December 13, 1960
Public Welfare.
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Information re: Mental Hospital Program in past Five Years
I believe I indicated to you that I was trying to pull together all pertinent information we can get on what has happened in mental health from 1955 to 1960. From you I would like information alone
these lines:

1. Some evidence of the fact that our mental hospitals now have a good start on "treatment" instead of more custody programs. (Open door policy, etc.)

2. Special projects, such as 4-county at Fergus; Follow-up at Moose Lake, etc.

5. Stepping up of volunteer services -
Number of volunteer in hospitals in 1955; in 1960.
4. Length of stay for mental patients now as compared with 1955. 5. Admission and discharge rate comparisons 1955 and 1960. 6. Development of patient activity programs.

7. Development of consultant services since 1955. e.g. L. Poor, A. Wrobel, LaRoux, Reuben.

8. Children's Unit at Hastings. 9. Development of local mental health centers

10. Placement of patients by county welfare boards in 1955 as compared with last couple of 7 years.

11. Report on mentally retarded programs:

Higher percentage now accept space when offered than in 1955.

Establishment of special classes, both in institutions and in local communities.

Day care centers and sheltered workshops in 1955 as compared with 1960.

Discussion of new philosophy relating to greater efforts in community program.

MINNESOTA'S MENTAL HEALTH PROGRAM

A

Fact Sheet

Q. What are the three prime objectives of our mental hospitals?

A. To admit patients early in their illness. To make a thorough diagnostic study and formulate a comprehensive treatment plan. To discharge the patient as soon as possible, with appropriate arrangements already made for community living and with necessary follow-up care.

Q. What sort of start has been made during the past biennium toward departure from the former mere custodial type of program?

A, In the past two years, all of Hastings State Hospital's psychiatric wards have become open wards, with the exception of 22 beds in the receiving ward which remains locked 24 hours a day. Willmar State Hospital is now 95% unlocked. At Rochester, too, emphasis is on treatment rather than custody; only two wards remain closed, and even on these, half of the patients are free to come and go. At Moose Lake, more than 85% of the patients now have non-supervised ground privileges. In all our mental hospitals, wherever practicable—except when it is necessary for the patients' own protection—Minnesota follows the open door policy.

Q. Is staffing adequate to meet recommended standards?

A. No. As of June 30, 1960, our seven hospitals for the mentally ill showed the following ratio of patients to staff: 171 patients for each physician, 497 patients for each psychologist and 448 for each social worker, 117 for each rehabilitation therapist or assistant and 225 patients for each registered nurse on duty, 28 for each psychiatric aide on duty.

Q. What is the degree of occupancy of our mental hospitals?

A. On the average—despite the decreasing resident population and the current building program--they are 15% overcrowded.

Q. What is the present population trend?

A. The trend in our state hospitals continues to reflect (1) lower Daily resident populations, (2) a slight increase in the number of admissions, (3) a continuing rise in the number of patients released and, (4) a alight decrease in the total number of **patients who have been** under **care** each year during **the past six years**

Q. Since the September, 1954, peak **population**, what **decreases have** occurred?

A. On June 30, 1958, the number of hospitalized mentally ill had dropped from September, 1954's 11,348 to 10,865, followed on June 30, 1960, by a further drop (7.7%) from the June, 1958, figure, to 10,028. This decrease is despite a continuing rise in the number of admissions.

Q. How do releases compare today with those of 5 years ago?

A. In the 1954-55 biennium, 148 net releases (either by direct or provisional discharge) were tallied per month. In the 1959-60 biennium, the monthly average was 226.

Q. What are the average daily resident population figures for these same biennium?

A. In 1954-55, the average daily resident population of Minnesota mental hospitals was 11,297; in 1959-60, the figure was 10,185. Total under care in 1954-55 was 14,879, as compared with 14,611 for 1959-60.

Q. What effect has the extensive use of drugs—both tranquillizers and energizers--had on hastening the release of patients?

A, On June 30, 1960, there were 2,426 patients on provisional discharge, as compared with 2,055 on June 30, 1958--and 1,591 five years ago.

Q. How does the average length of stay for patients in our mental hospitals today compare with 1955?

A. (See "white paper" attached.)

Q. How does the patient activities program fit into the treatment scheme?

A. Patient activities in the recreational, occupational, and industrial therapies programs have become increasingly important during the past biennium as more hospital wards were opened and patients were free to move about the hospital community. Some 165 professional and other trained personnel participate in helping to provide activities for the patient which closely resemble activities available in the patient's home community, to speed his adjustment when he returns. Such planned and prescribed activities are an Important part of the patient's treatment program.

Q. What role is filled by staff consultants?

A. Since 1955, but more intensively within the past two years, a staff of consultants has been assisting the medical director, the institutions, county welfare departments, and community mental health centers with guidance in. psychological services, institutional social service, community social services, rehabilitation therapies, nursing, volunteer services, and mental health education and information.

Q. What has been the development during the past biennium of the Hastings Children's Unit?

A. During the past year, extensive remodeling has changed the Children's Unit from a maximum security setting to a more therapeutic open environment. In addition, sleeping quarters have been moved to the second floor, facilitating adequate staff surveillance. Rooms have been provided for physical isolation of young patients stricken with contagious ailments. The Unit has the services of two full-time teachers. Population was 13 at the end of the biennium.

Q. What progress has been made in establishing local centers since the enactment of the Community Mental Health Act in 1957?

A. Since 1957, 14 community mental health centers have been established, making services directly available to some 45% of Minnesota's population. Administration is at the local level; 47 counties are served. Two centers were opened during the first (1957-59) biennium. With an increase in the biennial appropriation from $342,000 to $775,200, the dramatic expansion of 1959-60 was made possible. Recruitment of personnel was so vigorously pursued that in the past year alone, 22 positions in psychiatry, psychology, and social work were filled. With appropriations forthcoming, present plans call for 12 more centers between now and fiscal year 1963, to bring the total number to 26 and provide comprehensive community mental health services for all 87 counties.

Q. What mental health special projects have been initiated?

A. (1) The Minnesota Follow-up Study, with one staff stationed at Moose Lake State Hospital, the other at Duluth, following three years of study to determine whether a period of special planning for the state mental hospital patient's discharge, begun at the time of his admission, would significantly affect the quality and duration of his post-discharge adjustment, has one year to go in its final—research—phase. Results of study so far show that providing special discharge services increases the likelihood of the patient being able to remain out of the hospital. Also revealed is that the major factor in being able to gauge with accuracy how effectively the discharged patient will adjust to community life is the attitude of his family <u>and</u> their expectations that he will behave or function in a fairly normal manner. {2} A 4-county (Becker, Clay, Otter Tail, Wilkin) project, to study the extent of mental retardation in children, their needs, and how their community can meet these needs, was started on

October 1, 1957. Financed by a Children's Bureau grant, the original 4-year study has now been extended indefinitely as a result of encouraging progress in these three activities: case finding, providing evaluative services, helping to develop local community facilities for retarded children*

Q. How does placement of patients by county welfare departments today compare with the same function in 1955?

A. In 1955, such placements were nil. One reason: there were but 14 social workers assigned to our state mental hospitals. A year later, with 40 such workers, the referral for release program began to accelerate. Today, this momentum has increased to the point where county welfare departments initiate 65% of placement of patients back into their home communities.

Q. To what extent have volunteer services been stepped up since 1955?

A. In 1955, three full-time volunteer coordinators were hired and an advisory committee established. Between 1956-58, there were 2,000 regularly-assigned individuals working as volunteers in our mental hospitals; and during this period, some $44,743 in gifts were obtained through volunteer efforts. Growth of the volunteer program can be best expressed in the extension of these same data to the 1958-60 biennium, when there were 4,000 regularly-assigned volunteers; and gifts totaled between $150 and $200,000.

Q. In institutions for the mentally deficient and epileptic, what is the status of the waiting list today as compared with 1954?

A* In 1954, there were 705 on the waiting list; in 1956, 918; in 1958, 1,425; in 1960, 1,035. The big drop during the past biennium is attributable to the opening of additional beds at Brainerd and Cambridge, plus increased emphasis on careful screening and re-evaluation of cases to determine whether institutional care is most appropriate for the individual.

Services of Aid to the Disabled has also made it possible for more individuals to remain with their families,

Q. Have special classes for the retarded increased since 1955?

A. Tremendously. In September, 1959, the Minnesota Inter-Agency committee sponsored a project calling for the establishment of "county advisory councils for the trainable retarded." Forty-five counties organized such councils. Basic purpose was to encourage development of special education classes for the trainable retarded. Within a year it was clear that a broader approach would be necessary; and in October, 1960, the counties were requested to include concern for all of the problems of their mentally retarded persons. In the 1954-55 biennium there were 9 public education, classes for trainable and 172 classes for educable retarded. For the 196O-61 school term, there were 52 public education classes for trainable and 580 for educable retarded. (Attached is detailed explanation.)

Q. What are the figures on day care/centers and sheltered workshops?

A. In 1954-55, there was 1 day care center; today we have 9. There were 5 sheltered workshops which accepted the retarded in 1954-55; by 1960 this number had increased to 12. Now—as six years ago--only one sheltered workshop employs the retarded exclusively. In the past, workshops felt that the retarded could not fit into their programs but this concept is now changing toward greater acceptance.

Q. What is the new philosophy relating to greater efforts in community programs?

A. Today's philosophy is based upon four main convictions:

(1) That mentally .retarded persons are equal to others insofar as human rights and dignity is concerned.

(2) That mentally retarded persons have the same basic need and right as others to live in a family home in a community setting.

(3) That most retarded children can be eared for better in their own communities and homes than in the finest residential institution.

(4) That many of the retarded are not adequately served by existing community facilities and do not easily fit into these facilities.

Local communities have to furnish most of the services the retarded need, with assistance from various state departments,