MINNESOTA'S

Mental Health Program

A Two-Year Review

July 1, 1962 - June 30, 1964

DIVISION OF MEDICAL SERVICES
DEPARTMENT OF PUBLIC WELFARE

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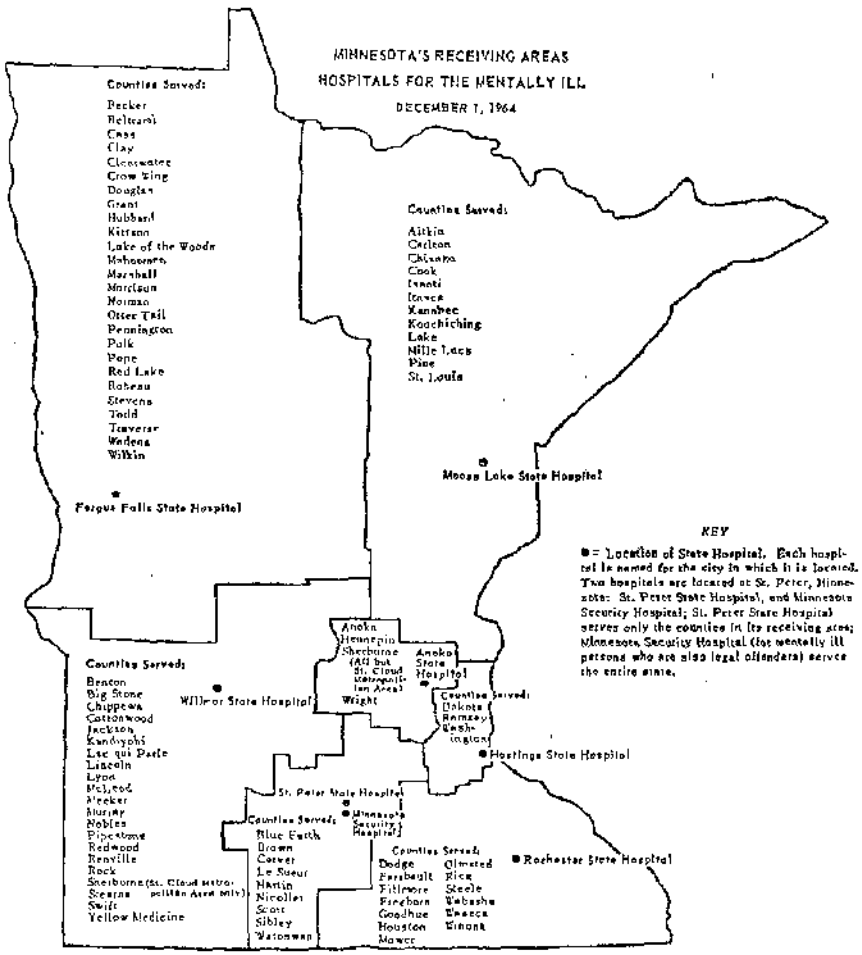

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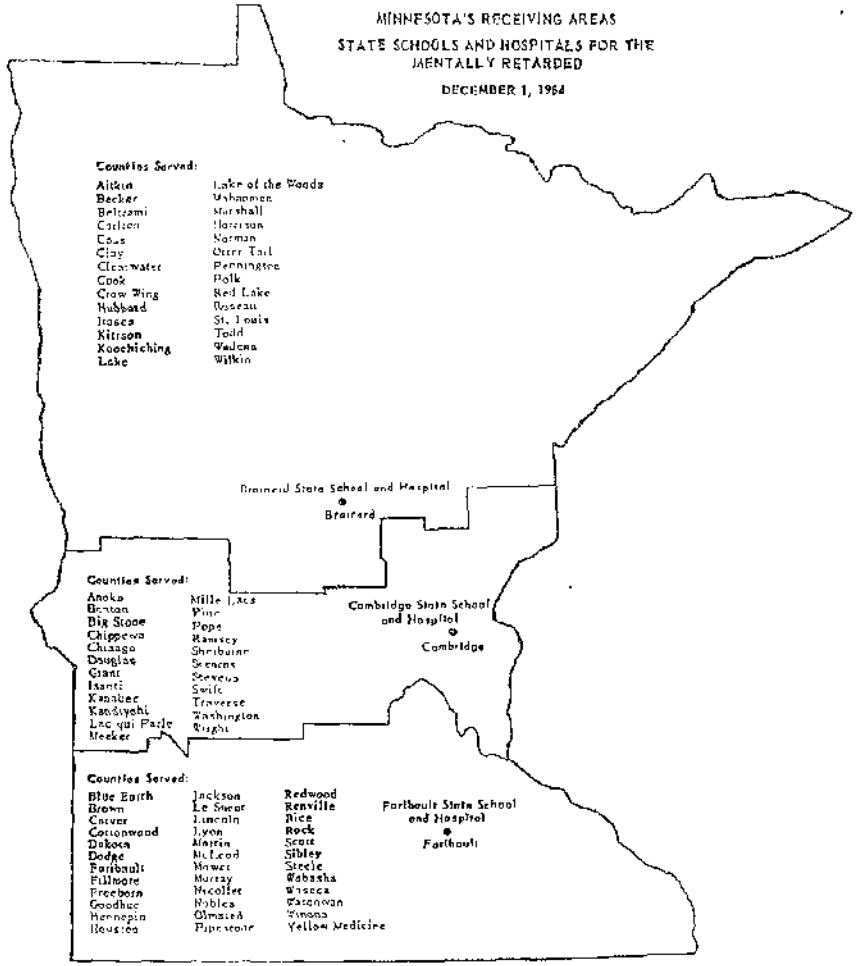

State Mental Health Program

THE DIVISION OF MEDICAL SERVICES OF THE DEPARTMENT OF PUBLIC WELFARE supervises and administers the state-wide program of mental health services which includes responsibility for:

1. Supervision of the treatment program in the eight state hospitals for the mentally ill.
2. Supervision of the Minnesota Residential Treatment Center for Children at Lino Lakes.
3. Supervision and program planning for the mentally retarded, both within the six state institutions for the retarded and in the community.
4. A state-wide mental health research program.
5. 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. A 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 April, 1964, the Oak Terrace Nursing Home was transferred out of the Division of Medical Services into the Division of Public Assistance. As a result, the Division of Medical Services is concerned almost exclusively with mental health programming and planning. The one exception is the state program of tuberculosis control, which is still in the Medical Division.

State Program Changes and Trends

A number of changes and developments have occurred during the past two years which will be explained in more detail on the following pages. To highlight a few of the most notable changes:

1. In January, 1963, a psychiatrist was hired as assistant medical director and director of community mental health services. He acts as psy-

chiatric consultant and program supervisor for community mental health operations which includes broad supervision at the policy level of the community mental health services in conjunction with hospital-community mental health services integration.

2. Minnesota now has 19 mental health centers, and a 20th community mental health center board recently organized. This represents a growth of three over two years ago.

3. The Minnesota Residential Treatment Center for Children opened in June, 1963.

4. Twenty day care centers for the retarded are in operation in the state.

5. The Minnesota Security hospital at St. Peter was made a separate institution by the 1963 Legislature.

6. A director of the Minnesota Mental Health Study and planning program started this project in July, 1962.

7. The 1963 Legislature gave its support to the redistricting plan whereby Anoka state hospital, rather than the St. Peter state hospital, would receive the admissions from Hennepin county.

8. In August, 1962, the program of regional mental health coordinating committees was established and during the biennium five regional coordinating committees were established.

9. During the past year Hastings state hospital received its accreditation, bringing the number of accredited state hospitals to three—Anoka, Hastings, and Rochester.

10. In the 1963 legislature, a law governing the Owatonna state school was modified so as to allow for direct admission from the community without prior guardianship proceedings.

11. In May, 1963 a Mental Health Planning Council was organized to develop a comprehensive mental health plan for Minnesota.

12. Grants totaling more than $250,000 for 1964-65 were received by three Minnesota institutions as part of a 10-year program of hospital improvement made possible through federal funds. The three institutions are Rochester, St. Peter and Faribault.

13. Minnesota also received in-service training grants through federal funds amounting to approximately $150,000 for six of its institutions. These include Anoka, Hastings, Rochester, St. Peter, Owatonna and the Minnesota Security hospital at St. Peter.

Early in 1964 a very successful series of Governor's bus tours was conducted, which included visits to mental health facilities in our state. The focus of the bus tours was on people and programs, not on buildings

and budgets, and each tour included a community mental health center, a day care center for the retarded, a state school and hospital for the retarded, and a state hospital for the mentally ill. These tours were sponsored by the Governor's office in cooperation with the Minnesota Association for Mental Health and the Minnesota Association for Retarded Children.

During the past year much of the Medical Division's attention has been centered on The Problem of Dehumanization. Since this Division is approaching its task from a problem-solving standpoint, it has deliberately avoided addressing itself to such things as "providing dignity" or "providing a humanitarian approach" since these are noble concepts but extremely difficult to measure in terms of progress or evaluation. In the course of the year, many notable changes have already taken place as the Medical Division and personnel of the state institutions have looked at the practices and systems which have developed over the years which adversely affect the dignity of the patient.

Continuing to be of concern are the work programs in the hospitals involving patients. One study has already been done in the institutions for the retarded to establish the cost factor involved in using patient help, and one is under way at the present time for the institutions for the mentally ill. The concern has been both for the therapeutic role of work for the patient as well as the opportunity for financial compensation to the patients for work performed.

Community Mental Health Center 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, 1964, a total of 68 counties (out of 87) including 4 municipalities, served 2,915,174 or 83% of the state population.

In the past two years, two new mental health centers came into being, bringing the total to 19, a 20th mental health center board was organized, and a day hospital program was developed in connection with one of these mental health centers. In addition, 11 other counties have indicated varying degrees of interest.

Mental health clinics and centers are now located in the following communities: Albert Lea, Austin, Bemidji, Braham, Crookston, Duluth,

Fergus Falls, Grand Rapids, Little Falls, Luverne, Marshall, Minneapolis, Owatonna, Rochester, St. Cloud, St. Paul, South St. Paul, Virginia, and Willmar. (Some financial support from the state is given to the Wilder, Washburn, and Hamm clinics, which are private facilities and not under the Community Mental Health Services Act.)

Applications for new centers, and for extension and consolidation of existing centers, continue to be filed at a faster rate than can be met by available funds. 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
1955-57	$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

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

At the end of the 2-year period of this report, there were approximately 96 full-time professionals working in the mental health centers. This includes 23 psychiatrists, 27 psychologists, 35 social workers, and approximately 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, correction, 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 throughout the state. Each center 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 have embarked upon research programs which include studies on children's mental health services, epidemiological studies, problems of illegitimate parenthood, etc., which will provide useful data to enable the staff to conduct more meaningful services to the areas being served.

Children's Mental Health Services

This section is based on a unitary concept of mental disorders of childhood aimed at reducing artificial dichotomies between "retarded" and "nonretarded" children. Thus there is afforded the opportunity, especially 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, to organize programs aimed at the totality of the child's clinical problems in all of its various dimensions. 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 during the biennium. The Pilot Project for Day Care centers proved itself so rapidly in 1962 that the 1963 Legislature appropriated $155,000 which has led to the establishment to date of 20 such facilities across the state, with additional applications pending when the funds are available. Institutional programs for retarded children and adults continue to be concerned with providing care and treatment aimed at meeting individual needs of the patients.

Treatment of children with a wide variety of disturbances took a major step forward with the opening of the Minnesota Residential Treatment Center at Lino Lakes in June, 1963, and with the employment of a medical director in May, 1964. This new unit will provide intensive diagnostic and treatment services to 64 youngsters.

Recent developments in the state mental hospitals in the direction of providing more specialized services for adolescents have served as a basis for an optimistic outlook for this phase of mental health programming for children.

Early in 1964 a subcommittee on children, advisory to the office of Director of Children's Mental Health Services, was established by the Mental Health Medical Policy committee.

Day Care Centers

There has been a marked acceleration of community services for the mentally retarded. This has been sparked by the state day care center program done as a pilot project in 1961. Beginning with the modest $36,000 1961 appropriation, DPW assisted local communities to establish nine day care centers, which in the period February, 1962, to June 30, 1963, served 124 clients. The clientele includes preschool and school-age mentally retarded children who are neither educable nor trainable under standards set by the State Board of Education, and/or post-school mentally retarded children who are unable to independently engage in ordinary community activities.

The success and popularity of the program were manifest by the remarkable appropriation increase (to $155,000 for the 1963-65 biennium, or over 400%) given by the 1963 legislature. At present there are 20 day care centers for the retarded in operation in the state.

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 rose from $200,000 to $280,000 for the current biennium. This $80,000 increase was used largely to provide research personnel. Career researchers or technicians and clerical assistants are now supported in seven 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, 1963, 85 studies were in progress, 42 were reported to have been completed during fiscal 1962-1963, and only 7 had been terminated. As of July 30, 1964, 50 studies were in progress, 41 had been completed during 1963-1964, and 16 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.

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 central office research 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.

State appropriations for training during the past two biennia have been as follows: 1961-63, $200,000; 1963-65, $350,000. The boost given to the training program is encouraging and the additional amounts will be used to support a stipend program for psychiatric residents. The director of the Division of Medical Services also acts as training program director of a General Practitioners' Psychiatric training program, supported by an NIMH grant made to the Minnesota State Medical association and the Minnesota Academy of General Practice.

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 amounting to approximately $150,000 were received by Anoka, Hastings, Rochester, St. Peter, and Minnesota Security hospitals and Owatonna state school, during the past year.

Regional Coordinating Committees

An administrative plan to use a regional approach to meeting state mental health needs was established in August, 1962. This plan provides for the realignment of hospital receiving districts to correspond directly to the areas served by existing and future community mental health centers. It is the plan to have regional mental health planning councils established in each of the seven regions with representation from the state hospitals, community mental health centers, county welfare departments, and DPW field representatives as a minimum committee. Closer coordination of services at the local level, liaison between the regional resources and the improved continuity of patient care, are the expected results. At present, five regional mental health coordinating committees are in existence, and meet regularly. These are located in the areas served by the Fergus Falls, Hastings, Moose Lake, Rochester, and Willmar state hospitals.

Minnesota Mental Health Planning Council

The Minnesota Mental Health Planning Council, which had its first meeting in May, 1963, was launched with federal financial support for the purpose of developing a comprehensive mental health program. An executive committee was organized and has met on numerous occasions since the Council has been in existence. Seven subcommittees of the Planning Council were developed and serve as the working committees. These are concerned with the following topics: 1. Aftercare; 2. Economics; 3. Facilities; 4. Forensics; 5. Institutions; 6. Nonmedical Problems; 7. Professional Practices.

At the May, 1964, annual meeting of the Planning Council, the regional coordinating committees were invited to meet with the members of the seven subcommittees of the Planning Council for the purpose of coordination and communication. As a result of that meeting it was decided to develop and circulate a special newsletter entitled, *The Switchboard* which would contain the minutes of the subcommittee and regional coordinating committee meetings, in order to improve and maintain communication and coordination between these important groups. In addition, central office staff has been assigned to each of the subcommittees and regional coordinating committees, and serves in a liaison capacity.

Mental Health Study and Planning

The Mental Health Study and Planning office has been assigned responsibility for two separate but related operations:

A. The administration of a special project, established under federal research funds, to evaluate Minnesota's state mental health program.

B. General supervision of a two-year effort to develop a comprehensive mental health plan for Minnesota.

The special project can be characterized as "basic planning"—the latter as "applied planning." Both are seen as necessary and ongoing functions complementing one another, but will be described separately below.

A. Evaluation of a State Mental Health Program.

This project is referred to as basic planning because it is concerned with broad policy questions and the machinery available or needed to formulate, obtain consensus, and implement such policy. In other words, the project is designed to be a catalyst in the growth of the state mental health program as an effective, coordinated system.

The goals of the project are two:

1. A state mental health program whose progress can be measured in relation to clearly defined goals; and
2. A state mental health program which will be more effective in achieving its clearly defined goals.

The development of clearly defined, agreed upon, goals is the first target. Subsequently, the effort will shift to the formulation of detailed plans to achieve these goals, and finally a reporting system that can measure progress and "signal" the need for program changes.

Principal developments to date are: 1. Minnesota's Operations Planning Schedule developed; 2. Section Heads Planning Committee established; 3. Mental Health Planning Council established; and 4. Planning Proposal approved by the United States Public Health Service. Also undertaken by this section has been an epidemiological study.

B. Comprehensive Mental Health Planning.

The bulk of the work being carried out under this project falls outside of the Mental Health Study and Planning office and is described in this biennial report under the heading *Minnesota Mental Health Planning Council*.

State Mental Retardation Planning Council

During 1964 the Minnesota Mental Retardation Planning Council was organized to assist with comprehensive planning for the mentally retarded. Its executive committee includes the heads of five key state departments—health, welfare, education, employment security, and corrections; a member of the Governor's staff; the executive director of the Minnesota Association for Retarded Children; and the chairman of the Advisory Board on Handicapped, Gifted, and Exceptional Children. The council employs a full-time director and secretarial staff, and includes among its other members specialists in mental retardation from colleges and secondary schools, authorities in mental retardation from the University of Minnesota, county welfare workers, and representatives of the legal and medical professions.

The Council will develop plans in each of the following areas: volunteer services and public awareness; prevention, diagnosis, and treatment; education and rehabilitation; residential care; community-based services; research; the law and mental retardation; staff training and recruitment; and employment of the retarded.

Information and Mental Health Education

During the past two years several projects have been developed with the Association for Mental Health and the Association for Retarded Children. These have involved a series of meetings on Minnesota's mental health program and extension and expansion of volunteer programs at both the community and institutional levels. Leadership training programs and other types of meetings have been held, aimed at developing greater public understanding. Through the State Volunteer Council, and its quarterly meetings, involvement in as many community groups as possible in programs of education and service were encouraged and developed. This section is continuing to cooperate with the Minnesota Department of Education in the development of mental health information and materials to be included in high schools throughout the state.

Already produced is the film, *Mental Health Careers*, and the pamphlet, *Getting to Know Us*, a tour guide for students who visit our institutions. A national survey was made by the section of mental health agencies and departments of education in an attempt to determine what kinds of things are being taught to high school students in the area of mental health, by whom, and how effective is the material. There was also an attempt to find out how much coordination and cooperation exist between the departments of education and the mental health agencies in the preparation and use of mental health materials. Work has begun in cooperation with the Nebraska Psychiatric Institute on the development of a series of animated cartoon films also aimed at high school students on the topics of mental illness, mental health, and mental retardation. Institutional assemblies and workshops for mental health program personnel are coordinated through this section along with the development and dissemination of printed materials.

Central Office Staff

In addition to the directors of the sections for community mental health services, children's mental health services, research, public information and mental health education, and study and planning, the central office staff of consultants assists the medical director, the institutions, the 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 and education, nursing, volunteer services, and informational programs. Also, a section supervisor and staff caseworkers coordinate the program for the mentally retarded and epileptic.

Hospital Social Services

The social services departments of the hospitals for the mentally ill and the schools and hospitals for the mentally retarded, have experienced many changes in staff and an increase in the areas of services during the past biennium. Hospital social workers continue to concentrate considerable service in the area of planning for discharge and in increasing services to patients and their families from the time the patient enters the hospital. Research projects have developed and continue in a number of the hospitals' social services departments.

As of June 30, 1964, there was an over-all ratio of one social worker to 178 patients. The ratio varies greatly between hospitals. The greatest need for staff is at the Faribault state hospital where the ratio is one social worker to 434 patients. At present there are 74 social workers in the 13 institutions and of these, 38 are fully trained. All the institutions have vacancies for trained social workers. Noncompetitive salary levels and absence of opportunity for promotion are still some of the chief problems in retaining staff.

Rehabilitation Therapy and Education Program

Rehabilitation therapy and education programs are conducted in all state institutions for the mentally ill and mentally retarded. While the total number of therapists and teachers has not actually increased during the biennium, program developments and advancements have greatly

improved therapeutic and educational services. Therapists and teachers are, in most cases, active participants in the treatment team which carry out the variety of activities which are part of the treament program. More attention is given to providing and promoting activities which promote balance between work, recreation, education, and leisure-time activities, to learn and re-learn the art of living in the community.

The following programs are examples of patient activities conducted in one or more of the state institutions: activities in daily living, public and institutional school programs, adult education, vocational training, education for living, patient councils, music education, private tutoring, art, camping, individual and group sport activities, garden clubs, home economics, speech clubs, independent and semi-independent living, work training and evaluation, woodworking. Because approximately 200 therapists and teachers serve the recreational, educational, occupational, musical, and industrial therapy needs of approximately 14,000 patients, these activities could in no way be interpreted as generally available to all patients, but do indicate that such programs can be expanded and improved if more staff teachers and therapists are added to the institution program.

A larger variety of community facilities are being used, such as rehabilitation centers, community job-training programs, community workshops, and community recreation facilities, in order to enhance our efforts to provide realistic and educational therapeutic experiences for the patients. Volunteers are used in order to assist the staff in carrying out rehabilitation and educational programs at all institutions.

Nursing Services

In August, 1963, the position of psychiatric nurse consultant in the central office was filled after a vacancy of approximately a year.

At present there are 420 professional nursing personnel for some 14,000 patients, or 1:33 nurse-patient ratio (24-hour period). However, the special nursing functions are more related to supervisory, advisory and teaching areas than to direct patient care.

The nonprofessional nursing staff consists of 2,700 psychiatric technicians for some 14,000 patients, providing one technician on duty for five patients (24-hr. period).

A standardized in-service training program for psychiatric technicians is offered at the hospitals for the mentally ill and the hospitals for the mentally retarded.

The nursing stipend program grants assistance for enrollment in the Diploma and Practical Nursing program. There has been an increasing interest in schools of practical nursing to secure, as part of their training program, a learning experience in the care of the mentally ill at our state hospitals. Of the 23 practical nursing schools, 5 now provide such experience at our state hospitals for the mentally ill.

A nursing service, with professional nursing staff, was introduced for the first time to the Minnesota Security hospital in the early Fall of 1963. The professional nursing staff is establishing a nursing department and have assisted the attendant guards to re-design their roles and responsibility in light of the treatment and rehabilitation focus of the institution. Numerous workshops and in-service training programs have been developed and nursing personnel is devoting considerable attention to the problem of dehumanization.

Volunteer Services

Major emphasis in the hospital volunteer services program has been aimed at individualizing the patients through the one-to-one program and, through volunteer services, to provide as many community experiences for the patient as possible. Under the supervision of the institution staff, volunteers assist with a variety of programs and serve in almost every department of the hospital. More and more staff are requesting volunteers to assist them in their development of programs aimed at the attack on the *Problem of Dehumanization*. Volunteers are also being more actively used in connection with the development of programs for the longer-term patients and for those patients who do not have visitors or families. A national study was conducted and published on "The Positions of Volunteer Services Coordinators in the United States."

At the community level there has been a considerable increase in interest on the part of county welfare departments and nursing homes in the development of volunteer service programs. During the past biennium 14 nursing homes and 13 county welfare departments have requested consultation in developing volunteer services; and a number of programs are under way.

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, and 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 hos-

pitalization, are scheduled periodically at several of the state institutions. All institution chaplains meet twice yearly at various institutions to learn more about each other's programs and exchange views as to how the religious needs of their patients can be better served.

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 (45), despite the formation of two additional departments, one within the Minnesota Security hospital, and the other at the Minnesota Residential Treatment Center for emotionally disturbed children. 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 a means of keeping abreast of the psychological literature, and major currents in the mental health field. The publication also serves as an aide to recruitment of new staff.

Programs for the Mentally Ill

The programs in the hospitals for the mentally ill have been addressing themselves to the problem of the career of the mental patient. They more specifically concentrate on 1) preventing and reducing chronicity; 2) loss of identity and selfhood; and 3) the problem of dehumanization. The voluntary admissions now stand at just under 50%, double the rate of two years ago. The mental hospitals are on the average 75% open, two of them being 100% open.

Patient Transfers

During the past two years, 72 adults and 2 children were transferred at a cost of $9,343.83. Of this amount, $3,329.26 was paid by relatives, guardians, or the federal government, with the balance, $6,014.57, paid by the state. 26 states were involved in these transfers, 11 compact and 15 noncompact states. 16 of the patients transferred were sent to compact states, with the balance of 58 going to the state of their legal settlement. Four patients were transferred to veterans' hospitals, and there were five deaths.

In addition, 25 patients were provided hospitalization and retained in Minnesota institutions under the terms of the Interstate Compact on Mental Health. Hospitalization was also provided to 81 patients whose return to other states could have been made, but whose condition warranted their early release or outright discharge. Authorization was given for the return of 75 patients to Minnesota for state hospital care. 64 of the patients returned came from noncompact states.

Returns were denied on 54 cases—35 of the denials going to noncompact states. In those cases where the return of the patient from a compact state was denied, the decision was based on the fact that a transfer either would not be in the patient's best interests, or the patient was not actually a proper one for referral. Arrangements were completed for the provisional discharge or trial placement of 87 patients from state mental hospitals and schools with relatives in other states. Permission was denied on another 13 cases. 47 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 for another 7 to do so. After-care services are provided each of these persons through Minnesota's mental health centers and/or the county welfare departments with periodic reports being provided to the home state.

Hospital Population Changes and Trends

The decrease in mental hospital population has continued through the 1962-64 biennium, with a drop of 1,200 during the past two years. As of June 30, 1964, the resident population of Minnesota state mental hospitals totalled 7,208 (6,950 mentally ill and 258 inebriates), down 4,300 from 1954-55, when the mental hospital population had reached its highest point.

The drop in resident population has been accompanied by increasing patient turnover. During fiscal year 1963-64, nearly 4,400 mentally ill patients entered the hospitals by admission or return from provisional discharge, 4,200 were released by direct or provisional discharge and 675 died in the hospital. This represents a 20% increase in patients entering, a 125% increase in patients released, and a 43% decrease in deaths in hospital as compared with 10 years ago. Most deaths occur among patients 65 or older, particularly recent admissions. The number of patients admitted in this age group has been decreasing the past few years and the resident population of elderly patients has dropped to only half that of 10 years ago. Placement of patients in nursing homes has accounted for much of the increase in releases in recent years. Although these population changes have occurred in all age groups, the greatest increase in releases has been among the older patients. During 1962-63, nursing home placements accounted for two-thirds of the elderly patients released as well as 1 in every 11 releases of patients under age 65.

Voluntary admissions have been increasing each year since 1959-60. During 1963-64, almost half (48%) of all mentally ill patients admitted entered on a voluntary basis. Ten years ago less than one-fourth of all admissions of mentally ill patients were voluntary.

Mental Hospital Staffing

The principal problems besetting hospital programs has continued to be the inability to fill professional staff positions in the numbers being requested. During the biennium a number of key positions were filled: however, in a number of professional areas, staff salaries still do not measure up to the competition from private practice, industry, and neighboring states.

Payroll records for June 30, 1962, and 1964 show the following ratio of patients to staff personnel in the hospitals for the mentally ill:

	1962	1964
Patients for each physician	127	118
Patients for each psychologist	312	225
Patients for each social worker	225	141
Patients for each rehabilitation therapist or assistant	94	68
Patients for each registered nurse on duty	192	101
Patients for each psychiatric aide on duty	32	14

Anoka State Hospital

In the past biennium an intensive effort has been made to reorganize the hospital's operation along modern administrative and therapeutic lines in preparation for greatly increased responsibilities in a much expanded receiving district.

Impetus for this reorganization came mainly from the new redistricting plan effective July 1, 1964. Although this plan reduces the number of counties in the receiving district from 11¼ to 3¼, it increases the receiving district population from 400,000 to 1,036,000. The admission rate is expected to rise some 75% as a result of this change.

Reorganization has affected administrative procedures, staff organization, building and plant utilization, and over-all treatment programs, and has attacked many of the hospital's basic problems.

The 1962 Anoka administrative plan, which is based on a predicted shrinking of the resident patient population, along with an increased admission rate, provides for no major new construction, emphasizes modernization and more effective utilization of the existing plant. During the biennium, 10 staff apartments in the front of patient cottages have been converted to patient care space, as have the former superintendent's apartment which occupied one entire floor of the administration building, and two staff dormitories occupying one floor of a patient cottage. This has resulted in very considerable relief of patient overcrowding.

Relocation of many patients within the hospital has been achieved, thereby further increasing available space. Relocation of the tuberculosis service into a cottage has freed 140 beds in the Burns building which were sorely needed for development of a new admission and intensive treatment psychiatric service.

Staff organization has been improved by a more formal departmental structure, by establishing some basic hospital committees and activating some defunct ones.

Recruiting of more psychiatrists, registered nurses, psychiatric social workers, and other professional staff continues. From a staff of one part-time psychiatrist at the beginning of the biennium, the psychiatric staff

has been increased to three full-time and six part-time psychiatrists.

The most significant change in administrative procedures in this biennium has been the introduction of the system of so-called "dual administration" consisting of sharing of the administrative and medical responsibilities between a professional hospital administrator and a psychiatrist. This enables the administrative and medical spheres of hospital program to be better correlated in terms of planning, organization, and execution.

A major area where modern methods have been introduced is the area of budgeting and stock control. Twenty-two decentralized, inadequate, and chaotic storerooms have been abandoned in favor of a newly-developed, spacious, central warehouse in the previously unused basement of the food service building. This project has eliminated waste due to confusion, stockpiling, and deterioration of unneeded supplies, and has enabled the hospital administration to develop a program of stock control which is at once efficient and able to meet the needs of the staff, while at the same time meeting the requirements of the Public Examiner.

Many new developments have occurred in the treatment program. Addition of psychiatrists and other professional staff has made it possible to give more intensive treatment to many patients, and has led to the establishment of a 56-bed therapeutic community program which is bearing fruit in terms of more discharges and fewer readmissions. The recreational therapy department, in spite of a limited staff, has undertaken corrective recreational therapy for surgical and geriatric patients. The hospital has increased its surgical services to other institutions, which now includes Fergus Falls state hospital and the Residential Treatment Center at Lino Lakes. There has been an increase in appropriate usage of tranquilizing and anti-depressant drugs; the use of seclusion is on a very limited and individualized basis with constant surveillance used in prescribing it; and electro-shock therapy facilities have been provided which make it possible to treat patients requiring this type of treatment, individually and in privacy.

Plans have been made to centralize and intensify the existing adolescent treatment program by converting the present admissions unit into a 70-bed adolescent unit under the supervision of a qualified child psychiatrist. This is essential in view of the steadily increasing adolescent population in the hospital.

The hospital's main problems in the past biennium have been the serious overcrowding complicated by the need to prepare for a greatly increased admission rate due to redistricting, and the many problems consequent upon the new administration's need to make a host of changes in an old and settled organization.

Much has been achieved in solving many of these problems and it should now be possible for the hospital to meet its new responsibilities with more adequate facilities, better equipment, more qualified professional staff, a better system of departmental organization and communications, and a higher *esprit de corps*.

Fergus Falls State Hospital

On June 30, 1964, the population was 1,343 compared with 1,546 on June 30, 1962. This decrease of 203 people results from improved treatment programs, increased community placement of geriatric patients, and shorter periods of hospitalization—in the face of increased admissions to the hospital each year.

Fergus Falls state hospital continues to maintain a children's unit for adolescents. The program has proved valuable not only in providing treatment for children but also in separating the treatment needs of young people from those of the older population.

Since 1962, considerable progress has been made in the development of the therapeutic community concept. This is based upon the assumption that this hospital, its buildings, its patients, its geographical community, and, most of all, the employees of the hospital, represent a major treatment resource. Program planning has, therefore, been geared mainly toward the development of this resource—a hospital environment for social situations.

Because of the success in developing the therapeutic community in the intensive treatment unit, the concept has expanded to other parts of the hospital. A new program has been developed to allow for greater utilization of existing staff. The hospital has been divided into four basic units, each unit set up on a progressive-care concept where patients, as they demonstrate their ability to assume responsibility for themselves, "graduate" from wards requiring maximum nursing assistance to wards requiring minimum or no assistance from the nursing staff. The four units are as follows:

1. Intensive treatment unit: made up of three wards; 1) the intensive treatment ward, which is for longer-term patients for whom there is a good prognosis; 2) the receiving hospital, which is for the patients with good prognoses but for whom a short-term hospitalization is anticipated; and 3) the children's unit. The intensive treatment unit has the greatest amount of staffing because of the new admissions and turn-overs.

The length of stay has been decreased considerably over the past years. As on other units the intensive unit team is made up of a social worker, doctor, psychologist, nurse, and a member of the rehabilitation staff. This group sets up the unit policies and handles administrative matters as well as the screening for patient placement within the unit.

2. Convalescent unit: an original state hospital concept in psychiatry. There are a considerable number of patients in the hospital who could live on a unit which has minimal or no nursing supervision. The hospital was screened for patients who could live independently, go to work every day, make their own decisions, and work toward the better acceptance of themselves as competent, capable people. The convalescent unit is designed to give patients the impetus and opportunity to be independent while in the hospital environment. It also releases a number of aides to work in a more critical psychiatric unit because the patients assume some of the responsibilities previously carried by personnel. This unit now has two wards with no nursing personnel at all, the rest of the wards have only a minimum of nursing coverage.

3. Geriatrics unit: the aged population has been moved into one general area to facilitate psychiatric care. Some decrease in total hospital population has come about by the discharge from the geriatrics population to relatives, the patient's own home, and nursing homes. It has been found that while many of the hospital geriatric population do not represent psychiatric problems per se, they do require nursing care because of their age and physical limitations. The outward flow in the future will probably not be as great as it has been in the past because of the decrease in the number of patients eligible for nursing home placement. However, there is a continuous intake of older people and the discharge rate among the geriatrics population has been equal to the intake rate.

4. Acute treatment unit: contains a large group of regressed patients, most of whom have been in the hospital a long time. The hospital is actively exploring new techniques and methods of attacking problems through program planning which is geared to meet the needs of this particular group of patients. As a result, progress has already been evidenced in the form of more patient involvement and concern about their environment and a greater awareness and more attention being paid to the niceties of social acceptance.

In conjunction with the establishment of the unit system, there are numerous workshops involving relatives of patients, such as workshops conducted every Monday afternoon which involve the patients with their relatives and the relatives with the hospital. On some units relatives have

been invited for a day's workshop to work with the patients, the staff, to discuss problems and participate in group meetings. The hospital still continues to enjoy close working relationships with community mental health centers and county welfare personnel and makes heavy use of these agencies for preadmission and aftercare work.

Hastings State Hospital

At the head of accomplishments for Hastings state hospital since 1962 stands the three-year approval of the Joint Commission on Accreditation of Hospitals, and the approval of the American Dental association, indicating that the standards meet the minimum requirements of patient care.

Educational programs were developed or extended through affiliations with the University of Minnesota, College of St. Catherine, and Macalester college. These were in the areas of psychology, social work and rehabilitation. Also included was a one-month interim course for 25 students who lived and worked at the hospital for college credits.

It is important to note that NIMH grants have been received for in-service training and for research totaling $100,000 in a period of five years. Research projects have been developed since 1956 and during this period, 30 have been completed and published, 27 completed and not yet published, and 15 still in progress.

Clinical programs, mainly in the area of psychotherapy, have doubled since 1962, from 5 group therapies with 47 patients, to 12 group therapies with a total of 141 patients. Individual psychotherapy also increased from 36 patients in 1962 to 75 patients in 1964.

An independent living situation (Altrusa House) for patients soon to be discharged has been established through the volunteer efforts of a service club. Nearly all regularly assigned volunteers in the hospital are in direct patient contact work and their contribution has been effectively tied to the treatment program mainly through a four-hour orientation program. A hospital auxiliary organized by Hastings citizens has expanded volunteer services into areas not directly concerned with patient activities.

The receiving district changed from two counties to three when the hospital started to receive patients from Washington county in 1963. Admissions increased but discharges also increased, with the census from 1962 to 1964 decreasing, while at the same time voluntary admissions increased from 20% to 40%.

The patient population has become increasingly active in industrial areas and presently there are 283 patients working in the different hospital

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DEPARTMENT OF PUBLIC WELFARE
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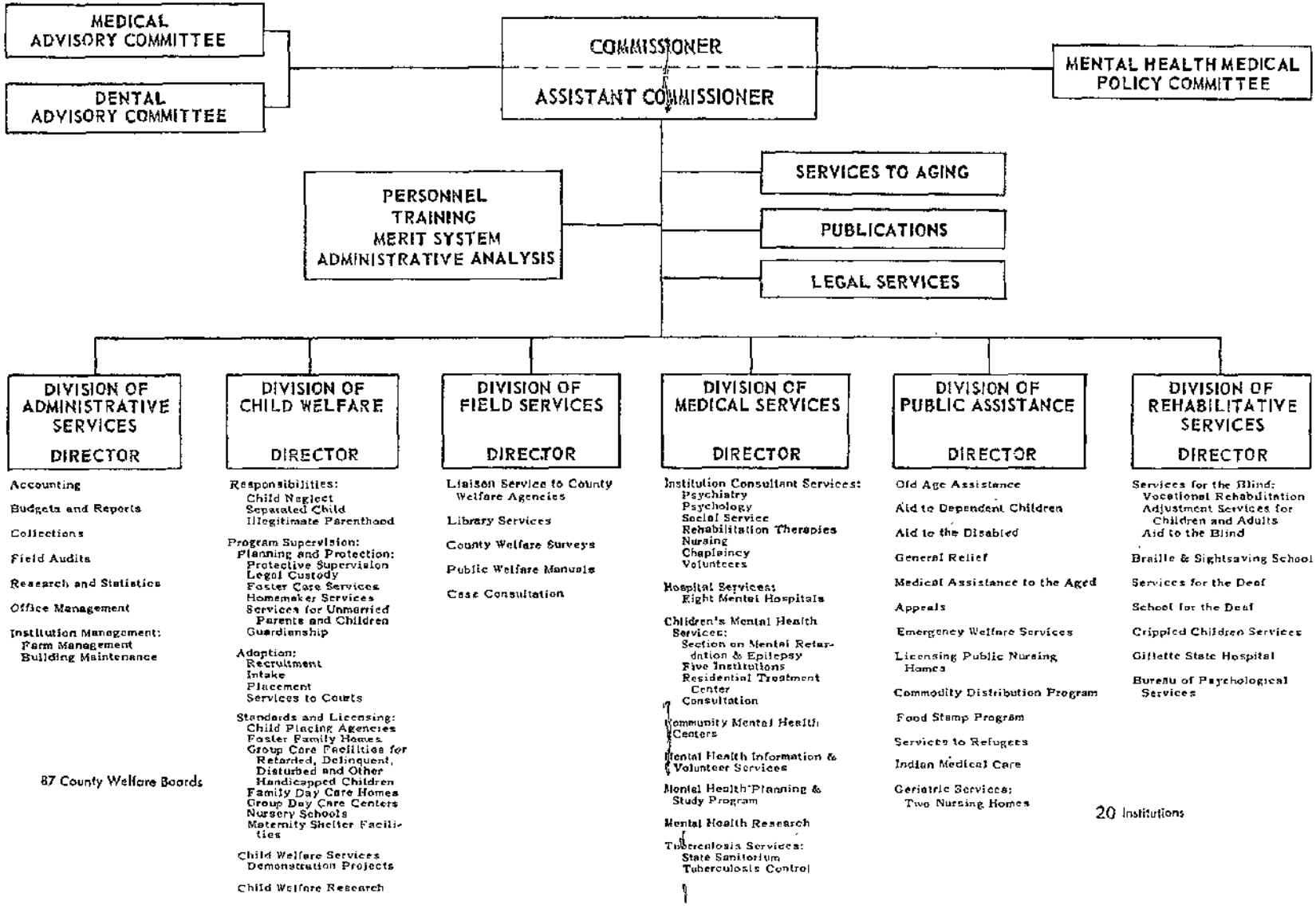


industries, representing an average of 4,928 hours per week. This time is equal to 80.9 full-time staff positions. Two grants from the Department of Public Welfare on predischarge use of the facilities of the Division of Vocational Rehabilitation have made it possible for patients to work in the community before discharge. The grants established a bus service to the Twin Cities where patients work while still under treatment in the hospital.

The industrial therapy in-service training for employees outside the nursing department is giving clinical staff more information on patients in work assignments, and giving employees who work as supervisors for patients in industrial areas more information on techniques for working with the mentally ill.

Living facilities were improved by the renovation of two psychiatric wards, one of which, a female ward, was furnished with an occupational therapy room, a kitchen and a recreation room. Construction of a new laundry building and completion of the powerhouse remodeling were the major structure changes in the two-year period. A new dial telephone system was installed and the main lobby switchboard area was completely remodeled.

Minnesota Security Hospital

Minnesota Security hospital receives male patients from the entire State of Minnesota. Patients come to this hospital by transfer from institutions for the mentally ill or the mentally retarded; from correctional institutions, and under special commitment from the courts. In contrast to the other mental institutions, most patients leaving Minnesota Security hospital do not return directly to the community.

Current bed capacity is 216. Average daily resident population for 1962-63 was 230, and for 1963-64, 201. During the past two years, ending June 30, 1964, admissions and transfers into this hospital have totaled 89, releases and transfers, 139; deaths, 9. Resident population decreased from 251 on June 30, 1962, to 190 on June 30, 1964.

On July 1, 1963, a change of administration took place at Minnesota Security hospital. The Legislature directed that the personnel complement at Minnesota Security hospital be separate from that of St. Peter state hospital and authorized the creation of a full-time treatment staff, headed by a medical director, which would devote itself exclusively to the needs of Minnesota Security hospital. Administrative duties in this institution were assumed by a hospital administrator.

During the first few months after July 1, Administration spent much time in recruiting staff to fill the new positions and in planning and carrying out a modest amount of remodeling and refurbishing of the physical plant. Staff recruitment included: four registered nurses, one social worker, one patient activities leader, one music therapist, one clerk stenographer, three attendant guards, and a half-time psychologist. Two part-time consultant psychiatrists (one the medical director) and three part-time consultant physicians complete the current additions to the staff. By November, 1963, most of the positions had been filled and the staff was ready to begin planning a new treatment program.

The new treatment program is based on the premise that there is a mandate from the public to provide, in addition to custody and security, a program of treatment and rehabilitation of these patients in an atmosphere of acceptance and hope. New nursing policies and procedures have been established. The social worker has helped bridge the gap between patients and their families, friends, lawyers, in brief any outside contact which might be of value to the patient. The part-time psychologist is carrying on a testing program of patients old and new. The rehabilitation therapist is developing a program of activities designed to meet the patients' special needs for meaningful activities as prescribed by the staff. A new recreation yard completed in July, 1964, will greatly help this department. The attendant guard staff are assuming certain nursing responsibilities, have become more sensitive to the needs of the patients and have been encouraged to seek staff help when unusual problems arise. However, *it is still not possible, because of lack of personnel, to engage all of the* patients who need it, in psychotherapy, group therapy, remotivation and rehabilitation activities.

Building improvements during the past two years have included: remodeling of the patient rooms in two cell block areas including the addition of new toilets, wash basins, and a new ventilating system; remodeling of a former ward in order to create a family visiting room and office space for the new staff; remodeling of the former attendants' quarters into an enlarged recreation room; and painting of most of the cells. Additionally we are now in the process of remodeling the dining room, adding vinyl asbestos floor tile, acoustical ceiling tile and fluorescent lighting. Many dayroom areas also are being improved with the addition of new lighting, acoustical ceilings, and paint.

Moose Lake State Hospital

Moose Lake state hospital continues to maintain its 100% open hospital status, originated more than three years ago. The open hospital ex-

emplifies our philosophy that we must strive to attain an unconditional, positive regard for all human beings.

Since 1957, the in-patient population of this hospital has decreased from 1,286 to 890 patients. During the last two years, however, the total population has decreased by only 38 patients, from 928 (35 inebriates) to 890 (52 inebriates). Some of the decrease in mentally ill patients is offset by the increase in inebriate patients.

The admission rate for mentally ill patients has remained nearly constant for several years. Since the inebriate program was transferred from Sandstone in 1959, however, the total number of admissions to the hospital has nearly doubled. During 1963-64, 939 patients, including returns from provisional discharge but excluding extended visits and transfers from other hospitals, were admitted to the hospital. Of this group, 417 were inebriates.

Moose Lake state hospital's role is to furnish care and treatment for mentally ill, senile, and inebriate patients from the counties of Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, Pine and St. Louis. Also, in November, 1963, excluding inebriate patients, the counties of Chisago, Isanti, Kanabec and Mille Lacs, were added to the hospital's receiving district.

The over-all decrease in total patient population accompanied with an increase in admissions reflects a more effective treatment program which is exemplified by shorter length of stay, improved therapeutic results with in-patients, better community acceptance of former patients, and improved hospital-community agency relationships.

The total hospital complement is 296 employees, which includes 49 for clinical services, 68 for administrative services, and 179 for patient care services. This is an increase of two employees over the complement for the preceding biennium. The hospital has been quite successful in recruiting most categories of employees except some professional groups such as physicians, social workers, psychologists, etc., where current salary levels are not too competitive.

Continued emphasis has been placed on educational programs for all levels of staff personnel based on the belief that education teaches an understanding of behavior and appropriate responses to it which is necessary for the therapeutic effectiveness of day-to-day care. A class of psychiatric technician trainees is hired once each year and given a formal one-year training program. This approach tends to decrease turnover and improve the level of performance. In 1962, the hospital was selected by the

American Psychiatric association as a regional training center for remotivation.

Treatment programming for the hospital has been reorganized and designed to function around the service or team concept. In this organization a group of professional personnel, including a physician, social worker, psychologist, chaplain, occupational therapist, industrial therapist, nursing personnel, remotivators, and nursing students function as a team responsible for a specific group of patients. Utilizing this approach, the patients, staff, and physical plant tend to become well-functioning, cohesive, smaller units within a large institution. This technique improves communication between different persons involved in treating specific patients and provides more intensive programming for individual patients.

Rehabilitation therapies is stressing education for daily living to better prepare patients for release from the hospital by improving their ability to function adequately in the normal day-to-day living situation. An increase in adolescent patients has resulted in the formation of a Young Adult club and the establishment of a formal educational program with courses being taught by a high school instructor and students receiving credit for such courses. The summer outdoor program, taking advantage of the natural facilities available, has been expanded with the acquisition of a pontoon boat.

Through the development of a team concept, the psychology department has assumed an active role in patient programming, particularly in the areas of evaluation and testing. The number of tests administered by this department has tripled in the past two years.

Chaplaincy services are recognized as an integral part of treatment programming and services of local members of the clergy are being expanded.

The social service department continues to develop communication and relationships with county welfare departments, mental health centers, and other community agencies. This approach is based on the theory that Moose Lake state hospital is a specialized treatment facility which serves as a community resource. Every social worker has responsibility for public relations and community development of a specific subdivision of the hospital receiving district.

No major building programs have been carried on during the past two years but considerable renovating is being done. The programming of industrial departments is being more closely coordinated with that of professional departments so as to improve therapeutic benefits derived from changes in physical plant and equipment.

The activities of volunteers, both in terms of services and material goods contributed to the hospital, have been sharply increased. Many avenues are being utilized to influence public opinion favorably and reduce fear and prejudice in the minds of the public. The hospital is placing priority on these sorts of activities, realizing that the ultimate strength of the hospital depends on the interest and support of the community it serves.

Rochester State Hospital

The period July 1, 1962, through June 30, 1964, has been marked by a continuing change in emphasis in treatment, continued successful placement of many patients in appropriate community settings, expansion of surgical services to other state institutions, administrative reorganization of the hospital, and demolition of the original hospital building first occupied in 1879.

The average population continued to decline during the two-year period, dropping from 1,244 to 1,095 patients. This continued drop was made possible by the teamwork of all hospital personnel. In this work it has been the therapeutic goal of all of the hospital staff to make the patient stay at Rochester state hospital dignified and pleasant. Patients are encouraged to leave as soon as they are ready, but with the understanding that should they feel the need of advice, help, adjustment of drug schedule, etc., they are encouraged to telephone for an outpatient appointment, or just come to the hospital. Many have been successfully sustained in the community because of the hospital's ready adjustment to meet the patients' needs. As a result, outpatient service has increased to over 250 calls per month and is expected to expand further.

Arrangements were made with county welfare departments for placement of 373 patients in foster-care homes; 349 patients were discharged to their own families.

The organization of a day hospital in April, 1964, via an NIMH hospital improvement grant, has made it possible for many patients to go home at night while participating in an intensive treatment program during the day. Attendance at the day hospital has varied from 8 to 20.

Altogether, research and federally-supported grants totaled eight in June, 1964. They include drug studies, investigation of the influence of deafness on mental illness, and a chemical study of seizures conducted in conjunction with the Mayo clinic.

The substantial growth of the hospital's surgical program is directly due to interagency cooperation. It has been possible to greatly increase the

service offered other institutions because of cooperation between Rochester state hospital and the Mayo clinic. The hospital supplies operating rooms, equipment and basic staff, while the Mayo clinic supplies surgeons to perform the surgery. This surgery is performed by surgical fellows and Mayo clinic consultants. The Mayo clinic gains an educational adjunct, the state gains talented services of surgeons to hundreds of institutional-"good grooming" group for young women, a drivers' training group, and a number of other groups in which social service shares responsibility. As many of the patients suitable for state nursing home placement have been transferred, it has been possible to consider another group, those eligible for Aid to the Disabled, i.e., patients younger than 65 who need long-term care. There are plans to develop other groups, such as classes for parized patients, with no charge rendered. During 1962-63, temporary medical admissions, on both in - and out - patient basis, for minor and major surgery, numbered 461; during 1963-64, the number was 509, almost double the 258 admitted in 1960-61.

In February, 1964, Rochester state hospital changed from administration by a medical superintendent to administration by hospital administrator and medical director. The medical director guides the hospital treatment program. All departments, except medical and consultants, fellows and dental, report to the administrator. Lateral communication and consultation between medical and administrative services is encouraged. Programs are being appraised, service and professional departments are being evaluated in terms of the cost of benefits received. General goals include upgrading the functioning of personnel through more efficient organization patterns and economy of use of materials and equipment.

In May, 1964, the final demolition of "Old Center" was begun. Since then a new reception center, administration and medical-surgical building, three continued treatment buildings, a service building, and power plant have been completed. Today most buildings are less than 16 years old.

During the past two years Rochester state hospital has been characterized by adaptation of services to meet patient needs, a growing integration into the Rochester community, and improvement and expansion of surgical services. Restructuring of the hospital organization is well under way. The demolition of Old Center will leave us with a virtually new hospital.

St. Peter State Hospital

The population at St. Peter state hospital has continued to decrease

from 1,792 on June 30, 1962, to 1,503 on June 30, 1964. In the year ending June 30, 1963, there were 535 admissions with 38% voluntary. The year ending June 30, 1964, there were 488 admissions with 47% voluntary.

During these past two years, various departments of the hospital have either organized or expanded numerous activities encouraging group participation by patients and personnel.

The social service department has increased its personnel so that it now numbers 10 workers. With the dropping of population, it has been feasible for this department to implement various plans for working with patients in groups. In addition to a "preparation for discharge" group, there is a "code of conduct" discussion group for the young patients, a ents of our youthful group of patients, motivation classes for the regressed, chronic patients, etc.

The psychology department has continued to devote attention to the program for the young patients. A team headed by a psychologist has set up an intensive treatment program for the hospital's younger patients. During the past year, new group psychotherapy sessions have been modified to better meet the needs of patients in different age groups, including patients over 65. A major new development—introduction of the machine scoring of the Minnesota multiphasic personality inventory—has permitted an evaluation of the entire patient population so that a number of long-term patients have taken a psychological test for the first time.

The rehabilitation therapies department has expanded its recreational services and occupational therapies in the hospital youth program. Activities include: physical fitness, dancing, bowling, swimming, canoeing, and horseback riding. All patients in the youth program are given a work assignment for those hours during which they are not involved in other activities. The off-station work program, the first of its kind in this state, has been reorganized and now includes a record system with signed medical referrals, time cards, employer and patient evaluations, and signed employer agreements of conditions for employing patients.

Two programs carried out in cooperation with the Division of Vocational Rehabilitation have resulted in the increased use of the Mankato area as a habilitation environment for the development of work skills, social skills, and training in independent living. One program is designed for the chronically-dependent, seriously-impaired patient who has some grave problems in returning to his home and community. The second program is a school program for patients ready for training and education, but not yet ready to leave the hospital on provisional discharge. The

Mankato rehabilitation center, Mankato state college and vocational schools in the area are cooperating in these programs.

The volunteer services program continues in its efforts to achieve greater community interest in St. Peter state hospital. Two busloads of volunteers come down regularly from the Hennepin County Association for Mental Health. College students participate in the one-to-one program. And the expansion of tutoring to Minnesota Security hospital is a forward movement.

Nursing education programs continue to be important. Student nurses from Lutheran Deaconess hospital, Minneapolis, and Naeve hospital, Albert Lea, affiliate for 12 weeks' experience in psychiatric nursing. Nursing students from Mankato state college, under the direction of their own faculty, affiliate for psychiatric training three quarters yearly. Nursing students from New Ulm Practical Nursing school will begin affiliating here for four weeks' experience in the care of the mentally ill, in 1965.

In-service training programs continue on an expanded level. In addition to a 40-hour orientation for new employees and a one-year program for psychiatric technicians, there is a monthly "new procedure" class for all nursing personnel, and a monthly "continued professional development program" on clinical psychiatric nursing and ward administration for registered nurses. In addition, an in-service refresher for all psychiatric technicians will be started as a result of a successful application for a Federal training grant. College courses taught at the hospital by instructors from local colleges will be part of that program.

The building program at St. Peter state hospital aimed at rehabilitation of the physical plant, made good progress during the past two years. Construction of Continuous Treatment building No. 2 (Pexton Hall) started in May, 1963, and is scheduled for completion in the Fall of 1964. Continuous Treatment building No. 3 started in May, 1964, and will be completed in the Fall of 1965. Bed capacity for each of these buildings is 214. A home for student nurses was completed for occupancy in January, 1964.

Willmar State Hospital

During the past two years, the basic policy of early return to the community has been in force and has tended to give the people we serve a responsibility in treatment and a buoyant hope of a minimal time away from their niche in the community. Coupled with this policy has been an increased emphasis on the voluntary admission to the hospital. During the

past biennium, about three-fourths of our patients came to the hospital of their own volition or after consultation with a responsible contact, family members, or friend.

Within the hospital an increase in numbers of workers in the social services department has gone far in developing treatment team support and service for the patient.

Not new nationally, but new at Willmar, was the formal introduction of remotivation therapy in the group setting. As many as 12 groups have been working inside and outside of the hospital.

Redistricting results in Benton, Stearns, and a part of Sherburne county joining the current 20-county Willmar family. The intensive psychiatric treatment program now serves a potential of 440,000 people.

In the past two years a cottage renovation program has been under way providing new plumbing systems, electric service, and related facilities. There are now contemporary bathrooms, private bathing, adequate lighting, and adequate personal effects storage. A new modern automatic gas-fired power plant serves as the nerve center for heating and electric power distribution. The maintenance department has used imagination, together with patient opinion, to lend color to everyone's lives at Willmar. The exterior of all buildings has been painted, giving a new and refreshing look to the campus by the lake. A paint shop with modern labor-saving equipment has recently opened, permitting an unprecedented outlook for the refinishing of furniture, etc.

A start has been made on a new building which will modernize and replace several services. It will house bed space for newly-admitted alcohol patients and provide care for patients requiring medical or surgical procedures. A fine ancillary services grouping is part of the building which provides physician examining rooms, dental suite, x-ray, laboratory, central sterile supply, and other related services.

In the service traditionally identified with Willmar, the alcohol treatment program has used its four new counselor positions to the utmost. Two clergymen from the Lutheran and Catholic faiths have contributed to this program, working directly with patient counseling. A small section of treatment of the narcotic addict was undertaken and is moving along. An educational program has completed its first cycle for training the counselor in alcoholism.

Minnesota Residential Treatment Center

In June, 1963, the Children's Center located at Glen Lake was closed and the 17 patients were transferred to the Minnesota Residential Treatment Center at Lino Lakes. Since then staff has been recruited, a treatment program developed, additional patients admitted, and a training program for staff started.

This facility was developed to provide psychiatric treatment services for 64 children from throughout the state. The program was phased in during the 1963-64 fiscal year period with an average population of 28. Present population is approximately 60 children and they have been referred from mental health clinics, state hospitals, county welfare departments, correctional facilities, and private agencies. Of the capacity population of 64, 48 will be boys and 16 girls.

Programs for Retarded & Epileptic

Minnesota's program for the mentally retarded 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. Guardianship program for mentally retarded and epileptic persons committed to his care; 3. The administration of an institutional program; 4. Working for the enforcement of all laws for the protection of all mentally retarded 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 therefor has not already been made.

This biennium has been a period when major work has been done in the following areas: 1. Utilization of a problem-solving approach rather than action on the basis of mental retardation alone. 2. Greater clarification and definition of responsibility of agencies, especially those of education and welfare. 3. Strengthening of local responsibility for services and programming for the mentally retarded. 4. Work toward the establishment of standards in institutional programs through a. decrease in overcrowding; b. individualized programming on basis of the individual's needs. 5. Development of a variety of resources to meet individual needs. 6. Emphasis on protection of rights of mentally retarded. 7. Abolition of Annex for Defective Delinquents on basis of deprivation of civil rights. 8. Increased use of voluntary admissions. 9. Provision for temporary institutional placements for relief of families at times of emergency or vacations. 10. An increase in daytime activity centers during this biennium from 3 centers to 20.

Guardianship Program

Emphasis in the Section for the Mentally Retarded and Epileptic has focused on service for all mentally retarded in the state rather than upon provision of guardianship for the mentally deficient. This is reflected in a slight drop in commitments in the last biennium. The following table shows trends in the guardianship program for the past 10 years:

	1952-54	1954-56	1956-58	1958-60	1960-62	1962-64
Number under Guardianship	8,533	8,852	9,372	10,054	10,895	10,385
Number of New Commitments	904	877	934	1,234	1,113	928

During this biennium a special summer project was devoted to a review for the purpose of determining those wards who might be restored to capacity or discharged from guardianship. Statistical figures on restorations and discharges are available only for the past two biennia. They are shown on the following chart:

	1960-62	1962-64
Number restored to capacity	24	80
Number discharged	229	456

For those wards who might require institutional care, a classification system was established based upon analysis of the individual, under the Bartman Classification system, together with an analysis of his program needs.

With emphasis being placed on utilization of the most appropriate resources to meet the 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.

The 1963 session of the legislature amended the statutes relating to Owatonna state school, making it possible to place any mentally deficient person under the age of 21 in that facility. With increased educational opportunities in the community for the educable retarded, the population of Owatonna state school dropped from 361 in July, 1962, to 266 in July, 1964. Current placements at Owatonna state school are mainly those educable mentally retarded whose problems of personality or behavior are too severe for them to be educated in the public school system.

A number of specialized projects and research projects were carried out during the biennium by this section, along with programs for staff development.

Institutions for the Retarded

During the past biennium, institutional populations were decreased from 6,566 to 6,375 despite the fact that new buildings were opened at Brainerd state school and hospital. This is an attempt to meet state Department of Health standards, eliminate overcrowding, and structure a more adequate program.

A very careful screening of all admissions has continued, with emphasis focused upon utilization of the institution only when that is the most appropriate resource to meet the needs of an individual. As a result, the institutions for the retarded are receiving increased numbers of younger, more severely retarded, patients and also the mildly retarded or borderline individuals with emotional and personality problems. The waiting list has increased slightly from 693 on July 1, 1962, to 764 on July 1, 1964.

The following table shows the trends for the past 10 years:

7-1-54	7-1-56	7-1-58	7-1-60	7-1-62	7-1-64
705	918	1,425	1,035	698	764

Discharges from the institution were slightly more than double. The figures for the past 10 years are as follows:

6-30-54	6-30-56	6-30-58	6-30-60	6-30-62	6-30-64
363	301	228	330	341	690

Institutional overcrowding continues to be serious. According to the Minnesota Department of Health standards, Faribault state school and hospital is 625 beds or 27% overcrowded; Cambridge state school and hospital, 317 beds, or 19% overcrowded. Efforts will continue to reduce the overcrowding, meet standards, and provide more adequate programming.

Some progress was made during the past biennium in providing more adequate staffing for the institutions for the mentally retarded. Payroll records for June 30, 1962 and 1964 show the following ratio of patients to staff personnel in the state schools and hospitals for the mentally retarded:

	6-30-62	6-30-64
Patients for each physician	412	362
Patients for each psychologist	929	616
Patients for each social worker	326	373
Patients for each therapist or assistant	171	126
Patients for each registered nurse on duty	432	370
Patients for each psychiatric aide on duty	32	30
Patients for each teacher	118	117

Institutional Programs for the Mentally Retarded

A number of changes are taking place in institutions for the mentally retarded in Minnesota. The changes tend to parallel those occurring in institutions for the mentally ill, with emphasis on early rehabilitation and social restoration, and early return to the community, to the extent that circumstances will allow. At the present time there are 6,400 patients in residence in various facilities for the mentally retarded. Whereas building programs in hospitals for the mentally ill are now aimed at replacement of obsolete structures and gradual diminution of total size, the building programs in institutions for the retarded have been aimed for the past decade at gradual expansion. Thus during the 1961-63 biennium, 432 beds were added at Brainerd state school and hospital; and during the 1963-65 biennium, another 430 beds are scheduled for the same location.

Owatonna State School

Owatonna state school has provided academic education and vocational training for educable mentally retarded children since 1945. In the past, admissions were determined by the functioning level of the child and his ability to profit from the training program. Because of the rapid growth and the number of public school classes for the educable retarded, many of the children now entering Owatonna state school present personality and emotional problems which not only influence their ability to learn but make impractical, if not impossible, normal development in a home or community setting.

The admission of many younger children with emotional and personality problems has expanded the program to include some degree of treatment, as well as academic education and vocational training. Many of these young people are not amenable to schooling until their mental problems are dealt with. More intensive care and supervision are required. As children mature and develop skills, and as their ability to adjust improves, the program is expanded to include opportunities for independence, self-determination, and self-control. These ideas are worked into programs by means of student councils, expanded use of community facilities (churchs, movies, shopping, work experiences), frequent home visits, use of public transportation, and small independent living units.

With emphasis on as early community placement as possible and a more restricted admission policy, the residential population is about 250 at present. This has made it possible for more intensive treatment and training to be provided. Some new plans have to do with the administrative organization in terms of teams devoted to functional units, a systematic training program for house parents, emphasis on reducing the dehumanizing influences of institutionalization.

Faribault State School and Hospital

Progress continues toward making this as much an open hospital as possible, retaining but a few necessary controls, and toward the discovery and elimination of conditions having a "dehumanizing" effect.

The book population July 1, 1962, was 3,131; and June 30, 1964, 2,908. 421 patients were discharged and 292 patients admitted. The reason for the reduced number of admissions was because beds vacated were largely in buildings for adult ambulatory patients, while those on the waiting list of the department awaiting institutional space were mainly very severely retarded children and/or those having additional

serious handicaps such as being crippled, blind, deaf, epileptic, or having serious behavior problems.

Advances have been made in all departments in spite of understaffing (critical in several areas) and overcrowding—which is very serious in many buildings.

The medical program has benefited greatly from the increased surgical services available in the Rochester state hospital, by temporary transfer, and through their out-patient department.

A group therapy program for a small number of young male adults, functioning below their potential because of emotional and social problems, has been undertaken by the social services psychology departments. This has been in addition to the individual counseling by physicians, social caseworkers and others, and is proving to be of value. In several wards a small number of patients are being assigned to psychiatric technicians for a specified period of time to assure giving them the maximum of personal attention in addition to routine care.

Off-campus privileges have been granted to some 200 patients. Ground privileges have also been liberalized, allowing many patients to go to and from work and to special activities without escort. Some patients volunteer to help others less capable by going for walks with them, or accompanying them to the out patient department at the hospital, to dental offices, stores, etc.

The social service and rehabilitation therapies departments selected and placed 12 male and female patients in temporary extramural paid work settings in Rice county with the approval of the Rice county welfare department. The local hospital, a rest home, a bakery, and a garage provided terminal vocational training while the patient lived in the institution.

The school department had 260 pupils at the close of the year, compared with 150 for the previous year. During the biennium the school principal completed the requirements for his master's degree; six teachers gained special certificates; and the school staff gained 229 credits by completing 53 courses in advanced work. Successful workshops for teachers for the retarded have been conducted in June of each year for college credits. These have been cooperative ventures conducted by the Mankato state college, Department of Welfare, special education section of the Department of Education, and the Institutions School department.

The volunteer services program has grown and there are now 406

registered volunteers on the roster. Serving on a regularly-assigned basis, they have given valuable services throughout the institution.

The chaplaincy program has become recognized as an outstanding one for the mentally retarded. It has also served to provide pastoral clinical training in mental retardation for those entering chaplaincy service in institutions.

During the past year a complete survey was made to determine and record all patients who were entitled to benefits from OAASI, VA, and railroad retirement funds.

June 30, 1964, 742 of the 766 authorized positions were filled. 48 new positions effective July 1, 1963, were authorized by the 1963 legislature. The available staff has been utilized to the fullest extent possible. The need for additional staff has been most acute in nursing services.

During the biennium the institution applied for and received a Hospital Improvement Project grant in the amount of $97,461 from the NIMH for the development of improved diagnostic and evaluation procedures, the installation of a mechanized data storage and retrieval system, which will permit quick reference to patient characteristics and the establishment of closer working relationships with educational institutions in the region. Through these programs we anticipate expansion of treatment programs for our patients; of training and consultative resources for staff; and research opportunities for both staff and students in training.

Cambridge State School and Hospital

Cambridge continues to function on the belief that there is capability of improvement in anything and everyone. In this goal for improvement is the development of each (patient and employee) to his highest potential. To do this and meet the needs of each individual patient resident, seven basic hospital programs have been set up:

1. *Evaluation:* The evaluation program has been designed for persons with problems of psychological adjustments and/or medical problems. Although all residents are evaluated at admission and regularly thereafter, the evaluation program is indicated for persons for whom it is not clear whether they would be best served by one of the programs at Cambridge or by some other kind of planning. A person in the evaluation program is observed by cottage personnel and professional people from all hospital services, and evaluations are made under varied life circumstances in work and recreation programs. Psychological testing and evaluation by medical specialists add to the fund of information and, on the

basis of this information, a group assessment is made of the resident's strong and weak points. The evaluation program results in a plan for further treatment based on this assessment.

2. *Vocational and Community Living:* This program is designed to meet the needs of those residents who, it is felt, have the greatest potential for return to the community as self-supporting, or at least semi-self-supporting, with appropriate supervision. This program is concerned with training or retraining of vocational skills, good job habits, social behavior acceptable by community standards, correction of educational deficits, and development of good leisure-time activities.

3. *Special Education:* This program is designed chiefly for those school-age residents who can benefit from structured learning experiences. The emphasis in the special education program is to provide the opportunity for growth and development in self-care, academic and social skills in keeping with individual abilities and potentials.

4. *Psychiatric:* The psychiatric program is designed to serve the special needs of the emotionally disturbed. This group includes persons who are psychotic, neurotic, or with character disorders often with marked behavior problems. The program involves individual treatment or therapeutic group experiences, psychotherapy and other specialized treatments.

5. *Physical Rehabilitation:* This program is designed for the physically disabled who require a period of specialized treatment to correct or minimize disabilities that interfere with normal functioning. The program uses intensive medical treatment in services from a variety of paramedical areas. Treatment such as corrective exercise and surgery are prescribed and carried out through specialized resources of orthopedics, psychiatry, physical therapy, occupational therapy, nursing, etc.

6. *Cadre:* The cadre program is designed for those residents who are productive but who have intellectual, emotional, social, or medical problems necessitating long-term institutional or sheltered environment. The aim is to establish an environment that guarantees individual dignity plus providing stimulation, correction, and development of more individual independence.

7. *Total Care:* Persons in this program are the totally dependent who, because of major physical or intellectual disabilities, are dependent upon others for daily needs. The program provides 24-hour-a-day nursing care, medical and paramedical services as needed, and an activities program that is diversional, socializing and stimulating.

A treatment unit has been developed to more adequately meet the

needs of those boys who are normal, dull normal, or mildly retarded, and who are emotionally disturbed or have acting-out emotional problems. The treatment unit is providing service for 20 boys between 11 and 12 years of age. In this special unit, with special staff, the hospital is providing these patients with a more normal type of living arrangement, group work services, special education services, and an individualized rehabilitation and recreation program.

The need for volunteers is ever-increasing as hospital programs change and new needs of the patient residents become known. Besides the personal one-to-one relationship, volunteers are needed in all areas of the hospital. One of the most serious problems at Cambridge is the overcrowded condition (20%), and staff shortage.

Brainerd State School and Hospital

Expansion of the facilities of this institution has continued through the 1963-65 biennium. During this period four 108-bed patient buildings have been completed, with full occupancy anticipated during the early part of 1965. Average resident population has risen from 906 patients in 1962-63 fiscal year to 945 for the 1963-64 year. It is expected that population will increase to an average resident population of 1,232 in the 1964-65 fiscal year. There is 1,386 bed capacity at the present time.

Plans have been completed and bids are being taken early in October, 1964, for the School and Rehabilitation building for which an appropriation was made by the 1963 Legislature. This building is to be completed by January, 1966. It will house the bulk of the rehabilitation activity for patients of this institution. Plans have been completed for programs for the trainable and a greater emphasis on classroom activities for the educable, using these new facilities. The completed building plans show academic classrooms, audio-visual equipment room and facilities, speech therapy, occupational therapy, industrial arts, music therapy, music education and home economics facilities, as well as space for necessary administrative functions. Testing and evaluation of patients in the various rehabilitation programs will be undertaken by the educational psychologist, vocational counselors, and industrial therapist planned for this facility.

The services of a psychiatrist have been obtained on a full-time basis. It is expected that he will be able to assume the full duties of medical director before the end of the current biennium.

During this biennium our chaplaincy has been expanded from one

part-time person to include a full-time resident Catholic chaplain and a full-time Protestant chaplain. Facilities for religious services will be greatly improved upon completion of the School and Rehabilitation building where two small chapels plus the use of the main auditorium for religious services is planned.

A full-time dentist has been employed, thus increasing greatly the capacity of this department to fulfill the needs of the increasing patient population.

Pharmacy services are being improved by the hiring of a full-time pharmacist.

Employment of the personnel authorized by the 1963 legislature has been completed, with the exception of certain professional personnel for which recruitment continues to be a problem. There is also a shortage of staff in the nursing service as well as many of the service departments. Staffing of the wards with psychiatric technicians and people to direct the recreational activities is in acute shortage.

A considerable amount of activity and effort has been directed to industrial therapy programs aimed toward community placement of patients. The industrial therapies department has searched out and developed placements for patients in learning situations, both within the institution, and in the community. New ideas and techniques for guiding the progress of the individual patients in this program have been and are being developed. Trial placement and the eventual return to the community of patients is a goal that is being accomplished. The cooperation of employers in the community and the labor unions of the area has been an exciting contribution to the rapid strides being made in this area of rehabilitation.

Lake Owasso and Shakopee Units

Two additional units for mentally retarded individuals are located at Shakopee and Lake Owasso. One cottage on the grounds of the Shakopee Reformatory for Women houses 30 girls, moderately retarded, ages 4 to 12.

The Lake Owasso Unit operates as an annex of the Cambridge state school and hospital, and houses 130 moderately retarded women.

Tuberculosis Control Section

Tuberculosis Sanatoria

The Riverside sanatorium at Granite Falls ceased operation on July 1, 1963. There are now five sanatoria, four maintained by counties and one operated by the State of Minnesota.

Populations of Sanatoria on June 30

Sanatorium	1963	1964
Glen Lake State Sanatorium	105	84
Mineral Springs	59	48
Nopeming	73	59
Ramsey County Pavilion	59	34
Sunnyrest	19	15
Riverside	1	–
Total	316	240

The 1963 Legislature authorized a grant-in-aid program that enables the State Board of Health to assist counties in the development, operation, and expansion of local tuberculosis control programs, especially out-patient clinics. This action was a factor in the expansion of out-patient facilities at Mineral Springs sanatorium out-patient department, St. Louis county out-patient tuberculosis control program, Sunnyrest sanatorium out-patient department, Hennepin county chest clinic, and Ramsey county out-patient department. It also encouraged counties previously served by Riverside sanatorium to establish an out-patient facility when the sanatorium ceased operation. The Riverside sanatorium out-patient clinic at Granite Falls now serves Chippewa, Lac Qui Parle, Renville, and Yellow Medicine counties. There has also been established a Central Minnesota out-patient clinic at St. Cloud; this is operated by Crow Wing, Kandiyohi, Meeker, Mille Lacs, Sherburne, Stearns, Todd, Wadena, and Wright counties.

Although the grant-in-aid program is administered by the State Board of Health, it is mentioned in this report because it provides services to areas not having local tuberculosis sanatoria. The tuberculosis programs of the State Board of Health and the State Department of Public Welfare are closely coordinated.

Another significant measure adopted by the 1963 Legislature enables counties to send persons who are not legal residents of any county in Minnesota to Glen Lake state sanatorium, or to the tuberculosis unit at Anoka state hospital if they are recalcitrant, for tuberculosis care if they have or

are suspected of having infectious tuberculosis. A special state subsidy is provided for these nonresidents so that the county pays only 20% of the cost of hospitalization. In the past, few counties could afford the cost of quickly hospitalizing such patients in sanatoria. The special state subsidy now available encourages more rapid case-finding and control of the infectious disease. Prompt action in case-finding and hospitalization is the best course of action for both the patient and the local community.

Expenditures of State Aid to County Sanatoria (Fiscal Year)

1962-63	1963-64
$218,324.85	$89,609.08

The 1963 Legislature reduced the appropriation for aid to county sanatoria, with the result that effective July 1, 1963, it has not been possible to pay the full amounts of state aid to county sanatoria as specified in the tuberculosis laws. The appropriation was approximately 60% of the amounts set by statute. The Legislature also provided that distressed counties as of July 1, 1963, would receive the special state subsidy for tuberculosis costs from the equalization aid program rather than under the fund of state aid to county sanatoria.

Care of Indians

The Tuberculosis Control section administers a contract with the U. S. Public Health Service for the sanatorium care of tuberculous Indians. Care is provided those with one-fourth degree or more Indian blood who have resided in Minnesota for one year or are public health menaces and who have residence on tax-exempt land. During the report period the special arrangements were continued whereby the staff at Nopeming sanatorium provides consultation services, including clinical interpretations of x-rays, to the Indian hospitals.

Indian Contract Costs (Fiscal Year)

1962-63	1963-64
$80,302.95	$72,905.11

One hundred per cent federal reimbursement was received for the above Indian contract costs.

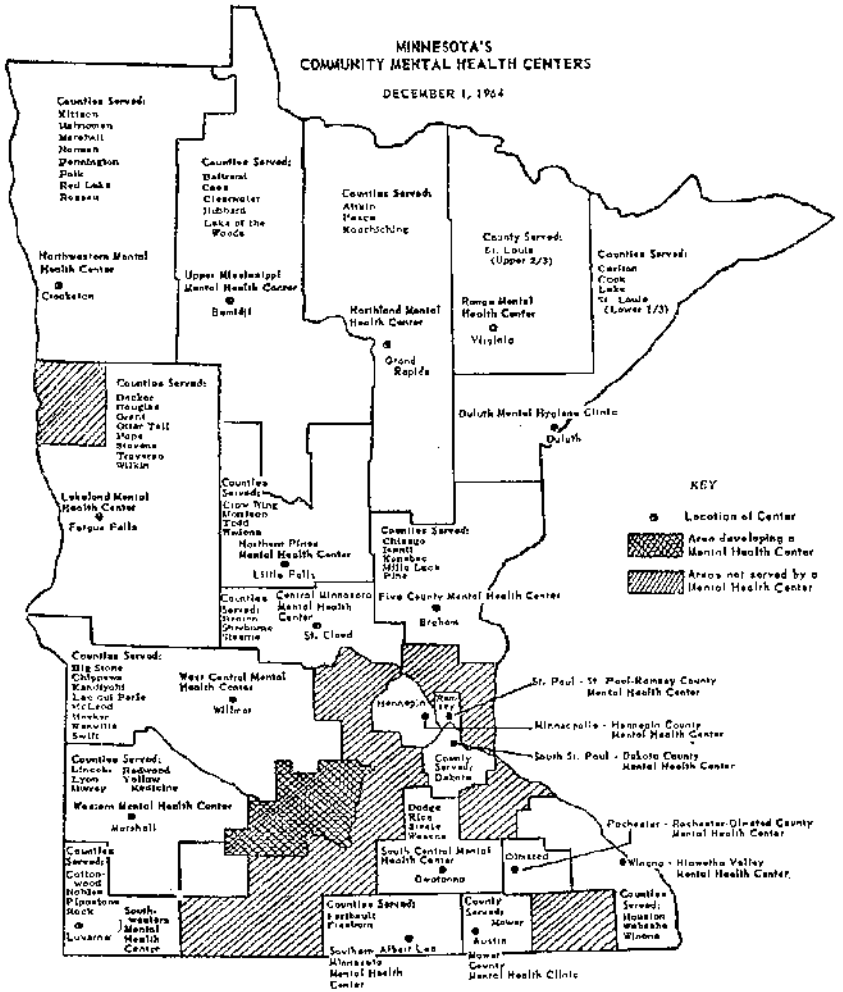
Tuberculosis Control for State Institutions

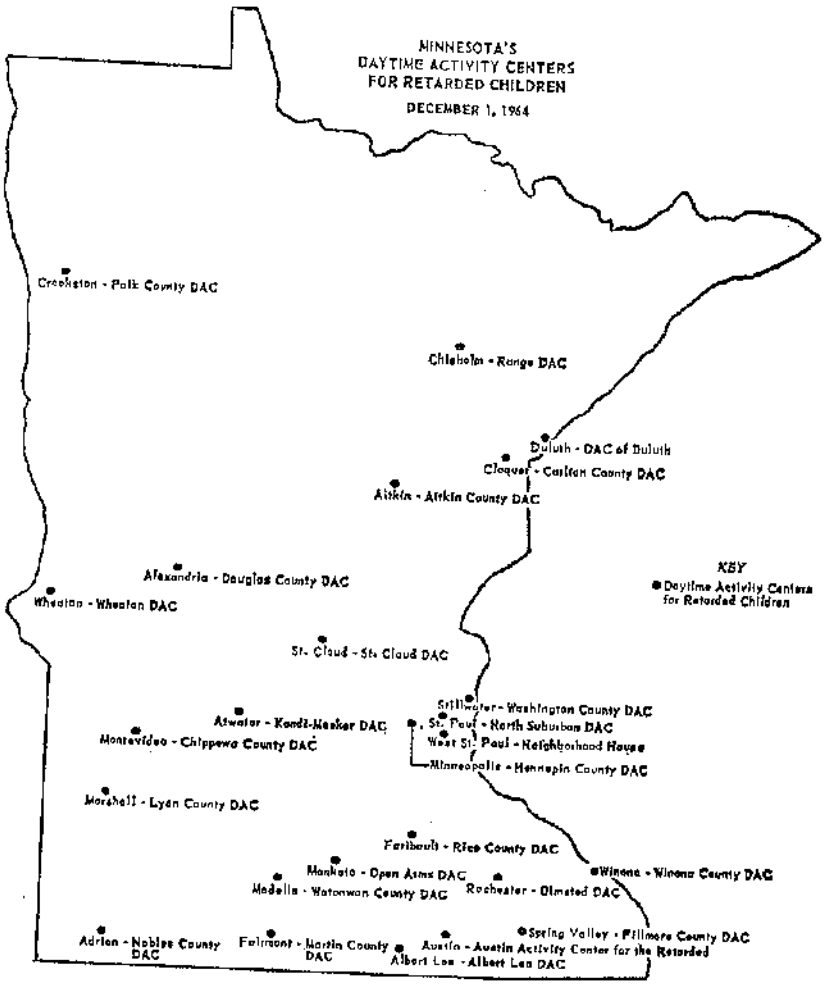
70mm. x-ray surveys of patients and employees at the institutions are conducted, and reports of the findings are prepared by the section. The x-ray equipment has been in operation for many years and should be replaced by a new portable x-ray unit. The section provides to state institutions the services of a consultant roentgenologist.

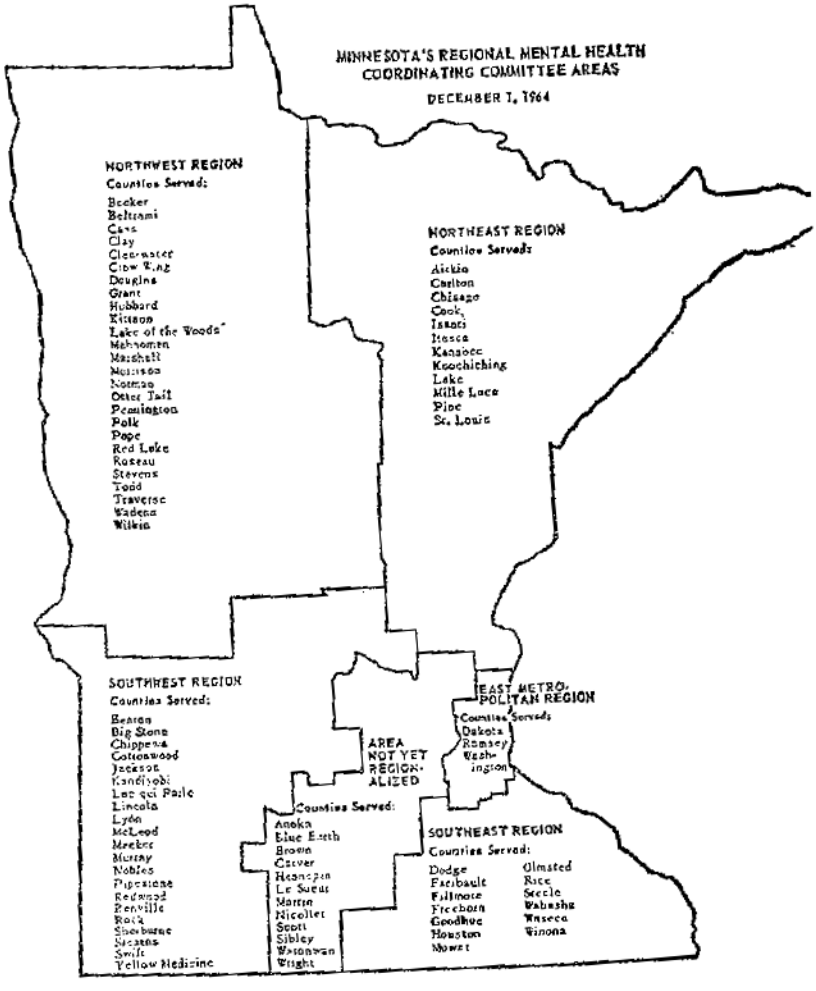
A reminder system is maintained to assure that all recommendations for follow-up are carried out. This includes recommendations as a result of findings on 70mm. and 14x17 chest films, bacteriological studies, and past history of tuberculosis. Reminders are sent to the institutions when necessary.

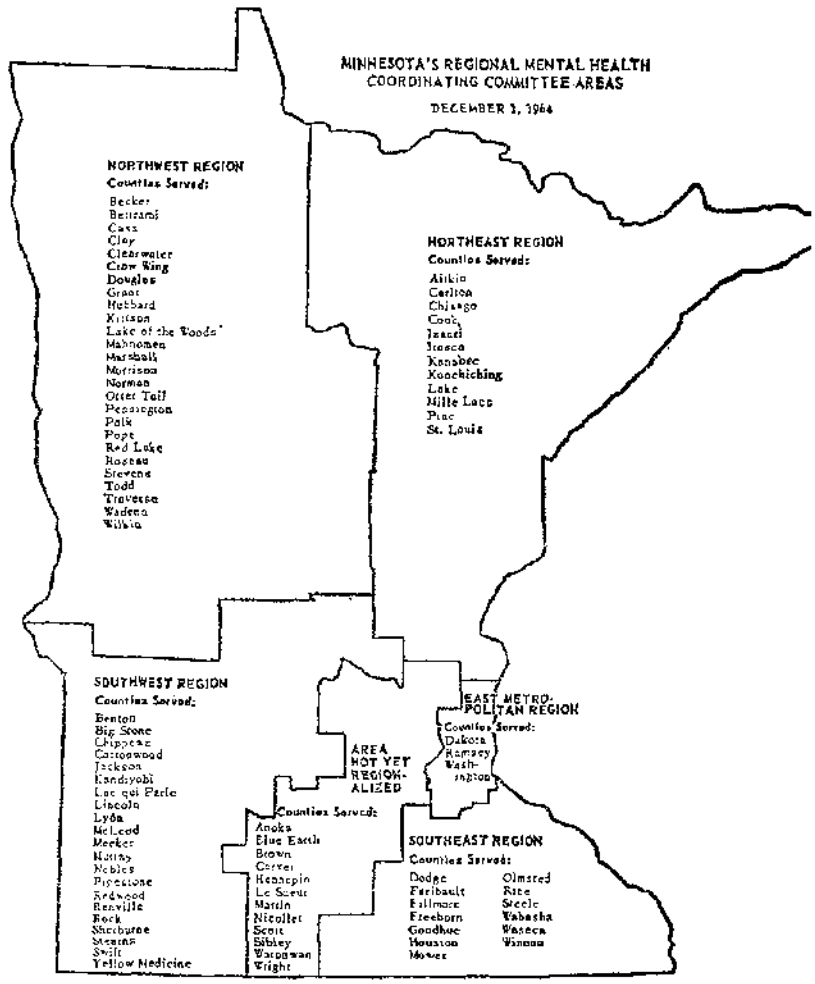
The frequency of surveys and of special follow-up examinations is considered and revised periodically by the head of the section to conserve the efforts of institution employees as much as possible. The total number of patients and employees under special observation of the section continues to increase 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, 1964, there were 44 patients in the facility for the tuberculous mentally ill and recalcitrant. The coordination of efforts among the Tuberculosis Control section, the state institutions, and the staff of the Tuberculosis unit at Anoka state hospital has made it possible to detect quickly patients having or suspected of having tuberculosis and to arrange for prompt isolation. The 70 mm. 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
DECEMBER 1, 1964
Counties Served:
Kittson
Marshall
Norman
Pennington
Polk
Red Lake
Roseau
Northwestern Mental Health Center
Crookston
Counties Served:
Beltrami
Cass
Clearwater
Hubbard
Lake of the Woods
Upper Mississippi Mental Health Center
Bemidji
Counties Served:
Aitkin
Itasca
Koochiching
Northland Mental Health Center
Grand Rapids
County Served:
St. Louis
(Upper 2/3)
Range Mental Health Center
Virginia
Counties Served:
Carlton
Cook
Lake
St. Louis
(Lower 1/3)
Duluth Mental Hygiene Clinic
Duluth
Counties Served:
Becker
Douglas
Grant
Otter Tail
Pope
Stevens
Traverse
Wilkin
Lakeland Mental Health Center
Fergus Falls
Counties Served:
Crow Wing
Morrison
Todd
Wadena
Northern Pines Mental Health Center
Little Falls
Counties Served:
Chisago
Isanti
Kanabec
Mille Lacs
Pine
Five County Mental Health Center
Braham
Counties Served:
Benton
Stearns
Sherburne
Stearns
Central Minnesota Mental Health Center
St. Cloud
KEY
Location of Center
Area developing a Mental Health Center
Areas not served by a Mental Health Center
Counties Served:
Big Stone
Chippewa
Kandiyohi
Lac qui Parle
McLeod
Meeker
Renville
Swift
West Central Mental Health Center
Willmar
St. Paul - St. Paul-Ramsey County Mental Health Center
Minneapolis - Hennepin County Mental Health Center
South St. Paul - Dakota County Mental Health Center
Counties Served:
Lincoln
Lyon
Murray
Redwood
Yellow Medicine
Western Mental Health Center
Marshall
Dodge
Olmsted
Wabasha
Winona
Rochester - Olmsted County Mental Health Center
Winona - Hiawatha Valley Mental Health Center
Counties Served:
Cottonwood
Nobles
Pipestone
Rock
Luverne
Southwestern Mental Health Center
South Central Mental Health Center
Owatonna
Olmsted
Counties Served:
Faribault
Freeborn
Southern Minnesota Mental Health Center
Albert Lea
County Served:
Mower
Austin
Mower County Mental Health Clinic
Counties Served:
Houston
Wabasha
Winona


MINNESOTA'S
DAYTIME ACTIVITY CENTERS
FOR RETARDED CHILDREN
DECEMBER 1, 1964
Crookston - Polk County DAC
Chisholm - Range DAC
Duluth - DAC of Duluth
Cloquet - Carlton County DAC
Aitkin - Aitkin County DAC
Alexandria - Douglas County DAC
Wheaton - Wheaton DAC
St. Cloud - St. Cloud DAC
KEY
Daytime Activity Centers for Retarded Children
Stillwater - Washington County DAC
St. Paul - North Suburban DAC
West St. Paul - Neighborhood House
Minneapolis - Hennepin County DAC
Atwater - Kandi-Meeker DAC
Montevideo - Chippewa County DAC
Marshall - Lyon County DAC
Faribault - Rice County DAC
Mankato - Open Arms DAC
Medelia - Watonwan County DAC
Rochester - Olmsted DAC
Winona - Winona County DAC
Spring Valley - Fillmore County DAC
Austin - Austin Activity Center for the Retarded
Albert Lea - Albert Lea DAC
Fairmont - Martin County DAC
Adrian - Nobles County DAC


MINNESOTA'S REGIONAL MENTAL HEALTH COORDINATING COMMITTEE AREAS
DECEMBER 1, 1964
NORTHWEST REGION
Counties Served:
Becker
Beltrami
Cass
Clay
Clearwater
Crow Wing
Douglas
Grant
Hubbard
Kittson
Lake of the Woods
Mahnomen
Marshall
Morrison
Norman
Otter Tail
Pennington
Polk
Pope
Red Lake
Roseau
Stevens
Todd
Traverse
Wadena
Wilkin
NORTHEAST REGION
Counties Served:
Aitkin
Carlton
Chisago
Cook
Isanti
Itasca
Kanabec
Koochiching
Lake
Mille Lacs
Pine
St. Louis
SOUTHWEST REGION
Counties Served:
Beaton
Big Stone
Chippewa
Cottonwood
Jackson
Kandiyohi
Lac qui Parle
Lincoln
Lyon
McLeod
Meeker
Murray
Nobles
Pipestone
Redwood
Renville
Rock
Sherburne
Stearns
Swift
Yellow Medicine
AREA NOT YET REGIONALIZED
Counties Served:
Anoka
Blue Earth
Brown
Carver
Hennepin
Le Sueur
Martin
Nicollet
Scott
Sibley
Watonwan
Wright
EAST METROPOLITAN REGION
Counties Served:
Dakota
Ramsey
Washington
SOUTHEAST REGION
Counties Served:
Dodge
Faribault
Fillmore
Freeborn
Goodhue
Houston
Mower
Olmsted
Rice
Steele
Wabasha
Waseca
Winona


MINNESOTA'S REGIONAL MENTAL HEALTH COORDINATING COMMITTEE AREAS
DECEMBER 1, 1964
NORTHWEST REGION
Counties Served:
Becker
Beltrami
Cass
Clay
Clearwater
Crow Wing
Douglas
Grant
Hubbard
Kittson
Lake of the Woods
Mahnomen
Marshall
Morrison
Norman
Otter Tail
Pennington
Polk
Pope
Red Lake
Roseau
Stevens
Todd
Traverse
Wadena
Wilkin
NORTHEAST REGION
Counties Served:
Aitkin
Carlton
Chisago
Cook
Isanti
Itasca
Kanabec
Koochiching
Lake
Mille Lacs
Pine
St. Louis
SOUTHWEST REGION
Counties Served:
Benton
Big Stone
Chippewa
Cottonwood
Jackson
Kandiyohi
Lac qui Parle
Lincoln
Lyon
McLeod
Meeker
Murray
Nobles
Pipestone
Redwood
Renville
Rock
Sherburne
Stearns
Swift
Yellow Medicine
EAST METRO-POLITAN REGION
Counties Served:
Dakota
Ramsey
Washington
AREA NOT YET REGIONALIZED
Counties Served:
Anoka
Blue Earth
Brown
Carver
Hennepin
Le Sueur
Martin
Nicollet
Scott
Sibley
Waseca
Wright
SOUTHEAST REGION
Counties Served:
Dodge
Faribault
Fillmore
Freeborn
Goodhue
Houston
Mower
Olmsted
Rice
Steele
Wabasha
Waseca
Winona