot be met in the community; and

(2) determination that the school is the best available facility to meet the individual's needs.

Cooperative planning between the school and the county welfare department staff begins with the individual referral, and ends with final return to the community. The planning includes family and community involvement at every step.

Rochester State Hospital

The hospital's primary function is the treatment of mental illness, although it also receives patients with related, or other problems. This institution covers 700 acres and has a total census of 660.

There are active programs in recreational, industrial, and occupational therapies. Social services and volunteer services play a major part in rehabilitation.

Rochester has long held a position of respect for its use of current, modern medical and hospital practices. In 1889, it was the ninth hospital in the U. S. to establish training of nurses to care for the mentally ill. Proximity to the Mayo clinic and affiliation with its staff has been an advantage enjoyed by few similar institutions. An active surgical and consultative program is conducted by clinic physicians.

St. Peter State Hospital

The hospital's population continues to decrease from a high of 2,400 ten years ago to a new low of 404.

Nursing Service and Nursing Education. The St. Peter hospital has converted into the unit system, of which there are now four, based on county distribution. The registered nurse is the unit coordinator with major responsibility to coordinate all therapies within the unit functioning as a team. The team concept encourages continuous review of patient's progress in the hospital. The team also works closely with the county welfare worker and public health nurse in discharge planning.

Current nursing education programs are continuing. Lutheran Deaconess Hospital, Minneapolis, and Naeve Hospital, Albert Lea, send professional students to the hospital for a 12-week experience in psychiatric nursing. Mankato state college students also receive 12 weeks' clinical experience under the direction of their own faculty member. Four weeks' experience for practical nursing students in care of mentally ill is given to the students from the New Ulm School of Practical Nursing and Austin Area Vocational School of Practical Nursing.

Two programs for psychiatric technicians are given: the basic and the advanced technician course, the latter taught under a NIMH in-service training grant.

In-service programs and workshops for registered nurses and psychiatric technicians continue. Under the direction of a remotivation coordinator, 22 technicians are enrolled in a series of remotivation sessions.

Social Service. With the rather marked changes in treatment programming which have occurred within the hospital during the past two years, continual evaluation of service needs and reorganization of staff to meet these needs has been a prime necessity for the department. Open communication between community and hospital is essential to providing effective service and consequently an emphasis has been placed on the worker moving into the community to better acquaint himself with the resources and vice versa. Considerable effort has been put into improvement of the hospital - county welfare relationship with a gratifying return of more effective coordinated service to the patient. Lower caseloads have permitted this increased community programming, as well as improved individual and group casework services to the patient. A brief staff development activity on group work skills has resulted in increased group services being offered. Additional effort is being placed on education activities as an increased demand is being made by colleges in the area to provide field work experience for undergraduate students. With the development of the Minnesota Valley Social Adaptation Center, social services are now being extended to the mentally retarded as well as the mentally ill patient.

Volunteer Services. During the past year, another county mental health association, the Blue Earth chapter, has become interested in the volunteer one-to-one program. Currently, three counties are involved: Hennepin, Nicollet and Blue Earth. The nearby colleges continue to be a tremendous resource. Volunteer services are being provided for the new residents of the Minnesota Valley Social Adaptation Center. Volunteers who worked with the patients at Faribault are now visiting at St. Peter.

Culinary Department. This last year has been spent in planning for the new $650,000 kitchen addition which should be completed by the fall of 1969.

During the past year, the kitchen at Minnesota Security hospital was closed, and now all food is prepared and distributed from the main kitchen of the St. Peter hospital. With the closing of and consolidation of the various dining areas, complete food service coverage is provided in all dining rooms throughout the hospital.

Housekeeping Department. The department has expanded to 23 employees, thereby relieving nursing service of many housekeeping chores. The main objective of the department is to create a cleaner, more pleasant and healthier environment for patients and staff.

Rehabilitation Therapies Service. In rehabilitation therapies, educational services were increased for adults as well as adolescents. The tutoring program for high school credit was continued and other nonacademic classes offered for supplemental education. Courses were given in basic reading and arithmetic, personal money management, driver's training, health, and personal grooming.

Occupational therapy offered a wider range of programs to more patients. These included homemaking skills, good grooming, and a wide variety of crafts and other activities.

Division of Vocational Rehabilitation. The division continues to provide counseling, vocational evaluation, training and job placement. The services of Mankato state college, the Mankato Rehabilitation center, and other vocational schools are being utilized. Two additions to the program have received renewed emphasis: basic work adjustment and advanced work training programs. Nearly every patient is receiving or has received assistance in vocational rehabilitation.

Minnesota Valley Social Adaptation Center

The center is a new residential treatment center for young adult and adult (ages 16-65) retarded patients, located on the St. Peter campus, to serve a receiving district consisting of the following southwest counties: Blue Earth, Brown, Carver, Cottonwood, Hennepin, Jackson, Le Sueur, Lincoln, Lyon, Martin, McLeod, Murray, Nicollet, Nobles, Pipestone, Redwood, Renville, Rock, Scott, Sibley, Watonwan, and Yellow Medicine.

The center came into being as a result of a 1967 legislative directive which instructed the Department of Public Welfare to transfer up to 450 mentally retarded patients from the Faribault state hospital. To comply with this directive, it was decided that a highly specialized residential treatment center and program for the retarded should be created which could serve as a prototype for future units throughout the state.

The purpose of the center is to enable each resident to achieve his highest level of attainment. This means that as many individuals as possible will be helped to return to the community. All others will be helped to reach a high level of "fulfillment" and dignified citizenship within the residential setting.

Shakopee Home for Children

Thirty mentally retarded girls live in the home, located on the grounds of the Minnesota Correctional Institution for Women at Shakopee.

Established in 1951, when facilities for the mentally retarded were overcrowded, the home offers a unique dual program of penal rehabilitation and habilitation for the severely retarded youngster.

- **It is the only one of its kind in the country serving this dual rehabilitative purpose.**
- **It is small enough to give each of its 30 residents intensive individual treatment in the areas of self-help, locomotion, communication, self direction, and socialization.**
- **It is small enough so that the residents can enjoy family-type activities directed toward as much exposure to community resources as possible.**

Willmar State Hospital

Willmar state hospital continues to provide care to the mentally ill patients from 20 counties in southwestern Minnesota, and to the patients with addictive problems from throughout the state with the exception of an area served by the Moose Lake and Hastings state hospitals. In the past two years, the policy of minimizing a person's time away from his community, his family, and his everyday work, has continued.

This period has seen a continuation of many programs which have been familiar to and related to the hospital's service. The adolescent unit continues to operate with a 28-bed unit for youth from the ages of 12 to 17. Many of the hospital's staff shared in the start of this unit and continue with a sincere interest in its operation and expansion. A very close relationship has been established and continues to be refined with the Willmar school system with teachers in residence at the hospital on a full-time basis. A psychiatrist from the area mental health - mental retardation program in St. Cloud gives consultation service to this group, and provides an invaluable tie with the St. Cloud area, if not a wider territory.

The volunteer program has seen a change to the extent that the number of one-to-one programs has been increased, and at present, combined with group programs, is a way of life. This is a sincere and productive contribution, and one of the keystones of the hospital and its community.

Vocational rehabilitation is an activity that has been expanded with a full-time counselor stationed at the hospital for the first time, which has rendered a very important service for patients referred by personnel.

Chaplaincy training again has seen refinement, and for the first time there is a consolidation of pastoral training accreditation.

Renovation of cottages has continued in an effort to provide basic facilities for patients. Many of the buildings have not had a major redoing since their construction many years ago, and this is a well-received project. In this regard, ward living conditions have been watched very closely. Frequent rating scales have been prepared so a definite measure could be made of these conditions, with most positive results.

The Humane Practices Committee at the hospital has addressed itself to a variety of items that range from the manner in which patients are addressed in conversation, to some of the leisure time activities and availabilities of self help and efforts to eliminate—or at least reduce—institutionalization personality changes.

A reimbursement agent for the collection of monies for care and treatment has been established at the hospital and has added one more dimension to the state's relationship to the people for whom it cares. A counseling service, social security, medicare, and related programs have been a benefit to everyone concerned.

Perhaps the highlight of the past two years is the implementation of the Minnesota Hospitalization and Commitment Act. This has had wide ranging effects for patients, personnel, and community persons alike. A more sincere attitude and outlook has existed in preparation for this move as well as the on-going implementation which includes the review board visiting the hospital, and a closer working relationship with the courts and county personnel in the receiving area.

Rehabilitation efforts have included a variety of innovations such as a summer activity education program for the young patients at the hospital, a new bus which has been purchased to provide regular and routine visits to the surrounding community for shopping, group attendance at activities, etc. A small bank-type window at the hospital business office provides a service close to the community type for patients to transact financial affairs so far as their own money matters are concerned.

A federal grant for in-service training for personnel has given staff a chance to take a second look at their proficiencies and learn in depth new techniques and refine existing practices as it concerns the care and treatment of those persons hospitalized here.

The alcohol treatment program continues to render service to a large number of persons each year. The keynote is more individual attention and availability of staff to the patients in the unit. A full staff of coun-

selors plus the involvement of social service and psychology personnel has given greater intensity to the patient care. A bibliography was prepared by the hospital on the subject of alcoholism, now said to be the most comprehensive work available.

All in all, the past two years at Willmar have seen a continuation of an informal, yet intense attitude of help, directed to the person in need of care and treament.

Community Programs

Area MH-MR Programs

The broad goal of the state and local mental health - mental retardation program is to bring about reduction of the incidence and prevalence of mental disabilities (1) directly modifying individual functioning or behavior; (2) modifying the ways that communities deal with problems, which means changing attitudes and values, changing certain practices and expanding services.

To accomplish this goal and achieve the desired results, the department is attempting to develop a method or operation which will define or clarify responsibilities at the county, area and state levels, and relationships of the three systems (state hospitals, county welfare boards, area mental health - mental retardation programs).

As understanding of importance of program development has increased, many area boards have decided that to increase their effectiveness, increased staff effort and direction is required. To accomplish this, several boards have created the position of program director, relieving the staff person of clinical and consultative responsibilities so that he might devote full time to program development and coordination of available resources. In other smaller centers, this responsibility still is held by the director of the mental health center who continues to carry some responsibilities for clinical and/or consultative services.

By 1968, a total of 24 boards had been organized to serve 85 of the state's 87 counties. Offices are located in Albert Lea, Anoka, Austin, Bemidji, Braham, Crookston, Duluth, Fergus Falls, Grand Rapids, Little Falls, Luverne, Mankato, Marshall, Minneapolis, New Ulm, Owatonna,

Rochester, St. Cloud, St. Paul, South St. Paul, Virginia, Willmar and Winona.

At the end of the two-year period of this report, there were 155 full-time professionals working in area programs. This included 22 psychiatrists, 40 psychologists, 69 social workers, 13 nurses, and 11 other professional workers such as speech therapists, alcoholism counselors, psychometrist, etc. In addition, 29 part-time professionals, chiefly psychiatrists, contribute their skills to the various area programs.

The following financial statement serves as an indication of the programs' expansion:

Total State Support of Area Programs*

1955-57	**$ 233,084**
1957-59	**342,000**
1959-61	**770,452**
1961-63	**1,400,000**
1963-65	**1,900,000**
1965-67	**2,580,000**
1967-69	**3,270,000**

* In general these funds are matched on an equal basis by local funds.

A development that may have state-wide implications for coordination and joint program planning is the passage of the Minnesota Hospitalization and Commitment Act which went into effect January 1, 1968. This statute clearly requires the cooperation of the county agencies, particularly the welfare departments, and the state hospitals. The county welfare department has a great deal of responsibility in screening proposed petitions for commitment, in submitting social history reports to the hospital, and in jointly cooperating with the hospital in treatment and post-hospital planning. The area boards have a substantial responsibility in assisting the counties in fulfilling these functions, and in making effective use of the range of facilities for temporary hospitalization while a person is awaiting a commitment hearing. Area boards are involved in working with local agencies to carry out the requirements of the new law and to provide effective assistance to persons in a crisis who are facing commitment. The passage of this law has resulted in a much greater study of available resources and has pointed out the need for cooperation and joint planning to make the most effective use of available services. Area boards have been increasingly active in assisting the hospitals and the counties to make this happen.

Daytime Activity Centers

The success and popularity of the program, which serves pre-school mentally retarded children of all functional levels, school-age retarded who do not qualify for public education, and post-school-age retarded of all functional levels, continues to be apparent. Centers are now operating in 45 counties.

The 1967 Legislature appropriated $900,000 for the daytime activity centers program. During this period, the number of centers receiving state grants-in-aid increased to 66, with more than 1,000 children and adults enrolled. Emphasis during the past biennium has been on providing additional consultative services for these centers, and development of more adequate in-service training resources for board members and staff. Greater efforts also were made to increase services in the area of parent counseling.

The daytime activity center advisory committee, an advisory unit to the commissioner of public welfare, has developed a larger membership during the past two years. Membership now includes individuals with special interest in and knowledge of retardation from all areas of the state.

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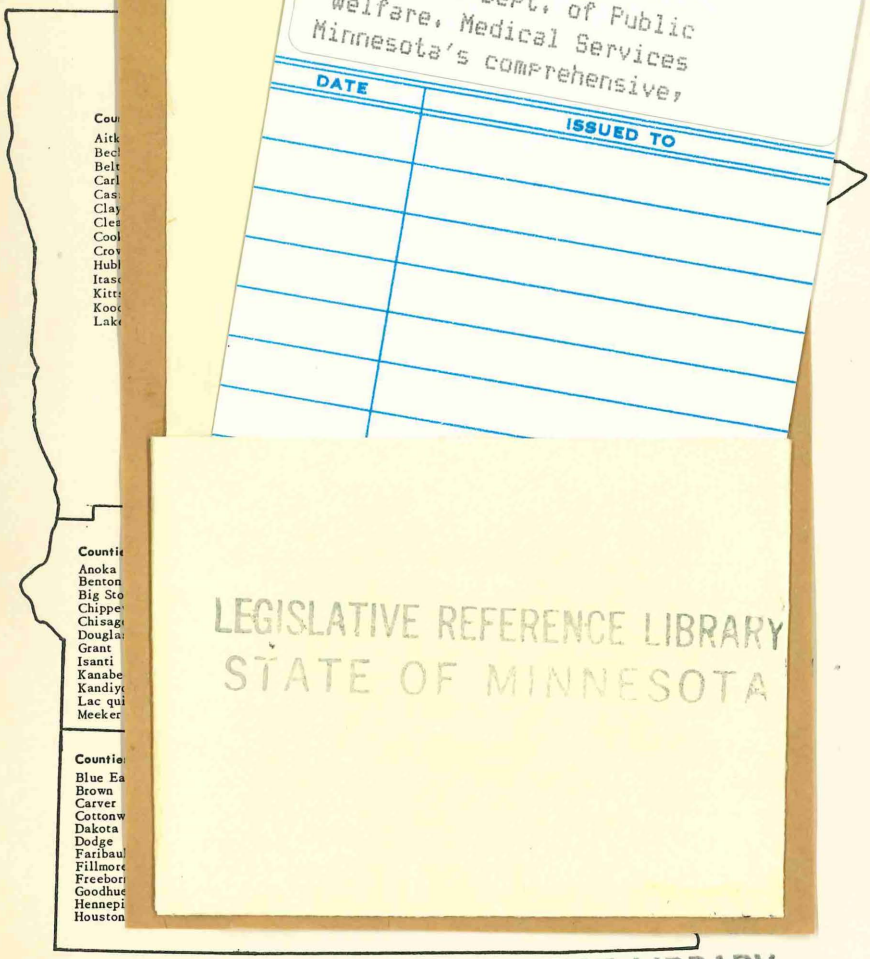

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