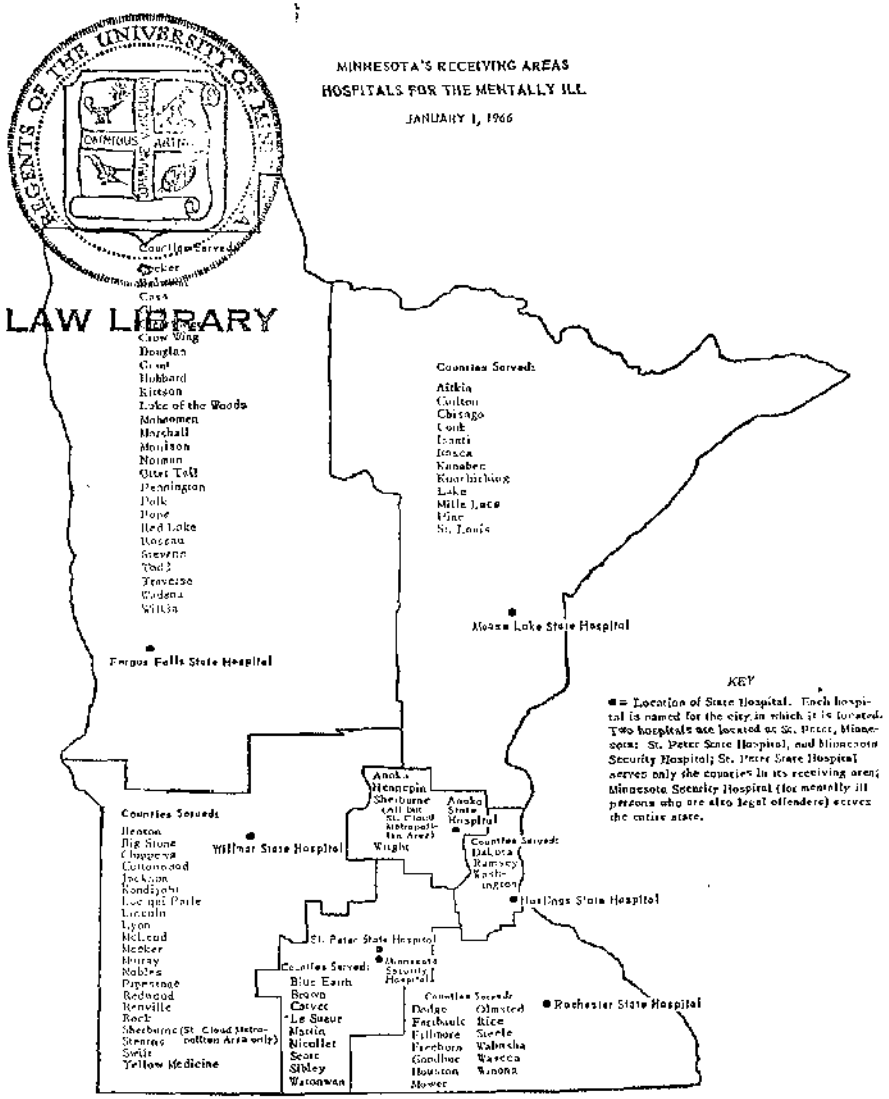
Minnesota's Mental Health Program

A Two-Year Review

July 1, 1964 - June 30, 1966

DIVISION OF MEDICAL SERVICES
STATE DEPARTMENT OF PUBLIC WELFARE

Centennial Building
St. Paul, Minnesota 55101



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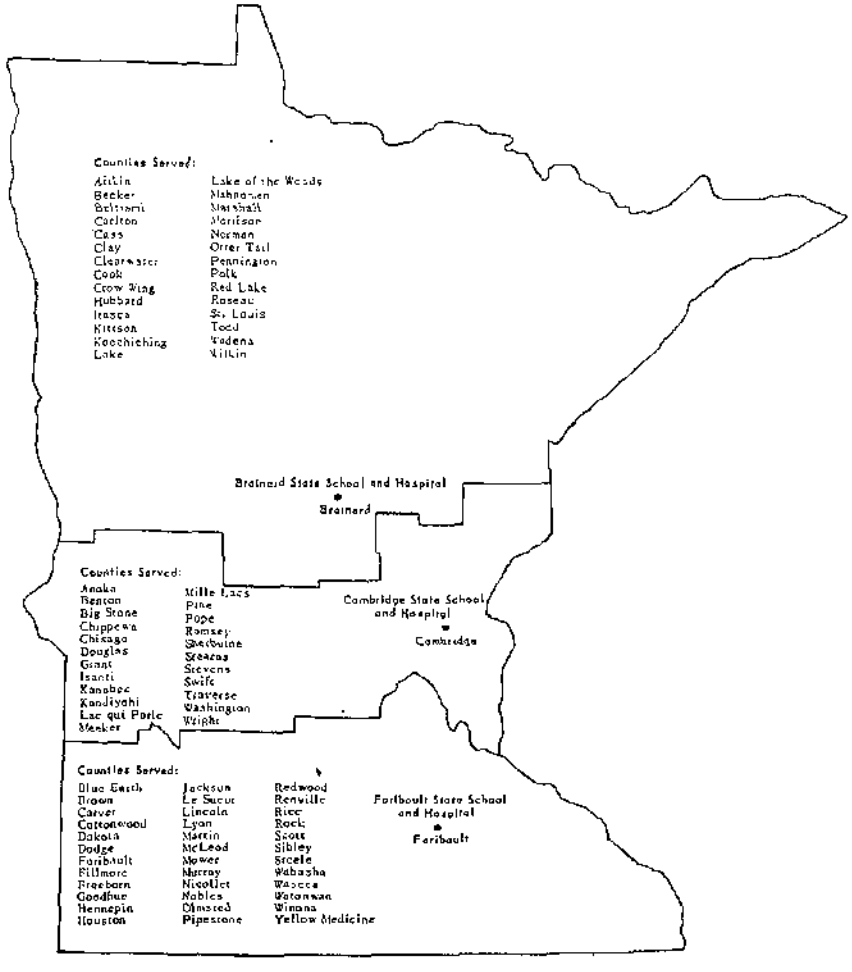
*The 1967 Legislature officially changed the name of the institutions from "state schools and hospitals" to "state hospitals." Since this report covers the 1964-66 biennium, the facilities are referred to as "state schools and hospitals."

MINNESOTA'S RECEIVING AREAS
STATE SCHOOLS AND HOSPITALS FOR THE MENTALLY RETARDED
JANUARY 1, 1966



State Mental Health Program

THE DIVISION OF MEDICAL SERVICES, DEPARTMENT OF PUBLIC WELFARE, is responsible for the state's mental health programming and planning. It supervises and administers state-wide programs of mental health services which include:

1. Supervision of the treatment program of the eight state hospitals for the mentally ill.
2. Supervision and program planning for the mentally retarded both within the six state institutions for the retarded, and in the community.
3. Supervision of the Minnesota Residential Treatment Center for children at Lino Lakes.
4. A state-wide mental health research program.
5. A mental health training program.
6. Community mental health services, including consultation and administration of state funds to the community mental health centers located throughout the state.
7. Mental health information and volunteer services.
8. The mental health study and planning program.
9. Consultation and administration of state funds to day care centers for the retarded located throughout the state.

(In addition to the programs and services for the mentally ill and mentally retarded, the Medical Services division also has responsibility for the state program of tuberculosis control.)

Follow-up services for discharged patients in the community, and responsibility for the retarded individuals in the community who are under guardianship, rests with the 87 county welfare departments which are under the supervision of the Department of Public Welfare.

Thus, the Minnesota mental health program consists of a network of services which includes hospitals for the mentally ill and mentally retarded, supervision and financial assistance to community mental health centers and day activity centers for the retarded, follow-up services to

patients discharged from state institutions, and services to the mentally retarded individuals under guardianship residing in the community.

State Program Changes and Trends

The central office staff, together with institutional personnel, continues the attack on the problem of dehumanization. Recent developments along these lines include the creation of a Committee on Humane Practices, which meets monthly, and consists of one representative from each state institution, plus the central office consultants. The purpose of the committee, which is advisory to the medical director, is to be concerned with those aspects of institutional life which affect the humanity of the patients—their dignity and integrity.

In the Spring of 1965 a scale was developed in an attempt to measure the degree of "institutionalitis" which actually existed on every ward in every state institution in Minnesota. In May, 1965, this "check list" was put into use in the institutions.

There continues to be concern focused on the area of patient work, on the development of patient councils, and on providing patients with a greater opportunity to participate in matters which are of concern to them. Also in the area of patient work, special projects and research have been undertaken to support the idea of patients being compensated financially for work performed. Also initiated during the past two years has been an exploration and experimentation of "industrial therapy enterprises" —which involves a pre-workshop experience on the hospital grounds.

The matter of open hospitals, hospital accreditation, and development of unit systems within the institutions, continues to receive attention, and considerable progress has already been made.

Some of the recent developments in the state program are:

1. Four of Minnesota's hospitals for the mentally ill are now accredited (Anoka, Fergus Falls, Hastings, Rochester).

2. The redistricting plan proposed in 1963-64, which would change some of the receiving counties of the hospitals, has been effected.

3. Federal Hospital Improvement Project grants were received by the state hospitals at Anoka, Fergus Falls, Hastings, Minnesota Security hospital, Rochester, the Brainerd, Cambridge and Faribault state schools and hospitals, and the Owatonna state school.

4. Federal in-service training grants were received by the following: Anoka, Fergus Falls, Hastings, Rochester, St. Peter and Willmar state hospitals, Brainerd and Faribault state schools and hospitals, the Owatonna state school, and the Minnesota Security hospital at St. Peter.

5. The Anoka Study Project was completed. The study focused on

planning for a public, tax-supported, community-based mental health program as distinguished from the services from a voluntary private agency or a professional person in private practice.

6. The subcommittees of the Minnesota Mental Health Planning Council met regularly, and in April, 1965, reported their findings and recommendations.

7. The Comprehensive Mental Health Construction Advisory committee was organized and a Plan for Comprehensive Mental Health Construction was submitted to the federal government.

8. The daycare center program has continued to grow and at the present time there are 42 such centers in the state serving the mentally retarded.

9. Community mental health centers number 22. A comprehensive mental health program was being developed on the campus of Rochester state hospital.

10. The pilot project in public health nursing and social services to patients in families with mental illness in the Fergus Falls area was functioning very well in providing some excellent follow-up services for patients in addition to those services provided by the county welfare departments.

11. The Child Development Center (formerly known as the Four-County Project for Retarded Children) has demonstrated what can be developed in rural counties to improve local services for the mentally retarded.

12. Commitment laws. Through the Minnesota Association for Mental Health and the interest and cooperation of the forensics committee of the Mental Health Planning Council, it has been possible to draft a bill for changes in the commitment and hospitalization laws for presentation to the legislature.

13. Two high school pamphlets: (1) on mental health, entitled *In Search of Balance* and (2) on mental retardation, entitled *A World of the Right Size*, were completed and made available to high schools.

14. Two 14-minute animated color cartoon films were in production. One, *How Are You?*, dealing with the concepts of mental health and mental illness, developed cooperatively with the Nebraska Psychiatric Institute for high school students, was released in June, 1966. The second, *Dehumanization and the Total Institution*, developed for use in state institutions as an in-service training tool, was to be released in Fall, 1966.

15. The Owatonna Child Development Center, a joint project of the Minnesota Department of Health and the Minnesota Department of

Public Welfare, had the latter assume responsibility for programming and leadership. Objectives of the center:

- To serve as an extension of the original pilot study at Fergus Falls to demonstrate what can be developed in rural counties to improve local services for the mentally retarded.
- To stimulate and foster the development and cooperation of community services for retarded children and their families.
- To demonstrate the necessity and value of specialized diagnostic services in multi-county or readily accessible regional areas in evaluating retarded children and relating handicapping conditions.
- To reduce the need for institutional care by early and complete evaluation and the provision for local health, educational, and community services.

16. Federal and state funds utilized to develop and expand programs and services in the state institutions. Recent developments, which include federal funds, are:

- Federal education funds
- Vocational rehabilitation funds
- Economic Opportunity funds (Manpower Development and Training Program)

17. A Minnesota Mental Retardation Planning council was appointed and at work during the past two years. Ten task forces were established to cover the following problems:

- Prevention, diagnosis and treatment
- Residential care
- Education and habilitation
- Community based services
- Employment
- Staffing, training, and recruiting
- Research
- Volunteer services
- Law
- Public awareness

Community Mental Health Programs

Since the Community Mental Health Services Act was passed in 1957, the mental health center program has continued to consolidate and expand. The growth of community involvement in mental health centers is indicated by the number of counties and the population of the state now being served by these facilities. In 1958-59, 13 counties and 2 municipalities served a population of 400,138 or 11.7% of the state population. By June 30, 1966, a total of 81 counties (out of 87) including 4 municipalities, served 3,400,000 or 94% of the state population.

In the past two years, 4 new mental health centers were established, bringing the total to 22. The six counties not yet in the community mental health system have all shown interest in organizing.

Mental health centers are now located in: Albert Lea, 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. (Some financial support from the state is given to the Hamm, Washburn, and Wilder clinics, which are private facilities and not under the Community Mental Health Services Act.)

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

Over-all Figures

	State-Supported Clinics	State Support of Local Centers[1]	Total State Support
1956-57	$233,084		$ 233,084
1957-59	242,000	100,000	342,000
1959-61	250,000	520,452	770,452
1961-63	Terminated	1,400,000	1,400,000
1963-65		1,900,000	1,900,000
1965-67		2,580,000	2,580,000

[1]In general, these funds are matched on an equal basis by local funds.

At the end of the two-year period of this report, there were 112 full-time professionals working in the mental health centers. This includes 23 psychiatrists, 30 psychologists, 48 social workers, and 11 other professional workers such as speech therapists, rehabilitation therapists, nurses, etc.

While direct clinical or out-patient services are provided at all centers, the over-all community mental health services program also focuses attention on (1) providing collaborative and cooperative services to the public health and other groups for programs for prevention of emotional and mental disorders; (2) informational and educational services to the general public, lay and professional groups; (3) consultative services to schools, courts, welfare, corrections, rehabilitation and other agencies; (4) in-service training programs for general practitioners, teachers, nurses, clergymen, caseworkers, and others throughout the region served by the centers; (5) focusing mental health activities within the community and, through in-service training, demonstration, and other means, promoting and furthering the development of existing and additional mental health and related resources; (6) rehabilitative services, particularly for patients discharged from state institutions, including the mental hospitals, state schools and hospitals for the mentally retarded, and correctional facilities.

There continues to exist wide variation in professional programming within each of the mental health centers. Relative autonomy of programming is encouraged within the broad guidelines and objectives of the state mental health program, and no effort is made to standardize professional operational procedures within the centers. Each has been encouraged to develop a high quality program geared to utilize the experience, training, and philosophy of the professional staff in association with the needs

and desires for services as expressed by the communities. All of the mental health centers have continued to show a marked involvement in local, regional, and state mental health planning, and are actively participating in the work of the regional mental health coordinating committees. Several centers continued their research programs which include studies on children's mental health services, epidemiological studies, problems of illegitimate parenthood, etc., providing useful data to enable the staff to conduct more meaningful services to the areas being served.

Recent trends developing in the community mental health programs of Minnesota have shown increased activity to serve the needs of school children, the mentally retarded, alcoholics, and cooperative work with county welfare departments to provide a full program of follow-up care for former hospital patients.

Children's Mental Health Services

This section is based on a unitary concept of mental disorders of childhood, aimed at reducing artificial divisions between "retarded" and "nonretarded" children. Thus, through collaborative relationships with Crippled Children and Child Welfare's services in the Department of Public Welfare, and the Maternal and Child Health in the Department of Health, programs are organized toward solving the child's clinical problems. At the same time, valid distinctions between programs for retarded and nonretarded children and adults can be preserved.

Programming for children with mental disorders advanced significantly both in the community and in institutions. Recent developments in the state mental hospitals in the direction of providing more specialized services for adolescents have served as a basis for better and more realistic programs according to the needs of this group.

Mental Health Research

Divisional interest in promoting careful scrutiny of questions relevant to its responsibilities was again supported by the legislature as in the previous biennium, by an increased research appropriation. Funds available were $280,000 for the current biennium. Funds for career researchers or technicians and clerical assistants are now supported in nine state institutions and the central office research section. Funds were also made available for "specialized consultation, assistance to state researchers in disseminating results of completed studies through publication," research equipment, and supplies.

State researchers maintain an excellent record of project completion. As of July 1, 1964, 50 studies were in progress, 41 were reported to have been completed during fiscal year 1963-1964; 16 had been terminated. As

of July 30, 1965, 85 studies were in progress, 25 had been completed during 1964-1965, and only 9 terminated. (Project termination occurs principally because of personnel changes.)

Topics under study include basic metabolic and physiological research, basic research into the modes by which mentally retarded persons learn, action studies testing the application of learning principles in overcoming the common self-care problems of long-term patients and the self-control problem of alcoholics, assessment of such varied facets of institutional programs as industrial therapy, independent living programs, dental care, evaluation of such treatments as group therapy, drugs, improved diet, study of the impact on personnel and students of various orientation and teaching programs, investigation of the bases on which clinical judgments rest, and development of improved diagnostic techniques. The central office carried on a program of research coordinated with its major attack on dehumanizing aspects of institutional care.

Cooperative research with the University of Minnesota and allied departments in the state continued, with many new projects launched during the biennium. In addition, federal grants continue to support a learning laboratory in one of the institutions for the mentally retarded.

Research, whether under state funds or carried without such grants, continues to be coordinated through the section. Procedures provide for review of all project proposals by the Medical Policy committee to assure scientific rigor and relevance of all researches, regard for the rights and welfare of patient subjects, and availability to the division of the fruits of research through annual progress reports.

Mental Health Training

The training program is an important one, not only in keeping present staff abreast of recent treatment developments and improving their knowledge and efficiency, but also in insuring the availability of future professional workers for the state program. The mental health training section is concerned with the development of adequate mental health training programs and the administration of state funds for this purpose. The latter are used mainly for stipends in various hard-to-recruit professions. Training responsibilities include coordination with other divisions in policy issues and the selection of candidates for training stipends. Funds are used to support workshops and seminars of various kinds and federal funds have been used together with state funds for these purposes. There has been recent increased emphasis on improving the capability of county welfare departments to carry out mental health responsibilities assigned to them by law.

Stipends were granted to a substantial number of trainees to assist them in securing professional education. In return, the trainees agree to work in the Minnesota public welfare program for a specified time. These stipends assist the department in hiring needed professional staff for important positions in the state institutions and in the central office. Stipends for professional education in nursing, social work, psychology, rehabilitation therapies, and for psychiatric residencies were paid from mental health training appropriations. Expenditures for 1965 totaled $166,859.00; for 1966, $155,416.88.

The federal government, recognizing the importance of in-service training, is making available to states in-service training funds based upon plans submitted by the institutions. Grants totaling $260,076 were received by Anoka, Fergus Falls, Hastings, Rochester, St. Peter, Minnesota Security, and Willmar state hospitals; Brainerd and Faribault state schools and hospitals, and Owatonna state school during FY 1966.

Regional Coordinating Committees

For purposes of local coordination of mental health services, the state has been divided into regions according to the receiving districts of the state hospitals for the mentally ill. By the end of 1964, five of the seven regions were being served by regional coordinating committees. By June, 1965, preliminary steps were taken to establish the remaining two regions. These regional coordinating committees, with representation from the state institutions' staffs (including institutions for the retarded), mental health centers, and county welfare departments, are designed to provide cooperation, coordination, and planning in order to assure maximum continuity of patient care.

Minnesota Mental Health Planning Council

The council held its first meeting in May, 1963. Seven subcommittees were established, concerned with the following topics: 1. Aftercare; 2. Economics; 3. Facilities; 4. Forensics; 5. Institutions; 6. Professional practices; 7. Nonmedical problems.

In May, 1965, a two-day planning retreat was held for the purpose of completing the final report of the subcommittees and to develop the major recommendations and a set of priorities. The forensics committee has continued to meet regularly to assist with the drafting of a proposed Hospitalization and Commitment bill. Other subcommittees continue to meet from time to time as appropriate. The medical director has assumed the primary responsibility for appropriate follow-up to the recommendations of the Mental Health Planning Council.

Mental Health Study and Planning

The mental health study and planning office is a six-year project supported entirely by federal research funds.

The office completed a study in Anoka county during the biennium. This study not only resulted in the development of a plan for a comprehensive mental health program for the county, but also led to policy revisions for the entire state mental health program.

In June, 1966, the office initiated a project in the 12 northeastern counties to implement the revised policies which grew out of the Anoka study. This project assists county welfare departments, community mental health boards, state mental institutions and the central office in developing the means of improving effectiveness in preventing, remedying, and controlling the problems of major mental disorders, i.e., mental illness, mental retardation, inebriacy, senility, epilepsy, psychopathic personality, and sex offense. An improved computerized information system linking the several agencies, a major part of the project, makes more information available when needed, and provides better use and more extensive inter-agency sharing by key persons who need such information for decision-making.

State Mental Retardation Planning Council

Minnesota's Comprehensive Plan to Combat Retardation was completed in January, 1966. It was the culmination of almost two years' work by 155 Minnesotans on 9 task forces and 350 members of 7 regional committees. Upon completion of the plan, a second federal grant was awarded to the council for its implementation during 1966-1967.

The council, its staff, the state departments involved, and the associations for retarded children, are now engaged in extensive action and public education programs. An early and important tangible result was the creation of a state civil service classification—service worker—for employment of the retarded.

Central Office Staff

In addition to the directors of the sections for community mental health programs, children's mental health programs, research, public information, mental health education, volunteer services, study and planning, the central office staff of consultants assists the medical director, the institutions, county welfare departments, and community mental health centers in developing programs and services for mentally ill and mentally retarded persons. These consultants give guidance in psychological services, social services, rehabilitation therapies, education, nursing, volunteer

services, and informational programs. Also, a section supervisor and staff caseworkers coordinate the program for the mentally retarded and epileptic.

Chaplaincy Services

Full and part-time staff chaplains continue to provide religious counseling and religious services within the state institutions. Several institutions also have the services with 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 pastors with early signs of mental illness, and to assist them in counseling emotionally disturbed persons before and after hospitalization, are scheduled periodically at several of the state institutions. All institution chaplains meet twice yearly at various institutions to exchange views as to how the religious needs of their patients can be better served.

Hospital Social Services

Hospital social services expanded considerably during the past biennium in the areas of program and service. Hospital social workers for many years have concentrated considerable time in the area of direct work with patients and families for interpretation of illness, the need for treatment, and planning for discharge. During the past biennium there has been a general push by the hospitals, particularly the social service departments, to bring the hospital to the community—that is, the hospital is a service arm of the community. This required attendance at many meetings, numerous speeches, both in the hospital and at almost every level of community life, to improve hospital-community relationships, to bring a better understanding to county welfare department personnel and boards for increased community service for families of patients as well as for patients before and after discharge from the hospital.

Decrease in the average daily population of the hospitals for the mentally ill, coupled with an increase of social service staff, resulted in a ratio of 1 social worker to 72 patients in the hospitals for the mentally ill. The Minnesota Residential Treatment Center for Children is included in this ratio. Approximately 68% of the social workers employed in state institutions have completed their professional training. Staff vacancies continue in all of these institutions and there continues to be a large turnover of staff, particularly directors of social service. Three of the hospitals have either training units or field placements for graduate social workers from the University of Minnesota.

During 1965 social service departments in the hospitals for mentally

ill spent some time implementing Title XVIII and XIX relating to Medicare: As of June 30, 1966, 1,400 state hospital patients over the age of 65 were receiving full or partial benefits under Title XVIII and XIX.

Nursing Services

In September, 1965, a public health nurse was hired in the capacity of community nursing consultant, her functions to be directed toward providing consultative, coordinating, and advisory services in community nursing programs. She also serves as liaison to the state Health Department, section on nursing. Under her direction the following workshops have been held for nurses from the state institutions for the mentally retarded and mentally ill, and for public health nurses: 1. Two-week workshop on the nursing care of the mentally retarded; 2. Continuity of nursing care services. Orientation workshops for public health and school nurses have been held at three of the institutions for the mentally retarded.

Under the U. S. Public Health Service in-service training grants, there now are advanced in-service educational programs at six of the institutions for the mentally ill and at three of the institutions for the mentally retarded. The focus is on enhancing clinical practice of registered nurses, psychiatric technicians, and houseparents.

The psychiatric technician in-service training program has been shortened to six months, with additional instructors hired to assist in clinical teaching, as well as classroom teaching. The curriculum has been revised to include Red Cross first aid and the remotivation technique as required curricula.

The nursing stipend program budget has been enlarged to provide a monthly allowance, plus tuition costs. The number of applicants has doubled in the last two years. The Department of Public Welfare stipends provide financial assistance which enable: 1. Registered nurses to secure a bachelor of science degree; 2. Psychiatric technicians to secure an associate degree in nursing or a bachelor of science degree in nursing; 3. Psychiatric technicians to become licensed practical nurses.

One of the community mental health centers employs two registered nurses on its staff. Both nurses have master's degrees in psychiatric nursing. The graduate program in psychiatric nursing at the University of Minnesota provides a quarter field experience at one of the state institutions for the mentally ill for their students.

Major emphasis has been placed upon reducing the problem of dehumanization by the nursing departments of the state institutions.

Psychological Services

Psychological services are provided in all state hospitals for the mentally ill and state schools and hospitals for the retarded. These services are composed of a wide variety of functions which include: the use of psychological tests and techniques for gaining an understanding of individual patients, the assessment of their abilities 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 institution staff to be of maximum assistance to the patient; the conduct of individual and group therapies for patients as part of the program of psychiatric treatment; consultation with other staff with regard to treatment and management of patients; assistance with the selection and training of institutional personnel; 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 institutions remains approximately the same as during the previous biennium (46). The department continues to have difficulty in recruiting a sufficient number of psychologists with full professional qualifications, including a doctoral degree. Nevertheless, there has been an increase in the over-all qualifications of psychologists in employment as is indicated in the increase in the number of psychologists who have received state certification.

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

The periodical, *Current Conclusions*, continues to be published and distributed to psychologists in the community mental health centers, as well as in the institutions, providing them with a means of keeping abreast of the psychological literature, and major currents in the mental health field. The publication also serves as an aid to recruitment of new staff.

Information, Mental Health Education, Volunteer Services

During the past two years a number of mental health education projects, information programs, and new developments in the volunteer services program have occurred.

In the mental health/retardation information program, a number of

pamphlets and proceedings of various workshops have been published and distributed. A series of governor's bus tours during the biennium has proved to be a very effective method for involving members of branches of the government, mass media, key organizations and citizen leadership, in visits to the state institutions and community facilities for the mentally ill and mentally retarded to learn more about treatment programs, new trends and developments, as well as problems.

In the field of mental health education, the section has been actively involved in leadership training programs with both the Minnesota Association for Retarded Children and the Minnesota Association for Mental Health. Through the state, Volunteer Council meetings, involvement of numerous organizations throughout the state in programs in education and service, on the subjects of mental illness and mental retardation, are encouraged and developed. During the summer of 1966, the first workshop on mental health for high school teachers for which they received college credits, was held at Bemidji State college. This project was developed in cooperation with the Departments of Health and Education. In addition, the section continues to work with these departments on summer workshop programs for teachers, school superintendents, and principals.

In the Spring of 1966 the first workshop for boarding care home personnel was conducted in Minneapolis, sponsored jointly by the Minneapolis Public Health department and the Medical Services division. Primary responsibility for setting up the training program for this workshop rested with the Minneapolis Department of Health, the mental health education section and the nursing consultant from Medical Services.

In the area of volunteer service, the greatest emphasis continues to be on development and extension of the one-to-one type of program. Although group volunteer activities continue and the value in such things as parties, games, sports, is recognized, there has been a growing emphasis on the value of the one-to-one relationship—particularly with the very young patients who need more attention, especially in the institutions for the retarded—and with older patients who no longer have contact with friends or family. There also continues to be an emphasis on projects, programs, and activities whereby patients in the institutions can be taken into the community, rather than on the hospital grounds.

Rehabilitation Therapy

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

1. Educational services—Significant advancement in program size and quality has been made. The 1965 legislature amended the Special Education Act to require public schools located near the institutions for the mentally ill to provide educational services to patients under 21 years of age. Schools providing such services are reimbursed for teacher salaries and supplies. Educational programs are jointly planned with hospital staff teachers and therapists, and coordinated by the special education section of the Department of Education.

In addition to this joint effort between public school and institution staff, the education program in institutions is augmented by the provisions of the Elementary and Secondary Education Act (Title I, Public Law 89-10, as amended by P. L. 89-313). Patients under 21 years of age in institutions for both the mentally ill and the mentally retarded are eligible for educational and educationally related services over and above those which the public schools and the institutions can provide. The first projects were started in May, 1966, to end on August 31, 1966. As an example of the impact of this project, 83 professional and nonprofessional staff were added in the institutions, and necessary supplies and equipment was purchased to conduct a variety of programs.

2. Vocational services—Industrial therapists, vocational counselors and nonprofessional assistants employed by the state schools and hospitals assist patients to develop and retain 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 patients' skills and the patients' needs to learn work skills.

Patients are also 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 developed during the last year under the Manpower Development and Training Act to train 84 mentally retarded in three different types of service work occupations. This shows an increasing use of community and agency facilities and services by institution staff. Cooperating agencies are: vocational education and the division of

vocational rehabilitation of the Department of Education, Department of Employment Security and local employment offices, institution staff, and central office. Area vocational schools located near the institution hire instructors and supervise the training program in the institution.

A pilot program for paying patients for work being done within the hospital setting has been developed at Hastings state hospital. Another new pilot program called Industrial Therapy Enterprises, which is a type of sheltered workshop within the hospital setting, has also been established. In this latter project, the patients are referred to Industrial Therapy Enterprises by the psychiatric team and are provided the opportunity to learn various kinds 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, they are either placed into sheltered workshops in the community or into full-time jobs in competitive employment.

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

During the past several years, nearly all personnel in the rehabilitation therapy programs in the institutions were employed through state-appropriated money to the hospitals. During the past two years, several positions were added through provisions of various state and federal programs (as aforementioned). 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 state institutions. These activities should not be interpreted as generally available to all patients, but do indicate that such programs are needed for more patients.

Institutional Programs for the Mentally Ill

Hospital Population Changes and Trends

During the 1964-66 biennium, the state's mental hospital population decreased by 1,300, continuing the downward trend which started in 1954-55. On June 30, 1966, there were 5,906 patients in Minnesota state mental hospitals (5,632 mentally ill and 274 inebriates). The number of mentally ill in residence is now less than half the number hospitalized when the mental hospital population was at its highest point (September, 1954).

Although the number of mentally ill patients in residence has been decreasing steadily, the number of patients entering and leaving the hospitals has been increasing. During fiscal year 1955-56, more than 4,800 mentally ill patients were released by direct or provisional discharge and 516 died in hospital, while more than 4,600 entered by admission or return from provisional discharge. Ten years ago, when almost twice as many mentally ill patients were in the hospitals, some 2,800 were released, more than 1,100 died and about 3,800 entered. There were fewer first admissions of mentally ill patients in 1965-66 than in 1955-56 (2,200 compared with 2,400), but many more re-admissions and returns (2,400 compared with less than 1,400). The ratio of re-admissions and returns to total releases has remained about the same, however.

More than half (over 55%) of all mentally ill patients admitted during 1965-66 entered on a voluntary basis. These included almost half (47%) of all first admissions and more than two-thirds (68%) of all re-admissions. The number of patients entering voluntarily has greatly increased during the past few years. Ten years ago only 25% of all first admissions and 53% of all re-admissions were voluntary.

One of the most notable changes in mental hospital population in recent years has been the drop in number of elderly patients hospitalized. As of June 30, 1966, there were fewer than 1,600 patients age 65 or older in residence, accounting for about 28% of the total number of hospitalized mentally ill. Ten years ago almost 4,300 or 38% of the 11,165 mentally ill patients in residence were age 65 or older. The much greater availability of nursing home care has helped to bring about a decrease in the number of older patients admitted and has greatly increased the number released.

Patient Transfers

During the biennium period, 55 patients were transferred to other states (including one alien returned to Japan) for hospital care. Of this number, 35 were transferred during the first year of the biennium and 20 during the second year. These included all transfers made under both residence and compact laws. A breakdown of these two areas reveals that 31 persons were transferred under residence laws involving 11 states, while 24 patients were transferred under the compact law and involved 14 states.

During the past year, four more states joined the Interstate Compact on Mental Health, thus bringing to 32 the number of states now operating under the compact.

The total cost of transfers amounted to $9,477.90, with $1,412.29 paid either by guardians or relatives and the balance of $8,065.61 paid by the state.

Minnesota has continued to provide hospitalization to patients who are subject to transfer to their home states but are allowed to remain here for humane reasons. Thus, Minnesota is operating under terms of the Interstate Compact on all nonresident cases, even though the state where they have legal settlement is not a member of the compact.

During the year 1964-1965, a total of 99 nonresident patients were admitted to Minnesota's state hospitals: 28 were voluntary patients with fairly short hospitalization, but 16 of the committed patients have continued to receive care here. During the year 1965-1966, of 85 nonresident patients provided hospitalization, 23 were voluntary short-term patients and 37 committed have been continued for care. In addition, 5 patients were transferred to Veterans' Administration facilities, 9 died, and 3 were found to have legal settlement in Minnesota.

In addition, authorization was given for the return of 75 patients to Minnesota for state hospital care: 53 were returned under legal settlement laws and 22 under the compact. Four of these were mentally retarded patients whose names were reached on Minnesota's waiting list. Returns were denied on 31 cases: 16 because of lack of legal settlement and 15 who were not considered proper referrals under the terms of the compact.

Arrangements were completed for provisional discharge or trial placement of 73 patients from Minnesota's state schools and hospitals with relatives in other states. Permission was denied in another 13 cases. Thirty-two patients were permitted to come to Minnesota to live with

relatives while on provisional discharge from mental hospitals or schools in other states and permission was denied on 6 cases.

Presently, there are 10 mentally retarded patients on waiting lists for transfer from Minnesota to other compact states while 2 are on Minnesota's waiting list.

Anoka State Hospital

The substitution of Hennepin county for nine rural counties in the hospital's receiving district in July, 1964, necessitated many changes in programs, organization, and facilities. This redistricting plan raised the receiving district population from 450,000 to 1,050,000. As a result, the admission rate of psychiatric patients increased by 54% over the previous biennium and discharges increased by 37%. The employee complement was increased from 410.83 to 428.83 by the 1963 legislature. The inpatient population rose at first then fell again, but in the last nine months of the biennium had leveled off at around 730. At the start of the biennium the population had been 821.

Many changes were made in the utilization of the physical plant. The admissions unit was moved to the Burns building, formerly the tuberculosis unit. Surgical service was moved from the Fahr building to Burns; and an intensive care unit established on the main surgical floor. Half of the Miller building was converted to an adolescent unit. Many office changes were made, aimed mainly at bringing the clinical staff closer to the patients they serve.

Capital projects included conversion of the old laundry building into a service center, thereby providing patients with a laundromat, expanded and improved barber and beauty shops. Construction is now well underway of a building connecting Cottages 6 and 7 on all floors. These cottages are being remodeled and will serve as dormitories for this new unit of 203 beds. When completed this will provide three wards for newly-admitted adult psychiatric patients. Greatly increased efficiency is expected because the wards are laid out horizontally instead of vertically as in the old cottages. Planning continues for the new medical-surgical building.

Upgrading of the hospital utilities was continued and production of electric power was terminated. Power is now purchased from the city of Anoka. The hospital farm was closed in May, 1966, because its therapeutic value had almost disappeared with the advent of more modern treatment. The farm staff now maintains the hospital grounds with excellent results.

In the summer of 1964, the hospital was accredited for a further three years by the Joint Commission on Accreditation of Hospitals. Reorganization of the medical staff to comply with the commission's requirements was continued, having begun in 1963. New committees established include infectious diseases, utilization review, tissue, and a medical staff executive committe. By the end of the biennium the active medical staff had been increased considerably and included seven full-time and six part-time psychiatrists.

The hospital's treatment philosophy and its many treatment programs saw considerable change. With the recruitment of well-trained psychiatrists, a more eclectic and multi-dimensional treatment program has become possible. A healthy diversity of opinions now exists between the members of the medical staff, and a highly competitive enthusiasm exists between the various treatment teams.

In attacking the problem of dehumanization, emphasis was placed on improving communications between the patients and the community. Visiting hours are now 9:00 A. M. to 9:00 P. M. daily. Pay telephones have been installed in most buildings. Patients have increased freedom to manage their own affairs and increasing responsibility is being given to them. Greater community participation in the hospital program has been sought. The volunteer program has expanded and more patients are taken into the community by volunteer groups and individuals. One-to-one volunteer programs also have begun.

A full-time vocational rehabilitation counselor was hired and the demand for his services has been so great that a second counselor is being added. Of the 200 patients in his caseload, many are on night-hospital status, spending the day in various vocational rehabilitation facilities in Minneapolis.

A pre-discharge clinic involving hospital staff and staff from Hennepin county agencies was established to review patients about to be discharged into the county.

A marked increase has been noted in the admission rate of patients with character disorders. This represents a serious problem within the hospital, especially with the female patients for whom there is no unit equivalent to the Minnesota Security hospital. New treatment methods are being devised for these patients and a forensic clinic now reviews all patients in the hospital with medico-legal problems on a weekly basis.

In December, 1964, an adolescent unit was opened with the aid of two federal grants. The average population is 25 boys. A full-time child psychiatrist is in charge of this program. A girls' unit is badly needed, but no staff is available as yet.

Two music therapists with a psychiatric consultant are rapidly de-

veloping the new music therapy program. About 30 patients per week receive individual therapy and about 200 take part in group therapy activities, including music appreciation, instrumental, and other programs.

A former staff house was converted into an independent living unit for eight female patients being prepared for discharge.

The remotivation program now reaches 325-350 patients.

Fergus Falls State Hospital

On June 30, 1966, the population of the hospital was 1,082, a decrease of 261 patients from June 30, 1964, and of nearly 1,000 patients from 12 years ago. This decrease in population has occurred in the face of an increased admission rate each year. It has occurred for many reasons, such as increased community involvement and acceptance; increased staff with designated assignments to help people plan toward discharge; increase in the development and use of staff in total as therapeutic agents; increase in the development and use of various community resources such as county welfare departments, sheltered workshops, day work placements; independent living situations and the development of better and more boarding and nursing care facilities.

To keep step with the increasing community involvement, the hospital has set a goal to divide into four geographical units, each one relating to the receiving district of the four mental health centers in the area. In April, 1966, the first of these geographic units serving the eight counties in northwestern Minnesota and relating to the Northwestern Mental Health Center, Inc., Crookston, was opened.

Since that time there has been a tremendous increase in the involvement of community agencies and resource people which has resulted in a much closer tie between this hospital and those resources. This move has made it possible for the staff of the Northwestern unit to become acquainted with the county welfare department staff, mental health center personnel, public health nurses, judges, county attorneys, pastors, on a close basis. It also has made it possible for the social workers to be keenly aware of these resources.

Other programs are a convalescent unit which is an area devoted to providing independent living situations for parients whose major "disease" is institutionalization; an acute unit for the more regressed patients where programming is built around socialization and basic work skills; and a geriatrics unit which serves all patients age 60 and over.

During this past year, there have been two additional living situations organized, one in the nurses' cottage and the other in one of the staff housing units. Both of these "half-way houses" have been developed

for patients who work in downtown Fergus Falls or will be working there while experiencing independent living, including self-medication.

Along with further developments in the maximum utilization of staff, several nonmedical program directors have been assigned to various units of the hospital. The directors have been delegated full responsibility to develop a treatment program through the use of various team involvements and has made the development of a unit system more tenable by rather thorough delegation of authority and responsibility to the various units.

A director for in-service training, financed by federal funds, and a nurse instructor, have been appointed. Classes covering a cross section of all staff are under way. The hospital also has begun a training affiliation for practical nurses.

The Hospital Improvement Program grant for family therapy has started and by next year should show results in closer family involvement in hospital programming, direct therapy of the patient and his family as an integral group, and keener awareness of community agencies of the importance of family involvement.

Hastings State Hospital

There has been broad involvement of personnel in planning sessions for the new 100-bed patients' building during the past year. The 1965 legislative appropriation of $1.8 million for the building was the first new patient living unit to be scheduled for the hospital in many years.

A request was made to the Building Commission early in 1966 for an additional 100-bed wing to the new building and for a new food service building.

A National Institute of Mental Health Hospital Improvement Program grant for the rehabilitation of long-term schizophrenic patients has been an effective addition to treatment. Concentration on patient experiences in the community and vocational guidance on work assignments in the hospital are added to the more usual rehabilitation programs. Ninety-four patients were in the program in the past year, and of these, 22 were discharged.

Just started is a therapeutic workshop on the hospital campus. Work contracts with private industry indicate continued, steady operation of the shop with 12 patients working full-time.

The St. Paul Rehabilitation center conducted a workshop for HIP staff members, which included information on improving supervisory ability, work evaluations and motivation techniques, a broader understanding of rehabilitation goals and facilities.

Social services began group meetings a year ago with relatives of patients on two wards. This informal series of discussions has been a new means of communication between families and the hospital, with relatives becoming acquainted with a large number of hospital personnel and also learning the hospital's total function and its contacts with community agencies.

Three of the six psychiatric wards now house both men and women patients, residing on separate floors. Immediate plans envision extending this arrangement to the other three psychiatric wards. In addition, one ward was designated as exclusively for patients from Dakota and Washington counties. This plan provides staff and county agencies with better means of communication and the opportunity to become better acquainted.

One geriatric section has an open door policy on one floor, allowing patients from one male ward and one female ward to share sitting rooms and TV rooms, as well as recreational programs. Double rooms in the center section can accommodate either men or women, who benefit from a more private and independent living plan. Therapeutic community meetings have become a part of the geriatric wards' weekly programs.

$2,300 was given to the hospital by Macalester college students; $1,000 of which was to create a geriatric park, completed with hospital funds. The remaining $1,300 was earmarked to maintain and expand the summer hospital camping program.

Recreation kitchens were installed in all ward buildings for more patient activity using volunteers to help in cooking programs for patients.

The present number of research projects in progress at the hospital is 18, including 5 conducted by staff members of the University of Minnesota. Four are financed by the state's research fund. Eight projects were completed during the last two years, with five papers published.

Psychology department devoted much more time than in the previous biennium to individual and group psychotherapy and in patient program counseling. Psychiatric teams were more active than in the recent past, with members involved in developing and administering the treatment program. Because of the hospital's lower population and more involvement with patients by clinical staff, there is a higher percentage of patients being seen and planned for—an extremely gratifying and promising trend.

A high mark in the two-year period was reached when 35 staff members participated in a human relations workshop. This challenging experience had a profound effect on the persons taking part and gave each

individual a new grasp of his personal impact or lack of it on a group in a series of planned tasks for individual and group interaction. The workshop was part of a broad in-service training program at the hospital.

The hospital also has reached further into the community. The patient-acted Christmas pageant was presented at the high school for the enjoyment of Hastings residents for the first time; patient art work was entered in shows in open competition and ribbons were won; luncheons, skating parties, coffee parties, shows, sporting events, shopping trips became part of regular hospital activities, with generous assistance from volunteers.

One major community relations effort was a conference on mental health for school superintendents, principals, and teachers in January, 1966, sponsored by the Hastings Junior Chamber of Commerce.

Minnesota Security Hospital

The new program at the hospital continues to expand and develop in a most encouraging fashion, and a patient forum has been established to allow free expression of the patients' concerns. An extensive decorating and remodeling program with the help of volunteers has given the hospital an attractive appearance.

An evaluation program for all patients has resulted in a decrease of population from more than 200 to its current level of about 135. An active social service department and a forensic psychiatric consultant help to facilitate the difficult job of releasing and transferring patients.

With the population decrease, more resources are available to develop new treatment techniques. An intensive employee training program, financed by a Hospital Improvement Program grant, and training in remotivation techniques, have done much to resocialize patients and to help them learn to relate to others in an acceptable manner.

Education of both the patients and the staff received high priority. An in-service training program was begun which has been most valuable in helping personnel understand the nature of the problems they deal with and techniques for working with such problems.

Two full-time teachers have been employed providing patients with a real opportunity to increase their learning skills. Classes in simple prevocational skills, such as completing job application forms, also have begun.

The recreation program has expanded and, for the first time, a program of excursions outside the hospital has started.

New programs being developed:

One-to-one Therapy—An intensive training program for the nursing staff to provide one-to-one relationships for those patients who are unable

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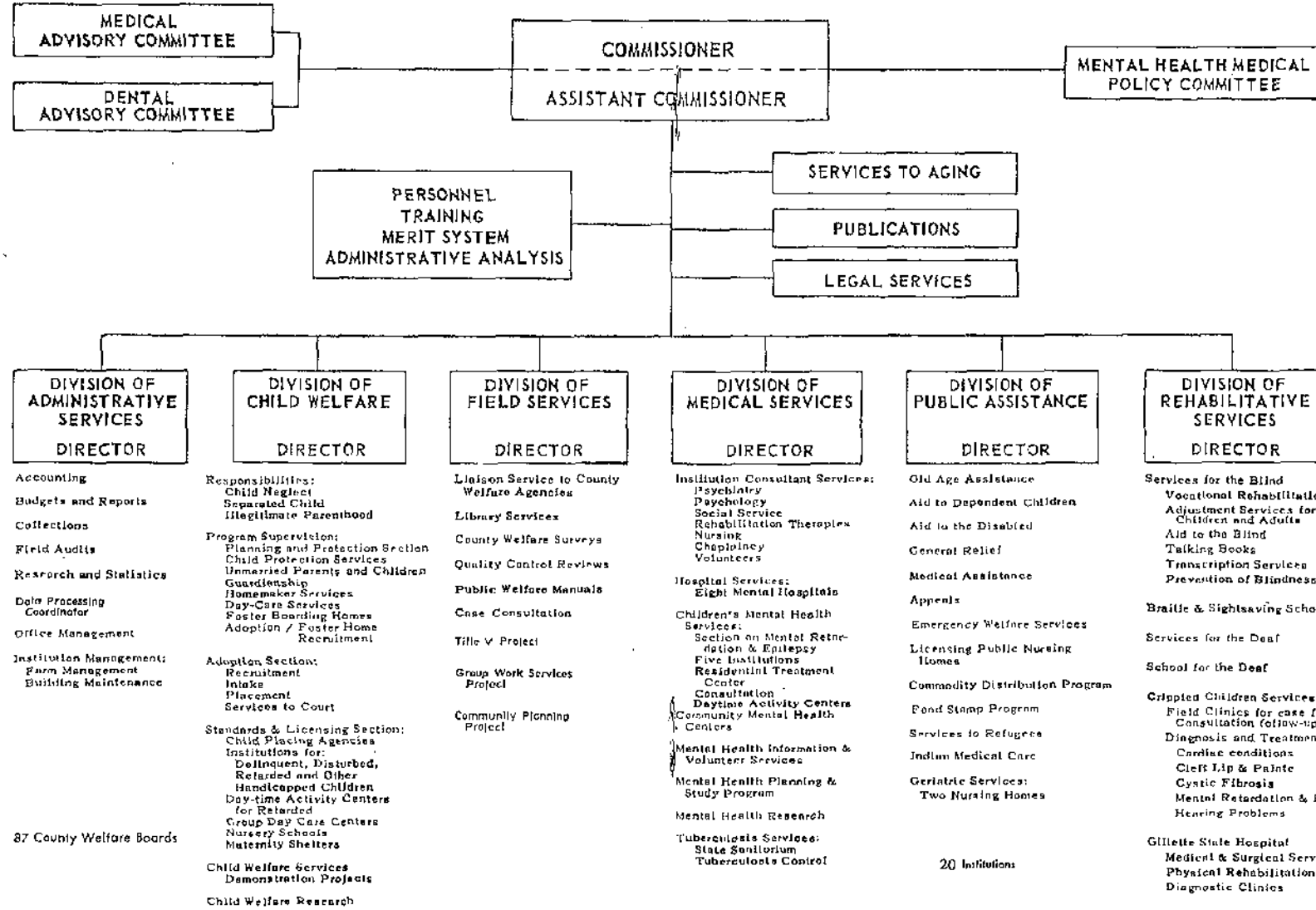
DEPARTMENT OF PUBLIC WELFARE

Centennial Office Building
St. Paul, Minnesota 55101



Accounting

Budgets and Reports

Collections

Field Audits

Research and Statistics

Data Processing Coordinator

Office Management

Institution Management:
Farm Management
Building Maintenance

87 County Welfare Boards

Responsibilities:
Child Neglect
Separated Child
Illegitimate Parenthood

Program Supervision:
Planning and Protection Section
Child Protection Services
Unmarried Parents and Children
Guardianship
Homemaker Services
Day-Care Services
Foster Boarding Homes
Adoption / Foster Home Recruitment

Adoption Section:
Recruitment
Intake
Placement
Services to Court

Standards & Licensing Section:
Child Placing Agencies
Institutions for:
Delinquent, Disturbed, Retarded and Other Handicapped Children
Day-time Activity Centers for Retarded
Group Day Care Centers
Nursery Schools
Maternity Shelters

Child Welfare Services Demonstration Projects

Child Welfare Research

Liaison Service to County Welfare Agencies

Library Services

County Welfare Surveys

Quality Control Reviews

Public Welfare Manuals

Case Consultation

Title V Project

Group Work Services Project

Community Planning Project

Institution Consultant Services:
Psychiatry
Psychology
Social Service
Rehabilitation Therapies
Nursing
Chaplaincy
Volunteers

Hospital Services:
Eight Mental Hospitals

Children's Mental Health Services:
Section on Mental Retardation & Epilepsy
Five Institutions
Residential Treatment Center
Consultation
Daytime Activity Centers
Community Mental Health Centers

Mental Health Information & Volunteer Services

Mental Health Planning & Study Program

Mental Health Research

Tuberculosis Services:
State Sanitorium
Tuberculosis Control

Old Age Assistance

Aid to Dependent Children

Aid to the Disabled

General Relief

Medical Assistance

Appeals

Emergency Welfare Services

Licensing Public Nursing Homes

Commodity Distribution Program

Food Stamp Program

Services to Refugees

Indian Medical Care

Geriatric Services:
Two Nursing Homes

20 Institutions

Services for the Blind
Vocational Rehabilitation
Adjustment Services for Children and Adults
Aid to the Blind
Talking Books
Transcription Services
Prevention of Blindness

Braille & Sightsaving School

Services for the Deaf

School for the Deaf

Crippled Children Services
Field Clinics for case finding & Consultation follow-up
Diagnosis and Treatment for
Cardiac conditions
Cleft Lip & Palate
Cystic Fibrosis
Mental Retardation & Epilepsy
Hearing Problems

Gillette State Hospital
Medical & Surgical Services
Physical Rehabilitation Services
Diagnostic Clinics

to participate in group programs. The goal would be to raise the level of functioning to a point where patients could participate profitably in the group program.

Youth Program—The hospital has seen a rapid increase in the number of admissions under age 21. From January to June, there were 13 such admissions. Because the hospital has no geriatric patients, the average age of patients is 39.

Modern Security—A high level of security is maintained without interfering with the treatment program. Modern electronic devices offer great promise in this area.

In the past two years many changes have occurred. No longer a terminal lock-up for "hopeless" social offenders, a modern treatment and rehabilitation program is provided in a secure setting.

Moose Lake State Hospital

The hospital continues to maintain its 100% 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.

Since 1957, the in-patient population of the hospital has decreased from 1,300 patients to 875. During the past several years, however, the total population has been fairly constant. During this same time, decreases in mentally ill patients have been offset by inebriate patients (70) and retarded patients (25). A review of the admission rate shows that while during the same period in-patient population has declined, the number of admissions have more than doubled.

The hospital is the specialized rehabilitation facility for mentally ill, senile, and inebriate patients from 12 northeastern counties. It 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.

The total hospital complement is 307.42 employees, a slight increase over the preceding biennium. These additional employees have been used to improve the hospital environment and to build a treatment program.

The treatment program is organized on the basis of six teams, including four psychiatric teams, one inebriate team, 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 is engaged in research projects such as the study of mental health resources in northeastern Minnesota conducted by the Department of Public Welfare, and is pioneering the "Cambridge-Moose Lake Project," which involves the transfer of selected retarded patients to the open integrated mental hospital.

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 the four mental health centers in the area are maintained through regular liaison committee meetings.

Rochester State Hospital

The most significant development in the past two years has been the growth and further formalizing of the relatively unique hospital-centered Comprehensive Mental Health Center program. Public Law 88-164 has outlined the complex of services which must exist before a facility may be recognized by the federal government as a Comprehensive Mental Health Center. Congressional intent was clearly to encourage the development of broad community-based mental health services as a desirable alternative to institutional treatment of mental health problems.

The program on the Rochester state hospital campus offers an interesting precedent for including the state mental hospital as an important and even pivotal resource in the total matrix of community mental health services.

The Rochester model has attracted nation-wide attention, in large measure as the result of a feature article in the February, 1966, issue of *Hospital and Community Psychiatry*, where the growth of the comprehensive program was fully described. The programs making up the comprehensive center are: Zumbro Valley Mental Health center, Day Activity center (for the retarded), Aldrich Memorial Nursery school, Alcoholism Information center, Olmsted county welfare department representative, Vocational Rehabilitation department representative, Governor's Commission on Aging, and Rochester state hospital and Day hospital.

These programs remain autonomous. However, the close cooperation and ready communications between personnel all located in physical proximity has led to a growing functional unity. This has been enhanced by administrative devices such as the use of the same medical record forms by the Zumbro Valley Mental Health center and the state hospital.

There also have been significant changes in the regular in-hospital

treatment, research, training and administrative programs.

Medical services are now divided into three functional units: psychiatric service, surgical service and medical service.

Psychiatric service has moved further toward a decentralized treatment emphasis, with the staff in each of three psychiatric service buildings tending to treat the full range of admission and long-term patients. There is an informal but genuine team treatment emphasis with representatives of all treatment and rehabilitation services participating in ward level treatment planning sessions. Psychology, social service, and rehabilitation therapy department members are assigned permanently to wards or buildings. Decentralized services have been particularly valuable in adding variety and meaning to the contributions of recreational therapists assigned to buildings.

The social service department has been expanded from 7 to 12 members; the psychology department from 3 to 6. There are 5 full-time board certified psychiatrists, compared with only 1 psychiatrist thus qualified in the previous biennium.

Although a systematic record of out-patient visits is not available before October, 1964, there has appeared to be a substantial steady growth in out-patient psychiatric service in recent years. Some indication of this can be gained from comparing the out-patient figures for the periods from August, 1964, to June, 1965, with those from October, 1965, to June, 1966. There was an approximate 28% increase (from 2,140 to 2,732 visits) in these comparable 9-month periods. The increased admission rate, the continuing trend toward early release, the need to review medications, and the accumulation of released long-term patients in the community have apparently contributed to this very heavy growing demand for out-patient services. Following this large population of patients in the community has placed a heavy additional demand upon the time of staff psychiatrists.

The hospital resident psychiatric population continues to decline (from 1,035 on July 1, 1964, to 650 on June 30, 1966) despite an increased admission rate. Much of the direct credit for this goes to the expanded and energetic social service department which has been instrumental in placing 443 patients through the county welfare departments, 298 in their own homes and 36 by transfer to Veterans Administration. In January, 1965, the pre-placement ward was initiated to provide more intensive self-help and self-planning training prior to placement. This innovation has probably reduced the re-admission rate for long hospitalized patients.

The expanding day hospital program has also served to reduce the

pressure of admissions and re-admissions to the resident hospital population. From April, 1965, to May, 1966, the patient-day monthly caseload increased from 246 to 636. During the biennium, the day hospital has admitted 209 patients and registered a total of 9,318 patient-days. Part of this growth rate can be attributed to the day hospital nursery which was initiated in January, 1965. Through June 30, 1966, the nursery cared for 4,132 children of day hospital patients, volunteers, and Zumbro Valley Mental Health center clients.

Volunteer services have been expanded with a particularly significant increase in one-to-one service to patients where a volunteer is assigned an individual patient on a psychiatric referral basis for intensive service both within and outside of the hospital. There has been a substantial growth in the participation of younger volunteers from Rochester Junior college and the local high schools. As of June 30, 1966, the program has 600 registered volunteers, 420 of whom are adults.

The hospital school has become the focus of the adolescent treatment program. A full-time school coordinator has been employed. The teaching staff (ranging from 2 to 4 members) is certified to teach a fully accredited curriculum. The school coordinator also offers consultation services to the other educational programs within the Comprehensive Mental Health center.

The surgical program has been expanded without the addition of hospital beds. During FY 1965-66, 1,072 operations were performed for Rochester State Hospital patients, and patients and inmates from other institutions. The major expansion, however, has been in the number of out-patient contacts. The surgical service is now organized to offer long term follow-up for patients who have undergone surgical procedures. There has been the remarkable total of 5,252 such return visits during the past biennium. This increase in number of patient contacts has been made possible in part by a streamlining of scheduling procedures and a general improvement in communications with referring institutions.

Medical service is responsible for thorough routine admission physical examinations, medical evaluation of all newly-admitted geriatric patients and special diagnostic studies upon request. It also is responsible for the acute medical treatment ward and the geriatric wards.

Rochester continues to have a very active research program with 8 projects financed from out-of-state sources. The research budget from these sources currently runs at $249,043 per year with research personnel numbering 26.

The training program at the hospital includes internships or less

formally structured traineeships for occupational therapists, chaplains, nurse anesthetists, dieticians, and medical technologists. The Mayo clinic surgical fellowship program has for many years made an important contribution to the total institutional medical program in the state. During the past biennium, the Mayo clinic psychiatry section has made a significant addition to this long-standing mutually profitable relationship. Mayo clinic fellows training in psychiatry spend from three to six months at the hospital and Zumbro Valley Mental Health center.

The chaplaincy department continues to "face the community" with a very active program of training, orientation, and active correspondence with local area pastors. Community participation in the religious program of the hospital has been demonstrated in a concrete way. In February, 1964, a nonprofit corporation was formed by representatives of more than 20 denominations to design, finance, and construct a Religious Activity center on the campus. Preliminary drawings were completed and funds, primarily congregation gifts and pledges, were being secured, with groundbreaking planned for Fall, 1966.

The administrative services in the hospital have been improved in a number of ways, largely the result of significant personnel additions.

In summary, the past biennium has seen many changes and innovations. The effective utilization of space vacated by released patients has presented a challenge, but also the opportunity to develop the Comprehensive Mental Health center program. This period of rapid flux creates a continuing need for intelligent long-range planning. In May, 1966, the Rochester state hospital Utilization Committee was formed to study and recommend to the Commissioner of Public Welfare the best possible use of resources and facilities of the hospital in the future. Membership of the committee includes prominent citizens from the Rochester area as well as professionals and representatives of special interest groups. It is anticipated that their recommendations will assist the hospital to further develop effective services for southeastern Minnesota and the state as a whole.

St. Peter State Hospital

The hospital's population has continued to decrease (from 1,503 on June 30, 1964, to 1,124 June 30, 1966). During the 2-year period ending June 30, 1966, there were 436 admissions, 62% voluntary.

Within the past year, the hospital has converted to the unit system, of which there are now 3 based on a county distribution. The team concept encourages earlier reviews of the patients' progress in the hospital.

The social service department has now increased its staff to 13. An

elaborate program has been developed for the youth group. Since the hospital developed the unit system, social service has shared with other team members in programs to include county welfare workers, county nurses, vocational rehabilitation personnel, and others in planning with and for patients. With an intensive vocational rehabilitation program, social service has been more active than ever in helping to plan for patients who are ready for a trial outside the hospital. Parents and other relatives have been invited to participate in programs at the hospital and have responded well. The caseloads still average well over 100 for each worker, but this is far under the previous number. As caseloads decline, social service is more and more in a position to better perform its functions.

Following the administrative reorganization and decentralization of the hospital into units, the psychology department has been reorganized by assigning psychologists directly to the units to function as members on the various teams in each. During the past two years the department has been devoting considerable time to collaborating with other professional staff in developing new programs with federal funds. One new program is an in-service training program for personnel which has the unique feature of offering for college credit college level courses in the behavioral sciences. Another, a hospital improvement project, is a program of intensive vocational rehabilitation services. The department is continuing an active program of individual and group psychotherapy and psychodiagnostic services, and remains actively engaged in professional and nonprofessional in-service training programs.

In the rehabilitation therapies service, a completely equipped occupational therapy center was opened in a 3-story building. With this change, the occupational therapy department has been able to expand its program to include a greater variety of therapeutic activities for the acutely ill, the continuous treatment, and the geriatric patients. The service has intensified the program for placement of patients in community employment.

One highlight of this program was the hiring of 35 patients at a turkey plant in a near by community. Originally seasonal employment, this has developed into year-around work. Several patients have been discharged to live in that community to continue their jobs.

All services are now participating in the unit-team system that was adopted by the hospital.

During this biennium, the hospital, in cooperation with the Division of Vocational Rehabilitation, has extended and improved the range of vocation services for the patient. A National Institute of Mental Health grant has provided for additional counselors and the establishment of a

work evaluation center. Today, nearly every patient admitted is provided counseling, vocational evaluation training, and eventual job placement, if they are capable. The night hospital and community integration programs continue to develop for the chronically dependent patient. The hospital programs continue to make use of Mankato state college, Mankato Rehabilitation center, and other vocational schools. More employers are hiring, both permanently and temporarily, hospital patients.

Community interest in the hospital continues to be a major goal of the volunteer services program. Volunteers from both the Hennepin and Nicollet county associations for mental health are now in the "one-to-one" program. The hospital continues to draw from the near by colleges, service organizations, and churches.

Nursing education programs have continued to expand. Professional nursing students (diploma) from Hennepin county general hospital, Lutheran Deaconess hospital, Minneapolis; and Naeve hospital, Albert Lea, come for 12 weeks' experience in psychiatric nursing. Mankato state college professional (degree) students also receive 12 weeks' clinical experience under the direction of their own faculty members. Four weeks' experience for practical nursing students in the care of the mentally ill is given to the students from New Ulm School of Practical Nursing, New Ulm, and Austin Area Vocational School of Practical Nursing, Austin. Two programs for psychiatric technicians are given: the basic and the advanced technician courses, the latter being taught under a National Institute of Mental Health in-service training grant. In-service programs for registered nurses and psychiatric technicians continue.

The building program at St. Peter progresses continuously. Treatment building 3 is completed and occupied.

Willmar State Hospital

Service to citizens requiring treatment and care for mental illness and addictive problems continues to be this hospital's mission. The two years just past have reinforced our policy of minimizing a person's time away from his community, his family, and his everyday tasks. To support this, the voluntary admission is prominent among the admissions.

In addition to the traditional functional duties of the various departments within the hospital, several programs of note have been added. August, 1965, saw the beginning of a most interesting and rewarding project when the adolescent treatment unit began operations. It is a 28-bed unit for boys and girls aged 12-17. All of the hospital staff shared and contributed to the highly successful start it has enjoyed. A close relationship to the Willmar school system has been established to give an

educational core to the many-faceted program. Ingenuity and imagination, in addition to professional know-how, are evident. This unit is characteristic of Willmar in that a close tie with the Central Minnesota Mental Health center, St. Cloud, and one of its psychiatrists has been developed to mutual advantage.

The open door policy contains a policy of patient recognition. The nationally famous remotivation technique has involved more and more patients. Employees too, in greater numbers, have learned the process giving them more confidence and resources.

The volunteer program has seen growth and adjustment since its origin. During the past two years the most important change has been to a one-to-one project wherein a closer and more meaningful tie has been developed between the volunteer and the patient. The volunteer continues to be "a bit of the community in the hospital."

Rehabilitation therapies have supplemented their shops, crafts, library, etc., with support of the adolescent unit. A high-appeal series of classes in the creative arts has made it possible for patients to select and pursue activities according to their interests. These creative arts have permitted virtually every patient participation in some phase of activity.

Patent councils have flourished, making many parts of the hospital community a more democratic process.

The need for a transitional experience between the hospital and the community with vocational structure is increasingly evident. The past two years has seen the start of Vocational Rehabilitation service. This will be a refinement of past practices to let the patient develop vocationally.

A milestone of the hospital was reached with the construction of the Medical Treatment center, after eight years of planning. Its major contribution is the gathering of clinical services into one functional setting. A medical-surgical care facility of contemporary quality is now available to all patients. The balance of the building is the reception hospital for the alcohol program.

The alcohol treatment program develops at a satisfying rate. A full staff of counselors plus involvement of social service and psychology personnel has given greater intensity to patient care. Willmar is known world-wide for what is believed to be the largest alcohol treatment program, and every effort is made to retain this reputation.

All in all, the past 2 years have seen refinement and development of the total hospital program.

Minnesota Residential Treatment Center

A full program of in-patient treatment for 64 children and intensive child-centered work with their parents has been in effect over the past 2 years.

The center has served as a training resource for trainees in child psychiatry, social work, psychology, and special education. Because of the wide range of psychiatric problems treated, it continues to offer an excellent training experience to these and other disciplines.

Through the cooperative work of the psychology and rehabilitation departments, a set of procedures for identifying and correcting problems of physical coordination is being developed with the aid of outside consultative service.

The thorough training of child care personnel in a well demarcated, definable discipline of professional child care is becoming formalized and will be set down in manual material available to other organizations also.

Programs for the Mentally Deficient (Retarded) and Epileptic

Minnesota's program for the mentally deficient and epileptic rests on a legal structure which gives the Commissioner of Public Welfare responsibility for:

1. Protection and financial assistance for children who are confronted with a mental handicap.
2. A guardianship program for mentally deficient and epileptic persons committed to his care.
3. The administration of institutional programs.
4. Working for the enforcement of all laws for the protection of all mentally deficient and epileptic individuals.
5. Cooperation with all child-helping and child-placing agencies of a public or private character.
6. Taking the initiative in all matters involving the interests of such children where adequate provision therefore has not already been made.
7. The administration of a daytime activity center program for mentally retarded persons.

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

1. Continued work on utilization of a problem-solving approach rather than action on the basis of mental retardation alone.
2. Continued clarification and definition of responsibility of agencies and central office staff.
3. Strengthening of local responsibilities for services and programming for the mentally retarded.

4. Work toward establishment of standards in private residential facilities in cooperation with Child Welfare division.
5. Continued development of a variety of resources to meet individual needs.
6. Emphasis upon protection of rights of the mentally retarded.
7. A large amount of long-range planning in cooperation with the Mental Retardation Planning council.
8. Increased use of voluntary admission to state residential facilities.
9. Increase in number of daytime activity centers from 20 to 40.

Guardianship Program

Emphasis in the section for the mentally deficient and epileptic has focused upon service for all mentally retarded in the state rather than upon the provision of guardianship as mentally deficient.

Analysis of the guardianship responsibilities has continued with considerable effort being made to clarify and strengthen county welfare department responsibility.

Guardianship Program Comparisons

	1960-62	1962-64	1964-66
Number Under Guardianship	10,895	10,885	10,783
Number of New Commitments	1,113	929	566

Discharges from Guardianship and Restoration

	1960-62	1962-64	1964-66
Number Restored to Capacity	24	80	67
Number Discharged from Guardianship	229	456	295

The sharp drop from 1962-64 was due to the fact that a special project with temporary help was completed during that period on restorations and discharges from guardianship.

With continuing analyses of the guardianship program and emphasis on services for all mentally retarded individuals, there has been a slight decrease in the number of new commitments and the number under guardianship.

With emphasis being placed upon utilization of the most appropriate resource to meet an individual's needs, there has been a slight increase in the use of foster homes. Since foster homes for the mentally retarded are in somewhat limited supply, the increase may not be as great as the need for such resources. Trends in the use of foster care for mentally retarded children are shown by the following tables:

Foster Care

	1960	1962	1964	1965
Absolute trend in number of children who are MRE state wards	372	528	641	646
Absolute trend in number of days of foster care for MRE state wards	83,969	108,662	160,356	162,260
Absolute trend in cost of foster care for MRE state wards	$312,628	$419,858	$638,250	$662,032

Trend in average cost per child (MRE state wards)	$859.22	$826.49	$995.71	$1,024.82
Average daily cost of board and room for MRE state wards.....	$3.64	$3.61	$3.70	$3.77

Daytime Activity Centers

The 1965 session of the legislature appropriated $425,000 for daytime activity centers for the mentally retarded. During this biennium, the number of daytime activity centers receiving state grants-in-aid increased from 20 to 40. Approximately 650 children were enrolled in daytime activity centers at the close of this biennium. Emphasis during the past biennium has been in securing additional consultative services for these centers. There was complete screening of all participants on sight and hearing problems. Two institutes for daytime activity center board and personnel were held—one in September, 1964, and another in May, 1965. Efforts were made to increase the services in parental counseling. The daytime activity center advisory committee was enlarged and restructured.

The success and popularity of the program which serves preschool mentally retarded, school-age mentally retarded who do not qualify for public education, and post-school age mentally retarded, was manifest by the remarkable appropriation increase from $155,000 for the 1963-65 biennium to $425,000 for the 1965-67 period.

Institutions for the Retarded

During the past biennium, institutional populations were decreased from 6,375 to 6,066. This decrease in population is an attempt to meet state Department of Health standards, eliminate overcrowding, and structure a more adequate program. Populations in the institutions for the retarded have been as follows:

7-1-60	7-1-62	7-1-64	7-1-66
6,045	6,340	6,375	6,066
7-1-60	7-1-62	7-1-64	6-30-66
1,035	693	764	617

The above figures include the time during which the Brainerd state school and hospital was being developed. On July 1, 1960, Brainerd had a population of 355 and 1,371 on June 30, 1966.

The section for the mentally deficient continued very careful screening of all admissions to make certain that the institutions are utilized only for those situations in which the institution was the most appropriate resource. This continued until October, 1965, when the institutions took over the responsibility of screening all admissions and screening the waiting list.

The waiting list has decreased from 764 on July 1, 1964, to 617 on June 30, 1966. The following table shows the trends on the waiting list:

Admissions to the institutions have continued to decrease as more community resources have been developed and more emphasis has been placed upon use of the resource that is most appropriate to meet an individual's needs. The following table indicates trends in admissions to state institutions:

6-30-60	6-30-62	6-30-64	6-30-66
1,255	963	561	502

Discharges from the institutions have continued to increase. The trends are as follows:

6-30-60	6-30-62	6-30-64	6-30-66
330	330	601	654

Institutional overcrowding continues mainly at the Faribault state school and hospital. However, population of Faribault has been reduced from 3,152 on July 1, 1960, to 2,762 on June 30, 1966. Cambridge has reduced its population so that there is not overcrowding, and Brainerd has never had population over its planned capacity.

Major program improvement took place during the past biennium when a plan for 6 program groups was established for population within the state schools and hospitals. These 6 program groups are as follows: Program No. 1—Child Activation; Program No. 2—Child Development; Program No. 3—Teen Age; Program No. 4—Adult Activation; Program No. 5—Adult Motivation; Program No. 6—Adult Social Achievement.

Prior to the 1965 session of the legislature, effort was made to define the quality of care which could be provided with various levels of staffing. It was determined that the following five levels of care were dependent upon varying levels of staffing: 1. Survival care; 2. Custodial care; 3. Group care; 4. Individual care; 5. Demonstration and research.

The 1965 legislature appropriated and allocated money for 421 positions in the institutions for the mentally retarded. This meant that all of the institutions were able to eliminate the level of survival care.

The number of voluntary admissions greatly increased during the past biennium.

A careful evaluation of all patients over 65 years of age was made to determine whether the facility for the mentally retarded was necessary and appropriate to meet their needs. Many patients over 65 years of age were referred to county welfare departments for placements in nursing homes or other appropriate facilities. On July 1, 1964, there were 226

patients over 65 years of age; 185 on June 30, 1966.

In April, 1966, the populations of the state schools and hospitals for the mentally retarded exceeded those for the mentally ill for the first time. The population figures were 5,775 for hospitals for the mentally ill and 5,873 for the mentally retarded.

The 1965 legislature amended the statutes relating to the Owatonna state school so that the facility might provide "related services" in addition to education and vocational training. Population of the school dropped from 266 on July 1, 1964, to 190 on June 30, 1966. With public education developing more classes in the local communities for the educable retarded, it was possible for many children to be referred to their homes for educational services. As a result of the development of more special classes in the local communities, Owatonna has been accepting more and more children with emotional and behavior problems.

As a result of the decrease of population in state hospitals for the mentally ill, efforts have been made to determine whether some mentally retarded could be integrated into programs in the hospitals 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 psychiatric problems at the Cambridge state school and hospital could profit by placement at Moose Lake state hospital: 24 patients were transferred from Cambridge to Moose Lake on this demonstration project. The Hastings utilization committee and the Rochester utilization committee were set up to determine whether these hospitals might develop programs for the mentally retarded.

Federal funds, especially the Manpower Development and Training Act, have made it possible for all 4 institutions for the mentally retarded to develop training programs with the goal of training for return to independence within the community.

During this biennium the section worked closely with the division of Vocational Rehabilitation, Civil Service department, and the Mental Retardation Planning council in developing a civil service worker classification in which a mentally retarded individual might qualify for state civil service jobs on the basis of an application and board interview rather than written tests. Minnesota is one of three states to have established such a position.

The section worked closely with the state Department of Health in developing a second Child Development Center for Mentally Retarded at Owatonna. Also, the Child Development Center at Fergus Falls was

merged into the Lakeland Mental Health Center, Inc.

The section prepared a directory of resources for the mentally retarded in 1965 and also prepared a great volume of material for the Mental Retardation Planning council.

The section worked closely with the Mental Retardation Planning council and the standards and licensing section toward establishment of standards for private residential facilities and also towards determining responsibility of Department of Public Welfare and Department of Health in relationship to group care for children requiring a medical facility and for adult facilities.

Institutional Programs for the Mentally Retarded

Brainerd State School and Hospital

Four vital developments have occurred during the past 2-year period. First, as a result of the 111 new direct patient care personnel authorized by the 1965 legislature, there has been a gradual improvement of level of care on all 44 wards.

The second development was the completion in November, 1964, of the school department and rehabilitation therapies building. This building affords a great variety of facilities for centralized programs and for encouraging the organization of programs which reach out of the building into the wards. Activities in this building also are coordinated with fuller use of the adjacent 7-acre play field. Incorporated in these central programs has been the acquisition of a school bus which was obtained through charitable contributions. This is in almost constant use in connection with various patient programs.

Third, has been the organization of patients on the basis of characteristics which differentiated groups from one another to the point that different programs could be developed for them. After considerable study of individual patients resulting in their division into 4 basic program groups, the patients were moved to adjacent and fairly homogeneous building settings on the campus.

On the basis of this new arrangement, there are now 4 treatment teams, one for each of the 4 major program groups. These multi-disciplinary teams again study each individual patient to discover his needs and

then attempt to develop programs for the whole group on basis of these needs. The decisions of the teams are carried out by its members and particularly by its program leader. Program leaders are the chiefs of psychology, social service, physical therapy, and the director of rehabilitation therapies. Some of the teams subdivide into three teams so that the whole area of patient population may be covered. Meetings are held every week and a strong attempt is made to develop programs which will be geared to the needs of each group.

A fourth development has been the award by the National Institute of Mental Health of a $100,000 grant for intensive training of severely retarded adults. The project provides for 19 psychiatric technicians who are assigned to a rotating ward of 36 severely retarded adults. Six patients are assigned to one psychiatric technician on each of 2 shifts, continuing 7 days per week. A program of intensive training, planned step by step, is being used which is based upon the principles of operant conditioning and related methods of learning. The purpose of the project is to modify certain poor habits of the severely retarded adult in the institution.

Cambridge State School and Hospital

Cambridge is attempting to bring "new hope" to its patient-residents with its continual search for new and better ideas by which the patient can develop to maximum ability and by which life can become more interesting and more complete. To meet the needs of the individual patient-resident, six basic programs have been set up or are in the planning stage plus a Mental Health Treatment Service.

Program I—Child Activation: for children from birth to puberty who are nonambulatory or bedfast.

Program II—Child Development: for ambulatory children up to the age of puberty.

Program III—Teen-age: for ambulatory children from puberty to approximately 16 years of age.

Program IV—Adult Activation for bedfast and nonambulatory patients who may be late adolescent, adult, and aged.

Program V—Adult Motivation: for ambulatory late adolescent, adult, and aged patients.

Program VI—Adult Social Achievement: for active late adolescents, adults, and aged.

Mental Health Treatment: to treat those persons who are being admitted who need help with their emotional, mental, and psychiatric problems.

Cottage 6 has 73 girls, ages 5-14, classified in Programs II and III. The psychiatric technicians in this cottage, together with other members of the team, discussed the various suggestions of gearing some program to the individual girl and small groups so every patient-resident would

be included. Each technician was then assigned 5 patient-residents, who were to be given special consideration for 1 hour some time during the 8 hours on duty each day. This small assigned family would be removed from the noise and commotion of the common dayroom and taken upstairs to a small apartment where the technicians and 5 youngsters could be by themselves. Here for the first time in their life, many of the girls have opportunities to cook, sew, and paint. Life takes on a new meaning for the patient-residents and also for the technicians whose tasks take on new purposes. They establish closer relationships between patient-residents and themselves; they have the opportunity to spend more time on a one-to-one relationship and to assure that there are no "forgotten" patients, and that each is treated as an individual.

Another cottage that has made noticeable strides is Cottage 4, which has 70 girls, ages 16-50, classified in Programs V and VI. The philosophy of this cottage is to make the living area as homelike as possible; and, to have the care of the total patient-residents as much as possible the responsibility of the psychiatric technicians. Here the technicians are assigned 10 girls. In their plan, "Education for Daily Living," they strive to teach better grooming and dress, social development, manners, higher standard of behavior, and leisure-time activities. Enthusiasm is high among the patients and the technicians.

A cottage housing severely retarded ambulant boys, ages 8-16, and classified in Program II, is now under concentrated study. Each technician has been assigned 5 boys to work with individually or as a group. The objective is to initiate a daily activity program, along with the regular cottage routines, whereby each resident in the cottage will be included in a group activity on a daily basis: self-help skills, recreation, arts and crafts, and remotivation in small groups. Even though this group is the most difficult group of youngsters in the field of mental retardation for whom to program and care, there is definite hope that these boys can be helped so that their lives are more meaningful and complete.

Summer camping was a valuable activity for 465 patient-residents. Activities at the camps included swimming, fishing, boating, hiking, volleyball, softball, and group games.

Faribault State School and Hospital

The population on July 1, 1964, was 2,908 and on June 30, 1966, it was 2,761. Our present authorized complement is 971. The 1965 legislature authorized 200 new, largely patient care type positions, to be phased in during the 1965-67 biennium. Appreciable advances have been made because of continued emphasis on a team approach by employees to

improve existing and initiate new programs to provide all residents with the best care, education, and training possible so that each may reach the maximum that is possible in the development of individual abilities in spite of existing handicaps.

At the start of the biennium, there were 6 full-time physicians and 1 half-time physician on the staff, including the clinical director. Three additional full-time physicians also were appointed. We have continued to have valuable assistance from consultants in various specialties and through the out-patient department of Rochester state hospital.

The following research projects have been conducted:

1. **Continuation of diet studies on PKU patients.**
2. **Aminoacid metabolism in PKU.**
3. **Behavior and blood phenylalanine level in PKU.**
4. **Genetic PKU family study.**
5. **Buccal smear survey for x-chromosomal abnormalities in mental retardation.**
6. **Survey of heparitin sulfate excreters (Forme Fruste of Hurler's Syndrome).**

To improve the team approach, a 6-unit system has replaced the former 4 divisions of the institution with the institution hospital continuing as a distinct unit. The presiding team member, designated unit program director, is a physician in 3 units and a registered nurse in the others. Facilities for physicians particularly have been improved under the new system with each now having an office in the unit area, making possible close working relations with all other members of the team dealing with the assigned patients. Though not included in separate units, the dental department of 3 full-time dentists and 3 assistants, continues to function very adequately in meeting the dental needs of all residents. To the medical and dental programs have been added annual examinations including cancer detection procedures.

The in-service training for psychiatric technicians has been materially improved through the addition of a director of nursing education with increased staff. The department occupies remodeled offices in Wylie hall, a former residence for women employees.

The school department added 7 more classes and a "home-bounding" service was established for about 20 children unable to attend a central school facility. In the past school year the enrollment reached 304, as compared with 260 in the previous year. The individual class load was reduced from 15 to 8 or 10, and as much as 4 or 6 for emotionally disturbed children.

A full-time qualified librarian is in charge of library services for school children, adult residents, and the professional staff. The number

of books purchased by the library for residents has remained about the same, but professional journal subscriptions have been increased to meet more adequately the needs of professional staff members.

The rehabilitation therapies department continued to carry out programs designed to further social adjustment and development by planning for on- and off-ward activities for residents. They provide exposure to a great variety of functions in neighboring communities. The occupational therapy department staff has been increased from 1 in September, 1964, when it started, to 6 in February, 1966. One of the many programs carried out has been the training of 102 severely retarded ambulatory boys in the Maple building, who were divided into 3 groups: (1) 37 able to carry their trays, find their places at the tables and to eat independently; (2) 45 able to feed themselves with minimal assistance; and (3) 20 who needed to be fed. The aims of the program were to make each boy as independent as possible in eating, to use utensils correctly and to establish good table manners. As of June, 1966, the number of boys in the third group had been reduced to 9.

Another that deserves mention is the facilitations program. This was an effort to determine techniques which would aid severely retarded, cerebral palsied children to develop to their maximum the potentials in motor and adaptive skills. The department began an investigation into the use of neuromuscular facilitations methods, and their first program for these children was organized in July, 1965. An extra-mural work program started in 1963 has continued and most of the residents who have completed the 6-month training program have been discharged to return to local communities and become successfully employed.

During the biennium, the chief psychologist has assisted and provided consultation in the development of many new institution programs, some of which are federally financed or involve the participation of other agencies: coordinated efforts needed to conduct the patient census project of the Hospital Improvement Program, trained and supervised the clerical personnel involved in the project; coordinated development of the census schedule; developed the system for coding patient census information; and conducted final review of information collected on each resident. Patient census schedules have been completed for 250 residents and partially completed for another 200. Diagnoses have been reviewed and when necessary, revised by the staff pediatrician and clinical director or superintendent for each of the 250 residents whose schedules were completed. The census data has been entered on data-storing metal plates so it is now possible to identify, select, and list or count residents with one or more quali-

fying characteristics from their personal data, social or personal background, medical history, and behavioral development.

The major project of the dietary department was the careful planning of the new central kitchen and remodeling the dining rooms. The completion of these projects has resulted in marked improvements including delivering food to all dining rooms.

The social service staff was increased from 8 to 11, making possible 1 full-time case worker in each unit. In no department has the volume of work increased more than here, as it becomes involved directly in all programs including admissions, camping, temporary and permanent transfers, and in planning for community placement for those no longer in need of care.

A new project was completed through cooperation by members of the Sunnyside unit staff with interested families of 120 ambulatory, moderately retarded male residents living in the Pawnee dormitory. This resulted in the formation of the first parent-cottage group in September, 1965, and the success of this venture has led to plans for organizing other such groups.

The volunteer services programs have made a steady growth during the biennium with the assistance of the volunteer council. On June 30, 1966, there were 790 registered volunteers on the roster participating in all programs. The hospital auxiliary was organized and the "Pink Lady Coffee Cup" canteen was opened in the Rogers Memorial building on May 25, 1966. These volunteers man the canteen, open to patients, their families, employees, and friends on Wednesdays, Saturdays, and Sundays. The main area is open at all times during the day and is available for special parties and gatherings when the canteen is not in operation.

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. As such, it was commissioned to provide academic education and vocational training to retarded children up to 21 years of age.

In recent years, the amount and kinds of services available to educable retarded children in the community have steadily increased. This increase in community services has brought about a change in emphasis in the school's admission policies which has resulted in a shift in types of children at the school. Admission is extended primarily to children with behavior or personality problems. These children need supervision and treatment that can best be provided in a residential facility where a variety

of essential professional services are available to the child in a single, well coordinated program on a 24-hour basis, along with academic and vocational training.

This range of services is available:

1. An intensive treatment program which concentrates on behavior modification and provides maximum supervision for the more seriously disturbed students.

2. A program emphasizing primarily academic education and the learning of socially acceptable behavior with some vocational training included. Twenty-four-hour supervision is provided for these students. Within well defined limits, they are allowed freedom for developing responsibility and for growth of other individual personality patterns.

3. Semi-independent and independent living programs which de-emphasize supervision and places major emphasis on vocational training.

As a student develops independence, self-reliance and acceptable social behavior patterns, an effort is made to integrate him into such community activities as shopping, attending church, work experience, and recreation.

Attention has also been given to the dehumanizing aspects of institutionalization. An effort is being made, by giving the students a voice in institutional management through an active student council, to minimize those conventional institutional characteristics which tend to dehumanize. In-service training of employees and periodic review of programs, buildings, and facilities by Department of Public Welfare personnel tends to assure a major corrective emphasis on those influences that tend to dehumanize.

With more clearly defined objectives and programming, it has been necessary to give attention to intake policies and to maximum population figures. At present, those children are admitted who are in need of one of the first two types of programs listed above, i.e., intensive treatment and the regular institutional program.

The building space, the program facilities and treatment emphasis have made it necessary to limit enrollment to about 210.

Tuberculosis Control Section

Tuberculosis Sanatoria

There are now 5 sanatoria, 4 maintained by counties and 1 operated by the state.

Populations of Sanatoria on June 30

Sanatorium	1965	1966
Glen Lake State Sanatorium	62	50
Mineral Springs	60	58
Nopeming	62	52

St. Paul-Ramsey	43	48
Sunnyrest	9	8
Total	236	216

It is anticipated that the present Sunnyrest Sanatorium at Crookston will close, effective January 1, 1967.

State aid to county sanatoria continued during the report period. The appropriation made by the legislature was not adequate to pay the full amounts of state aid to county sanatoria as specified in the state aid laws. State aid of $1.50 and 90¢ per patient per day respectively were paid for fiscal years 1965 and 1966 rather than the $2.50 per day as specified in the state aid laws.

Expenditures of State Aid to County Sanatoria
(Fiscal Year)

1964-65[1]	1965-66[2]
$50,000	$50,000

1 State aid was paid at the rate of $1.50 per day (based on the appropriation available and the estimated number of patient days) throughout fiscal year 1965. Total payments at $1.50 per day throughout the year amounted to less than the $50,000 appropriation; so the balance of $15,169.78 was paid to county sanatoria at the end of the year on a prorated basis.

2 State aid was paid at the rate of 90¢ per day throughout fiscal year 1966. From the total amounts billed by the sanatoria as of the writing of this report, it appears that the bills may exceed the $50,000 appropriation; if so, the payments of state aid for June, 1966, will not cover the full amounts billed by the sanatoria for that month.

The legislature continued the plan that distressed counties should receive the special state subsidy for tuberculosis costs from the equalization aid program rather than under the funds for state aid to county sanatoria.

Special resources are available for problem groups because of the history of greater incidence of tuberculosis among:

1. *Non-settled Persons:* Special state subsidy is available at Glen Lake state sanitorium whereby the responsible county pays only 20% of the cost of care.

2. *Indian Contract:* The Tuberculosis Control section administers a contract between the Department of Public Welfare and the U. S. Public Health Service for the sanatorium care of persons who are one-fourth degree or more Indian blood and who are from tax-exempt land. One hundred per cent federal reimbursement was received for the following costs:

Indian Contract Costs (Fiscal Year)

1964-65	1965-66
$96,936.92	$96,776.32

3. A grant-in-aid program is administered by the state Board of Health to establish or extend local tuberculosis out-patient facilities. This program was adopted by the 1963 legislature and was continued by the 1965 legislature. The tuberculosis programs of the state Board of Health and the state Department of Public Welfare are closely coordinated.

Tuberculosis Control for State Institutions

The section conducts a control program for state institutions because for many years this was a problem area of tuberculosis morbidity among patients and employees.

As a result of improving the control program over the years, there has been a significant decrease in the incidence of tuberculosis among employees.

In July 1956, there were 16 state employees receiving workmen's compensation because they contracted tuberculosis in connection with their work at a state institution. There are currently only 3 such individuals receiving workmen's compensation; and these people are individuals whose tuberculosis was contracted many years ago and who cannot work because of restrictions due to residual from their tuberculosis.

70mm. x-ray surveys of patients and employees at the institutions are conducted, and reports of the findings are prepared by the section. The section provides the services of a consultant roentgenologist to state institutions.

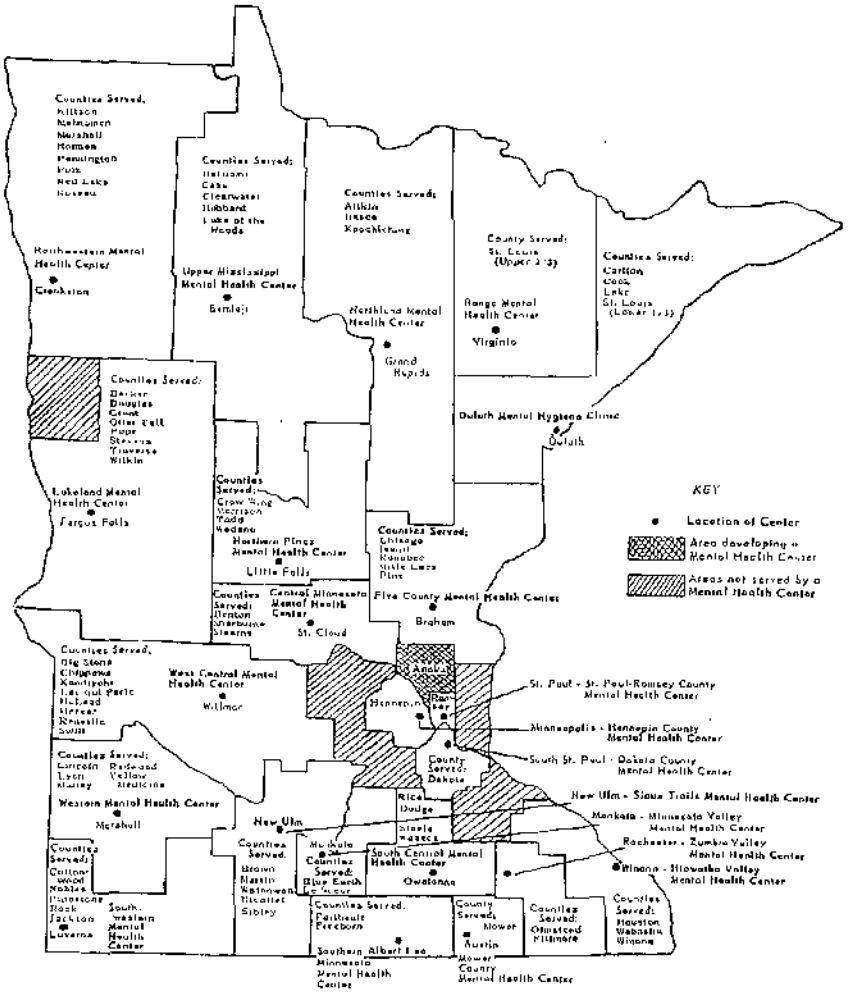
A reminder system is maintained to assure that all recommendations for follow-up are carried out. This includes recommendations as a result of findings on 70mm. and 14 x 17 chest films, bacteriological studies, and past history of tuberculosis. Reminders are sent to the institutions when necessary.

The frequency of surveys and of special follow-up examinations is considered and revised periodically to conserve the efforts of institution employees as much as possible. The total number of patients and employees under special observation of the section continues to increase as the case-finding methods have been improved and the reminder system has assured that recommendations are followed.

The number of tuberculosis patients at the special unit at Anoka state hospital has continued to decrease. On June 30, 1966, there were 37 patients in the facility for patients or inmates from state institutions who have tuberculosis and for recalcitrant tuberculosis patients. The coordination of efforts of the section, the state institutions, and the staff of the tuberculosis unit at Anoka has made it possible to detect quickly patients having or suspected of having tuberculosis and to arrange for prompt isolation. The 70mm. x-ray surveys and other screening methods are finding cases of suspected tuberculosis and relapses early, and the teamwork within the state hospitals system makes it possible to arrange for special study and treatment without delay.

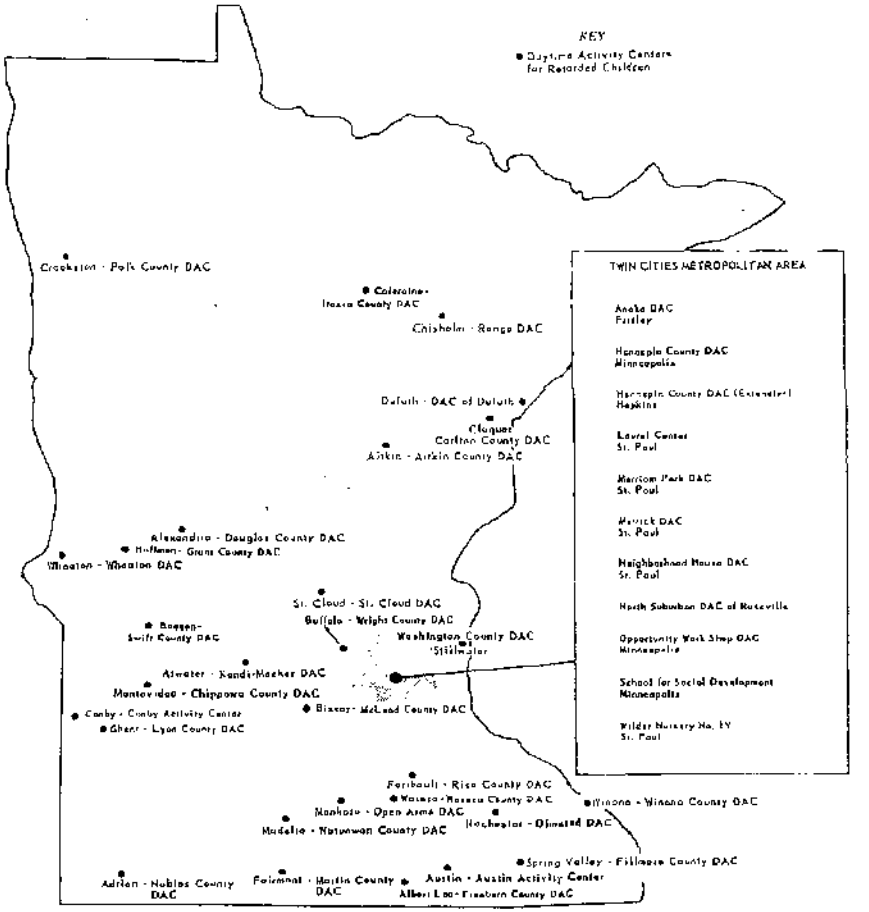
MINNESOTA'S
COMMUNITY MENTAL HEALTH CENTERS

JANUARY 1, 1966



MINNESOTA'S
DAYTIME ACTIVITY CENTERS
FOR RETARDED CHILDREN

JANUARY 1, 1966



MINNESOTA'S REGIONAL MENTAL HEALTH
COORDINATING COMMITTEE AREAS

JANUARY 1, 1966