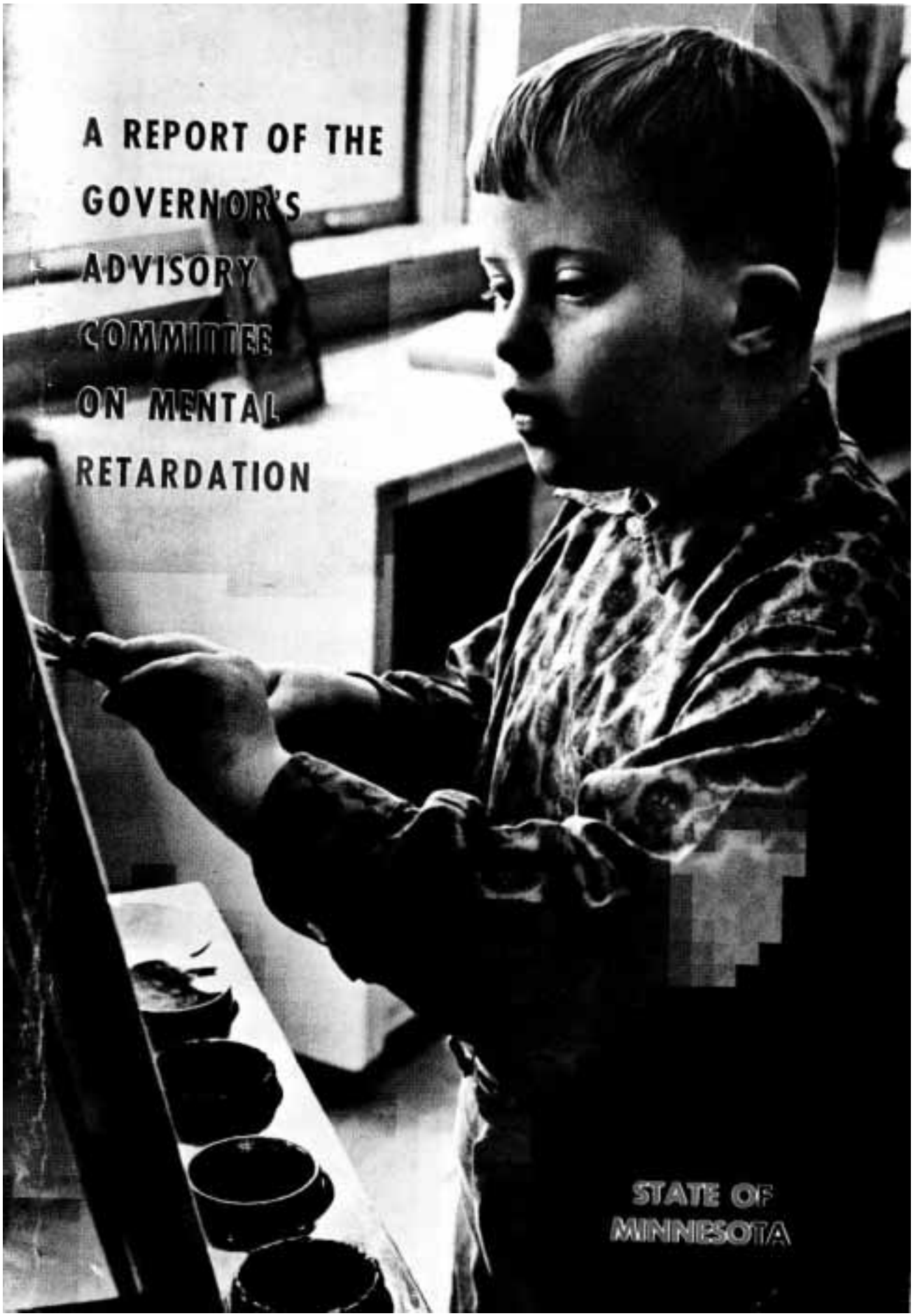
A REPORT OF THE
GOVERNOR'S
ADVISORY
COMMITTEE
ON MENTAL
RETARDATION
STATE OF
MINNESOTA

A REPORT OF THE

GOVERNOR'S ADVISORY COMMITTEE

ON MENTAL RETARDATION

October 8, 1962

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The Honorable Elmer L. Andersen
Governor of Minnesota

October 8, 1962

Dear Governor Andersen:

Enclosed herewith is the first report of the Governor's Advisory Committee on Mental Retardation. In this report the committee summarizes its work of the first year and respectfully submits its recommendations .

Besides this written report, the committee is submitting a parallel audio-visual report, which we hope, will be used broadly in the State to create citizen interest in the mentally retarded. Problems in this field are of great magnitude and deserve attention of all citizens of the State. The committee is grateful to officers and directors of the Nevin Huestad Foundation of St. Paul for a grant of $3,000.00 to pay some of the production and reproduction costs of the film. We are also grateful to WCCO-TV of Minneapolis for producing and editing the film report.

The committee met with many individuals and agency representatives and made many visits in the process of its study. It is not possible to list here all who contributed to the study, but we express to each person involved our appreciation. Special thanks are expressed to the Minnesota Association for Retarded Children, which gave help to the committee in many ways, including funds to print the present report.

The recommendations, which we make, taken individually, represent logical and necessary extensions of present programs. But, taken together, they envision a bold forward step, mainly in the direction of improving and broadening community-based programs for the retarded. We have recommended substantial increases in research activities and improvements in State Institutions. We hope that our recommendations will help to launch a vigorous effort for favorable legislation in the field of mental retardation in 1963.

Very truly yours,

Maynard C. Reynolds, Chairman
Advisory Committee on
Mental Retardation

GOVERNOR'S ADVISORY COMMITTEE ON MENTAL RETARDATION

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CHARGE TO THE ADVISORY COMMITTEE ON MENTAL RETARDATION

By Governor Elmer L. Andersen

The problems of mental retardation present enormous challenge. About 3 per cent of the general population are mentally retarded in sufficient degree to require special attention in the schools, in institutions or other agencies. In addition to the retarded themselves, their families frequently require sympathetic help and guidance. The problems of mental retardation thus touch directly upon a very large number of the people in our state and in the nation. A wide variety of agencies and professions, including medicine, education, social work, psychology and others, are constantly involved in the development of services to the retarded and their families. The public investment in the work of these professions and agencies is substantial.

Fortunately, there is growing interest in the mentally retarded and many improvements in programs for them have been made. Minnesota has been among the leading states in its programs for the retarded. The cooperation shown among all agencies, public and private, in our state has been exemplary and gives us good hope that Minnesota will continue to lead in developments in this field.

Our general goal in this field should be two-fold. First, through research and all other appropriate procedures, we must attempt to prevent mental retardation. Second, we must provide programs for retarded individuals so that they shall have every opportunity for development of their abilities, however limited they may be. Many of the retarded can occupy respected and useful positions and enjoy the normal rewards of life if we but provide the opportunities for understanding, guidance and education which they need. To the extent that we succeed in achieving these two objectives we will have served both the retarded themselves and their society at large.

I am concerned that we constantly review our programs for the mentally retarded and that we take advantage of every opportunity to extend and improve such programs. I have called the present committee to assist us in this general task. Committee members themselves

represent a variety of agencies and professions. I wish you to make still broader contacts with all agencies, public and private, in making your studies and developing recommendations. I ask the committee to study and make recommendations with regard to:

(1) Improvement of all treatment, education and rehabilitation programs for the mentally retarded and their families, giving special attention to those of public character.

(2) Recruitment, training and in-service development of all personnel required to conduct programs for the retarded.

(3) Existing and needed programs of research and development. Especially do I wish you to give attention to programs of preventive character. The committee should also give careful attention to the coordination of Minnesota activities with those of other states, the Federal government and the several private organizations now sponsoring research and demonstration activities in this field.

(4) Long-range development of all necessary facilities (including institutions) for the retarded.

(5) Improvement of administrative and leadership services and other requirements for the further development of local, community-based services for the retarded.

The committee is asked to give early attention to all matters which will need consideration as we prepare for the 1963 legislative session. I am asking for a report on this phase of the committee's work by October 1, 1962.

CHAPTER I - INTRODUCTION TO THE REPORT

A Definition of Mental Retardation

The common denominator among all types of mental retardation is "sub-average general intellectual functioning" which originates during the developmental period and is associated with adaptive behavior. This definition, proposed by the American Association on Mental Deficiency, encompasses a wide range of intellectual inadequacies. Some individuals function so inadequately so as to require constant physical care; others, if given adequate education, may be able to live independently as adults. Very frequently the mentally retarded person finds his life further complicated by emotional, physical and/or sensory disabilities.

It is clear that no simple system of classification or treatment is adequate in this field. Complexities abound and eventually reliance for program planning must be placed in the hands of professional persons responsible for diagnosis, treatment, education and rehabilitation.

For some purposes it is necessary, however, to use general categorizations of the mentally retarded. Three terms which are used repeatedly in this report are defined below:

THE EDUCABLE RETARDED (Upper Range)

The Educable Retarded are those individuals who, because of impaired mental development, are unable to benefit adequately from regular school classes. The majority of them can become economically and socially independent when given added attention, specially trained teachers, and a level and type of curriculum adjusted to their ability and future needs.

THE TRAINABLE RETARDED (Middle Range)

The Trainable Retarded are those individuals whose severe degree of mental handicap precludes successful participation in programs of instruction for the educable retarded. In classes of instruction geared

to their level, however, they can learn self-care, social adjustment, and practical skills that will allow them to become semi-independent in a sheltered environment.

THE DEPENDENT RETARDED (Lower Range)

The Dependent Retarded are those individuals completely dependent or so profoundly retarded that they can probably learn only very basic self-help skills and whose level of potential can best evolve by participation in community day-time activity centers or in programs of a residential care facility.

A Frame of Reference

The committee has found it useful to develop a general frame of reference within which the various facets of programs for the retarded might be considered. The following statements summarize the general point of view taken by the committee.[1]

1. The Mentally Retarded are Entitled to Opportunities for Maximum Development of Their Potentialities. Services to the retarded should be an integral part of total state and community efforts to provide for the development of all its citizens.

2. The Integrity of the Family Unit Should Be Preserved Whenever Possible. This suggests that services for the retarded should be provided at the family and community levels whenever possible.

3. It is Desirable for the State to Assume Leadership in the Development of Comprehensive Community Programs, but with Responsibility Left With Community Agencies, both Public and Private, for Actual Administration of Most Service Aspects of the Programs. The State must take major responsibility for some matters, such as research and training. In most areas of community programming, how ever, State function should be restricted to leadership, financial aid, determination of standards and consultant services.

[1] Adapted from William I. Gardner & Herschel W. Nisonger, American Association on Mental Deficiency, A Manual on Program Development, monograph supplement to the American Journal on Mental Deficiency, Vol. 66, No. 4, January, 1962.

4. Although the Chief Responsibility for Providing Programs for the Mentally Retarded Should Rest with Public (Governmental) Agencies, Voluntary Agencies Should Assume a Vital Role in This Endeavor. The valuable contributions made by voluntary organizations in Minnesota should be recognized and encouraged. Public agencies should advise and consult with voluntary groups, so as to strengthen and coordinate the total resources of the State.

5. Emphasis in the State Program Should be Given to Both Primary and Secondary Prevention of Mental Retardation. By primary prevention is meant prevention of conditions which result in mental retardation. Efforts which serve to lessen the consequences of intellectual retardation, once it has occurred, are termed secondary prevention.

6. State Residential Institutions for the Mentally Retarded Should be Viewed as Modern Treatment, Care and Training Centers, with the Goals of Providing for the Maximum Development of Each Resident Person and Return to Community Placement Whenever Feasible and Desirable.

Elements of a Total Program

Views as to what constitutes an adequate approach to problems of mental retardation have changed from time to time. A brief history of Minnesota's program is presented in Chapter II. With increasing experience and research it is clear that no one type of program is adequate. The trend is toward coordinated multiple programs geared to life-long planning, including at least the following elements: 1

a. Service Aspects:

(1) Provisions for diagnosis, treatment, and parent counseling.

(2) Programs of training and education.

—Home training —
Nursery classes

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1 Gardner & Nisonger, op, cit.

—Special education programs during the school-age years including vocational guidance and selective placement in employment for those sufficiently capable to make use of these services.

—Adult education

(3) Programs of vocational (re)habilitation and placement.

—Vocational training centers and sheltered workshops, with programs of training, employment, and selective placement and supervision.

—Social adjustment or occupation day centers for those older adolescents and adults who are unable to profit by training for or placement in employment, either competitive or sheltered.

(4) Day and residential care

—Custodial day care

—Short term residential care

—Long term residential care

—Foster homes, group care homes, boarding homes, half-way houses

—Institutional care

(5) Recreational opportunities.

(6) Programs for long term supervision and guidance,

b. Supportive Aspects:

(1) Research

(2) Training of Personnel

(3) Case Finding

(4) Public Education

Areas of Committee Study

This first report of the Advisory Committee covers a period of about nine months' study. Obviously the committee has not made an exhaustive study of all elements of a total program as listed above.

Attention has been given mainly to selected areas where public responsibility is clear and where immediate action seemed indicated.

Three outstanding areas of need have appeared, which can be stated in terms of general recommendations:

(1) The State of Minnesota should undertake every necessary action to put real thrust into the development of community-based programs for the mentally retarded.

(2) The State of Minnesota should undertake immediate and intensive efforts to improve greatly its institutional programs for the retarded, as a means both of offering better programs to residents of institutions and of limiting the size of the institutional population.

(3) The State of Minnesota should substantially increase its investment in research and demonstration projects as a means of prevention of mental retardation and of program improvement.

These three areas of need and interest are discussed in detail in later portions of the report. They are all-of-a-piece, in the sense that one requires each of the others. Fortunately, the goals which we envision can be reached without great increases in public costs. If we do not build community programs, costs will go up in the form of increased capital and operating expenses of institutions. Minnesota now has many more institutionalized mentally retarded persons (on a per capita basis) than most States, but spends substantially less, per capita, than the average State in operating its Institutions. Improvements in the institutions and in community programs should make it possible to reduce or limit the institutional population. Such improvements are probably best planned, initially, on a "pilot" or "experimental" basis. Truly, these three areas of concern are "of-a-piece." Happily, achievements in these areas represent economic, social and humanitarian gains.

Size of the Problem

No precise data on incidence of mental retardation are available. Generally, however, it is estimated that about three per cent of the total population are mentally retarded. Further breakdown can be estimated as follows:

	Per Cent
Educable Retarded	2.5
Trainable Retarded	0.4
Dependent Retarded	0.1
Total	3.0

The estimated prevalence of mental retardation in Minnesota for the total population and the school-age population is summarized in Table (1) .The figures pertaining to the school-age population are particularly relevant, since special emphasis in program development should be given to the early "developmental" years. Included as Appendix A to this report is a table reflecting the estimated incidence of mental retardation in Minnesota by county, along with figures showing the numbers of persons now enrolled in special classes, institutions, and day activity centers.

Table 1

Estimated Incidence of Mental Retardation in Minnesota

	Incidence in Total Population*	Incidence in School-Age Population**
Educable Retarded	85,347	24,910
Trainable Retarded	13,655	3,986
Dependent Retarded	3,414	996
Total	102,416	29,892

* Calculated against total State population of 3,413,864, according to 1960 census report.

** Calculated against school-age State population (ages 5 to 20), according to 1960 census report.

It is apparent that problems of mental retardation are of major magnitude. Over 100,000 retarded persons are involved, plus uncounted parents and relatives who are also directly affected.

Outlook for the Future

This is a time of great interest in the mentally retarded and the committee is optimistic about future developments in the field. Minnesota's program for the retarded has generally been a good one. In recent years, community programs have been expanding at a good rate, but even further efforts are needed to expand and improve such programs. Minnesota has failed to provide adequately for its institution programs and major readjustments here are necessary. We believe Minnesota can and should become an outstanding center for research and demonstration work in this field.

There are many problems in the field of mental retardation that will continue to require the attention and investigation of a committee of this nature.

I. IT IS RECOMMENDED THAT A LEGISLATIVE INTERIM COMMISSION AND/OR A GOVERNOR'S ADVISORY COMMITTEE BE ESTABLISHED TO STUDY AND MAKE RECOMMENDATIONS CONCERNING FUTURE PROGRAMS FOR THE MENTALLY RETARDED.

CHAPTER II

A BRIEF HISTORY OF PROGRAMS FOR THE MENTALLY RETARDED IN MINNESOTA

Minnesota's first institution for the retarded was established in 1879 on a "trial" basis. It was for children transferred from the hospital for the mentally ill to the School for the Deaf, Dumb and Blind at Faribault, where a separate unit for the retarded was established. The children, 14 in number but increased to 25 during the year, were those who it was felt would profit from an educational program. Much emphasis was placed upon the educational aspects of the institutional program in these early years. It was hoped that the problems of mental deficiency would prove to be remediable through education. The "trial" was so successful that in 1881 the school was made permanent and children were accepted from the community. A new building was constructed and filled with 41 children in 1882, but already there was a waiting list of 59.

In 1885, Dr. A. C. Rogers became superintendent of the new school. He initiated many forward looking programs and policies including the following: payment of highest possible salaries, incentives for continued teacher training, same salaries for those caring for the lower grade children as for those caring for the higher grade ones, contacts with the University to promote research and to provide medical students with knowledge of the mentally retarded, studies in heredity, and the use of psychologists to aid in understanding the children. Even before 1900, Dr. Rogers employed a psychologist, the first in any institution in the United States. In 1910, after the development of the Binet tests, Dr. Fred Kuhlmann was employed to lead the psychology program. This distinguished appointment was made possible by a $5, 000 legislative appropriation for research made in 1909 .

In these early days, the sketchy evidence available was interpreted to make it appear that "feebleminded" parents produced "feebleminded" children and at the same time created the poverty, vice and crime of the world; therefore, so it appeared, the "feebleminded" should be permanently segregated for their own and the public's protection and to prevent the birth of more of their kind. Dr. Rogers, in common with

many other Superintendents, held these beliefs but he also stressed the improbability of the "feebleminded" and the need for the best possible teaching and training so that each would learn according to his capacity.

Because of Dr. Roger's intensity of feeling that the "feebleminded" produced the "feebleminded", he was anxious for a guardianship law in order that he might have authority to hold them in the institution for an indefinite period. They would live in a "colony" -a more homelike arrangement than in the central buildings of the institution but close enough to join in recreation activities. A farm colony was actually established. He thought there were a few who could return to the community and for them there should be supervision in the community. These ideas ware incorporated in the 1917 laws providing for guardianship.

Thus began the evolution of the institution away from its initial purpose as a school. This change came about partly as a result of the erroneous views concerning causes of retardation and because of the experiences accrued from the attempts to educate the retarded. It was found that many of them were not benefiting to the extent, which had been hoped. It became evident that many of them could not be returned to the community. Thus the colony concept was added and we had the "School and Colony" type institution.

Dr. Kuhlmann also influenced the commission responsible for the 1917 guardianship law and other laws relating to children. He had come to Minnesota just after the development of Binet tests and believed firmly in these new psychological tools. In this period, physicians left the diagnosis of mental deficiency largely to the psychologists and Dr. Kuhlmann fully accepted this responsibility. By 1917, he had developed an extensive program of testing and diagnosis.

Summer classes for the training of teachers were started at Faribault in 1913 and continued until Dr. Kuhlmann left the institution in 1921, when they were taken over by the University.

In 1915, a law was passed for subsidizing special classes for the retarded in public schools. Its proponents thought that, even after training, many of the pupils would go to the institution but that the

training would help them make an adjustment there. The Department of Education set an I.Q. of 50 as the lower limit for children in classes getting State aid and many children of lower ability, who had previously been in classes organized in the cities without such aid, were excluded. By 1921, questions were being raised concerning the school's responsibility for those excluded. The responsibility of the schools for programs to serve these severely retarded children, the trainable retarded, has continued to be controversial even to this date.

By 1914, Dr. Charles Bernstein, the superintendent of the institution in Rome, New York, had raised a controversy by suggesting "colonies" which would be completely off the institution grounds, with the mentally deficient working in the community for pay, to be followed by discharge after a period of success. This extension of the colony idea to the community was of interest to Dr. Rogers, but he became ill in 1915 and never fully accepted the idea.

The State Board of Control, however, did accept the general idea. By 1923, arrangements were made to adapt the colony plan to the community and open a "club house" in Minneapolis for girls who could not be returned to their own homes. This idea got legislative backing and additional "club houses" were later set up in both St. Paul and Duluth. Due to changes in work opportunities during the depression, and perhaps for other reasons, all three clubs were closed before 1940. But they had made it possible to place many girls in the community. No community "colony" plan was ever tried for boys.

A permissive sterilization law stemming partly from misconceptions concerning the causes of retardation was passed in 1925. This law helped to gain acceptance for the "club house" plan of placement by making possible the coordination of two ideas - the "feebleminded" must not have offspring, and the "feebleminded" can be self supporting and can participate in community life.

One reason for the interest of the Board of Control in plans for community placement was economic. The state could not support a sufficient number of institutions to house all of the "feebleminded" and epileptic requiring some degree of support or supervision. Even before 1925, a Colony for Epileptics had been established at Cambridge

and already it was realized new dormitories were needed. It was not until 1945, however, that other institutions were opened—Owatonna State School and the Annex for Defective Delinquents. In 1957, another new institution was opened at Brainerd. The Colony for Epileptics at Cambridge gradually began accepting the mentally retarded as well as the epileptics and the three general institutions"- Faribault, Cambridge and Brainerd - were put on a regional basis.

In recent years there has been a strong trend toward use of these institutions mainly to serve the severely retarded, and many of the more capable retardates have remained in the community. Because the institutions have had fewer patients able to work and more patients needing physical care, staffing problems have been mounting over the years.

The Second World War showed that many retarded persons of the brighter levels could be successful in jobs previously thought to be beyond their ability to perform. This encouraged interest in vocational rehabilitation for the retarded. Until after World War II, the schools and the state welfare agency had devoted most of their efforts to this group of relatively high ability.

It was becoming evident, however, that there was great need to help the more severely retarded children and their parents. The publication of "Teach Me", in 1946, the first booklet designed to help parents care for such children was an effort to begin to meet the need. This booklet was produced by a committee activated by the Bureau for the Feebleminded and Epileptic of the Minnesota State Division of Public Institutions.

An important event occurred in December, 1946, when parents of children at Hammer School organized and were joined by others to become the Minneapolis Association of Parents and Friends of the Mentally Retarded. Within a few years, similar groups were organized in other parts of the state. These associations soon became part of a great national movement. Within a short time they had representation in almost all groups or committees planning programs for the mentally retarded and now are an important force in all phases of work with the retardates.

Another important influence on the program came in 1947 with the arrival of Dr. Sheldon Reed in Minnesota to head the Dight Institute on Human Genetics. This has meant a different emphasis on heredity and other causes of mental retardation. It is now realized that although some retardation does occur because of inherited traits from parents of low-level intelligence, some is caused by the transmission of recessive genes from parents of normal intelligence. Also, it has been learned that mental retardation often results from birth or pre-natal brain damage and other causes, some yet to be discovered. The establishment at Dight Institute of consultative services to parents on genetic problems was a milestone in Minnesota in bringing about understanding in this important field.

In the late 1940's, the Federal Government was beginning to allocate funds for the establishment of pilot programs for the mentally retarded. After the National Association for Retarded Children was organized in 1950, such grants were increased in Minnesota and elsewhere.

State and local advisory and planning groups have been much in evidence in the past decade. Between 1951 and 1961, inclusive, there were four legislative commissions appointed, a part of whose study was concerned with the needs of the mentally retarded. In addition, there were studies made by the Legislative Research Committee and by the State Department of Education.

As a result of the recommendations of these various groups, the law for institutional payment has been twice amended, state aid for special classes in the public schools has been raised, and such classes made mandatory for educable retarded children. At the same time, classes for the trainable have been recognized and state aid granted to these classes also. Community mental health centers providing service to the mentally retarded as well as to others with mental health problems were given the backing of state subsidies. The Minnesota Advisory Board on Handicapped, Gifted and Exceptional Children was established to act in an advisory capacity to the State Departments of Health, Education and Public Welfare. Subsidies have been provided on a pilot project basis for day care community centers.

During the 1950's, several groups recommended increased research, increased personnel - professional staff as well as institution aides -and increased facilities for the institutions serving the retarded. These recommendations have not been fully implemented. Some recommendations have not been carried out even partially. The report of the Minnesota Mental Health Survey, for example, contained a recommendation for a separate administrative unit within the Department of Public Welfare to carry responsibility for all institutional and community programs for the mentally retarded. This recommendation has been controversial and never implemented.

Two recommendations of the Interim Commission on Youth Conservation and Mental Health Programs made in 1953 have not yet been acted upon. One was that steps should be taken to improve greatly the level of supervision of the mentally deficient in all counties; the other that "All committed mentally retarded in need of institutionalization should be admitted and no waiting list permitted to again develop." A goal for the future!

The 1957 laws relating to special classes resulted in great expansion of special programs for the retarded in the schools as well as very definite "side" effects on the institutional population. Owatonna, a school for the higher grade retardates, now has a larger percentage of children presenting emotional or other problems. Those with less complex handicaps are more often accommodated in special classes of the public schools. The opening of classes for the trainable has often meant refusal of space in a residential institution if the child is attending school.

Through the years, there has been a changing concept of responsibility for the mentally retarded. In the very early years, only when they were placed in an institution did the retarded become a group separated from others and a state responsibility. In 1953, it was established that parents, if able, were expected - though not actually required - to pay 52 per cent of the per capita cost of institutional care; if parents failed to pay, the charge to the county was doubled. It would seem that the legislature no longer felt that institutional care was totally a state financial responsibility but should be shared by the

family or county. In 1961, the law was changed to reduce the portion paid by the family but it retained the idea that while the state should bear the greatest load, institutional care was not totally a state responsibility. Following the 1961 change, the total amount paid by parents for institutional care of children has gone up substantially.

The 1917 guardianship law had also changed the concept of public responsibility. Until then, public responsibility for the retarded was recognized only at the State level. The 1917 law emphasized public responsibility on both the state and county levels. During that period, private agencies rarely accepted a mentally retarded person for service. More recently, there has been evidence of private agency responsibility. The development of privately sponsored community activities has been accelerated by parent groups who themselves often set up day care centers or other group activities and urged other private agencies to set up similar programs. By 1956, the Community Health and Welfare Councils of both Minneapolis and St. Paul had recommended that private agency services be increased. The idea was that the activities - clubs, camping, etc. - furnished for other individuals by an agency should also be furnished for the retarded. This idea has been largely accepted so that now a total program includes participation by the state, the county - and sometimes the city - the private agency, and the parents. The state still has major responsibility financially, administratively, and socially in the fields of education, health, and welfare, but it has many helping hands in the overall program.

Today, programs for the retarded are once again being subjected to critical analysis and inspection. There is a strong trend in Minnesota and elsewhere to change the institutions from the "School and Colony" concept to the "School and Hospital" concept. The new concept would make the "State School and Hospitals" part of an overall community plan, would effect changes in admission policies, would create additional smaller specialized residential facilities, and would greatly increase the number of community facilities for the mentally retarded.

It is to be hoped that these profound changes proceed in an orderly fashion based on careful planning and good evidence. It must be emphasized that the Minnesota State School and Hospitals are still

"Colonies" more than anything else, and that except for a handful of pilot projects and the public school program, community programs for the retarded are still at the stage of hope and plan.

CHAPTER III COMMUNITY SERVICES FOR THE MENTALLY RETARDED

Almost 95 per cent of the mentally retarded live in their home communities and will continue to do so. This in itself is desirable, but community facilities must be adequate if the retarded who remain in their home communities are to develop their potentialities most profitably for themselves, their families, and society.

The retarded vary widely in their capabilities and needs . Some require total care from infancy throughout their lives, while others will need services during only part of their lifetime, such as special education during the school years. A comprehensive program of community services will be outlined in this chapter, but it must be understood that all parts of this program will not apply to every retarded person.

Responsibility for development of community programs in Minnesota has been divided and indefinite, leading to overlap in some areas and some serious gaps in services. The following basic recommendations were developed by the committee as a guide in establishing responsibilities in this area. They are listed as a background for specific recommendations which follow.

Responsibility For Community Services For The Mentally Retarded

1. Mentally retarded persons are entitled to all the services normally provided to other children and adults.
    A. These services should be provided by the governmental body, institution, or private agency that normally provides such services to others. For example:
        1. Education and training should be provided by the public schools.
        2. Vocational training and placement should be offered by the Office of Vocational Rehabilitation.
        3. Recreation, when provided by a local govern mental body, should be extended to the retarded.

4. Camping and religious nurture should be in the hands of non-public institutions and agencies .
5. Preschool training should be provided by other agencies up to the age when the school's responsibility begins.

B. There should be a recognition of the excess cost factor in providing public services with reimbursement by the state to the local public body providing such service.

II. Because the retarded have special needs and handicaps, additional services to them and their families must be provided.

A. All plans for supervision including special living provisions, whether in or out of the home community, should be the responsibility of the Department of Public Welfare and its agents. This would involve additional financial resources to provide supplementary services such as the following:

1. There should be continuing diagnosis and evaluation in order that adequate plans may be made.
2. There must be counseling with parents to help them make realistic plans.
3. There should be provision for long or short term boarding care.
4. Provisions for day care should be made when needed.
5. Sheltered or independent living arrangements should be adequately supervised.
6. Provision should be made for the coordination of services offered by other public and private agencies.

B. Recognition should be given to the place of private agencies such as Associations for Retarded Children for the part they play in parent education, parent counseling, and services.

The following sections of this chapter provide background information and recommendations concerning education, day activity centers, foster home care, and vocational rehabilitation and employ -

ment programs in the community.

Current Status, Needs and Recommendations Concerning Components of a Community Program for the Mentally Retarded

Education

In 1956-57, 46 school districts in Minnesota had 212 special classes for retarded children. In the 1961-62 school year, 190 districts had 485 classes. This shows a very satisfactory growth rate in special education programs for the retarded. (See Table 2 for a detailed summary of special class development since 1957.) A number of problems concerning education of the retarded in the community exist, however, and they are summarized below:

1. There is only one consultant on mental retardation in the State Department of Education. He cannot make even token visits to all classes in a year much less provide real help or supervision.
2. Only about twenty-five percent of the educable retarded needing special education are receiving proper help.
3. Only about ten per cent of the trainable retarded needing special education services are receiving proper help.
4. There has been a lag in developing local supervisory services for special education programs, with the result that present programs are sometimes of doubtful quality.
5. The greatest problems in program development continue to exist in small towns and rural areas.
6. The shortage of specially trained teachers to conduct classes for the mentally retarded continues to be a major problem.
7. There is very great need in all parts of the state to develop secondary school programs for the educable retarded. Programs are needed which combine school experience with supervised work experiences to provide transition from school to employment situations.
8. The form of present legislation pertaining to school programs for the retarded seems adequate, except that the limitations in reimbursements for special teachers and other school personnel should be eliminated. The limit of state reimbursements at the present time is

two-thirds of salary for essential personnel up to a limit of $3600. This is unrealistic and is especially limiting in the case of supervisory personnel whose salaries are usually relatively high.

Table 2

Growth of Special Education Programs for the Mentally Retarded in Minnesota

	1956-57	1957-58	1958-59	1959-60	1960-61	1961-62
Educable Classes	191	220	296	338	379	438
Pupils in Classes	3300	3596	4378	4736	4773	5583
Trainable Classes	21	22	31	36	40	47
Pupils in Classes	200	210	303	349	380	406
Total Classes	212	242	327	374	419	485
Total Pupils in Classes	3500	3806	4681	5085	5153	5989
Cost of Special Services and Instruction	$1,215,563	$1,281,297	$1,730,143	$2,068,771	$2,479,484	$*

*** Figure not available when this report was prepared.**

Recommendations Concerning Education

II. IT IS RECOMMENDED THAT THE DEPARTMENT OF EDUCATION SEEK AND BE AUTHORIZED PERMANENTLY TO EMPLOY FOUR ADDITIONAL CONSULTANTS IN SPECIAL EDUCATION. THESE CONSULTANTS SHOULD BE PLACED IN OUTLYING COMMUNITIES OF THE STATE AND BE GIVEN REGIONAL RESPONSIBILITIES TO ASSIST IN THE DEVELOPMENT AND SUPERVISION OF SCHOOL PROGRAMS FOR HANDICAPPED CHILDREN (INCLUDING THE RETARDED) IN SMALL SCHOOL DISTRICTS.

III. IT IS RECOMMENDED THAT THE PRESENT STATUTES 124.32 AND 124.33, PERTAINING TO EDUCATION OF THE HANDICAPPED, BE AMENDED TO PROVIDE STATE REIMBURSEMENT FOR ESSENTIAL PERSONNEL IN SPECIAL EDUCATION PROGRAMS AT A LEVEL OF TWO THIRDS SALARY WITHOUT LIMITATIONS. (See Appendix B for information on the cost of the amendment).

IV. IT IS RECOMMENDED THAT APPROPRIATION REQUESTS OF THE SEVERAL STATE COLLEGES AND THE UNIVERSITY OF MINNESOTA, AS THEY PERTAIN TO TRAINING PROGRAMS FOR TEACHERS OF THE

MENTALLY RETARDED, BE GIVEN FAVORABLE CONSIDERATION.

V. IT IS RECOMMENDED THAT THE DIVISION OF SPECIAL EDUCATION AND REHABILITATION OF THE STATE DEPARTMENT OF EDUCATION BE AUTHORIZED AND FUNDED TO EMPLOY A SPECIAL CONSULTANT WHO HAS PROFESSIONAL BACKGROUND IN BOTH SPECIAL EDUCATION AND REHABILITATION FIELDS TO PROVIDE LEADERSHIP IN THE DEVELOPMENT OF SCHOOL-WORK PROGRAMS FOR MENTALLY RETARDED YOUTH.

Day Activity Centers

Day activity centers for the mentally retarded provide an essential service. They serve children below school age, children of school age who do not profit from school programs and those beyond the school-leaving age. They often become focal centers for parent education and long-range planning for retarded individuals .

The 1961 law, Minnesota Statute 252.15, to provide state reimbursement at the level of 50 per cent of operating costs for pilot project day activity centers, has resulted in the establishment of several new centers. Each of them has demonstrated the feasibility of successful cooperation of public and private agencies to provide this essential type of service. Centers have now been established in Olmsted, Kandiyohi, Meeker, Freeborn, Carlton, and Watonwan Counties. Applications for five additional centers have been received, but at the time of this writing, state support had not yet been finally allocated for them.

Inquiries from several areas of the state indicate readiness to move ahead in the establishment of day activity centers, and the success of the early pilot efforts indicates that this interest should be encouraged. Since these centers frequently serve retarded persons who have quite severe limitations, further development of this program is likely to lead to reduced institutional enrollment. In addition, of course, day activity centers provide a means of preserving normal home and community life for many individuals.

A number of problems concerning day care centers have been observed by the committee and are summarized below:

1. The present legislation which calls for reimbursements to local agencies has been handicapping. The law should be amended to author-

ize the Department of Public Welfare to make payments In advance for approved programs. Since local agencies must provide, on their own, all necessary capital equipment, including buildings, the problem of initial expenditures has been great. This proposed change in the law, without increasing costs to the state, would facilitate program development.

2. The present law prohibits state matching funds for monies collected from fees charged to parents. Whether parents should be expected to pay part of the costs for services in day activity centers, especially for children of school age, can be argued. It is likely, how ever, that day activity centers will increasingly serve children who are below or above school ages . In any case, removing this limitation would have a facilitating effect on the development of day activity centers.

3. The present appropriation ($36,000) for the 1961-63 biennium is not adequate. This amount could have been spent in one or two centers in the Minneapolis - St. Paul metropolitan area alone.

4. There is a marked lack of service to adolescent and young adult retarded persons. Efforts are needed to develop day activity centers to fill the gap existing between the end of school programs and the beginning of vocational training programs. Such centers should assist the retarded person in the development of social and prevocational skills, attitudes of self-responsibility, and good habits of work and use of leisure time.

5. There is also a need for expansion of day activity centers serving retarded children of nursery school age. Recent research has shown that some preschool retarded children respond very favorably to a good nursery school program. A program for this age range also gives parents help and counseling during the years when adaptation to the child's handicap and good home training are most needed. There is the additional advantage that such programs give time for evaluation of the many borderline and difficult children before it is necessary to plan school programs for them.

VI. Recommendations Concerning Day Activity Centers

IT IS RECOMMENDED THAT APPROPRIATIONS FOR STATE MATCHING FUNDS FOR DAY ACTIVITY CENTERS BE INCREASED TO $215,000 FOR THE 1963-65 BIENNIUM.

Listed below in Table (3) are the estimated requirements for a state-supported day activity center program during the coming two years. Included are funds for employment of a special consultant to assist in their orderly development.

Table 3 Estimated Costs of Day Care Programs, 1963-65

Operation of Present Programs Financing	$ 85,000.00
of Other Planned Programs Expansion of	79,000.00
Existing Services Financing of Newly	7,000.00
Developed Programs Employment of	36,000.00
Special Consultant	8,000.00
TOTAL NEEDS	$215,000.00

VII. IT IS RECOMMENDED THAT MINNESOTA STATUTE 252.15 BE AMENDED OR PROVIDE ADVANCE PAYMENTS RATHER THAN REIMBURSEMENTS BY THE STATE FOR EXPENSES IN OPERATING DAY ACTIVITY CENTERS.

VIII. IT IS RECOMMENDED THAT THE FEATURE OF THE PRESENT LAW WHICH EXCLUDES PARENT FEES AS A SOURCE OF LOCAL FUNDS TO BE MATCHED BY THE STATE BE AMENDED TO ALLOW USE OF SUCH FEES AS A LOCAL RESOURCE. The committee favors administration of the law in a way to minimize use of parent fees, especially for school-age children. Certainly, parent ability to pay fees should not be a decisive factor in offering or withholding service to any child. On the other hand, it does not seem necessary to exclude fees as a source of income for those willing and able to pay.

IX. IT IS RECOMMENDED THAT THE DEPARTMENT OF PUBLIC WELFARE GIVE PARTICULAR ATTENTION TO THE DEVELOPMENT OF DAY ACTIVITY CENTERS FOR ADOLESCENT AND YOUNG ADULT RETARDATES. THIS ASPECT OF COMMUNITY PROGRAMMING SHOULD BE HIGHLIGHTED BY EVERY SUITABLE MEANS ALONG WITH FURTHER DEVELOPMENT OF CENTERS FOR CHILDREN.

X. IT IS RECOMMENDED THAT THE DEPARTMENT OF PUBLIC WELFARE UNDER MINNESOTA STATUTE 252.15, GIVE LEADERSHIP TO THE DEVELOPMENT OF ONE OR MORE PILOT CENTERS FOR NURSERY

SCHOOL-AGE RETARDED CHILDREN.

XI. IT IS RECOMMENDED THAT THE DEPARTMENT OF PUBLIC WELFARE BE AUTHORIZED AND FUNDED TO EMPLOY A SPECIAL CONSULTANT TO ASSIST IN DEVELOPMENT OF DAY ACTIVITY CENTERS.

Boarding Care For The Mentally Retarded

There are now, and probably always will be, mentally retarded persons who must be cared for outside of their family homes but not necessarily in a state institution. Because of the lack of space in the state institutions, and for other reasons, there are now 483 retarded in foster homes and 299 in group homes. A group home is a facility caring for more than ten persons .

Foster homes and group homes care for a variety of types and ages of retarded. Many are placed directly from the hospital at birth; others when care becomes too great a burden for the family. These usually remain in the boarding care facility for two or three years until institution space becomes available.

The cost of care in foster homes ranges from about $1.00-$5.00 per day. In rural counties, twenty-seven homes charge $3.00-$4.00 per day, twenty-five homes charge $4.00-$5.00 per day. The average cost in Ramsey County is $2.52 per day; in Hennepin County, $4.04 per day; and in St. Louis County, $4.37 per day. Group homes cost an average of $135.00 per month. If the parent cannot pay these costs, the county of residence may, and often does, pay all or part. Generally, these costs are less, per capita, than the costs of institutional care.

At the present time, there is no state aid for Such care, although there is state aid for boarding care of dependent and neglected state wards. If the state were to participate in meeting this cost, counties would then be willing to evaluate carefully the relative merits of state institutional care versus boarding care. Care in a small facility, with more individual attention, enables many retarded children to develop more fully and at a faster rate. Under the present system, the county welfare board usually elects to place the child in a state institution, at a yearly cost to the county of no more than $120.00, as opposed to boarding care, which can run as high as $1,800.00 per year.

Some retarded individuals could leave the institution if financial aid in the form of state participation in paying for boarding care were

available. Some older retarded persons need financial assistance for short periods of time to enable them to train in workshops not near their home.

Recommendation Concerning Boarding Care XII. IT IS RECOMMENDED THAT THE LEGISLATURE APPROPRIATE FUNDS FOR REIMBURSEMENT TO COUNTIES OF UP TO 50% OF THE COST OF BOARDING CARE FOR MENTALLY RETARDED WARDS OF THE STATE COMMISSIONER OF PUBLIC WELFARE.

Vocational Rehabilitation and Employment Most mentally retarded persons, if given adequate training and guidance, are able to work in competitive industry in simple jobs or to make useful economic contributions in sheltered environments. It is short-sighted for public agencies to fail to provide adequate assistance to retarded persons as they reach employable age. Although progress has been made in Minnesota in providing useful occupations in the community for many retarded, a number of problems exist. Some of these are summarized below:

1. The Division of Vocational Rehabilitation of the State Department of Education lacks necessary personnel to provide services to the retarded in evaluation, training, and job placement. Because of a substantial backlog of cases, the Division must now work with those cases which promise quickest returns and, as a result, the retarded are often neglected. Besides lack of sufficient numbers of rehabilitation staff, the Division has had problems of excessive turnover in staff, caused at least in part by inadequate salaries. With sufficient and stable personnel, the Division might be expected to take more leadership in coordination of school programs, sheltered workshops and employment programs. It has been noted by the Committee that the state of Minnesota failed to match all funds available through the Federal Government for Rehabilitation programs for the 1961-63 biennium. A substantial increment in the Minnesota rehabilitation program could be achieved at relatively low cost by matching all available federal funds.

2. An expansion of sheltered workshops in the state is necessary to provide for the evaluation and training of both trainable and educable young adults. At present there are only two workshops in operation for

mentally retarded individuals exclusively. Twelve other workshops throughout the state have a very limited number of mentally retarded clients. Probably fewer than one hundred and fifty of the mentally retarded are receiving service at any given time, emphasizing the great need for the development of programs of this nature.

Recommendations Pertaining to Vocational Rehabilitation and Employment

XIII. IT IS RECOMMENDED THAT THE STAFF COMPLEMENT OF THE DIVISION OF VOCATIONAL REHABILITATION BE SUBSTANTIALLY INCREASED, WITH A VIEW TOWARD INCREASING SERVICES TO THE MENTALLY RETARDED.

XIV. IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL RE HABILITATION PREPARE A PLAN AND SPECIFIC PROPOSAL FOR DEVELOPMENT AND PARTIAL SUPPORT OF COMMUNITY SHELTERED WORKSHOPS BY THE STATE GOVERNMENT THROUGH THE DIVISION OF VOCATIONAL REHABILITATION. IT IS APPROPRIATE THAT DE VELOPMENT OF SUCH FACILITIES BE A COOPERATIVE VENTURE BY STATE AND LOCAL AGENCIES. SUPPORTS BY THE STATE SHOULD INCLUDE GRANTS FOR A PERIOD OF INITIAL DEVELOP MENT AND OPERATION OF APPROVED FACILITIES PLUS CONTIN UING AID THROUGH "FEES FOR SERVICE" PROVIDED TO MENTALLY RETARDED INDIVIDUALS.

Community Sheltered Living

Many older retarded persons do not need institutional care but have no family to supervise them in the community. It is believed that sheltered living facilities can be developed in various communities which would offer a richer life to these adult retardates than is now offered in residential care facilities. Some of the older retardates would be capable of productive work in a simple community setting if they had adequate general supervision.

XV. IT IS RECOMMENDED THAT THE DEPARTMENT OF PUBLIC WELFARE INITIATE A DEMONSTRATION PROJECT ON SHELTERED LIVING FACILITIES IN THE COMMUNITY FOR OLDER RETARDED

INDIVIDUALS.

Included as Appendix C to this report is a preliminary statement developed by Dr. Richard Bartman of the State Department of Public Welfare which it is hoped will be completed as a plan for such a demonstration project.

Diagnosis

Facilities for diagnosis of puzzling or multiply handicapped individuals are very limited outside of the Twin City metropolitan area and Rochester. Establishment of centers providing complete medical, psychiatric, social and psychological services are needed in other areas of the state. At present the Department of Public Welfare is formulating plans for establishing diagnostic facilities which would serve the mentally retarded as well as other children. The committee has viewed the tentative plans with much favor.

Community Supervision

Often the essential service to the retarded that enables them to function adequately in the community is proper supervision. This supervision is the responsibility of the Commissioner of Public Welfare and his agents. The case-loads of the social workers in some counties, however, may be so great that little time is left for the mentally retarded and the workers assigned to supervise them may have little or no training in the problems of the retarded. It is suggested that the Commissioner of Public Welfare initiate further studies to find ways of improving the supervision of the retarded in local communities.

Summary

Most mentally retarded persons now reside in the community and will continue to do so. The committee believes that further efforts should be made to accelerate the development of community resources so that the retarded who remain in the community have suitable opportunities for care, education, recreation, supervision and employment. A series of recommendations concerning development of programs of necessary types has been presented. The implementation of these recommendations should result in both economic and social gains to the State and richer lives for the retarded .

CHAPTER IV - RESIDENTIAL CARE FACILITIES

The committee has given particularly close attention to state operated institutions for the mentally retarded. The State's responsibility for the institutions is full and clear, more so than for any other type of program. A sub-committee visited each of the four major residential care facilities, collected a variety of reports and consulted with many individuals and agencies to develop a report on this important facet of the State program.

The committee finds the conditions of State institutions for the mentally retarded to be grossly unsatisfactory. The three largest institutions, at Faribault, Cambridge, and Brainerd, are each called "State School and Hospital." Actually, the Cambridge facility lost its accreditation as a hospital in 1941; Faribault lost its accreditation in 1959. 1 The Brainerd School and Hospital has not applied for accreditation, but clearly fails below requirements. The major reasons for lack of accreditation at all three centers are apparent - overcrowding and lack of staff.

The residential facilities at Faribault and Cambridge also fail to meet standards of the Minnesota Department of Health and of the State Fire Marshal. In 1955, the State Department of Health issued a report on these institutions which included a number or recommendations. The needs specified in that report, especially those pertaining to overcrowding, have not been met. At Faribault, some patients are still housed in buildings recognized as fire traps.

The educational programs at Faribault, Cambridge and Owatonna have made good and steady progress in recent years, but much further effort is needed before they meet adequate standards. At Brainerd, our newest and finest physical plant, there are but two makeshift classrooms . There is an urgent need for a school building there.

The accreditation body in the field is the Joint Commission on Accreditation of Hospitals. Member organizations include the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Hospital Association.

Apart from these evaluations by outside agencies, it is also clear that the institutions fail to meet standards of our own Department of Public Welfare. Testimony given to the committee by administrators of the Department of Public Welfare, the institution Superintendents, and other staff members indicates their painful awareness of inadequacy in staffing, institutional programs, and facilities. The committee believes that the failure to provide adequately for the mentally retarded wards of Minnesota is the inevitable result of insufficient appropriations and the failure to adhere to such standards as now exist.

XVI. IT IS RECOMMENDED THAT THE DEPARTMENT OF PUBLIC WELFARE, IN CONSULTATION WITH THE STATE DEPARTMENTS OF HEALTH AND EDUCATION, DEVELOP A DETAILED AND EXPLICIT STATEMENT OF STANDARDS FOR STATE INSTITUTIONS AND A SCHEDULED PROGRAM FOR MEETING THOSE STANDARDS AS A GUIDE FOR THE LEGISLATURE.

To assist in meeting present urgent needs, the committee itself has outlined in subsequent portions of this chapter additional recommendations pertaining to several of the obvious problems.

In order to understand the complicated and confusing facts relevant to a study of the state residential facilities, a point of clarification is in order. Most of the institutions for the retarded have their roots in the school and colony concept, which evolved around 1900. This concept held that the institution was primarily a colony to provide life long care for the retarded. Society would be protected from the real and imagined ills attributed to the mentally retarded. The mentally retarded would be protected from an uninformed society. Once admitted, most of the mentally retarded were expected to live out their lives within the institution. Those who could work or perform useful tasks would do so, and thus help with the running of the facility. Special medical care would be given to those who needed it. Schooling would be provided for some of the more capable residents. The general objective, as stated as late as 1959 by the Minnesota Association for Retarded Children, was to provide, "Decent, humane, minimum standard custodial care."

There has never been a set of standards to define what colony-care is or should be. In the absence of such standards, the committee has resorted to the technique of making comparisons between the Minnesota "colonies" (our State School and Hospitals) and similar institutions in our sister states.

Modern thinking is now evolving to a concept for residential care facilities which is a cross between the colony concept and that of a school and medical-psychiatric hospital. Again, this concept is not yet clearly defined, but it does envision a level of care, training, and medical excellence which would increase the staffs of the "colony" type institutions. In addition, it would raise patient costs from the present level of about $5.00 per day to approximately $8.50 per day. This, of course, is still far removed from the community hospital level where the per diem costs per patient average about $30.00 per day.

Kansas and California have pioneered in this new approach. They are examples of states that have managed to keep appropriations within range of patient needs. Kansas' Parsons State Hospital and Training Center, for example, operates on a per diem of $8.50 with an overall staff-patient ratio of 1:1.65. This provides patients with very adequate, but not luxurious care. The institutions in these states are accredited, have better staff ratios than do residential facilities in other states, and have higher per diem patient allowances.

It must be understood, that the Minnesota Department of Public Welfare is now aiming for a level of care within the "Minnesota State School and Hospitals" equal to or better than that now being provided in Kansas and California.

XVII. IT IS RECOMMENDED THAT THE LEGISLATURE FORMALLY RECOGNIZE THE MAGNITUDE OF THE PROBLEM OF RESIDENTIAL CARE AND ADOPT A LONG RANGE PROGRAM WITH THE GOAL OF PROVIDING CARE AT THE LEVEL OF OTHER PROGRESSIVE STATES.

For lack of better terms, we shall use the term "Colony" in subsequent pages when talking about the older concept of institutional care, and the term "School and Hospital" when talking about the concept of care now provided by Kansas and California, and advocated

by the Minnesota Department of Public Welfare.

Staff Shortages

The most serious deficiency in the Several State Schools and Hospitals is the shortage of staff, especially the shortage of psychiatric aides who provide most of the direct patient care.

Committee Observations

The needs for additional staff will be documented by comparison with other states, but such statistical methods fail to convey the real meaning of this problem. The committee, while visiting residential facilities, made these observations which emphasize the human aspects of staff shortages .

(1) Many children spend all day in bed, often with soiled diapers, because no staff member is available to care for them out of their cribs or to change their diapers - except by schedule;

(2) Some children cry, but do so alone because no one is available to comfort them;

(3) Children look out of windows at playgrounds, but are con fined indoors because of lack of recreational workers;

(4) Patients, hundreds of them, have nothing to do but to sit, walk aimlessly, sleep excessively, or watch television;

(5) Meals are gulped and spilled by patients who should have help in eating; helpless patients are fed in rushed fashion by other patients;

(6) Patients, in large numbers, come up to visitors, obviously craving a touch, a word or some other form of attention.

One member of the committee reported the following observation which helps put a human metric on the staff shortage problem:

The committee visited a cottage at Cambridge. It housed about one hundred women patients. They slept on the second floor in two large dormitories where the beds were crowded one beside the other. There was no room for a bedside table or a small chest where the women could keep personal belongings. During the day in this cottage, the women patients lived in four day rooms, two on the first floor and two in the basement. Two female aides worked the building and were responsible for all that went on inside of it. When the committee showed up, one of the aides was asked to be our guide. We could see that she was apprehensive about leaving the day rooms she was overseeing. When we reached the basement, we went into a day room where there was no aide. A patient was lying on the floor, stiffened by a seizure. Several patients were standing over her, whimpering. Another patient was over in a corner crying about some-

thing else. Our guide rushed over to the prone patient, then rushed out of the room to get some help. Just then the telephone rang. Then the doorbell. At that instant, this harassed woman had no less than seven things to do, namely:

Attend to her day rooms upstairs .
Show visitors through the building.
Attend to a patient with a seizure.
Attend to a patient who was distressed and crying.
Ease the fears of two other patients who were whimpering and concerned about the patient with the seizure. Answer the telephone. Answer the doorbell.

Other undesirable situations, reported to the committee, reveal the very great need for increasing the staff-patient ratios at all institutions. The heads of institutions and their associates agree that their Number One problem is staff shortage.

Requests for Additional Staff - Past and Present

In Table (4) is tabulated the new staff requests over the last six legislative sessions, along with data reflecting legislative authorizations for new personnel. It may be noted that, except for positions authorized to operate new buildings, the legislature has essentially "held the line".

This policy has raised extraordinary difficulties because of recent changes in the nature of the patient population. Evidence is clear in showing a strong trend toward institutionalization of younger and more severely retarded persons, requiring many varieties of professional services.

Table 4

New Staff Positions Requested by the Institutions in Past Years and New Staff Positions Authorized by the Legislature

Institution	Biennium	Institution Requests for New Personnel	Legislative Allowance for New Personnel	% of Request Received
Faribault State School and Hospital	1951-53	268*	123	46%
	1953-55	70	35	50%
	1955-57	106	(-4)	--
	1957-59	153	16	10%
	1959-61	136	29	21%
	1961-63	175	35***	11%
Cambridge State School and Hospital	1951-53	196	2	1%
	1953-55	10	2	20%
	1955-57	146*	91	62%
	1957-59	293	251	86%
	1959-61	69	(-21)	--
	1961-63	150	7	5%
Brainerd State School and Hospital	1959-61	121¼*	70	58%
	1961-63	132*	81	61%
Owatonna State School**	1951-53	18	10	56%
	1953-55	13	0	0%
	1955-57	1	1	100%
	1957-59	8	3	38%
	1959-61	5	0	0%
	1961-63	10	2	20%

* New buildings opened for additional patients account for majority of new positions.

** Prior agreement usually with D.P.W. at O.S.S. limits the size of requests.

*** Fifteen of these positions were for laundry workers for the new laundry which now processes all laundry for the Owatonna State School, the Faribault Braille and Sight Saving School, the Faribault State School for the Deaf in addition to the normal load for the Faribault State School and Hospital.

The committee asked each of the institution Superintendents to submit his requests for new personnel for the 1963-64 biennium. These are included in Appendix D.

Comparisons of Minnesota with other States

The committee assembled data showing staff-patient ratios in large residential care facilities in the Midwest as a basis for comparison with Minnesota institutions. Table (5) points out that of seven large midwestern institutions, Minnesota's State School and Hospital at Faribault ranks next to the bottom in its overall staff-patient ratio. Only Illinois ranks lower, and the situation there has recently been the object of close scrutiny and criticism.

Table 5

Examples of Staff-Patient Ratios in
Typical Institutions of "Biq 10" States

	Patients in Res.	Staff	Ratio	Rank
Indiana Fort Wayne State School	2,091	759	1:2.8	(1)
Wisconsin Northern Wisconsin Colony and Training School	1,709	598	1:2.9	(2)
Iowa Woodward State Hospital & School	1,484	474	1:3.1	(3)
Ohio Gallipolis State Institution	2,312	687	1:3.4	(4)
Michigan Lapeer State Hospital and Training School	3,745	1,030	1:3.6	(5)
Minnesota Faribault State School and Hospital	3,200	719	1:4.5	(6)
Illinois Dixon State Hospital	5,000	988	1:5.1	(7)

Table (6) points out the relative position of the Faribault State School and Hospital among the same "Big Ten" state institutions in provision of psychiatric aides. Again, Minnesota's relatively low standing is clear.

Table 6

Examples of Aide-Patient Ratios in
Typical Institutions of "Big 10" States

	Patients in Res.	Aides	Ratio	Rank
Ohio Gallipolis State Institution	2,312	435	1:5	(1)
Wisconsin Northern Wisconsin Colony and Training School	1,709	311	1:5	(2)
Indiana Fort Wayne State School	2,091	373	1:6	(3)
Michigan Lapeer State Hospital and Training School	3,745	609	1:6	(4)
Iowa Woodward State Hospital and School	1,484	212	1:7	(5)
Minnesota Faribault State School and Hospital	3,200	394	1:8	(6)
Illinois Dixon State Hospital	5,000	446	1:11	(7)

Table (7) shows that in comparison with the national average, Minnesota's three largest residential facilities have fared badly. A special comparison with Kansas' two major institutions is also provided.

From these several comparisons, it is apparent that Minnesota has not provided staff for its institutions as well as the average state nor as well as other Midwestern states.

Table 7

Staff Comparison Between Minnesota -
- Kansas - US Average

	Patients	Staff	Ratio	Prof. Services	Ratio	Aides	Ratio
*Minnesota	6,162	1,496	1:4.1	122	1:50	869	1:7.1
**Kansas	1,932	1,048	1:1.8	119	1:16	543	1:3.6
***United States	158,119	49,892	1:3.2	5,032	1:31	28,734	1:5.5

*Faribault, Cambridge, and Brainerd State School and Hospitals.

**Parsons and Winfield State Hospital and Training Centers.

***Includes all public residential facilities for which current statistics were available to the committee.

Staff Ratios in Minnesota Institutions

Table (8) points out the staff-patient ratio for each of the three major Minnesota institutions for the mentally retarded. Faribault and Brainerd present the greatest problems, but Cambridge also lags behind the institutions in Indiana, Iowa, Wisconsin, Ohio, Michigan and Kansas. Owatonna serves a special purpose and its needs are not directly comparable with other institutions.

Table 8

Staff Comparisons Among Minnesota's Institutions

	Capacity	Staff	Ratio
Faribault State School and Hospital	3,200	719	1:4.46
Cambridge State School and Hospital	2,008	552	1:3.63
Brainerd State School and Hospital	954	225	1:4.13

Recommended Staff Improvements

Since the three largest institutions serve essentially the same types of population and the same purposes, it seems illogical to maintain discrepancies among them.

XVIII. IT IS RECOMMENDED THAT, AS A VITALLY NECESSARY STEP TOWARDS BRINGING THE THREE MAJOR MINNESOTA INSTITUTIONS FOR THE MENTALLY RETARDED UP TO AN ADEQUATE LEVEL OF "COLONY" TYPE CARE, EACH OF THEM BE AUTHORIZED ENOUGH ADDITIONAL POSITIONS AT A MINIMUM TO BRING ITS OVERALL STAFF-PATIENT RATIO TO THE U.S. AVERAGE LEVEL OF 1:3.2.

This would necessitate a total of 430 new positions allocated as follows:

Faribault State School and Hospital 281 new positions
Cambridge State School and Hospital 76 new positions
Brainerd State School and Hospital 73 new positions

XLX. IT IS RECOMMENDED THAT FIFTEEN ADDITIONAL POSITIONS REQUESTED BY CAMBRIDGE STATE SCHOOL AND HOSPITAL FOR ITS EXPERIMENTAL INTENSIVE THERAPY UNIT BE GRANTED.

Dr. Richard Bartman, Director, Children's Mental Health Services, Minnesota Department of Public Welfare, estimates that "colony" type care meets the needs of only 15% of the patients in the three major institutions for the mentally retarded. The other 85% would benefit by the additional treatment and training implied by the "School and Hospital" concept. He believes that Minnesota, over a period of six years and three legislative sessions, should develop staff-patient ratios based on an analysis of patient needs. In Appendix E, Dr. Bartman summarizes his views on staffing.

On the basis of a "Patient Needs" analysis, Dr. Bartman would predict a necessity for staff-patient ratios comparable to those prevailing in Kansas and California institutions. Based upon his estimates and a six year time table, Dr. Bartman will be requesting the Commissioner of the Department of Public Welfare to ask the 1963 legislature to provide a total of 588 new positions for the three major institutions allocated as follows:

Faribault State School and Hospital 275 new positions
Cambridge State School and Hospital 186 new positions
Brainerd State School and Hospital 127 new positions

This is 158 more positions than was estimated by the committee to restore the standard of care to "colony" levels.

The committee regrets that it did not have the opportunity to appraise fully Dr. Bartman's plan. It is apparent to the committee, however, that something rather dramatic is needed to upgrade the level of care currently being provided by our three major institutions for the mentally retarded.

XX. IT IS RECOMMENDED THAT MINNESOTA GO BEYOND THE COLONY LEVEL OF CARE WHICH MEETS THE NEEDS OF ONLY 15% OF THE PATIENTS, AND THAT THE GOVERNOR AND THE LEGISLATURE CAREFULLY APPRAISE DR. BARTMAN'S PLANS AND SUPPORT THEM TO THE FULLEST EXTENT POSSIBLE.

The Owatonna State School is a special facility and cannot be compared directly with other institutions. The committee believes requests of that institution for 33 additional staff positions represents a necessary minimum for immediate improvements. This would bring the total Owatonna staff to 179 .

XXI. IT IS RECOMMENDED THAT THE OWATONNA STATE SCHOOL BE AUTHORIZED 33 NEW STAFF POSITIONS IN 1963.

The Space And Housing Problem

A brief look at the overcrowding problem in each of the Minnesota residential facilities for the mentally retarded is given below. Following is an excerpt from a letter to the sub-committee from Faribault dated July 5, 1962, with reference to overcrowding:

> "As of this date there were 3, 317 beds in use or available in dormitories or in the institution's hospital, representing a total overcrowding of 820 beds (33%) based

on the minimum standard of 60 square feet per bed." 1

Both short term and long term solutions to this overcrowding are required. The issue has been avoided for many years. Seven hundred patients at Faribault are in inadequate, antiquated buildings which should be demolished. The Department of Public Welfare and Dr. E. J. Engberg, the Superintendent, recommend that the overcrowding be solved by a combination of actions which includes:

1) Constructing at least two new 100-bed dormitories
2) Demolishing the old buildings
3) Reducing the population to 2,500 residents

Another alternative is to alleviate the overcrowding by constructing the appropriate number of new buildings and also replacing the antiquated dormitories with new buildings. Still other alternatives are considered in a later section of this chapter.

Following are excerpts from a letter dated June 29, 1962, to the sub-committee concerning overcrowding at Cambridge State School and Hospital:

> "According to Minnesota Health Department Standards, we are approximately 17% overcrowded. According to National Health Standard figures, we are 28% overcrowded. The overcrowding figures are based on square feet of dormitory space per patient. Minnesota uses 60 square feet per patient, while most other states use 70 square feet per patient."
>
> "We also have orders from the State Fire Marshal, dated April 6, 1962, which state as follows: 'Discontinue the overcrowding in buildings 1, 2, 3, 4, 5, 6, 7, 9, 12 and 14. The beds in these dormitories are so overcrowded that proper aisle space between beds is not maintained. This condition makes it impossible for the attendants to get to the patient and render assistance in the event of a fire emergency. There should be a minimum of at least three feet between beds .'"

Cambridge would also prefer to reduce its overcrowding by reducing the patient population. But because the grounds and utilities are designed for 2,000 patients, and since Cambridge is close to the

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The Committee on Psychiatric Hospital Standards and Policies of the Council of the American Psychiatrics Association recommends a minimum of 70 square feet per patient in dormitories. Regulations of the Minnesota Department of Health specify a minimum of 60 square feet per patient in dormitories. Some institution dormitories in Minnesota provide no more than 30 square feet per patient.

huge Metropolitan population center, it seems more advisable to add new beds when needed by construction of additional buildings on the site and thereby increase its capacity to the required level.

Happily, there is no overcrowding at Brainerd. Following is a statement dated June 27, 1962, from the Brainerd State School and Hospital:

> "We may be lacking in number of aide personnel and personnel in certain other categories but I can say that this institution is not in any other sense overcrowded. We have stayed religiously to the blueprint bed number allowable by the space standards set up by the Minnesota Department of Health and intend to continue to do so."

The Owatonna State School presents its own unique problems, as best articulated in this statement by Superintendent Henderson, July 13, 1962:

> "We are requesting that Cottage #2 and Cottage #4 be replaced. Cottage #2 is completely inadequate, not only because of the inadequacy of the structure of the building, but because there are more children housed in this cottage than there should be."
>
> "Cottage #4 does not present a problem of overcrowding, but we do feel this cottage is inadequate structurally. By-and-large, overcrowding is not an extreme problem at Owatonna.'
>
> "Our School building is, in the real sense of the word, overcrowded. There are not enough classrooms for the type of program carried on here."

Overcrowding in the Minnesota institutions, especially at Faribault and Cambridge, is serious and prevents adequate care of patients. Vigorous efforts should be made to improve this condition.

For Faribault State School and Hospital, there is a great need to develop a design plan, which would firmly establish a patient population limit and specify a schedule for demolition and construction of dormitories. Lack of a clear plan for Faribault will only result in further delays in the solution of a very urgent problem.

The Building Program

In describing some of the inadequate buildings at the Faribault State School and Hospital, the 1959 Joint Accreditation Inspection

Team used the expression, "Facilities which are not modern and are not good".

The Committee did not consider the building needs of the State School and Hospitals to any great extent. It was felt this would only duplicate the work of the Legislative Building Commission. The sub-committee thought it was in order, however, to take cognizance of "Facilities within our institutions which are not modern and are not good" as well as of any which might be critically needed for program purposes. A building priority schedule for residential facilities for the mentally retarded is included in Appendix F.

Faribault State School and Hospital

While there are many buildings and facilities at Faribault State School and Hospital which are as good as will be found in any state institution, there are also buildings and facilities which are so poor as to have no equal elsewhere in the state.

As early as 1956, the Faribault Superintendent presented a priority schedule for the replacement of inadequate dormitories. Table (9) describes the schedule. Since it was drawn up in 1956, no new dormitories have been constructed. The 1961 Legislature did authorize the erection of one 110 bed dormitory which would allow for the demolition of two of the older buildings; however, the problem of state debt limitation postponed any action on the authorization. The buildings, judged inadequate, are all in use today with one exception . One of the three colony buildings mentioned caught fire and was so badly damaged that it was razed. The other two remaining colony buildings are fire traps and provide accommodations that are so primitive that committee members, viewing them, were shocked. The colony buildings house patients ranging from young adult males to old men. The patients are, for the most part, moderately retarded and can shift for themselves within a confined area. Since the buildings are not fireproof and are all wood within a brick shell, the patients spend most of their time in the basement because this is the only area where they can smoke. Here are basements right out of the nineteenth century. The walls are the foundation stones. Water seeps through the joints. The cement in the joints is crumbly. Illumination is

provided by bare bulbs hanging by a cord from the ceiling. The ceilings are simply a view of the floor joints and flooring for the first floor. In one building, there are two toilets in a room adjoining the basement day room. Since the men spend most of their time in the basement, the two toilets are insufficient and give forth with an odor typical of public rest rooms. In short, the "day room area" most used by the patients is dark, dingy, damp, musty, smelly, and totally inadequate.

The many details involved in establishing dormitory building priorities at Faribault State School and Hospital and elsewhere are beyond the scope of this report. However, the committee is cognizant of the needs and wishes to express its deep concern that prompt consideration be given to the problems of housing.

Table 9

Needed Dormitory Replacements For The Faribault State School and Hospital*

Replacement Schedule	1956 Schedule Building	No. Residents
First	Grandview - old men's dormitory (5 miles out - isolated - not fireproof, food supplies trucked out - a separate kitchen is maintained)	70 old men
Second	Three "Colony" buildings (very poor shape - in need of repair - not fireproof - day area and dining rooms in basement)	150 men
Third	Two buildings - Skinner Hall group (Daisy and Iris) - old - very crowded, not fireproof)	120 girls
Fourth	Hillcrest (old - not fireproof, frame building - dayroom in basement)	60 boys
Fifth	Sunnyside (old - very crowded - very limited day space - very inadequate yard space)	300 boys and men
		700 Total

♦Authorization for 110 bed dormitory granted by 1961 Legislature

In 1956, the Faribault Superintendent and staff expressed their concern over the kitchen and food distribution systems. In January, 1958, Mr. A. C. Avery, U.S. Navy, an expert on food handling and preparation, was invited to inspect and appraise the facilities. His report clearly defined the many shortcomings of the food service system.

Again in May, 1961, Mr. Avery surveyed the Faribault kitchen. In this report, he states, "In the opinion of the undersigned, this feeding system is one of the most outmoded, unsanitary, and inefficient facilities that I have surveyed. What they have at Faribault is less than minimal and it is a travesty of what a fine state like Minnesota should be providing the dedicated personnel at Faribault to do a decent job. Faribault is riding a dangerous road along the ragged edge of disaster." He suggested a thorough survey be initiated, conducted by competent personnel.

The 1961 Legislature authorized an independent survey. Preliminary reports of the survey team indicate that they are in total agreement with Mr. Avery on the gross inadequacy of the facility and the need for a new food service building.

XXII. IT IS RECOMMENDED THAT PRIORITY CONSIDERATION BE GIVEN TO THE CONSTRUCTION OF A NEW FOOD SERVICE AND HANDLING BUILDING AT FARIBAULT STATE SCHOOL AND HOSPITAL.

Cambridge State School and Hospital

Cambridge State School and Hospital's general building program represents genuine needs of the institution and should be given careful consideration. Brainerd State School and Hospital

As stated previously in this report, Brainerd State School and Hospital has not developed a state of overcrowding in its dormitory buildings. Generally, requests for additional buildings in the years ahead are based on the systematic increase of its capacity.

The one critical building need of this institution that the committee observed was for a School and Rehabilitation Therapies Building. Testifying before the committee, Mr. Peterson, The Superintendent, said, "This proposed building is nothing less than the Heart of this institu-

tion. The primary therapeutic functions of Brainerd State School and Hospital are handicapped and condemned to superficiality without it" . The committee whole-heartedly agrees with this statement.

XXIII. IT IS RECOMMENDED THAT PRIORITY CONSIDERATION BE GIVEN TO THE CONSTRUCTION OF A SCHOOL AND REHABILITATION THERAPIES BUILDING AT BRAINERD STATE SCHOOL AND HOSPITAL.

Owatonna State School

Owatonna State School's request for new buildings has been considered by the committee and it concurs with the Owatonna administration's recommended priorities.

Long Term Needs

While the committee had hoped to make tangible contributions bearing on long term aspects of residential care for the mentally retarded in Minnesota, the complexity of the subject and the rapidly changing views concerning the role of institutions make this impractical. Thus we shall offer a few general observations and leave to future committees the task of making specific recommendations relative to the more basic changes in program.

Today's state school and hospital has roots deeply implanted in the past. It represents an evolution in concepts, circumstances, and public attitudes. Based upon the lessons of history, as they apply to certain theories of the present time, the committee offers these opinions for consideration.

(1) Major changes in the inward and outward flow of individuals from residential care facilities and the timing of these changes should take into account the availability of community resources and a development of community acceptance for such modifications in procedure.

(2) Program changes should be carefully built from well thought out and carefully documented demonstration projects rather than from untested theories which are as numerous as the people who advocate them. Society, legislators, parents, and professional people have the right, and indeed the responsibility, to insist that new programs, if they are to be universally adopted, be based on sound evidence. In order to promote progress professional persons of sound background, with direct responsibilities for the programs, should be encouraged to establish pilot studies and projects. Funds to support them should be granted by

the legislature. The committee most profoundly believes that Minnesota must now invest substantially more of its resources in research and the development of pilot projects in this field. (See Chapter V)

(3) During the past decade, a keen interest and involvement in the affairs of the mentally retarded has been shown by many public and private agencies.

While this interest is gratifying and of the utmost social significance, the involvement of so many different agencies and professions has created problems. Programs are developing along many fronts with varying degrees of effectiveness. Many services have developed independently in response to specific needs, with little regard as to their integration into an overall or comprehensive plan. While many see the need to integrate such diverse programs as state residential institutions, state and community mental health and diagnostic clinics, public school programs, community programs such as day care centers, rehabilitation and sheltered workshop programs, and so on, it remains that program integration and the creation of a total program for the mentally retarded is still a dream and objective, not a fact in being. As interest in mental retardation has skyrocketed, a bewildering and staggering volume of information, opinions, theories, published papers, and minutes of innumerable hearings about mental retardation and programs for the mentally retarded has developed. At this point in time, it would be difficult, if not impossible, to sift thru this material and come up with the optimum solutions to program development for the mentally retarded.

Suffice it to say programs for the mentally retarded are developing quite rapidly. When viewed over a thousand year span of human history, today's forward progress is thrilling and stimulating. When viewed from the point of view of a parent who urgently needs a facility for his retarded child within the next few years, the speed at which the programs are unfolding is almost a cause for despair.

In spite of this, bearing in mind history's lessons as to the undesirable consequences of acting too fast on the wrong information, the committee must defer to future study groups the decisions which will establish the future programs for the State's residential facilities. The committee anticipates many changes.

Regardless of the probable development of small, specialized institutions, small boarding homes in the cities, or other related changes, there will always be an urgent need for such facilities as Faribault, Cambridge, and Brainerd State School and Hospitals and the Owatonna State School. But there is a strong possibility that once Brainerd is expanded to a 2,000 bed capacity, there may not be a need for another such large general facility.

Summary

Minnesota's residential care facilities for the mentally retarded suffer from major deficiencies and are therefore incapable of providing the standards of care required by their residents and offered in many other comparable states.

The most serious areas of insufficiency result from a lack of necessary personnel, inadequate and antiquated dormitories, and excessive overcrowding.

The committee believes that, unless prompt attention is given to its recommendations concerning residential care, the results of postponement may well be more costly to Minnesota in the long run than would be the increased appropriations involved at this time.

CHAPTER V - RESEARCH

Research is the key to the long-range solution of problems of mental retardation. The major orientation of research in this field should be toward the discovery of preventive measures to reduce the incidence of mental retardation. Secondly, research is necessary to evaluate and improve programs for the retarded.

The State of Minnesota has invested very little in research in this field. Indeed, the lack of innovation and research is one of the most striking observations to be made in institutions and other programs. As a result, services are developed and plans are made with very few guide lines having been established through careful study.

The situation for research activities in the field is, however, changing favorably. The federal government is allocating increasing amounts of money for research in mental retardation. This money will go to centers well prepared to undertake serious studies. The lack of research personnel, everywhere, is a major stumbling block. Methods must be devised to recruit, train, and support outstanding young scientists in this field of work. The Advisory Committee has given close attention to methods by which Minnesota may become a more active center for research.

Current Research in Minnesota

The first goal of research in mental retardation - prevention - has two major aspects: the prevention of genetic types of mental deficiency, and the prevention of those types of environmental origin.

A major study concerned with genetic aspects of mental retardation, now being completed at the Dight Institute of the University of Minnesota, shows that a substantial proportion of the institutionalized cases of mental retardation in Minnesota is of genetic origin. Very little thought has been given to the sociological aspects of the prevention of genetic mental retardation. As an example of what could be done, it is clear that if all the women in Minnesota refrained from having offspring after the age of forty, the absolute number of Mongoloid children born would be reduced by one-third. This is, of course, a problem in health education. Another intriguing problem results from current strenuous

efforts to detect children with phenylketonuria soon after birth, in order to prevent the development of symptoms of the disease. Each time the treatment is successful, the "cured" child will be capable of reproduction and thereby increase the birth rate of phenylketonurics in subsequent generations.

Another study concerned with prevention of mental retardation is the so-called "collaborative study" being conducted at the University of Minnesota. This is the largest research project in Minnesota which will contribute to the field of mental retardation. It is one of fourteen such studies coordinated by the National Institute of Neurological Diseases and Blindness, and costs about $400,000 per year for the University of Minnesota branch. Each public patient coming to the University Hospitals is followed through her pregnancy and child birth. The child is studied at various times until he is at least seven years of age. For each who turns out to be mentally retarded, an attempt will be made to correlate any unusual happenings during his mother's pregnancy with the type of retardation he shows. It is expected that if environmental factors are discovered which might have produced the retardation, some of them, at least, can be remedied.

The second goal of research-evaluation and improvement of existing programs and planning of new ones - is more complex; several state and local projects are devoted to this goal. A listing of some of these follows:

(1) The Pilot Day Care Project. The 1961 Legislature allocated $36,000 to establish county or community centers for day care of the retarded. Six counties now have such day care centers in operation; others are developing plans for them. (See Chapter III of this report, "Community Services," for further information.)

(2) The Four County Project. The U.S. Children's Bureau has allocated funds for the past few years for a study centered at Fergus Falls. The goals are to coordinate diagnostic, educational, and other facilities; to focus community interest on mental retardation; and to develop community facilities.

(3) Federal Work-Training Project No. 681. This project, in cooperation with the Office of Vocational Rehabilitation, involves placement of retarded adolescents in a work-training program centered

at Central High School in Minneapolis. It is designed for retarded adolescents who are unable to compete in the special education programs at the high school level, but who are judged capable of achieving some economic and social independence if provided with suitable training and experience.

(4) Transitional Classes. This is a project supported by the Minneapolis Public Schools. These special classes are for retarded children who might be able to keep abreast of the regular school program if given a year or two of special preparation.

(5) Experimental Classes for Special Learning Disabilities. The Minneapolis Public Schools, in cooperation with the State Department of Education, have been conducting some pilot classes for children showing specific and severe learning disabilities of various types.

(6) The Sheltering Arms Projects. The Sheltering Arms is a private charitable organization working in cooperation with the Minneapolis Public Schools. Extensive studies of trainable and educable retarded children and their families are under way. Psychological studies, student training, community education, parent education, and volunteer services for the retarded are among projects now active, as are also attempts to develop improved curricula and improved methods of evaluating behavioral adjustment.

(7) Studies by the Staff of the Institute of Child Development, University of Minnesota. Professor Harold Stevenson has a grant from the National Institute of Mental Health to support studies of learning and perception in mentally retarded children.

(8) Owatonna Follow-up. A Federal Office of Education grant has assisted Professor Maynard Reynolds to follow the destinies of children after the completion of their training at the Owatonna State School.

(9) Psycho educational Research Laboratory at Cambridge State School and Hospital. A laboratory for research on discrimination learning, language development, and other learning problems has been established at the Cambridge State School and Hospital, in cooperation with the Special Education Department of the University of Minnesota. The Department of Public Welfare and the Minnesota Association for Retarded Children have assisted in the development of this project.

Other state projects, supported very modestly by the various state

institutions, are being carried out by Dr. Howard Davis, Nathan Mandell, Tong-Me Choo, Arnold Madow, and others.

The Advisory Committee has given particular attention to the State Mental Health Research Grant. This is the core research grant provided by the people of Minnesota. This grant was $100,000 per year for the 1961-63 biennium; of course, the total sum is not restricted to work in mental retardation. This year, $26,380 of the total was awarded in three grants for work in mental retardation. The work of Dr. Heinz Bruhl at Faribault on phenylketonuria was supported to the extent of $7,553, and Dr. Franz Halberg at the Cambridge State School and Hospital was granted $14,774. A modest sum of $4,103 was used by the Central Office to employ a consultant who provides data gathering and analysis services for any state hospital on request. This sum, of course, is inadequate for the employment and retention of a fully competent research scientist.

In view of present day research costs, one can expect little significance to result from an annual expenditure of only $26,380. At the state level, the taxpayers are spending only some tiny fraction of 1% of the total cost of mental retardation for research in the field. We cannot afford to spend so little on research. Although the State Hospitals are short of competent research men, the State should clearly provide more generous support for the efforts of the few able men available. According to the summaries of some of the projects now active, it appears that much of the support for the research comes from the "local general budget and out of the researchers' pockets." This is poor economy.

Problems and Needs in Research

1. Lack of research personnel. The lack of competent research personnel is, at this point, perhaps the most crucial of all problems in research in mental retardation. Long ago, the National Association for Retarded Children recognized that not lack of funds, but rather the lack of competent and interested personnel was the most crucial deficit. Consequently, the NARC has invested practically all of its research funds in career fellowships of generous amounts.

At the University of Minnesota, a federally supported program is in operation for students in training for leadership positions in the field of special education. The major orientation of this program is toward leadership of practical programs in special education. It is unlikely that this program will encourage very many people to enter research in mental retardation, as they will take teaching or administrative positions upon receiving their degrees .

There is also a state stipend program in social work and psychology. About $22,000 is available for training in social work and $20,500 for training in psychology. The stipends are not restricted to the field of mental retardation and therefore do not provide many fellowships each year for this specific field. This fund, if expanded, might make a significant contribution toward preparation of research personnel.

2 . Facilities for research. A laboratory for research on psychoeducational problems is now nearing completion at the Cambridge State School and Hospital. A similar facility is planned at Faribault. Facilities for medical research in mental retardation are in short supply in the state of Minnesota.

A major problem of research facilities is that the present state hospitals are too remote from the Twin Cities to interest University and other research staff in working at them in intensive fashion. Wisconsin has solved this problem by establishing a research hospital for the retarded near the University of Wisconsin at Madison. This action paid off handsomely for them at once. In the absence of this central research hospital, the discovery by Dr. Klaus Patau of a number of the chromosomal abnormalities responsible for previously unidentified types of mental retardation probably would not have occurred. The research atmosphere there is most exciting and highly productive.

Recommendations Pertaining to Research

XXIV. IT IS RECOMMENDED THAT ALL RECEIPTS FROM CHARGES TO INDIVIDUALS, GUARDIANS, AND RELATIVES OF THE MENTALLY RETARDED BE DEDICATED TO A RESEARCH AND DEVELOPMENT FUND. The income to the State Department of Public Welfare from these sources in the period July 1, 1961 to June 30, 1962, was $310,723. This represents an increase of nearly $100,000 in income over the

preceding year, the increase being accounted for by the changes in the charges plan made effective by the 1961 state legislature. It is believed that these funds should be administered by the Department of Public Welfare with the advice of an advisory committee on research in mental retardation. The following specific kinds of activities are suggested:

a. The employment of a competent research scientist by the Department of Public Welfare to give leadership to the development of research programs in state institutions and in other facilities of the state serving the retarded.

b. The support of special intensive research projects in institutions designed to improve operation of selected aspects of the institutional program. The committee has become greatly concerned with the lack of innovation in institutional programming and believes that we must find ways to encourage new and more effective methods of education and treatment for the retarded. Consideration should also be given to the employment of research scientists in educational psychology in each of the state institutions.

c. The funds should be used to support a number of stipends for graduate students at the University of Minnesota who wish to train for research positions in the field of mental retardation. The fellowships should be unrestricted as to discipline.

d. The funds should be used to support special research projects on prevention and on other topics, such as follow-up studies of retarded children who have attended special classes in the public schools. We are quite ignorant of their ability to adjust to the community as adults, their employment records, their marriage and reproductive patterns, and the proportion who are eventually institutionalized.

It is difficult to attract and retain research personnel of high caliber without offering them some assurance of continuing, long-range support of their research programs . Research results cannot be guaranteed in advance; in the long run, negative findings may be of equal or even greater value than positive findings. Neither is it possible with all research projects to put them on a definite time schedule with completion guaranteed for a specific date. Careful selection of research personnel, and careful appraisal of proposed research undertakings by qualified judges, have proven to be effective techniques for insuring that the projects accepted for support are worthwhile. Such procedures make possible continuing support of creative, well trained, qualified scientists who can then with some confidence devote themselves to research careers. We believe the above recommendation, if implemented would put Minnesota in good position to develop a strong research

program. It might be expected that if the State makes this investment, other money would come into the State to double and treble the investment.

XXV. IT IS RECOMMENDED THAT, AS PART OF LONG RANGE PLANNING, CONSIDERATION BE GIVEN TO ESTABLISHING A CENTRAL RESEARCH HOSPITAL IN THE TWIN CITIES AREA. Placing such an institution where the research workers are located will be most profitable in terms of results.

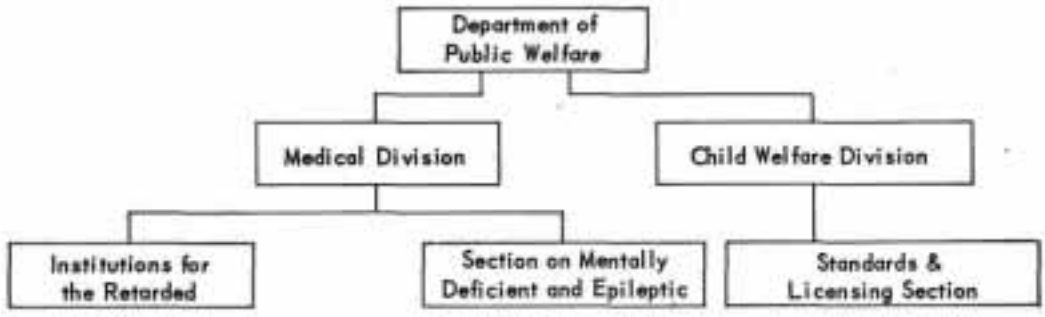
Summary

Minnesota has made very little investment in research in the field of mental retardation. It is believed that such investment should be substantially increased for purposes of finding means of preventing mental retardation and of improving programs for the retarded. The committee suggests a change in statutes governing "charges", to dedicate all receipts from individuals, guardians and relatives to a research and development fund. Minnesota is in a strategically advantageous position to become a major center for research in the field if the State establishes the basic research support program as recommended.

CHAPTER VI. ADMINISTRATION AND PERSONNEL PROBLEMS

Publicly supported services to the mentally retarded in Minnesota are primarily the responsibility of the State Departments of Public Welfare, Health, and Education. Recommendations pertaining to the Department of Education have been included in Chapter III.

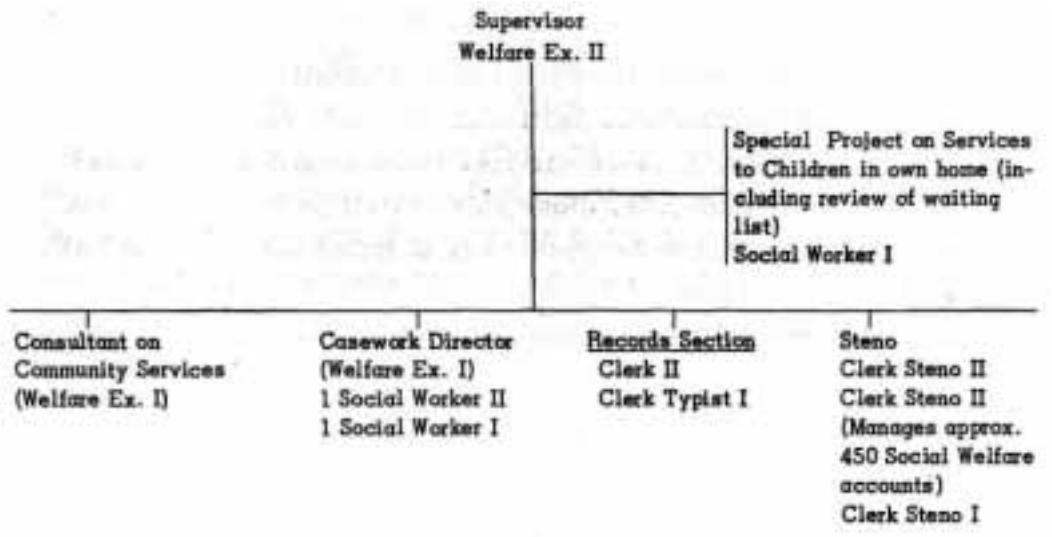
In the Department of Public Welfare, the Medical Division carries the major responsibility. The Child Welfare Division is responsible for licensing and supervision of boarding homes, day care centers, and group care facilities. Within the Medical Division, the Section for Mentally Deficient and Epileptic is assigned the responsibility for institutional placement and for the development of community services. The organization of the Department of Public Welfare, as it pertains to programs for the mentally retarded, is represented in the chart below:



Staffing and Coordination within the Department of Public Welfare

The Department of Public Welfare program for the retarded involves more than 10,000 committed retarded persons, 6,400 of them in institutions and 782 in boarding homes or private group care facilities. The committee believes that the department lacks the staff necessary to perform its duties to these many individuals. The Section for Mentally Deficient and Epileptic is staffed by one supervisor and five other professional staff members. The organization of the section is as follows:

SECTION FOR MENTALLY DEFICIENT AND EPILEPTIC



The extensive program of this section requires more adequate staffing. The committee believes that some everyday problems and some aspects of long-range planning have been bypassed and delayed because of lack of staff.

Responsibilities delegated to the Section by the Commissioner of Public Welfare are as follows:

a. To admit service of notices or summons issued by courts; issue orders to apprehend and convey mentally deficient per sons or epileptics committed as wards to a certain destination.
b. To issue orders to sheriffs to take persons committed as men tally deficient or epileptic to institutions .
c. To give consent to the furnishing of any necessary medical or surgical care required by wards committed to my guardianship as Commissioner of Public Welfare.
d. To authorize autopsies upon the bodies of wards committed as mentally deficient or epileptic.
e. To sign applications for old age and survivor's insurance and applications to the Veteran's Administration for benefits to which a ward may be entitled.
f. To petition courts for discharge of guardianship or restoration to capacity of wards committed as mentally deficient or epileptic.

g. To consent to the marriage of mentally deficient persons.

h. To authorize the withdrawal of monies from the Social Welfare Fund.

Definition of duties of the Section for Mentally Deficient and Epileptic and of the Standards Section of the Child Welfare Division needs to be clarified. Because services to the retarded are divided between these two divisions, close coordination is necessary. The committee has considered the possibility of bringing together in one new division all programs of the Department of Public Welfare concerned with mental retardation, but has decided not to recommend such action at this time.

Superintendents of state institutions for the retarded have authority to conduct their programs within the framework of the state laws and Department of Public Welfare regulations and policies. This individual authority will sometimes result in variations in programs in our four state institutions; this, however, is desirable, since the institutions differ in size and location and present different problems.

County Public Health Nursing Services

County Public Health Nurses play a vital role in services to the mentally retarded. The nurse, probably more than any other professional person, visits the homes of the mentally retarded and is able to observe the child in his home situation and give assistance to parents with problems of care, feeding, training, and other aspects of the child's life.

XXVI. IT IS RECOMMENDED THAT STATE AID FOR PUBLIC HEALTH NURSES IN ALL PARTS OF THE STATE BE INCREASED FROM $1,500 TO $3,000 FOR THE FIRST NURSE EMPLOYED AND STATE AID BE GRANTED ON A DECLINING SCALE FOR EACH ADDITIONAL NURSE EMPLOYED. THIS WILL ENCOURAGE THE EXPANSION OF PUBLIC HEALTH NURSING SERVICES.

Inter-Agency Committee on Mental Retardation

This committee, organized in 1958, has representation from the Departments of Health, Public Welfare, and Education, and Associations for Retarded Children. Its purposes are coordination and exchange of

information.

Through this committee, those concerned with mental retardation in Minnesota have become better acquainted. There is opportunity at each bi-monthly meeting for members to be brought up to date on latest plans of each agency.

The Inter-Agency Committee is the basis for what could be a strong coordinating body. However, agency plans are not brought to the committee for discussion or advice before instigation. Usually only general plans or progress are reported.

To achieve truly effective inter-departmental coordination, the committee believes that there should be a permanent committee composed of individuals having direct operational responsibilities in the several departments, including:

Department of Public Welfare - Director of Children's Mental Health Services
Department of Education - Director of Special Education
Department of Health - Director of Maternal and Child Health Services Representative of the
Governor's office

The Governor should officially appoint such a committee and thereby give it definite authority for coordination.

One specific project needing attention by the Inter-Agency Committee is the revitalization of county Inter-Agency committees. Such committees were recommended several years ago and progress was made for a brief period, but they now appear to be languishing. The county committees offer much hope for the development of local programs for trainable retarded children.

Charges

The 1961 Legislature made a major change in its policy of charges to responsible relatives and counties for the care of the mentally retarded in state institutions. Previously, the charge to relatives was 52% of the average annual per capita cost, if they were able and willing to pay. The charge to the counties was $80.00 per year. The present charge is $10.00 per month to relatives and/or counties. Charges to relatives are based on ability to pay. No person with a

gross annual income of less than $4,000.00 is required to pay anything. County payments are reduced by the amount paid by relatives. Patients are responsible for the entire per capita cost if they are able to pay. This new Charges Law appears to be working well. No change is recommended, except that funds received should be used to support research. (See Chapter V on Research for further discussion on this recommended change.)

Guardianship

Minnesota's Guardianship Law was enacted in 1917. Mentally retarded persons may be declared incompetent by the county probate court and placed under the guardianship of the Commissioner of Public Welfare. Obtaining guardianship does not require that the individual be placed in a state institution. However, guardianship has been a requirement for institutional placement by policy of the Department of Public Welfare.

From time to time, there has been discussion of a policy of voluntary admission to institutions for the mentally retarded, without the requirement of guardianship. One view is that requiring guardianship as a condition for institutionalization confuses two independent . factors: the need for guardianship, and the need for (sometimes temporary) training, treatment, or care in a residential facility. The mentally retarded child, like all other children, has a natural guardian— his parent or parents. It has been asked whether the family with a retarded child who needs care in a residential facility for the retarded should be treated differently than one who might need services in a residential facility caring for the physically disabled.

The committee does not recommend a change in guardianship statutes or policies at this time, but -

XXVII. IT IS RECOMMENDED THAT CAREFUL STUDY BE MADE TO DETERMINE WHETHER SOME RETARDED INDIVIDUALS NOT UNDER GUARDIANSHIP SHOULD BE ADMITTED TO INSTITUTIONS, AND THAT THE DEPARTMENT OF PUBLIC WELFARE CONSIDER WAYS OF GIVING SUPERVISION AND AID WITHOUT GUARDIANSHIP. WHEN DESIRED BY PARENTS, GUARDIANSHIP SHOULD ALWAYS BE AVAILABLE.

Personnel

Personnel employed on Civil Service status are given permanent tenure following satisfactory performance for an initial probationary period of six months. For professional personnel, this period of time is too short. An example of the difficulty may be cited in the case of teachers employed through Civil Service. Teachers often reach the end of the six months' probationary period during a school year when it is all but impossible to obtain a replacement for someone who would otherwise be judged inadequate—hence the inadequate person is retained.

XXVIII. IT IS RECOMMENDED THAT THE PROBATIONARY PERIOD FOR ALL TEACHERS EMPLOYED UNDER CIVIL SERVICE BE CHANGED FROM SIX MONTHS TO TWO YEARS AND THAT STUDIES BE MADE OF PROBATIONARY POLICIES AND PROCEDURES FOR ALL OTHER CLASSES OF PROFESSIONAL PERSONNEL.

Present salary policies provide only five salary "steps" for staff members. Since increments at the various steps are quite small, there is a very narrow range between beginning salary and ceiling salary. Such a narrow range of salaries, within classes, is not in conformity with general practice in the state. Teachers in the public schools, for example, now usually receive yearly salary increments, within class, for a period of about twelve years .

XXIX. IT IS RECOMMENDED THAT POLICIES CONCERNING PROFES SIONAL PERSONNEL EMPLOYED UNDER CIVIL SERVICE BE RE VIEWED WITH THE GOAL OF INCREASING THE RANGE OF SALARIES WITHIN CLASSES.

At present, no distinction in certification standards is made by the State Department of Education between teachers of trainable retarded children and teachers of educable retarded children.

XXX. IT IS RECOMMENDED THAT THE DEPARTMENT OF EDUCATION INITIATE A STUDY TO DEFINE MORE ADEQUATELY NECESSARY QUALIFICATIONS AND CERTIFICATION STANDARDS FOR TEACHERS OF EDUCABLE AND TEACHERS OF TRAINABLE RETARDED CHILDREN.

Summary

The committee finds that the general structure of central administrative services in the field of mental retardation is potentially effective. Recommendations have been made to strengthen the Section for Mentally Deficient and Epileptic, the Inter-Agency Committee on Mental Retardation, certain policies of the Civil Service Department and Public Health Nursing Services. The committee has noted the need for further study of guardianship statutes and policies.

CHAPTER VII RECOMMENDATIONS OF THE COMMITTEE

I It is recommended that a Legislative Interim Commission and/or a Governor's Advisory Committee be established to study and make recommendations concerning future programs for the mentally retarded.

II. It is recommended that the Department of Education seek and be authorized permanently to employ four additional consultants in special education. These consultants should be placed in outlying communities of the state and be given regional responsibilities to assist in the development and supervision of school programs for handicapped children (including the retarded) in small school districts .

III. It is recommended that the present statutes 124.32 and 124.33, pertaining to education of the handicapped, be amended to provide state reimbursement for essential personnel in special education programs at a level of two-thirds salary without limitations.

IV. It is recommended that appropriation requests of the several state colleges and the University of Minnesota, as they pertain to training programs for teachers of the mentally retarded, be given favorable consideration.

V. It is recommended that the Division of Special Education and Re habilitation of the State Department of Education be authorized and funded to employ a special consultant who has professional background in both special education and rehabilitation fields to provide leader ship in the development of school-work programs for mentally retarded youth.

VI. It is recommended that appropriations for state matching funds for day activity centers be increased to $215,000 for the 1963-65 biennium.

VII. It is recommended that Minnesota Statute 252.15 be amended to provide advance payments rather than reimbursements by the state for expenses in operating day activity centers.

VIII. It is recommended that the feature of the present law which excludes parent fees as a source of local funds to be matched by the state be amended to allow use of such fees as a local resource.

IX. it is recommended that the Department of Public Welfare give particular attention to the development of day activity centers for adolescent and young adult retardates. This aspect of community programming should be highlighted by every suitable means along with further development of centers for children.

X. it is recommended that the Department of Public Welfare, under Minnesota Statute 252.15, give leadership to the development of one or more pilot centers for nursery school-age retarded children.

XI. It is recommended that the Department of Public Welfare be authorized and funded to employ a special consultant to assist in development of day activity centers .

XII. It is recommended that the legislature appropriate funds for reimbursement to counties of up to 50% of the cost of boarding care for mentally retarded wards of the State Commissioner of Public Welfare.

XIII. It is recommended that the staff complement of the Division of Vocational Rehabilitation be substantially increased, with a view toward increasing services to the mentally retarded.

XIV. It is recommended that the Division of Vocational Rehabilitation prepare a plan and specific proposal for development and partial support of community sheltered workshops by the State Government through the Division of Vocational Rehabilitation. It is appropriate that development of such facilities be a cooperative venture by state and local agencies. Supports by the state should include grants for a period of initial development and operation of approved facilities plus continuing aid through "Fees for Service" provided to mentally retarded individuals.

XV. It is recommended that the Department of Public Welfare initiate a demonstration project on sheltered living facilities in the community for older retarded persons.

XVI. It is recommended that the Department of Public Welfare, in consultation with the State Departments of Health and Education, develop a detailed and explicit statement of standards for state institutions and a scheduled program for meeting those standards as a guide for the legislature.

XVII. It is recommended that the legislature formally recognize the magnitude of the problem of residential care and adopt a long range program with the goal of providing care at the level of other progressive states.

XVIII. It is recommended that, as a vitally necessary step towards bringing the three major Minnesota institutions for the mentally retarded up to an adequate level of "colony" type care, each of them be authorized enough additional positions at a minimum to bring its overall staff-patient ratio to the U.S. average level of 1:3.2.

XIX. it is recommended that fifteen additional positions requested by Cambridge State School and Hospital for its experimental intensive therapy unit be granted.

XX. It is recommended that Minnesota go beyond the colony level of care which meets the needs of only 15% of the patients, and that the Governor and the legislature carefully appraise Dr. Bartman's plans and support them to the fullest extent possible.

XXI. it is recommended that the Owatonna State School be authorized 33 new staff positions in 1963.

"XXII. It is recommended that priority consideration be given to the construction of a new Food Service and Handling Building at Faribault State School and Hospital.

XXIII. It is recommended that priority consideration be given to the construction of a School and Rehabilitation Therapies Building at Brainerd State School and Hospital.

XXIV. It is recommended that all receipts from charges to individuals, guardians, and relatives of the mentally retarded be dedicated to a re search and development fund.

XXV. It is recommended that, as part of long range planning, considera- tion be given to establishing a central research hospital in the Twin Cities area.

XXVI. It is recommended that state aid for public health nurses in all parts of the state be increased from $1, 500 to $3, 000 for the first nurse employed and state aid be granted on a declining scale for each addition-

al nurse employed. This will encourage the expansion of public health nursing services.

XXVII. It is recommended that careful study be made to determine whether some retarded individuals not under guardianship should be admitted to institutions, and that the Department of Public Welfare consider ways of giving supervision and aid without guardianship. When desired by parents, guardianship should always be available.

XXVIII. It is recommended that the probationary period for all teachers employed under civil service be changed from six months to two years and that studies be made of probationary policies and procedures for all other classes of professional personnel.

XXIX. It is recommended that policies concerning professional personnel employed under civil service be reviewed with the goal of in creasing the range of salaries within classes.

XXX. It is recommended that the Department of Education initiate a study to define more adequately necessary qualifications and certification standards for teachers of educable and teachers of trainable retarded children.

APPENDIX A
A COMPILATION BY COUNTIES OF INFORMATION REGARDING THE MENTALLY RETARDED IN MINNESOTA

COUNTY	Population, 1960 Census	Estimated Number of Retarded (2)				M.R. on (3) Books of State Inst. and on Waiting List June 30, 1961	Special Classes for M.R. Fall, 1961 (4)				Non-Profit Day Schools & Day Care Centers	
	Total Pop. (1)	Tot. Care (.1%)	Train. (.4%)	Educ. (2.5%)	Total (3%)		Educ. Classes	Pupils Enr.	Train. Classes	Pupils Enr.	Day Schools and Centers	Total Part.
Aitkin	12,162	12	48	304	364	55	2	28				
Anoka	85,916	86	344	2,147	2,577	92	10	106				
Becker	23,959	24	95	599	719	65	3	35	1	7		
Beltrami	23,425	23	94	586	703	82	2	21				
Benton	17,287	17	69	432	518	71	2	27				
Big Stone	8,954	9	36	224	269	32	2	13	1	4		
Blue Earth	44,385	44	178	1,110	1,332	98	4	53	2	15	1	5
Brown	27,676	28	111	691	830	75	2	19	1	5		
Carlton	27,932	28	112	698	838	56	3	32			1	7
Carver	21,358	21	85	534	640	50			1	7		
Cass	16,720	17	67	418	502	80	2	23				
Chippewa	16,320	16	65	408	489	47	3	21				
Chisago	13,419	13	54	335	402	37	1	7				
Clay	39,080	39	156	977	1,172	56	6	47	2	10	1	14
Clearwater	8,864	9	35	222	266	20	1	14				
Cook	3,377	3	13	84	100	9						
Cottonwood	16,166	16	65	404	485	42	2	21	1	6		
Crow Wing	32,134	32	129	803	964	79	4	57				
Dakota	78,303	78	313	1,958	2,349	127	9	94	1	8		
Dodge	13,259	13	53	331	397	39	1	4	1	8		
Douglas	21,313	21	85	533	639	42	3	32				
Faribault	23,685	24	95	592	711	61	3	35				
Fillmore	23,768	24	95	594	713	47	2	29				
Freeborn	37,891	38	152	947	1,137	73	3	39	1	8	2	17
Goodhue	33,035	33	132	826	991	71	2	22				
Grant	8,870	9	35	222	266	24						
Hennepin	842,854	843	3,371	21,071	25,285	1,426	132	1,920	6	57	6	150

COUNTY	Population, 1960 Census	Estimated Number of Retarded (2)				M.R. on (3) Books of State Inst. and on Waiting List June 30, 1961	Special Classes for M.R. Fall, 1961 (4)				Non-Profit Day Schools & Day Care Centers	
	Total Pop. (1)	Tot. Care (.1%)	Train. (.4%)	Educ. (2.5%)	Total (3%)		Educ. Classes	Pupils Enr.	Train. Classes	Pupils Enr.	Day Schools and Centers	Total Part.
Houston	16,588	17	66	415	498	24	2	18				
Hubbard	9,962	10	40	249	299	40	1	13				
Isanti	13,530	14	54	338	406	29	2	16	1	3		
Itasca	38,006	38	152	950	1,140	72	7	89				
Jackson	15,501	16	62	387	465	36	2	15	1	9		
Kanabec	9,007	9	36	225	270	23	1	9				
Kandiyohi	29,987	30	120	750	900	49	3	28			1	9
Kittson	8,343	8	33	209	250	28	3	20				
Koochiching	18,190	18	73	455	546	62	4	41	1	8		
Lac Qui Parle	13,330	13	53	333	399	26	1	9				
Lake	13,702	14	55	343	412	17	1	9				
Lake of the Woods	4,304	4	17	108	129	7						
Le Sueur	19,906	20	80	498	598	44						
Lincoln	9,651	10	39	241	290	28						
Lyon	22,655	23	91	566	680	53	3	24				
Mahnomen	6,341	6	25	159	190	27						
Marshall	14,262	14	57	357	428	43	2	17				
Martin	26,986	27	108	675	810	58	3	28			1	7
McLeod	24,401	24	98	610	732	51	2	20				
Meeker	18,887	19	76	472	567	32	3	33	1	4	1	11
Mille Lacs	14,560	15	58	364	437	34	4	32				
Morrison	26,641	27	107	665	799	84	2	34				
Mower	48,498	49	194	1,212	1,455	85	7	99	1	5	2	27
Murray	14,743	15	59	369	443	28	1	5	1	5		
Nicollet	23,196	23	93	580	696	29			1	7		
Nobles	23,365	23	93	584	700	52	1	10				
Norman	11,253	11	45	281	337	40						
Olmsted	65,532	66	262	1,638	1,966	101	7	81			1	14
Otter Tail	48,960	49	196	1,224	1,469	113	9	81	2	11		
Pennington	12,468	12	50	312	374	22	1	5	1	6		
Pine	17,004	17	68	425	510	62	1	5				
Pipestone	13,605	14	54	340	408	29	1	12	1	9		
Polk	36,182	36	144	905	1,085	91	6	59				

COUNTY	Population, 1960 Census	Estimated Number of Retarded (2)				M.R. on (3) Books of State Inst. and on Waiting List June 30, 1961	Special Classes for M.R. Fall, 1961 (4)				Non-Profit Day Schools & Day Care Centers	
	Total Pop. (1)	Tot. Care (.1%)	Train. (.4%)	Educ. (2.5%)	Total (3%)		Educ. Classes	Pupils Enr.	Train. Classes	Pupils Enr.	Day Schools and Centers	Total Part.
Pope	11,914	12	48	298	358	28	1	8				
Ramsey	422,525	423	1,690	10,563	12,676	953	66	1,036	4	70	5	172
Red Lake	5,830	6	23	146	175	25						
Redwood	21,718	22	87	543	652	55	1	12	2	17		
Renville	23,249	23	93	581	697	68	4	38				
Rice	38,988	39	156	975	1,170	100	5	56				
Rock	11,864	12	47	297	356	17	3	28			1	7
Roseau	12,154	12	49	304	365	40						
St. Louis	231,588	232	926	5,790	6,948	501	30	432	7	79		
Scott	21,909	22	88	548	658	57	3	38				
Sherburne	12,861	13	51	322	386	36						
Sibley	16,228	16	65	406	487	29	1	10				
Stearns	80,345	80	321	2,009	2,410	199	8	76	1	11		
Steele	25,029	25	100	626	751	33	1	6				
Stevens	11,262	11	45	282	338	23	1	12				
Swift	14,936	15	60	373	448	40			1	5		
Todd	23,119	23	92	578	693	68	4	35				
Traverse	7,503	8	30	188	226	28	2	23				
Wabasha	17,007	17	68	425	510	40						
Wadena	12,199	12	49	305	366	29	1	13	1	6		
Waseca	16,041	16	64	401	481	43	2	12				
Washington	52,432	52	210	1,311	1,573	87	9	122				
Watonwan	14,460	14	58	362	434	41	1	8			1	7
Wilkin	10,650	11	43	266	320	34	2	20	1	5		
Winona	40,937	41	164	1,023	1,228	83	5	53	1	11		
Wright	29,935	30	120	748	898	58	2	18				
Yellow Medicine	15,523	16	62	388	466	40	2	16				
TOTALS	3,413,864	3,414	13,655	85,347	102,416	7,230	438	5,583	47	406	24	447

(1) Taken from Final Report, U.S. Bureau of the Census
(2) Breakdown by Minnesota Dept. of Welfare
(3) Report of Section on Mental Deficiency and Epilepsy, Department of Public Welfare, 8-28-62
(4) Class Lists - 1961-62 Division of Special Education, Department of Education, Minneapolis Statistics - Dr. Evelyn Deno, Consultant on Special Education & Vocational Rehabilitation, Minneapolis Public Schools

APPENDIX B

Estimated Cost of Amending Minnesota Statutes 124.32 & 124.33 to Allow for State Reimbursement of Essential Personnel in Special Education at a Level of Two-Thirds Salary Without Limitations

1960-61 Statistics*

1. Total Cost Essential Personnel in Special Education Programs	$5,322,593
2. Total State Aid for Essential Personnel - Present Law	2,997,926
3. Total State Aid for Essential Personnel - If Based on Two-Thirds of Salary Without Limitations	3,548,395
Difference in Cost - (3) minus (2)	$ 550,469

1963-64 Estimated Statistics**

1. Total Cost Essential Personnel in Special Education Programs	$6,818,168
2. Total State Aid for Essential Personnel - Present Law	3, 840,302
3. Total State Aid for Essential Personnel - If Based on Two-Thirds of Salary Without Limitations	4,545,445
Difference in Cost - (3) minus (2) (Cost of Amendment, 1963-64)	$ 705,143

* Statistics compiled from worksheets for Annual Report, 1960-61, Minnesota Department of Education, Division of Special Education

** Statistics projected from report of Minnesota Department of Education, Division of Special Education, Special Education Reimbursement Aids for the Present Biennium and Recommended Appropriation Requests for the 1963-65 Biennium.

APPENDIX C

Small Residential Facilities for Intellectually Handicapped Persons

Dr. Richard Bartman, Director

Children's Mental Health Services
Minnesota Department of Public Welfare

Appropriate living situations for intellectually handicapped persons are unusually difficult to conceptualize and define. The place of an intellectually handicapped person in society has varied over the centuries and has always been determined as much by fear, frustration and anger, as by love, acceptance and compassion. The greater the deviation from average that the intellectually handicapped person manifests, and the greater his or her needs for economically expensive care, the greater has been societies efforts to conceal him or her from view. This reaction is based, and perhaps rationalized, by valuing an individual primarily in terms of his or her economic usefulness. This is expressed occasionally in case conferences by saying that the "therapeutic" goal is to "make the patient a useful member of society" Intellectually handicapped persons have been placed in facilities called homes, colonies, training schools, and hospitals. Whatever these facilities have been called, the net effect has been the extrusion of such persons from ordinary community contacts into facilities which regardless of name, all share the characteristics of over-crowding, under-staffing, great size, "herd" living, and emotional bleaching.

During very recent years, largely through the efforts of the national, state and local Associations for Retarded Children, there have been and are indications that communities are ready to incorporate certain intellectually handicapped persons. This is evidenced by laws relating to special education, development of day-care centers, increase in numbers of sheltered workshops which employ retarded persons, and the establishment of various federal and state committees to study the plight of intellectually handicapped persons.

This metamorphosis of attitude has led to an appraisal of

institution populations that is indeed agonizing. One finds literally hundreds of adults who when seen in the light of current understanding and facilities need not have spent 20, 30 or 40 years living a colorless or at best pastel existence. Not only do they have the problems which originally lead to their hospitalization, but they also have problems produced by the circumstances under which they have been forced to live.

The presence of this population in the institutions for retarded, although it currently comprises only 15% of the total institution populations, has produced an illusion that the sole need of the retarded person in an institution is for a home. Per diem rates, consequently, have become entrenched at a level that can provide this and no more. For this reason, the remaining 85% of the population receives grossly inadequate pediatric, psychiatric, medical and nursing care. It is, therefore, in the best interests both of those persons who need not be in the institution, and of those who truly need highly specialized professional care to develop satisfactory extra-institutional facilities for the former group. In the past attempts have been made to provide for some of these persons through the use of foster homes, boarding homes, and half-way houses. These facilities have not been particularly successful probably for two main reasons . First, each of these facilities by definition imposes various expectations on the persons living in them. For example, the person living in a boarding home is usually expected to be able to hold a regular job, and a person in a half-way house is expected to in a fairly short period of time, be able to find totally independent living arrangements . Secondly, adequate provisions usually are not made for medical care, psychological and psychiatric studies, recreational activities, and support in making the sometimes frightening and confusing transition from institutional life to community life.

To solve this complex of problems, what is needed are small living units for no more than eight persons, located in areas where the required professional services are available when needed. For example, a mental health center could be a resource for psychiatric and psychological services, recreation could be provided in part by

a community recreation worker, medical services on a contract basis with a local medical society, vocational training, if indicated, by a sheltered workshop or adult special education program, and volunteer services by local ARC groups and service clubs. Overall integration and supervision of such programs could be provided by a community services consultant who would be responsible for four or five such facilities.

APPENDIX D

PERSONNEL REQUESTS OF THE INSTITUTIONS FOR THE MENTALLY RETARDED

CAMBRIDGE STATE SCHOOL AND HOSPITAL

Cambridge State School and Hospital's most current personnel requests for new positions are:

Classification	Number Requested
Ass't. Hospital Superintendent	1
Psychiatrist II	2
Psychiatric Aide I	74
Registered Nurse II	14
Custodial Worker I	41
Food Service Supervisor	15
Hospital Social Worker	3
Psychologist II	3
Laundry Worker	6
Plant Maint. Engineer	1
Clerk Typist II	3
Registered Nurse IV	1
Physical Therapist I	1
Occupational Therapist II	1
Special Teacher (Range 28)	1
Dental Assistant	1
General Repairman	1
Patient Activities Ass't. I	8
Patient Placement Agent	1
Barber	1
Nurse Instructor	1
Instructional Supervisor	1
Dietitian I	1
Patient Activities Leader II	1
Patient Activities Leader I	1
Plant Operations Superintendent	1
Registered Nurse III	1
Special School Counselors	10
Hospital Social Worker	1
Psychologist I	1
Registered Nurse II	1
Occupational Therapist	1
Special Teacher	1
	186

Submitted July 10, 1962, by Mr. John H. Stocking, Assistant Superintendent

FARIBAULT STATE SCHOOL AND HOSPITAL*

Faribault State School and Hospital's most current personnel requests for new positions are:

Classification	Number Requested
Medical Specialist II	2
Medical Technologist II	1
Psychologist II	3
Social Worker II	2
Social Worker I	1
Patient Activities Leader I	1
Patient Placement Agent	1
Occupational Therapist I	2
Patient Activities Assistant II	2
Patient Activities Assistant I	2
Barber	1
Cosmetic Therapist	1
Special Teacher	6
Physical Therapist II	1
Physical Therapist I	2
Registered Nurse II	5
Psychiatric Aide II	12
Psychiatric Aide I	122
Cook I	6
Baker I	2
Painter	1
Carpenter	1
Mason	1
Herdsman I	1
Laundry Worker	9
Custodial Worker I	14
Clerk I	1
Clerk Typist I	8
Total	211

Submitted July 6, 1962, by M. E. Krafve,
Assistant Superintendent

* The above requests for additional staff do not necessarily represent their final request. Faribault State School and Hospital did not have sufficient time to re-develop its personnel requests in agreement with the Department of Public Welfare's plan of reflecting one-third of total needs . As of this time, its requests have not been reviewed by the Department of Public Welfare.

BRAINERD STATE SCHOOL AND HOSPITAL

Brainerd State School and Hospital's most current personnel requests for new positions are:

Classification	Number Requested
Chaplain	3/4
Physician II	1
Dentist	1
Rehabilitation Therapies Coordinator II	1
Psychologist II	2
Occupational Therapist II	2
Patient Placement Agent	1
Patient Activities Leader I	2
Patient Activities Assistant II	3
Dental Hygienist	1
Electroencephalograph Operator	1
Patient Activities Assistant I	1
Special Teacher - Range 29	1
Patient Activities Leader II	1
Hospital Social Worker	3
Registered Nurse IV	1
Registered Nurse III	5
Registered Nurse II	11
Registered Nurse I	2
Nurse Instructor	1
Surgical Nurse II	1
Surgical Nurse I	1
Psychiatric Aide I	149
Barber	1 3/4
Cosmetic Therapist	1 1/4
Psychiatric Aide II	8
Dietician II	1
Personnel Officer	1
Plant Maintenance Engineer	1
Painter	1
Cook II	2
Baker I	1
Tailor Shop Foreman	1
Clerk Steno II	2
Bookkeeping Machine Clerk II	1
Laundry Supervisor II	3
Janitor	5
Clerk Steno I	3
Custodial Worker I	13
Food Service Supervisor, ½ Time (10)	5
Laundry Worker	2
Cook I	1
Food Service Worker	5
Food Service Worker, ½ Time (8)	4
Total	255 3/4

Submitted August 3, 1962,
by Harold Peterson, Superintendent

OWATONNA STATE SCHOOL

Owatonna State School's most current personnel requests for new positions are:

Classification	Number Requested
Recreational Therapist	2
Custodial Worker I	1
Houseparents I	13
Hospital Social Workers	3
Psychologist III	3
Clerk Steno I	2
Industrial Therapist	1
Special Teachers	4
Plant Operations Superintendent	1
Occupational Therapist	1
Music Therapist	1
Volunteer Coordinator	1
Total	33

Submitted July 13, 1962, by C. M. Henderson, Superintendent

APPENDIX E

"Philosophy" of Staffing Patterns for Institutions for Mentally Retarded Persons

Dr. Richard Bartman, Director

Children's Mental Health Services
Minnesota Department of Public Welfare

If an institution is established to care for persons with disabilities , the staffing pattern should be determined by the nature and extent of the disabilities of those persons admitted to the institution. This statement would appear to be a truism. It is, in fact, a truism if one looks at the staffing patterns of tuberculosis hospitals, general hospitals, private psychiatric hospitals, rehabilitation centers, and special schools. Curiously, however, this is far from the case when one compares the needs of persons in public institutions for the mentally retarded with the staffing patterns provided for them. The recent survey of the patient population in Minnesota's institutions for retarded has clearly shown the broad range of the disabilities that one finds in such facilities, and also demonstrates the remarkable discrepancy between the needs of these patients and the services that are provided for them through current budgetary allotments . This discrepancy is too great to be accounted for by variations in professional opinions. It appears to rest on lack of information on the part of those who have the final say in budgetary allotments which in turn may be related to reluctance to come to grips with such a massive, complex, and costly problem. Another factor is the fact that mental retardation is as much a sociological problem as it is an individual problem. Definitions of mental retardation are relative to cultural values and can change within a decade. Goddard's, Jukes' and Kallikak's myth was eagerly believed a few decades ago and now is equally eagerly discredited. Mentally retarded persons are no longer believed to be the threat to modern civilization. This role, as a matter of fact, has been displaced on to the atomic physicist.

Progress in public institution care is a measure of the ability of

members of society to overcome irrational fears of persons with various kinds of handicaps. Much progress has been made during this century with respect to blindness, deafness, epilepsy, and mild degrees of mental illness and mental retardation. The latter is evidenced by reduced pressures on parents of retarded children to remove them from sight, development of community facilities, and establishment of special education classes. Institutions for retarded today have considerably fewer mildly retarded persons on their rolls. These persons have been largely replaced by children and adults with needs for expensive nursing care, or elaborate educational and psychiatric programs. The concept of the institution as a "protective" colony is changing to that of the school and hospital. This is quite obvious when one looks at the residents of these facilities, but could not be deduced from looking at the budgets. Budgets continue to be based on the concept that the residents are chiefly persons who need "colony" care and would be adequate for this purpose. To actually meet the needs of the residents, however, the per diem should be raised from about $5.00 per day to $8.50 per day. This latter would be close to adequate, and would be a bargain compared with community hospital costs of about $30.00 a day. It is a mystery why no one seriously complains about the latter, but many cannot understand the need for the former.

APPENDIX F Building Priorities at

Institutions for the Mentally Retarded

FARIBAULT STATE SCHOOL and HOSPITAL

	1963		
1.	One 1600 KW Generator	$ 250,000.00	
2.	Replace Roof, Ivy Cottage	10,000.00	
3.	Repair Elevator, Hospital Building	6,000.00	
4.	Replace Roof, Boiler Room	7,500.00	
5.	Additional Facilities, Ivy Cottage Cafeteria	10,000.00	
6.	Loading Docks, Garbage Rooms- nine cottages	27,000.00	
7.	Sprinkler System, Tailor Shop	4,000.00	
8.	Grading & Blacktopping Service Roads	26, 000 .00	
9.	Replacement, Herdsman's Cottage & Garage	20,000.00	
10.	New Central Kitchen	1,250,000.00	
11.	Replacement Dormitory, Male Patients	1,000,000.00	
12.	Replacement Dormitory, Female Patients	1,000,000.00	
13.	Garage for Storing Cars & Trucks	25,000.00	
14.	Two 500 Ton Silos	9,000.00	
15.	Two Pole Type Hay and Straw Storage Sheds	6., 600.00	
16.	Three Concrete Feeding Slabs	1,500.00	
17.	New Wing, Existing Hospital	528,000.00	
18.	Chapel	95,000.00	
19.	Razing Grandview Cottage	3,000.00	
20.	Automatic Heating Controls	35,000.00	
21.	Architectural & Engineering Service	10,000.00	
	Sub Total		$4,232,600.00
	1965		
22.	Replacement, Chippewa Cottage	1,700,000.00	
23.	Toilet & Water Facilities, Patients' Playground	undetermined	
24.	Ventilating Sand Rock Cellar	25,000.00	
25 .	Automatic Heating Controls	25,000.00	
	Sub Total		$1,760,000.00
	1967		
26.	Replacement, Ivy Cottage	1,700,000.00	
27.	Automatic Heating Controls	35,000.00	
	Sub Total		$1,735,000.00
	1969		
28.	Replacement, Hillcrest Cottage	800,000.00	$ 800,000.00
	1971		
29.	Replacement, Poppy Cottage	800,000.00	$ 800,000.00
	Grand Total		$9,418,600.00

CAMBRIDGE STATE SCHOOL AND HOSPITAL

1963

1. Supplemental funds to finish laundry, carpenter and paint shop building	$ 145,000.00	
2. Architectural services for preliminary plans for buildings to be constructed in the year 1965	85,000.00	
3. Construct warehouse	375,000.00	
4. Construct garage for state vehicles, with shop facilities	70,000.00	
5. Repairs and rehabilitation of cottages and other buildings	528,250.00	
6. Addition to employees' dining room plus equipment and enlargement of the kitchen	118,000.00	
Sub-Total		$1,321,250.00

Priority 1965

1. Construct patient buildings	$4,200,000.00	
2. Construct Rehabilitation Center	1,400,000.00	
3. Research Building	500,000.00	
Sub-Total		$6,100,000.00

1967

Item

1. Nurses dormitory together with repair and rehabilitation work of older buildings.

1969

Item

1. All faiths chapel together with repairs and rehabilitation work of older buildings.

1971

Item

1. Repair and rehabilitation work on older buildings at both Cambridge and Lake Owasso.

Grand Total $7,421,250.00

BRAINERD STATE SCHOOL AND HOSPITAL

1.	School Department and Rehabilitation Therapies Building	$1,170,000.00	
2.	Four 108-bed Patient Buildings	3,000,000.00	
3.	Extension of Tunnels to new Buildings	146,000.00	
4.	Roads and parking areas, sidewalks, curbs and gutters	20,000.00	
5.	Extension of landscape	10,000.00	
6.	Extension of Sanitary Sewer System, Water Distribution System, and Storm Water Drainage System	50,000.00	
7.	Extension of Street Lighting	10,000.00	
8.	Addition of Third Boiler	115,000.00	
9.	Completion of Laundry Facilities	60,000.00	
10.	Completion of Dietary Facilities	10,000.00	
11.	Expansion of Water Softening Facility	20,000.00	
	Sub-Total		$4,611,000.00

1965

12.	Three 108-bed Patient Buildings	$2,250,000.00	
13.	Extension of tunnels to new buildings	140,000.00	
14.	Roads and parking areas, sidewalks, curbs and gutters	22,500.00	
15.	Extension of landscaping	10,000.00	
16.	Extension of Sanitary Sewer System, Water Distribution System, and Storm Water Drainage System	58,000.00	
17.	Extension of Street Lighting	10,000.00	
18.	Additional Emergency Generator	40,000.00	
	Sub-Total		$2,530,500.00
	Grand Total		$7,141,500.00

OWATONNA STATE SCHOOL

	1963		
1.	New Cottage Building	$ 350,000.00	
2.	New Service Building	1,100,000.00	
3.	New Addition to School Building	300,000.00	
4.	New Carpenter Shop & Storage Bldg.	68,000.00	
5.	New Paint Shop	40,000.00	
6.	Street & Sidewalk Repair & Construction	33,500.00	
7.	Street Lighting	25,000.00	
8.	Landscaping & Watershed	13,650.00	
9.	Relocate Buildings	6,500.00	
10.	New Garage	21,000.00	
11.	Major Repairs to Cottages and Other Buildings	40,000.00	
12.	Demolition of Old Buildings	20,000.00	
13.	Repairs to Smoke Stack	2,000.00	
	Sub Total		$2,019,650.00
	1965		
14.	Re-roof Administration Building	20,000.00	20,000.00
15.	Clean and Paint Water Tower	5,000.00	5,000.00
	1969		
16.	Re-roof Cottage #12	15,000.00	15,000.00
	1971		
17.	New Cottage Building	370,000.00	370,000.00
	Grand Total		$2,429,650.00