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1961 Legislative Budget Presentation  
On Mental Health and Mental Institution Programs

-by-  
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This document is to serve as a brief introduction to budget requests before the 1961 Legislature for the 1961-63 biennium. Particular attention is given to the requests of hospitals for the mentally ill and retarded,

The Division of Medical Services includes three major program areas: mental health, tuberculosis care and control, and crippled children's hospital and field services. The latter two areas will be covered in the individual budget requests for the institutions involved and are otherwise financed through central office and federal funds,

The mental health program divides further into a number of over-lapping sections or branches. These are:

1. Services for the mentally ill and the inebriate
2. Services for the mentally retarded and the epileptic
3. Psychiatric services for children
4. Community mental health, including prevention
5. Mental health training
6. Mental health research

Children's services, community mental health, training and research and some aspects of mental retardation, together with special funds appropriated to the Department of Public Welfare, are covered more thoroughly in the central office budget request. Henceforth I will speak about institutional services and more particularly hospital services for the mentally ill and retarded,

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A. General Commentary

I am deeply concerned that in any given instance we could affirm the following three propositions:

1. This is a Hospital
- 2, This is a Psychiatric Hospital
- 3» This is a Mental Health Program

The last refers to the program integration which it is my job to try to obtain through coordination and direction centrally. This is covered in our material pertaining to central office requests,

Proposition 1: This is a Hospital

In attempting to affirm this I have turned to the Joint Commission on Accreditation of Hospitals, This is a body comprising five national organizations such as the American Hospital Association and American Medical Association, I have set for the hospitals the difficult but not inconceivable goal of obtaining full Accreditation in three years' time.

What does Accreditation require? Above all it will require improved professional staff ratios and a reduction in overcrowding. These are some of the basic conditions:

1. More physicians, especially psychiatrists and other skilled specialists,
2. More professional nurses,
3. Continuing in-service training for medical and nursing personnel at all levels,
4. Adequate medications in assured supply and a drug room under the management of a registered professional pharmacist.
5. Professional dietician services,
6. Medical records procedures including histories and physicals on admission, case summaries, extensive pre and post surgical annotations, and full documentation on deaths and untoward occurrences,

7. X-ray, laboratory and special treatment facilities adequately staffed to meet requirements of modern general and psychiatric care,
8. Adequate physical plants, safe and sound of construction and free of fire hazard,
9. Adequate living space, which means reduction in overcrowding, which means increased discharge programs,

The three year goal is based on the assumption that with luck and a constant effort to improve ourselves from within we have a fighting chance of achieving that goal. We have no illusions however, about the need for continuing staff development in numbers and quality during this biennium and the biennia to come,

Accreditation is a seal of approval by a nationally and internationally recognized group. It allows the hospital to take its place among those recognized as meeting acceptable national standards of hospital performance. More importantly the standards are sound ones, certifying that this hospital, whatever its special function, is properly administered and safe. Accreditation by the J.C.A.H, is a basic condition to other types of accreditation. Psychiatric residencies hinge on this and the advantages of having our own psychiatric training programs are obvious. The same applies to nursing affiliations. Even if not accredited a hospital can sometimes honestly state that <sup>it</sup> both effective and safe. Still the external validation is obviously significant. The processes of self-improvement involved in obtaining it are tremendously beneficial for the hospital service,

Proposition 2; This is a Psychiatric Hospital

We want to complete the process of conversion from custodial to treatment hospitals. For this reason I have asked that our hospitals be opened as rapidly as can reasonably be done. The Open Hospital is the most concrete and vital example of modern treatment hospital management,

A treatment hospital, sometimes called a "therapeutic community", is characterized by benevolence, hope, and action. The hospital environment is as home-like and community-like as possible. The outlook is for early return of short and long-term residents alike to their homes or to society at large, where this is possible, and for useful citizenship in the institution where it is not. There is a balanced and prescribed program of work, recreation, and rest to allow maximum self-fulfillment of the patient and to develop his sense of personal and social responsibility. There is careful attention to needs at all levels - - from homely niceties, like evening snacks, individualized clothing and improved grooming to intensive social casework services and specific psychiatric and other medical therapies. More patients are getting more effective drugs under better supervision. There is rapid turnover of patients and an increased discharge rate. No patient remains in the institution for want of medication, psychotherapy, casework planning or other services. There is increased freedom of flow and communication at all levels between hospital and community to the end that the hospital will be truly a part of the community and a community facility.

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Drugs and medical supplies are obviously essential to a hospital program. Our needs are for tranquilizing drugs - about a third of our 10,000 mentally ill and ,a sizeable proportion of our mentally retarded are on them - and for many others as well. Anticonvulsants, agents to combat tuberculosis, and a wide variety of drugs and supplies in connection with our surgery programs are three notable examples. Tranquilizers are paradoxical. By reducing disturbance they make hospital management simpler and less costly. At the same time they make more patients accessible to rehabilitation and personal services and thereby increase the demand for and complexity of such services. They are economical in the long

run, especially in their contribution to human values and dignity. If we err in using them it is probably in the direction of using them too little. From the therapeutic point of view, there should always be assurance of continuing ample supply.

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With obvious adjustments, the above concepts apply to programs for the mentally retarded as well as the mentally ill, and they apply to all age groups, Programs of this sort require staff. As in the instance of Accreditation, we have a margin and a chance for success, through internal rearrangement and continuing efforts at self-improvement. In the light of what we consider to be the needs of our patients along the lines of modern treatment concepts, we consider<sup>'the</sup> requests for this and future biennia to be entirely moderate.

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Improved staff-patient ratios are fundamental. The need for professional personnel is obvious.

Of a somewhat more subtle order is the increasing need for non-professional supporting personnel. Simple numerical ratios do not reflect changes in program and in the character of our population. Patients are in for a shorter time, Increasingly those who remain are infirm, elderly, incapacitated or in need of close supervision. Those of the work force who are apparently not capable of returning to the community are able to do less and less. Beside the basic work of the institution which must be done there is another factor to be borne in mind, This is that better and more supervision by employees is required if the benefits of institution work programs are to be maximized. The conversion from custody to treatment also involves intensive activation programs on chronic wards and in all hospital work and play areas.

Demands on the clerical staff are intense. The medical records requirements

of Accreditation have been touched on. Increasing activity of the professional staff means more annotation, recording and communication. Failure of clerical support not only is demoralizing but actually retards the flow of work. In the most extreme situations it leads to the absurdity of professional people wasting good and highly-paid time doing their own clerical work. Increasing activities in relation to discharge of patients requires more forms, accurately completed. I have contributed my own share to the burden by requiring essential reports having to do with achievement of the basic goals of Accreditation and the Open Hospital.

Salary levels will help determine what we are able to do in our program, since this is one of the most important ways by which to attract and retain employees, especially professionals.

Medical recruitment problems are presented more fully in relation to training. The Civil Service plan for physicians and medical specialists has been developed separately from the main body of these proposals, and is self-evident. A few facts might be mentioned at this point, however. Extensive correspondence with thirty-eight different physicians during a sample six month period last year, involving altogether something like three full weeks of time on the job and around eight hundred letters, brought two people into the state. Despite increasing efforts of this kind we have lost ground. We have only eight board-certified psychiatrists to care for sixteen thousand patients in our system at the present time. Advertisements have generally produced responses only from overseas. The Board of Medical Examiners has wisely placed a limitation on the number of such physicians whom we may employ. It is possible to obtain foreign-trained physicians at present salary levels but apparently not high-qualified graduates of U.S. and Canadian schools. The evidence is pretty clear that medical

salaries should be improved: this refers both to medical superintendents and physicians in the classified service,

The opportunity for professional people to keep abreast of progress is reflected in out-of-state travel allowances. This is an awkward subject, but still the point should be made that a recent survey discloses Minnesota as extremely conservative in this regard in relation to other states.

While freely and gratefully acknowledging the hard work done by the Department of Civil Service in the matter of pay raises, we would respectfully call your attention to what we consider inadequacies in the proposed Civil Service pay plan to go into effect July 1, 1961. The following classes, we believe, merit additional attention if our programs are to continue to develop:

1. Social Workers
2. Volunteer Coordinators
3. Professional psychiatric nurses
4. Psychologists
5. Pharmacists
6. Dieticians

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Fiscal accounting of services is another problem of general importance. Inevitably budgets are analyzed on a per capita basis--on the face of it this would seem to be a sensible way. It has been our experience, however, that analysis on this basis tends to give a misleading and incomplete picture. In particular it can allow no real observation of activity of service. It leads furthermore quite naturally into per capita cost comparisons from one hospital to the next. Here again, because populations and programs vary and are in many respects not comparable, is a source of misunderstanding and confusion. These issues will all become manifest in subcommittee hearings,

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B. Specific Commentary

1. Hospitals for the mentally ill

a, Population trends

The chart shows statistics for the past five years. With some plateau effect in the curves latterly, there is a continuing increase in admissions and in the total number receiving care during a given year. The key to the chart, however, is the increased number of releases thus allowing a decline in population. This increased release rate shows what the staff can and should do,

One of the problems we had in preparing this material was to decide whether to show many charts of this kind or to add more lines to this one, I have chosen a third path, namely to leave the chart as it is and attempt to elaborate verbally on some additional subtleties. The fact is that a chart of this kind tells only part of the story. The release rate gives some indication of program activity but is still incomplete. For each patient released there are many hours of activation therapy before he reaches the threshold, many hours of careful social casework, a heavy load of communications and conferences with outside agencies, Special missions of some hospitals, for example the rapid turnover of inebriate patients and surgical transfers, which require in many instances new work-ups, are not reflected, A chart of this kind does not reflect the heavy burden of caring for the infirm and dying patient. In other words, the danger of this chart is that it does not truly reflect work load. Furthermore an increase of releases increases, so to speak, the population "at risk"--a discharged patient, even if no longer on the hospital books, may be removed as a statistic, but he is not really outside the purview of the on-going program of the hospital, The nature of the problem with which we deal is such that between a quarter and a third of patients released can be expected to return at some future time, and

this is not a sign of failure either, it is expected.

We are trying to offset the natural tendency to two suppositions: (1) that the population decline is a natural, not man-made, phenomenon and that once begun it will continue of its own momentum and (2) that as the decline continues fewer people and material resources are required in order to continue the work. Our experience is that this is not the case and that indeed the decline in population is made possible by continuing augmentation of such resources.

b. Staff ratios

Staff ratios were developed. The standards are those that would be required in implementing a good basic on-going program. They relate to all levels of care beginning at the basic ward levels, and were applied ward for ward, service for service in all seven mental hospitals. We applied standards for medical and other professional positions also. The standards also include deliberate consideration of basic maintenance, clerical, and administrative support areas.

The major defect of these standards is that they are based for the most part on the static condition of patient population, and not on service activity. Thus as the hospital improves service and releases patients a rigid application of these standards will increasingly work to the hospital's disadvantage. As I have already commented this is a basic fault of the classical per capita approach to program budgeting.

According to our estimates it would take 1,770 new positions to bring all hospitals up to 100% of the standards which we used. We originally asked for a third of this amount, sufficient to bring them up to around 73%. You will of course be hearing about these matters in greater detail in individual institutional presentations.

## 2. Hospitals for the Mentally Retarded

We have made no attempt to apply the same standards to hospitals for the retarded. This would have meant a complex analysis of program similarities and differences, and ultimately an even greater request. Standards for such hospitals are if anything even more indeterminate at the present time than for those for the mentally ill,

We are asking restoration of positions previously lost at the Cambridge State School and Hospital and then a general increase to bring all the hospitals in this branch of the program to a level of one employee to between 3 and 3.5 patients. Within the total number, designation of particular positions has been left at the discretion of the individual superintendent. You will note here again the need for professional staff and also for basic supporting personnel, reflecting the gradual reduction in "work patients" and increased clerical demands,

The institutions need help in implementing in-service staff programs and especially enhanced discharge programs to return a presently unknown number of potential dischargees (estimated between 500 and 1000) to their home communities, Without such enhanced discharge programs, a careful evaluation of our waiting list, and a marked increase in community programs for the retarded the outlook is for an increasing institutional population for an indefinite period,

The Owatonna State School is primarily an educational, not a hospital, program and the Annex for Defective Delinquents is even more specialized. Medical and nursing considerations do not strictly apply. But the same "therapeutic community" principles still hold and the problems are similar,

In closing I would like to make two general observations. The first concerns the sensitive issue of uniformity. Here I take the liberty of quoting from myself, using the final paragraphs of a document entitled "A Statement of Expectations" in which I first set forth the dual goals of Accreditation and Open Hospital on July 29, 1960:

"There has been and will continue to be discussion pro and con on the issue of uniformity in the operation of our hospitals. This is ultimately a constitutional problem, to be resolved by the balance of authority which exists between the hospital superintendents, who properly desire sufficient individuality so as to be able to carry out their assigned missions with professional freedom and with the opportunity for creativeness according to their own lights, and this office, which with equal propriety, in view of its responsibility to the executive and legislative government and the people, requires some measure of consistency of form and a full measure of unity of purpose. Our problem is analogous to that at the national level in the balance of sovereignty of the federal government and the various states,

"A most sublime statement of national purpose is the motto over the door of the U.S. Supreme Court Building in Washington, D.C, This reads: "Equal Justice under Law", There is no requirement that laws in various localities be uniform. But justice must be equal everywhere. By the same token, I am interested not primarily in uniformity of method but in equality of service at a standard of excellence. This interest is dedicated to the end that patients under treatment in all of our institutions will have an equal opportunity to get well and return to their rightful places in society: equal among ourselves and equal to the opportunity for the mentally ill and mentally retarded which exists anywhere,"

My second observation concerns quality of service. Just as you have your constituents who expect you to represent them, we have ours also. Our constituents are 16,000 mentally ill and retarded patients, and several additional thousands who may in the future enter or re-enter our mental institutions. Whether there are more or fewer of them than there were five years ago is not the fundamental point at issue, What is more significant, what is really behind our continuing drive for more resources to do a better job, is that they expect more of us and we expect more of ourselves.

You have the awesome and fearful responsibility of weighing service needs in relation to the realities of available revenue. I hope and trust that you will bear in mind the points which in these presentations we are trying to bring out.