78-ENR-GTH

Rec'd 2/4/78

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MINNESOTA
Mental Health Research
Department of Public Welfare

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APPLICATION FOR RESEARCH GRANT OR CLEARANCE

TITLE:

Effects of New Resources on Patient Behavior and Care at Cambridge State Hospital

If State research funds are not being requested by this application, please check source of anticipated support:

- [ ] Local Support (including regular institution budget)
- [ ] Federal Grant
- [ ] Phase of Program Already Receiving State Research Funds
- [x] Other Support: (e.g., U. of M., foundations) Northwest Area Foundation

If a State research allocation is requested in this application, please check classification:

- [ ] Single Project Grant
  Amount requested $_____
- [ ] Phase of Program Grant
  Amount requested for total program $_____

PRINCIPAL INVESTIGATOR
Name Dr. Gordon T. Heistad, PH.D.
Title Professor
Facility University of Minnesota

CO-INVESTIGATOR
Name Dale Offerman
Title Chief Executive Officer
Facility Cambridge State Hospital

RELEVANCE: (What may be said in relating importance of this project to legislators and citizen groups?)
New resources which will become available to Cambridge State Hospital under term of the consent decree approved by the US District Court include significant increases in staff, programs and physical facilities. This research will be directed toward evaluating the effects of such improvements as a guide to resourc allocations to bring about maximum gain to CSH residents from the new resources.

PATIENT PARTICIPATION: (Approximate number? Description? What is expected of them?)
Daily behavior reports will be collected from residential care staff on all CSH patients (currently 586). All decisions concerning care, training, and treatmen of CSH residents will continue to be made in accordance with routine clinical procedures. This research will be concerned only with collecting data on goals selected by hospital staff and progress toward attainment of those goals based on daily hospital staff reports on batient behavior and progress.

APPROXIMATE ANTICIPATED COMPLETION DATE:
The data collection and analysis system proposed here is intended to be a "permanent" part of hospital routine. The developmental phase of the evaluation system should be completed, with foundation support, by June 30, 1979 Continuation of the system beyond that date will be the responsibility of Cambridge State Hospital.

A PROPOSAL SUBMITTED TO THE NORTHWEST AREA FOUNDATION
BY THE UNIVERSITY OF MINNESOTA ON BEHALF OF

Gordon T. Heistad, Ph.D., Professor
Department of Psychiatry

EFFECTS OF NEW RESOURCES ON PATIENT BEHAVIOR AND CARE AT CAMBRIDGE STATE HOSPITAL

The applicants: Organizational structure and key personnel. The University of Minnesota is a tax-exempt, state supported educational institution governed by a Board of Regents elected by the Minnesota legislature. Its financial support comes from state appropriations, federal and private grants, and student tuition and service fees. It is not authorized to operate on borrowed money. The principal investigator, Dr. Gordon T. Heistad, has served as a faculty member at Minnesota for 23 years and has been director or co-director for several major research and training grants totalling several million dollars in federal and state funding. He has served on several federal advisory research committees, including the chairmanship of a White House advisory committee on drug abuse. He is a professor in the Department of Psychiatry with essentially full-time research duties and also serves as research consultant to Cambridge State Hospital.

The statistical consultant, Dr. Robert Zimmermann, is a private research consultant after serving seven years as a university faculty member. He is author or co-author of several dozen publications in the area of therapy evaluation.

Mr. Dale Offerman, co-investigator and Chief Executive Officer of Cambridge State Hospital, initiated and directed a program for 300 retarded patients at Fergus Falls State Hospital for 5 years before becoming the Chief Executive at Cambridge. Under his guidance, the program at Cambridge has changed from one of the most seriously challenged programs in Minnesota to one of the best in the Nation. To a degree that is almost unique among hospital administrators, he is deeply committed to evaluation and has worked harmoniously with the principal investigator for the past year and a half on evaluation of drug treatment for retarded patients at Cambridge State Hospital.

History and Significance of Research Proposal: On December 28th, 1977, the U.S. District Court for Minnesota (U.S. Judge Earl Larsen) gave final approval to a consent decree between the

State of Minnesota and plaintiffs representing patients at Cambridge State Hospital which requires extensive physical improvements, substantial program changes, and an increase of almost one-third in state supported staff/patient ratio at Cambridge State Hospital as compared to 5 years ago when the court action was initiated. The court orders which will now be fulfilled under the consent decree have especially profound implications because they were based on a federal court finding, later upheld by an Appeals Court, that retarded patients who are confined to state institutions have a constitutional right to a specific level of care and training. Since all other institutionalized retarded patients have equivalent constitutional rights, the way has been paved for demanding equal resources at all other state institutions in Minnesota and the Nation. The cost of comparably increased resources in Minnesota State hospitals would be approximately 100-150 million dollars in the next decade and the National cost would be between 5-10 billion dollars in a decade. The need for systematic evaluation of the effects of such improvements is too obvious to require further justification here.

Current status at Cambridge State Hospital: There are now 586 residents at Cambridge, of whom more than 90% are diagnosed at seriously or profoundly retarded. The small remainder of mildly or moderately retarded residents remain hospitalized due to concurrent psychiatric illness or severe behavior problems. Approximately 250 patients are non-ambulatory. Not more than 15% can eat a meal with normal eating utensils without staff assistance. Less than half are fully toilet trained although the majority have some degree of bowel and bladder control. Many thousands of less severely handicapped retarded patients have been discharged to community resources in recent years and those who remain in Minnesota State Hospitals are far more profoundly handicapped than is generally realized by the public.

Evaluation Plan: As outlined in the detailed proposal submitted for scientific review, the court ordered changes will result in a year or more of drastic improvements in resources available for Cambridge patients. The hospital has already conducted a partial "baseline evaluation" of every resident in preparation for these changes and has firmly allocated substantial resources for continuous evaluation of every patient, beginning approximately May 1st when funds become available for both increased training programs (and other improvements) and for continuous evaluation. With grant support, these investigators propose to initiate an evaluation system on every patient in February (instead of May or later) to obtain baseline information before the drastic improvements in staff, programs and facilities occur. The hospital will assume full responsibility for data collection, utilizing their new resources, after only four months but the research program will maintain a skeleton staff to coordinate a constant data collection system for a one year period of rapid change in resources. The research program will also develop improved analysis methods (refinements of current methods already in use) and complete an analy-

sis of changes associated with improved resources with publication of the results scheduled by June 30, 1979.

The study of improved resources will include contrasts of specific large groups of patients who have improved staffing, excessive crowding, remodeled quarters, new programs, and other changes as compared with others who do not have those same things at some point in time during the transition year. The methods used to make these comparisons will be similar to methods already in use for our current studies of effect of drugs on patient behavior in compliance with earlier court orders.

Policy Implications: The court ordered level of care and training at Cambridge is no longer in dispute, since it has been agreed to by the State. Data on effectiveness of that level of resources should ideally be available before the legislature makes its decisions on other Minnesota hospitals or further court actions dictate such actions. However, such decisions might be made by the current legislature before such data become available from this research under court and public pressures to do so. Our data should certainly be available to guide legislative actions of other states (or court decisions) as the new judicial doctrine of "constitutional right to a specific level of care" is gradually extended.

Within Minnesota, a recent meeting on program evaluation at the Department of Public Welfare strongly supported the statement that there shall be evaluation of effectiveness of these new resources on patient progress on all patients at all Minnesota State Hospitals, if possible, on instructions from the highest levels of State government. This research is viewed by both the investigators and state officials as a prototype of evaluation methods that might be applicable with little change at other hospitals but, at least, will assist other hospitals to develop their own evaluation system. The primary intent of a statewide evaluation of the effect of resources on patient progress will be to obtain maximum benefits from available levels of support but a secondary benefit will be assistance in determining the level of resources required to achieve the State's goals with respect to institutionalized retarded citizens.

Principal Investigator Assurance: The undersigned agrees to accept responsibility for the scientific and technical conduct of the project and for provision of progress reports and/or a final report if a grant is awarded as a result of this application.

Gordon T. Heistad

January 16, 1978

Gordon T. Heistad, Ph.D.
Professor, Department of Psychiatry
University of Minnesota
Minneapolis, MN 55455
Telephone: (612) 373-5025

Budget Summary: (Detailed budget submitted elsewhere).

Phase A: Implement an evaluation system before major resources become available and obtain baseline data: (First four months).

$30,855.00 personnel plus supplies and other costs.

Phase B: Maintain a constant evaluation system during the transition year: (First 12 months).

$23,352.00 personnel plus supplies and other costs.

Phase C: Coordinate project, develop analysis methods, analyze data and publish results: (Entire 16.5 months).

$39,634.00 personnel plus supplies and other costs.

Supplies, Computer Fees and Other Costs:

$24,740.00 (Spread over 16.5 months)

Total Direct Costs:

$118,581.00

Indirect Costs:

To be negotiated with University.

EFFECTS OF NEW RESOURCES ON PATIENT BEHAVIOR AND CARE AT CAMBRIDGE STATE HOSPITAL

Submitted by: Gordon T. Heistad, Ph.D.
Professor
Department of Psychiatry
University of Minnesota

Detailed Statements of Research Strategy, Methods, and Schedule Submitted for Scientific Review by Northwest Area Foundation Consultants:

To a degree that is unique in the experience of this investigator, Cambridge State Hospital has already demonstrated by its actions and firm committments to future action a determination to build a comprehensive evaluation system. The federal court has required systematic data collection on patient behavior and progress for slightly more than one-third of the total Cambridge population who are currently being treated with major tranquilizer drugs. For the remainder of the patients, state and federal regulations require a formal (but not necessarily structured) statement of treatment goals for each individual patient and "quarterly review" of progress towards those goals. The hospital has shown its determination to build and use an evaluation system by firmly allocating new staff resources which will become available in May, 1978 to provide the same kind of systematic data collection on all patients that is required for those on tranquilier medication. Whether or not this request for foundation support is approved and funded, the hospital will begin to collect an extraordinarily large amount of patient behavior data, beginning in May, 1978, to be used for making treatment and training decisions about individual patients at the hospital. Unfortunately, the beginnings of that system will occur too late to provide baseline information that could be used to evaluate the changes in resources that will become available in May and the system will be implemented too gradually to provide a constant source of data during the period of rapid transition after the new resources become available. Also, the evaluation system which the hospital currently intends to implement may not have sufficient uniformity and structure to be usable in comparing groups of patients since it is intended primarily for use in decision making concerning individuals.

If this proposal is approved and funded in early February we propose to (1) initiate a major component (but not all) of the total evaluation system early enough to obtain baseline information on patient behavior and progress before the major increases in resources that will occur in May. (2) Maintain that partial evaluation system constant for at least a year to obtain comparable data on all patients at different points in time during the rapid transition in available resources. (3) Structure and formalize the procedures for data collection that are already planned to permit

comparability across groups of patients, programs and periods of time. (4) Further develop and apply the methods of analysis of data that are currently used in our on-going research on drug evaluation in Cambridge patients and explore additional methods of analysis borrowed from industrial product control technology. (5) Transfer full responsibility for data collection to the hospital as soon as they obtain their new resources, but maintain a skeleton staff for coordination and data processing to insure constancy of the evaluation during the year of the proposed study. (6) Analyze the data and publish the results of an evaluation of the effects of added resources on patient behavior and progress before, during and after there are major changes in available resources at the state hospital.

PHASE A: RESEARCH PLAN AND SCHEDULE. Implement a constant data collection system for all patients February 15th - June 15th, 1978.

As soon as possible, hopefully by February 15th, we propose to recruit six research behavior analysts (psychology graduates with special training in behavior modification techniques) from among the applicants for permanent positions at Cambridge State Hospital. We are assured of cooperation from the Department of Public Welfare in order to recruit persons for temporary positions on the University payroll who have a high likelihood of being offered permanent positions at Cambridge State Hospital when funds become available for the hospital to hire 30 additional behavior analysts during the months immediately following May 1st, 1978. We propose to place one of these behavioral analysts in each of the six major residential units of Cambridge State Hospital to begin the implementation of an evaluation system before major new resources become available for patient care and training. In each unit, every patient is already scheduled for a quarterly review of goals and progress; thus, all patients will be reviewed in this way within 3 months after the program is initiated. Our research behavior analysts will attend the quarterly review for each patient in their unit to formalize the structure (but not determine content) of the goal statements which must be made by the participating hospital staff. Such goal statements will henceforth be made in terms of small increments of behavior that are observable and quantifiable by residential care staff in constant contact with each patient. The behavior analyst will prepare a "behavior report form" for each individual patient listing the discreet behaviors which are to be reported daily by the hospital staff because they have been selected by the hospital staff as unique goals for that individual patient. The report form will typically include no more than 10 discreet behaviors to be reported, including both objectionable behaviors (like yelling or physical agression) and desirable behaviors (like dressing skills and eating skills). The daily report on each patient's behavior will require no more than 5 minutes per patient per day; however, the total reporting time for all patients in the hospital will accumulate to 50 hours per day of hospital staff time. After initiating the daily report procedures for each individual the behavior analyst will also assume responsibility for training the unit staff in

uniform methods of data collection and monitoring the data collection. Within three months every patient in each unit will be included in the system.

PHASE B: MAINTAIN DATA COLLECTION SYSTEM AND DEVELOP METHODS OF ANALYSIS. June 1978 - February 1979.

As soon as funds are allocated to the state hospital and civil service procedures can be followed, we expect that all six of the behavior analysts will be transferred to the state hospital payroll to continue the functions they began in Phase A, but they will also be joined by 24 additional behavior analysts who may share those functions. There will be relatively modest changes in the residential care staff of each unit since the hospital has already hired an additional 100 residential care staff members and the new resources to become available soon will be devoted to primarily training-staff. Therefore, the data collection system derived from residential care staff will remain relatively constant throughout the year. However, concurrently with data collection described above, the massive increase in behavior analysts and other training staff will result in additional components of the total evaluation system being added gradually throughout the year. Virtually the entire job description of a behavior analyst is to (1) Specify goals in discreet behavioral terms. (2) Obtain baseline quantitative data on the behavior to be modified. (3) Implement a behavior modification system (specific training). (4) Continue to quantify the behavior being trained and (5) Specify additional new goals when the data show that old goals have been achieved. This highly quantitative supplementary data will become available gradually through the year on several behaviors for virtually every patient in the hospital. Such data will be treated separately from the basic system of evaluation, derived from residential staff described above, but will be analysed to determine whether the results from the basic system are consistent with results of these supplementary components.

During Phase B, grant support will be used for a skeleton staff to collect and collate both kinds of evaluation data and transfer them into language compatible with computer storage and analysis. Concurrently, the principal investigator, statistician and computer programmer will be utilizing relatively small segments of that data to refine and validate appropriate procedures for statistical analysis of the rapidly growing data bank.

In our present studies on Cambridge patients, we are collecting time samples of behavior data on patients during periods when treated with tranquilizer drugs vs. periods of placebo. We have developed analysis procedures that appear to be thoroughly workable for that kind of data. The data to be collected under this proposal is similar to, but not identical with, the behavior time sample data in our drug studies. Initially, we will apply the same methods to the new kind of data that we are using with our present data, but we expect to encounter serious, but not insolvable problems. We will have data from many observers instead of a small number and data that will be strongly related to learning curves, which tend to asymptote or otherwise deviate from the mathematical assumptions of "normality" underlying

our present analysis techniques.

At present, we are obtaining many samples of behavior per day over extended periods of drug versus placebo treatment and we therefore obtain sufficient data on variability within a single individual so that we can apply conventional statistical procedures (e.g., analysis of variance, and t tests) to determine whether a sudden change or gradual change in the slope of a regression line are outside the range of normal variability for that individual patient. Thus, we are able to utilize refined statistical analyses to assist in decision making regarding future drug treatment on individual patients. This kind of analysis within individual subjects gives a unit of measurement for behavior change of each individual patient based upon intra-individual variability of that same patient. That unit of measurement is comparable to the "Z" scores often employed by statisticians to create comparable units of measurement for combining the results from individuals into groups or for comparing one group with another or one time period with another time period. Utilizing this unit of measurement based on variability, we are now using an unweighted means analysis of variance for repeated measures as our primary statistical technique for testing the effectiveness of the tranquilizer drug vs. placebo in the total group of patients who serve as research subjects in our studies. We have also explored in some depth the use of "regression analyses" to determine the rate of change in patient behavior (and in groups of patients) on drug vs. placebo.

Since the data to be derived from the basic evaluation system proposed above will be similar to the data from our drug studies, we are confident that we can use similar analyses in the research proposed here, but we will have many technical problems which must be solved. (The principal investigator has already received an 8-page memo from the statistical consultant on these technical problems that must be dealt with). In addition, we have found that the "time series analyses" that are routinely used in industrial product control applications are very probably usable for both our drug study purposes and for the kind of data to be collected under this proposal. Such techniques would be particularly valuable for evaluation research such as we propose here because they were specifically designed to separate changes that are associated in time with a specific event (e.g., a new production method in industry or re-modeled buildings at a state hospital) from across-the-board trends in the data associated with irrelevant variables such as weather conditions and other events that apply equally to all groups. Technical reviewers of this application are particularly referred to the book, Time Series Analyses by Box and Jenkins, San Francisco, Holden-Day, 1970, for a discussion of these methods as they are used in industry and to an article by Donald Campbell entitled "Reforms as experiments" in the American Psychologist, 1969, Volume 24, pps. 409-429 for a discussion of similar methods applied to the measurement of social and behavioral consequences of public policy actions.

As we attempt to measure changes in patient behavior associated with specific kinds of added or different resources and programs at Cambridge State Hospital, we will sometimes be able

to allocate patients to different "treatments" in accordance with a true experimental design (e.g., continuation of the drug-placebo comparisons now under way), but more often the groups of patients who receive different "treatments" (e.g., re-modeled residential quarters in early 78 as compared to remodelling in late 1978) will be only approximately comparable. This is almost always the case in evaluation studies as distinguished from true experimental designs. For such problems, we will have the distinct advantage of a complete set of data on every patient at Cambridge utilizing the Minnesota Developmental Program System to evaluate the skills of each patient in 18 different areas of behavior. That evaluation on every patient has just been ordered by the Hospital Director and completed by the hospital staff as the first major step in fulfilling their committment to evaluation in connection with the great changes that are about to happen at their hospital. Utilizing that data, we can determine whether "approximately equal" groups of patients are actually equal. To a considerable degree, we can statistically correct for inequalities in the different groups to be compared with each other and we will at least know when important differences exist between the groups being compared so we can exercise necessary cautions in interpreting our results. We do not expect that we will be able to develop perfect or ideal methods for statistical analysis during Phase B of this proposed project; however, we are confident that we can develop and use methods that are valid, with reasonable sensitivity and precision.

The research staff proposed in this application will retain primary responsibility for the "basic system" of constant data collection during the year and participate in development of the additional components described above. However, primary responsibility for development of a permanent evaluation system compatible with future hospital procedures, will be vested in a hospital employee to be appointed as soon as possible as "Director of Evaluation". Recruitment has already begun to locate a Ph.D. level psychologist to fill that position as soon as possible - possibly as early as March or April, 1978. This is further strong evidence of an intense committment to evaluation on the part of the hospital administration. Our research staff will serve in a consultant capacity to the new director of evaluation with respect to long term evaluation plans and that person will function as a full co-investigator in the research proposed here. Our data will contribute greatly to development of a valid and sensitive long term plan; however, the final responsibility for long-term evaluation will rest with qualified hospital personnel rather than the temporary research team at the end the Phase B.

PHASE C: ANALYSIS OF FIRST YEAR DATA AND PUBLICATION OF RESULTS ON EFFECTIVENESS OF IMPROVED RESOURCES ON PATIENT BEHAVIOR.
February - June, 1979.

At the end of one year of data collection during a period of rapid changes in available resources, we will utilize the statistical procedures then available to analyze the entire data bank to compare the "haves" versus the "have nots", at various

points in time with respect to the new (and sometimes old) resources that will not be uniformly available to all patients. These comparisons will include the following: (1) Approximately 200 patients will be severely crowded into cramped temporary quarters in early 1978 while their permanent quarters are being remodeled. The same events will occur for 200 other "comparable" patients about 8 months later.

(2) Approximately 300 patients now receive 6 hours per day of training operated by an adequately staffed public school program that will not receive additional staff. Another 300 (older) patients are trained in a hospital program and will receive double their current level of professional training staff for their daytime training program.

(3) The school-operated daytime training program will take a 6-weeks vacation with no daytime formal training available during July and August, but the hospital-operated daytime program will continue uninterrupted throughout the summer. (Optional summer school training has been a point of controversy for several years).

(4) Approximately 40 students, age 21-25, will be disqualified for further school training on the basis of funding "technicalities", while about 100 "comparable" others will remain in the program. During the following year, one group will receive hospital training, heavily dominated by "behavior modification" staff while the others will remain in a program operated in the traditions of "special education".

(5) All 586 patients will receive a 600% increase in "behavior modification" staff and programming in their residential settings (aimed primarily at the control of maladaptive behavior) but that change will occur at least a month or 6 weeks earlier for half of them than for the other half.

(6) Carpeted training areas were ordered by the court, but installation will occur very soon for about one-third of the patients, 8 months later for another one-third and possibly more than a year later for the remainder.

(7) Approximately 240 patients currently treated with major tranquilizers will have court-ordered "drug holidays" to compare behavior with and without medication. (A continuation of our present drug studies).

(8) All 586 patients will have substantially higher total staff/patient ratios during weekdays as compared with weekends and holidays.

(9) There will be a 400% increase in physical and occupational therapy staff and programs for all patients needing such services, but the change will occur many weeks earlier for some than for others.

For each comparison listed above (and other possible compari-

sons) the groups to be contrasted for patient behavior and progress will be compared with respect to age, functional level, diagnoses, and other characteristics on which we have baseline data from the hospital-wide preliminary evaluation now underway. Where groups differ in various respects, we will apply statistical corrections (e.g., stratified sub-samples) when possible and qualify our conclusions on the basis of known demographic data when necessary.

Analysis of data will be scheduled for completion by June 30, 1979, and further evaluation at Cambridge State Hospital will be the sole responsibility of hospital staff.

Rec'd 2/4/78

DETAILED BUDGET February 15, 1978 - June 30, 1979

I. PERSONNEL:

	Salary		Salary	Fringe Benefits**
Principal Investigator (Gordon T. Heistad)*	15% time	16.5 months	$ 9,000.00	$1,800.00
Statistical Consultant (R. Zimmermann)	40% time	16.5 months	15,840.00	NA
Computer Programmer (P. Grabow - Grad. Res. Assistant)	75% time	16.5 months	12,994.00	NA
Sr. Data Entry Operator (To be selected)	Full time	12.0 months	9,650.00	2,026.00
Sr. Clerk (To be selected)	Full time	12.0 months	9,650.00	2,026.00
6 Behavior Analysts (To be selected - Jr. Scientists	Full time	4.0 months	25,500.00	5,355.00
			$82,634.00	$11,207.00
	TOTAL PERSONNEL COSTS		$93,841.00	

II. OTHER COSTS:

Supplies (Including approximately 350,000 data sheets and computer cards)	$ 6,000.00
Equipment Purchase (Mimeograph and data files)	1,200.00
Equipment Rental (Keypunch and Xerox)	5,200.00
Computer Usage Fees	10,000.00
Mileage (300 miles per week - University to Cambridge)	2,340.00
	$24,740.00

TOTAL DIRECT COSTS $118,581.00

* The principal investigator will spend nearly full time on the project, but 85% of his salary is already provided by regular University funds on a basis under which this research will be a part of his regular University duties.

** Fring b nefit r c lcul t d t 20% [illegible] A[illegible] m[illegible] [illegible] and 21% of civil servi[illegible]. Fringe benefits do not apply to consultants or Graduate Research Assistants.

CX 22 781

OFFICE OF THE
COMMISSIONER
612/296-2701

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

GENERAL
INFORMATION
612/296-6117

January 30, 1978

Mr. Paul M. Olson
Senior Program Associate
Northwest Area Foundation
West 975
First National Bank Building
St. Paul, Minnesota 55101

Dear Mr. Olson:

As you are aware, Dr. Gordon Heistad, Professor, Department of Psychiatry, University of Minnesota; collaborating with Mr. Dale Offerman, Chief Executive Officer, Cambridge State Hospital; has submitted for Foundation consideration, a grant request. Essentially the request for funds is to underwrite startup costs of an evaluation system at the Cambridge State Hospital which is intended to measure program results given increased staffing and other applicable resources generally to the Cambridge State Hospital. The increased staffing and resources for the Cambridge State Hospital is being brought about by virtue of the approved Consent Decree in the Welsch vs. Dirkswager litigation.

The Department of Public Welfare, specifically staff of the Residential Services Bureau and Community Services Bureau, have been briefed in regard to the purposes of the grant and what is anticipated would be accomplished if the grant were approved. As a Department, we endorse and support the request as submitted. Apart from the impact the grant request will have specifically for the Cambridge State Hospital, we envision that the criteria utilized at Cambridge State Hospital for purposes of measuring activities, can be translated and utilized by the Department as a component(s) for an ongoing monitoring and evaluation system for mental retardation services generally as provided within the State of Minnesota.

Again, I wish to advise that the grant request that has been submitted by Dr. Heistad has the Department of Public Welfare's support and endorsement. We look forward to being advised that Dr. Heistad's grant request has been acted upon favorably by the Foundation.

Very truly yours,

(s) Edward J. Dirkswager, Jr.
Edward J. Dirkswager, Jr.
Commissioner

~~EJD:WGR:jml~~

cc: Dale Offerman, Cambridge State Hospital
Dr. Gordon Heistad, University of Minnesota
Dr. Ronald Young

AN EQUAL OPPORTUNITY EMPLOYER