A Report
to the 1973 Minnesota State Legislature
on the Status of Minnesota's
Mentally Retarded Citizens
Residing in State Hospitals.

MINNESOTA DEPARTMENT OF PUBLIC WELFARE

February 1973

I N T R O D U C T I O N

The information contained herein comprises a portion of a presentation prepared for the 1973 Legislature. It is intended to apprise legislators of the status of approximately 4,000 mentally retarded citizens who currently reside in the ten Minnesota state hospitals. The data have been accumulated from a variety of sources and are documented as to source and date. It is hoped that this information will assist legislators with the decision-making process in their role as the primary "change agents" for the mentally retarded citizens of Minnesota.

This written report is intended as a supplement to a direct oral presentation to the involved legislative committees in February of 1973. The visuals emanate from that presentation. Many of the visuals used in the presentation are reproduced as tables in the appendix to this report.

VISUAL # 1 - RESIDENTIAL CARE IN MINNESOTA'S STATE INSTITUTIONS FOR THE MENTALLY RETARDED

Comments: The following report concentrates on the 4,000 institutionalized mentally retarded persons in Minnesota for whom the Department of Public Welfare has primary responsibility. This report will attempt to show what changes have happened over the past century and, more specifically, the last decade, with regard to changing philosophy, treatment, and characteristics of the mentally retarded. It will also compare Minnesota with other states in the nation with regard to population trends, programatic efforts, and staffing ratios. A major effort has been made to describe in behavioral terms the abilities and disabilities of the population under discussion.

VISUAL # 2 - MINNESOTA'S STATE INSTITUTIONS FOR THE MENTALLY RETARDED - POPULATION 1880-1970 (See table 2.)

Comments: Institutional programming for the mentally retarded has changed drastically since 1880 when there were 21 residents. Since then, there has been a steady increase in the number of institutionalized mentally retarded until the trend reached its peak in 1962 with over 6,000 residents at which time the trend reversed itself. This reversal can be explained by a number of factors. Three primary ones are the changing philosophy about the retarded, the advent of community-based facilities, and the availability of additional staff and resources in the institutions for the purpose of training and education. (Minnesota 1966-7, Minnesota 1967-8)

VISUAL # 3 - MINNESOTA'S STATE INSTITUTIONS FOR THE MENTALLY RETARDED - POPULATION 1962-1972 (See table 2.)

Comments: The last decade has clearly demonstrated in Minnesota the effects of the factors enumerated above. Society's demand for better living conditions, as well as training and education for the retarded, has resulted in a drop of over 2,000 residents in Minnesota's institutions. (Minnesota 1966-7, Minnesota 1967-8, Likens, 1972) Factors that have most dramatically influenced this reduction include:

1. federal monies for training and education through Title I of the Elementary and Secondary Education Act (ESEA), Vocational Rehabilitation monies, and Hospital Improvement Project monies through the National Institute on Mental Health (NIMH);

2. additional staff granted to hospitals in 1965 and 1967 by the Minnesota Legislature, making possible a greater shift from purely custodial care to training programs;
3. community based programs such as day activity centers; (In 1963, there were 10 DAC's serving less than 100. In 1973 Minnesota has 117 licensed DAC's serving 2,368 mentally retarded persons.)
4. and finally, society's increased understanding and acceptance of the mentally retarded in the community which has been strongly influenced by such groups as the Minnesota Association for Retarded Children. It has been reflected by the elimination of a waiting list of 1,500 in the early 1960's to virtually no waiting list today.

VISUAL # 4 - MINNESOTA'S INSTITUTIONS FOR MENTALLY RETARDED COMPARED WITH ALL STATE INSTITUTIONS

Comments: To better understand how Minnesota fares in the nation with regard to trends in population, the following information is presented so that one may see how Minnesota ranks in the nation in its care for the retarded.

VISUAL # 5 - RANK FOR TOTAL ADMISSIONS - MINNESOTA 39TH IN FISCAL 1970

Comments: The last two factors listed previously, that of society's acceptance of the retarded (especially the mild and borderline) and the advent of community based programs, have greatly influenced Minnesota admission rates. In 1970, Minnesota was 39th among the states in number of admissions per 100,000 population. (Eagle 1972)

VISUAL # 6 - RANK FOR RELEASES FROM INSTITUTIONS - MINNESOTA 6TH IN FISCAL 1970

Comments: By the same token, factors such as increased staff numbers in the middle '60's, and better institution and community based training programs for the retarded, as well as a changing philosophy, have greatly affected the release rate. In 1970, Minnesota ranked 6th in the nation in its rate of releases per 1,000 average number of residents at the beginning and end of the year. (Eagle 1972)

VISUAL # 7 _ RANK FOR NUMBER OF FULL-TIME PERSONNEL. MINNESOTA - 35TH IN FISCAL 1970

Comments: Conversely, in 1970 Minnesota only ranked 35th in the nation in terms of its number of full-time personnel per 1,000 average daily residents. (Eagle 1972) However, the 1970 legislature did decrease the state hospital allotment by approximately 10%, so it is not known at this time if Minnesota is still 35th.

VISUAL # 8 - 1962-72 INSTITUTIONALIZED MENTALLY RETARDED POPULATION TRENDS (See table 3.)

Comments: In collecting data on institutionalized mentally retarded in the U. S., the two populations, that of Minnesota and that of the nation, were compared to see if there existed any significant trend differences. To make this visual meaningful, the scale was reduced to approximately 30 to 1 for comparison purposes. In looking at the population changes over the past 11 years, one can see that the nation's institutions realized an increase in population through 1966. At that time, a decrease in population was noted. (Statistical Abstract 1968 and 1972)

However, when one compares this trend to Minnesota's, it is readily apparent that Minnesota is about one-half decade ahead of the nation in philosophy and subsequent population shifts. It is interesting to note that not only did Minnesota begin its population decline five years ahead of the rest of the nation, but also it continues to enjoy a decrease at a much higher rate. Significant decreases occurred for Minnesota in 1968 and 1969. This has been attributed to a number of factors that will be pointed out later in this report. The most recent information available indicates that the rate of decline is starting to slow. It is presently around 4% per year. (Minnesota 1966-7, Minnesota 1967-8, Likins, 1972)

VISUAL # 9 - AMERICAN ASSOCIATION ON MENTAL DEFICIENCY ADAPTIVE BEHAVIOR SCALE

Comments: For years, professionals in Mental Retardation have hoped to be able to measure the skills and abilities of the retarded, but no systematic method or instrument existed by which to accomplish this end. However, the American Association on Mental Deficiency had just completed a scale that would carefully measure behaviors. Therefore, early in 1971, the MR program directors decided to carefully examine the social competencies of the retarded institutionalized in Minnesota. This was not a minor decision since it was estimated that it would take anywhere from one to one and a half hours to administer this instrument to each individual. Nevertheless, the decision was made and the administration was completed. It is estimated that between 4,000 and 5,000 man-hours went into this endeavor.

There were several reasons contributing to the decision to do this. One of the major reasons was the need to systematically and

objectively determine what type of population the state institutions were serving so that program priorities could be established. A second major reason was the need to provide the department with objective, measurable data so that a systemwide program evaluation model could be developed to determine not only how effective each unit and program is, but also to determine which methods and techniques prove to be the most effective and efficient. As of this date, the evaluation model has not been developed due to lack of funds and manpower.

The second administration of the Adaptive Behavior Scale has been completed and information is just now coming out of the computer. Not all the data necessary to minutely determine the results of this past year is available. A cursory analysis of the data so far, however, would seem to indicate that, except in a few specific areas, few behavioral gains have been made in the population as a whole. No content analysis has been made to determine the causes for this lack of gain, due to the lack of the above-mentioned evaluation model. Program personnel have tended to attribute the lack of gain to shortage of staff, hiring freezes, and certain other administrative decisions that have imposed hardships on the units.

Briefly, the information about to be presented is a direct result of the efforts of many people in their attempt to systematize their work with the retarded. It should also be noted that Minnesota was and remains the only state to undergo this massive undertaking.

VISUAL # 10 - CHARACTERISTICS OF MINNESOTA'S INSTITUTIONALIZED MENTALLY RETARDED, 1962-1972

Comments: Up to this point, the report has been discussing institutionalized mentally retarded persons as a total group as though they were a relatively homogenous group of persons. Not only is it important to realize that mental retardation is not a static condition but, in fact, that there are more differences among the mentally retarded as a group than among the general population. For this reason the following information is presented to better explain the type of individuals now being served. This data illustrates not only the wide range of abilities and disabilities within this group but also what has happened to the group over the past decade. All of the data for 1971 and 1972 are a direct result of the efforts taken in the administration of the previously described Adaptive Behavior Scale.

VISUAL # 11 - AGE DISTRIBUTION OF MINNESOTA'S MENTALLY RETARDED RESIDENTS (See table 4.)

Comments: It is significant to note the changes that have taken place in the distribution of age groups between the periods 1960-63 and 1970-73. There has been a slight decrease in the percentage of persons aged 25 and over. There has been a significant increase of nearly 20% in the 15-24 age group, no significant change in the 10-14 age group, and an approximate 4% reduction in the 10 and under age group. (Minnesota 1966-7, Minnesota 1967-8, Likins, 1972) The increase in the 15-24 age group can be accounted for when one considers the factors indicated as contributory to the increase in the severely and profoundly retarded in the next visual. This primarily includes greater

life expectancy and the elimination of the waiting list. A decade ago, the severely and profoundly retarded were seldom expected to live beyond the age of 20. Another factor contributing to this difference is that family and community tolerance decreases sharply by the time the child is 15 and he starts to exhibit more inappropriate behaviors. Nonetheless, this age group, which represents approximately 43% of the total population in our institutions, is the age group most likely to benefit from training and rehabilitation programs.

VISUAL # 12 - DEGREE OF MENTAL RETARDATION OF RESIDENTS IN MINNESOTA'S INSTITUTIONS (See table 5.)

Comments: As previously mentioned in connection with visual # 10, mental retardation is not a static condition. Diagnostically, professionals in the field have accepted five levels by which mentally retarded persons are classified. Two of these categories, severe and profound, have been combined for this report. Persons who are severely and profoundly retarded have approximate I.Q.'s ranging between 0 or untestable and 32. Those described as moderately retarded have approximate I.Q.'s between 33 and 48. Those diagnosed as mildly retarded have I.Q.'s somewhere between 49 and 64. The borderline retarded have I.Q.'s between 65 and 80.

Education traditionally has grouped the retarded into three categories: The highest is the "educable" with I.Q.'s between 50 and 84. "Trainable" children are generally considered to have I.Q.'s between 35-50 and those possessing I.Q.'s below 35 are referred to as "custodial."

The graph shows an extremely changing population. Information collected between the years 1962-68 was based solely upon I.Q. scores in Department of Public Welfare files. However, data

collection of this nature was stopped in 1968 so that for the years 1969-70 no data on this factor was readily available for this presentation. (Minnesota 1966-7, Minnesota 1967-8, Likins, 1972) The 1971-72 data are based on the Adaptive Behavior Scale results. (Responses)

It is readily apparent that there has not only been a significant decrease in the number of moderately and mildly retarded persons in institutions, but a significant increase in not only the percentage, but the actual number of the severe and profoundly retarded.

The drastic increase between 1968 and 1971 can be attributed to a number of factors. One is that during the years from 1962 to 1968, the borderline classification also included a number of persons who were not diagnosed. Many of those were in actuality severely or profoundly retarded. This subsequent reclassification would account for some increase. Other factors that have contributed to the increase in the severely and profoundly retarded include: 1) prematurity and neonatal deaths as well as infant mortality being down; 2) a greater life expectancy for everyone, including the severely and profoundly retarded, due to advances in medicine and the advent of the wonder drugs; 3) the elimination of a 1,500 name waiting list; (Prior to 1965, decisions to admit the retarded to institutions was not based on the degree of retardation, but rather on the order their name appeared on the list. Subsequently, many of the severely and profoundly retarded were being kept home by their parents. This procedure has, of course, changed. Now, the decision to admit an individual to

an institution is based on his need rather than such artifacts as the order one's name appears on a waiting list. Today there is no official waiting list.)

4) an increase in illegitimate live births; (It is felt that these are the babies least likely to receive appropriate prenatal and neonatal care.) 5) more working mothers, leaving no one at home to care for the retarded infant; 6) the increasing urbanization of American life which results in a more complex life style to which retarded person must adapt; 7) increased suburban migration away from traditional family neighborhoods; and 8) a more accepting attitude of society toward the family with a retarded child in a state institution. (Wolfensberger 1971) Some also feel that there appears to be evidence that the venereal disease epidemic may be increasing the number of prenatal syphilitic babies who have high probabilities of being retarded.

In summary, one can see that, at the present time, 76% of the institutionalized population in Minnesota is severely and profoundly retarded.

By the same token, there have been a number of factors identified which are attributed to the decrease in the number of mild, moderate, and borderline retarded in Minnesota's institutions. First, there has been a greater awareness of the condition of Mental Retardation by society and, subsequently, a greater acceptance of them in the community. This is demonstrated by the passage of mandatory education laws which prescribe their education in the open community. There has been a greater increase in the number of sheltered workshops, group homes, and day activity centers in

the community. For example, in 1963 there were 10 day activity centers in Minnesota serving less than 100 persons. On January 29, 1973, there were 117 licensed centers serving a total number of 2,368 retarded persons.

Secondly, there was a greater demand by society to improve the care and increase the training of the retarded in institutions. This was evidenced by national leadership in legislating funds to shift from a custodial care philosophy to one of training and education. Significant programs made possible by these funds include the Cooperative Vocational Rehabilitation Projects (CVRP), Title I ESEA projects such as Project Teach, Hospital Improvement Projects (HIP), and the Foster Grandparent Programs.

VISUAL # 13 - SOCIAL COMPETENCIES OF RESIDENTS OF MINNESOTA'S INSTITUTIONS FOR THE MENTALLY RETARDED, 1972

Comments: The following information has been gleaned from the data accumulated on the Adaptive Behavior Scale. It is presented in a format which should give some idea of the capabilities and disabilities of the retarded - especially in some of the more basic functions enjoyed by a normal person. The data does not reflect all of the information gathered by the Adaptive Behavior Scale but are representative of the group at large. This information is from the 1971 administration of the Scale, but, as mentioned previously, no significant percentage changes have been noted in the 1972 administration.

VISUAL # 14 - EATING COMPETENCIES OF MINNESOTA'S MENTALLY RETARDED RESIDENTS (See table 6.)

Comments: This chart shows the competencies of the population in one of the most basic functions of man. It is interesting

to note that there were 750 persons who were considered to be totally dependent on others for eating - to the extent that without total assistance, they would die. The balance of eating competencies, such as drinking from a cup without help, ordering meals in a restaurant, or using utensils are broken down by percentages. (Responses)

VISUAL # 15 - TOILETING COMPETENCIES OF MINNESOTA'S MENTALLY RETARDED RESIDENTS (See table 7.)

Comments: The information collected on the Adaptive Behavior Scale shows that nearly half the population, or approximately 2,000 persons, in Minnesota's institutions cannot toilet without some assistance. Not depicted on this graph is a substantial number of that group who are totally dependent on others in the toileting process 24 hours per day, seven days per week, 52 weeks per year. (Responses)

VISUAL # 16 - SPEECH SKILLS OF MINNESOTA'S MENTALLY RETARDED RESIDENTS (See table 8.)

Comments: Fifty-three percent of the institutionalized population, or over 2,000 persons, have no effective speech to make known their wants, their needs, their joys, their sorrows, or even their thoughts. (Responses)

VISUAL # 17 - AMBULATION SKILLS OF MINNESOTA'S MENTALLY RETARDED RESIDENTS (See table 9.)

Fifty-eight percent, or well over 2,000 people, cannot move about without some difficulty. Again, not reflected in this chart is a substantial number who cannot move at all and are totally dependent on others to lift and carry them from one place to another

if they are to move at all. Since experience has shown that no human organism is incapable of learning to some degree, it is unimaginable how many of these persons could be taught to walk and move if provided with appropriate individualized training.

(Responses)

VISUAL # 18 - DRESSING COMPETENCIES OF MINNESOTA'S MENTALLY RETARDED RESIDENTS
(See table 10.)

Comments: Approximately half of the total population, or some 2,000 persons, are dependent on others in varying degrees in dressing and undressing themselves. Fifty-five percent, or over 2,000 persons, cannot put on or remove their shoes without help.

(Responses)

VISUAL # 19 - SENSE OF DIRECTION OF MINNESOTA MENTALLY RETARDED RESIDENTS
(See table 11.)

Comments: Sixty-two percent of the population, or 2 1/2 thousand persons, will become lost if they get more than a few blocks from their residence. Again, training can and has changed this.

(Response)

VISUAL # 20 - WORK SKILLS OF MINNESOTA'S MENTALLY RETARDED RESIDENTS
(See table 12.)

Comments: One of the more significant characteristics of the population is the absence of work skills. In the study, it was determined that only 9%, or approximately 400 persons, in Minnesota's institutions could work with tools or machines. It is estimated that nearly all of these persons are presently working with such machines as dishwashers in the cafeterias, washing machines in the laundry, and possibly some floor scrubbers.

A little over one-third of the population was described as being capable of performing only very simple work, such as mopping a floor, making a bed, dusting. Most significant is the fact that 55%, or over 2,000 persons, were reported as not being able to perform any work at all. This is actually quite understandable when one considers the increase in the proportion of the population which is severely and profoundly retarded. (Responses)

VISUAL # 21 - PHILOSOPHY FOR CARE FOR THE MENTALLY RETARDED, 1850-1973

Comments: It is important to study the drastically changing philosophy of care for the mentally retarded over the past century to understand the equally drastic changes in the institutionalized population. White and Wolfensberger have identified five distinct phases society has undergone in the way it perceives the retarded individual and his relationship to society. (See table 13.) Historically, there have been four common strategies with which society has dealt with deviancy. (Deviancy refers to any individual perceived as significantly different from the average person. It includes the retarded, the insane, the criminal, the poor, and others.) These strategies have been to prevent, to reverse, to segregate or isolate, or to destroy the deviancy. (White and Wolfensberger, 1969)

Dr. Edouard O. Seguin has been recognized as one of the fathers of the initial philosophy that the retarded could be rehabilitated or the deviancy reversed - that is, to make the

deviant undeviant. He, along with Drs. Samuel Howe and Harvey Wilbur of Massachusetts, believed that through education and training, the retarded could be enabled to live their lives in the open society. (White and Wolfensberger, 1969)

In efforts to accomplish this end, Hower founded the Massachusetts School for Idiotic and Feebleminded Youths in 1851. After 18 years, a case study of the records indicated that the school's total enrollment was still less than 90 and that during those 18 years, 476 children had been admitted and 365 had been discharged, many of them as self-supporting members of the community. (White and Wolfensberger, 1969) After 30 years of experience with the retarded, Seguin was quoted as saying,

> Not one in a thousand has been entirely refractory to treatment, not one in a hundred who has not been made more happy and healthy. More than 30% have been taught to conform to moral and social laws and rendered capable of order, of good feeling, and of working like the third of a man. More than 40% have become capable of the ordinary transactions of life, of friendly control, of understanding normal and social abstractions, or working like two-thirds of the man; and 25-30% have come nearer and nearer the standard of manhood till some of them will defy the scrutiny of good judges when compared with ordinary young men and women. (As quoted in White and Wolfensberger, 1969)

During the period of 1870-1890, the philosophy changed to that of sheltering the retarded from society. This represented a shift to segregation or isolation thus acting as the catalyst to the building of institutions. (White and Wolfensberger, 1969)

At approximately the turn of the century, attitudes toward the retarded changed from positive to negative. The predominant theme was to protect society from the deviant. During this period,

the emergence of large, dehumanizing, but "economical" institutions came about. (White and Wolfensberger, 1969) So drastic was the change in philosophy that professional leaders were quoted as saying such things as: "I do not think that, to prevent the propagation of this class (the mentally retarded), it is necessary to kill them off or resort to the knife; but if it is necessary, it should be done." These remarks were made by Alexander Johnson in 1901 who served at that time as the president of the National Conference on Charities and Correction, as well as the American Association on Mental Deficiency. (White and Wolfensberger, 1969)

By 1920, the United States was well on its way toward the construction of large institutions housing the retarded. From that period until about 1960, the nation seemed to have lost any rationale for the treatment of the mentally retarded. (White and Wolfensberger, 1969)

It was about 1960 that clear evidence of a changing philosophy came about. It is interesting to note that the philosophy that eminated, not only from society at large but from national leadership as well, closely paralleled that of Seguin, Howe, Wilbur, and other early pioneers in the field. Stress is now placed on rehabilitation, training and, above all, humane normalized treatment. This more than anything else accounts for the drastic reduction in the institutionalized population of Minnesota, as well as the nation. (White and Wolfensberger, 1969)

Hopefully, this presentation will help insure that the philosophy now affecting the Mentally Retarded will continue - especially now that we find ourselves working with a more severely handicapped population.

MINNESOTA STATE INSTITUTIONS FOR THE MENTALLY RETARDED

POPULATION - 1880 - 1970

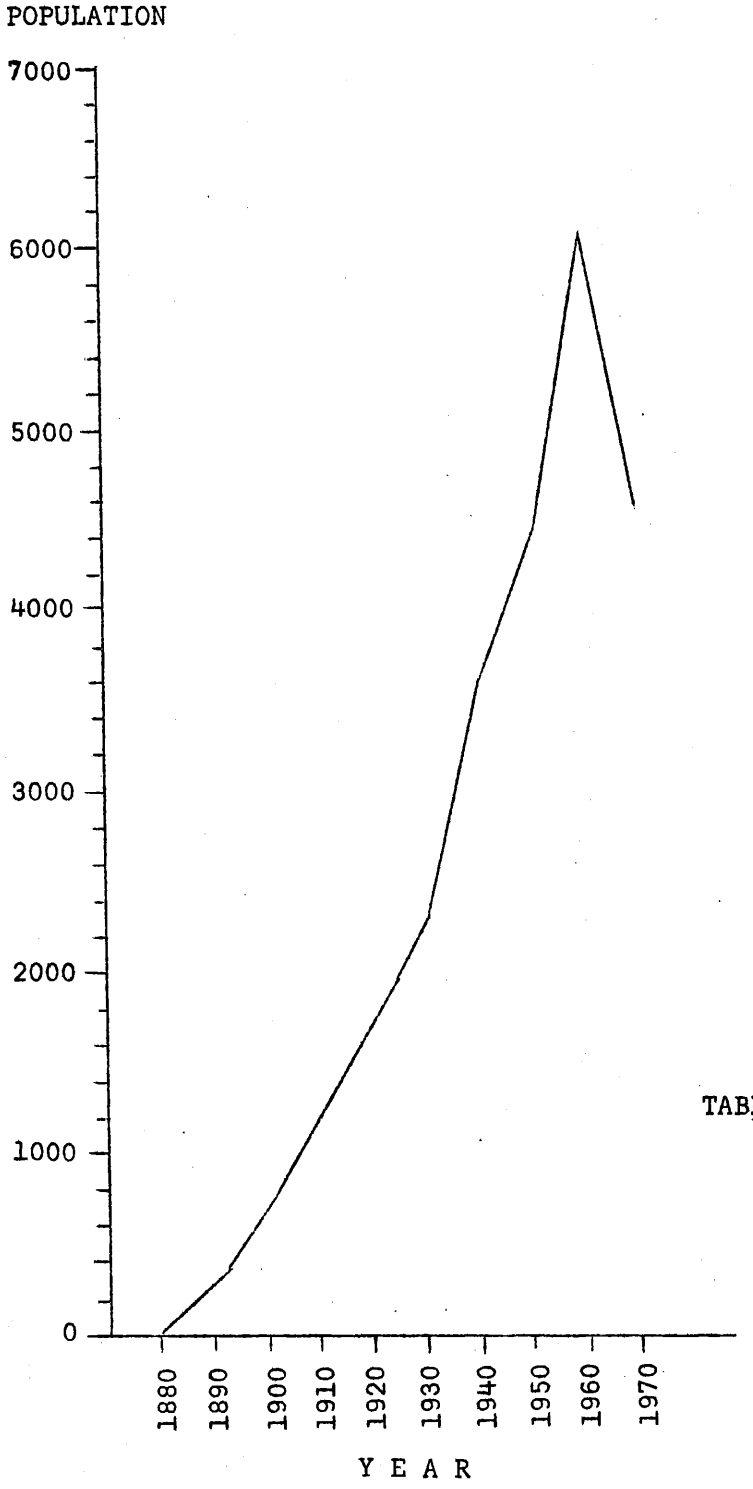


TABLE 1

MINNESOTA STATE INSTITUTIONS FOR

THE MENTALLY RETARDED

POPULATION - 1962 - 1972

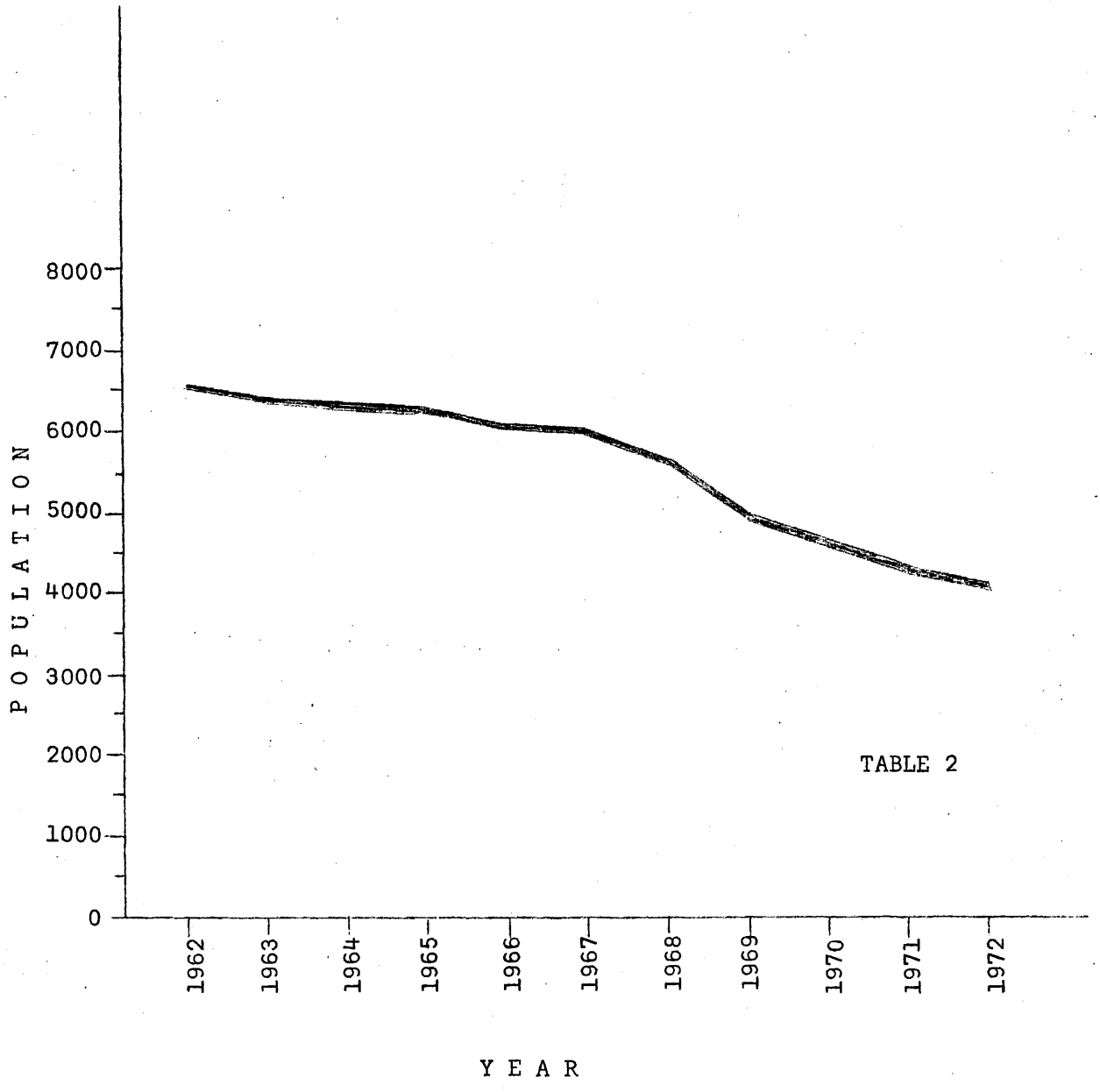


TABLE 2

1962 - 1972 INSTITUTIONALIZED

MINNESOTA - NATIONAL MR POPULATION TREND

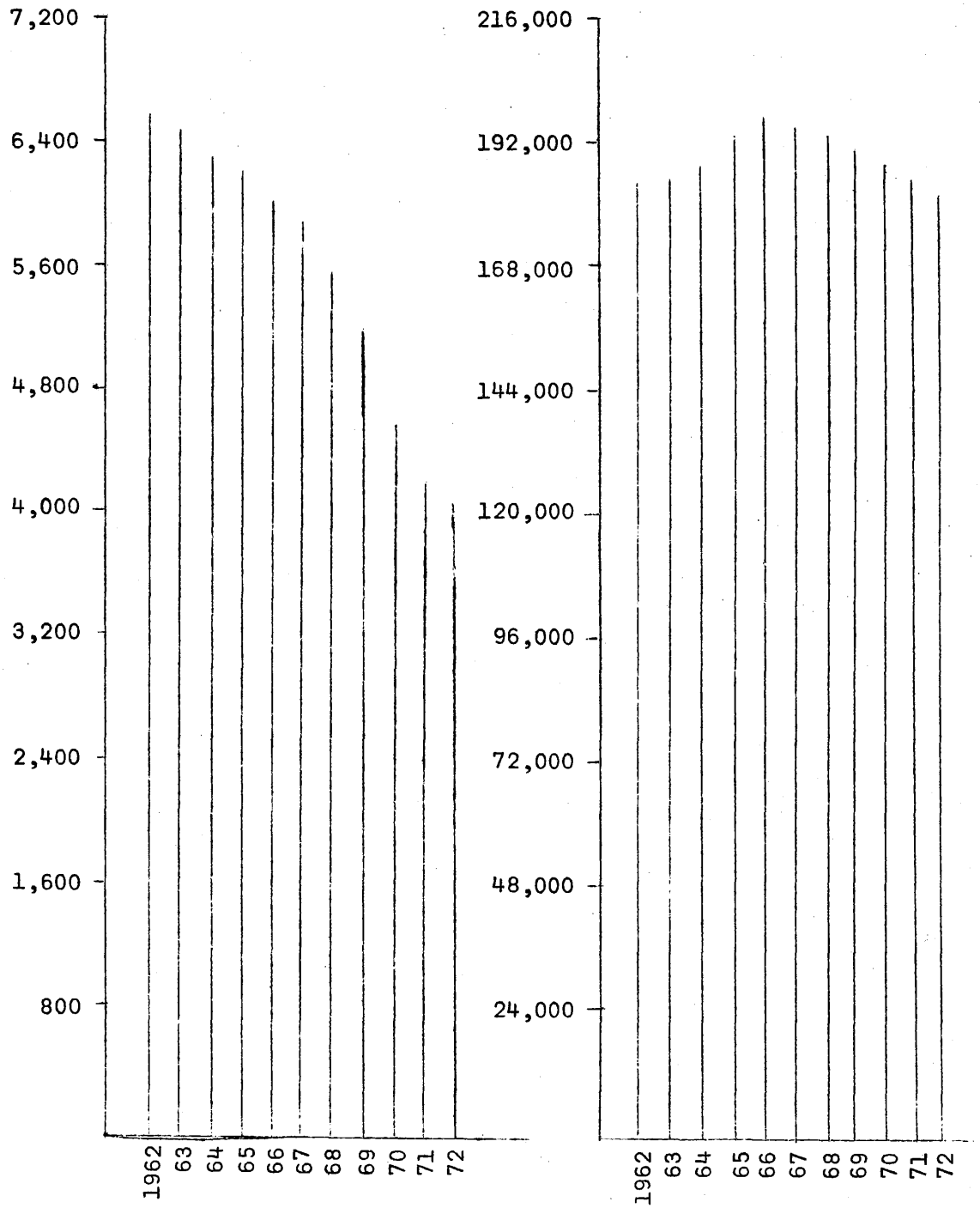
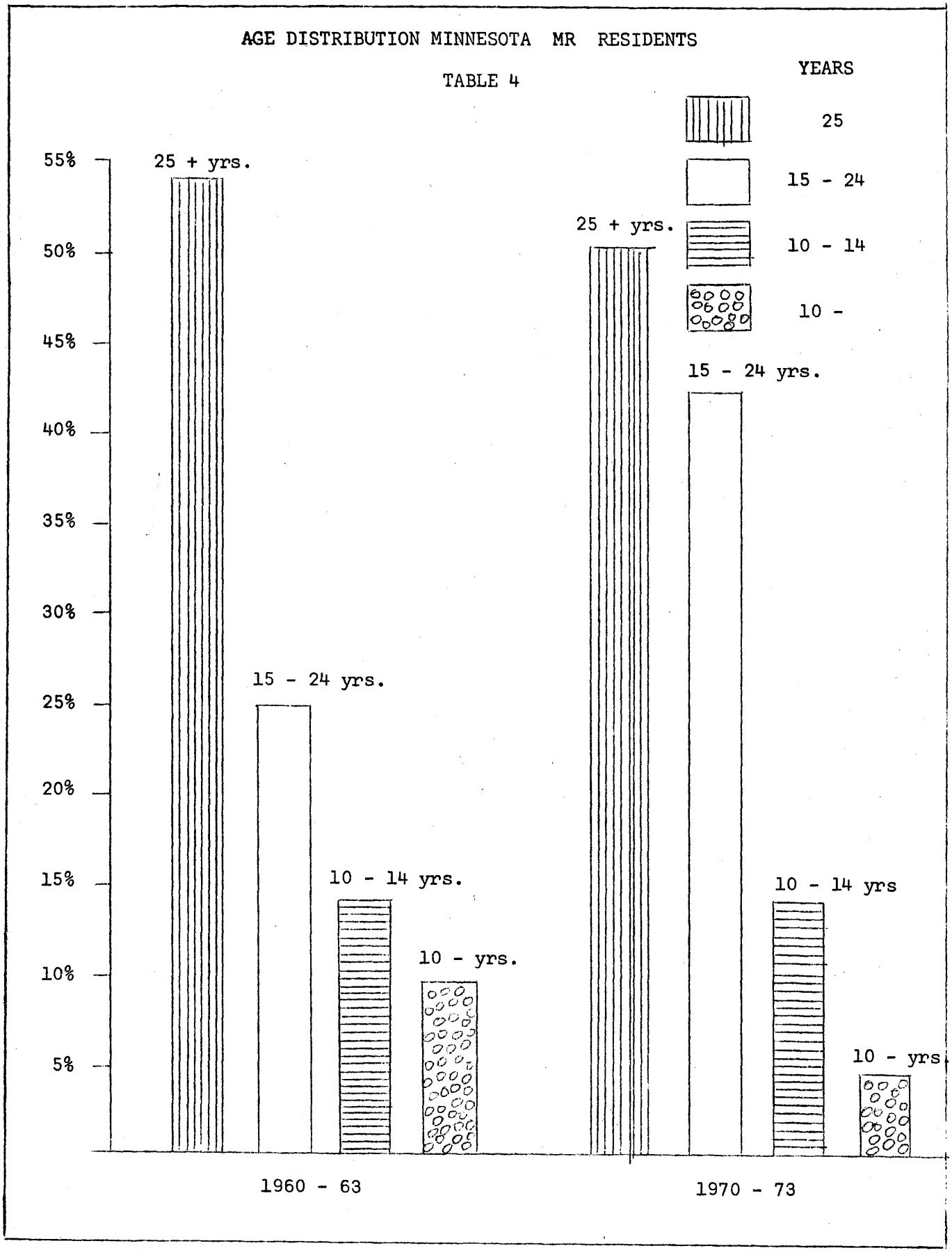


TABLE 3

AGE DISTRIBUTION MINNESOTA MR RESIDENTS

TABLE 4



DEGREE OF MR RESIDENTS IN MINNESOTA INSTITUTIONS

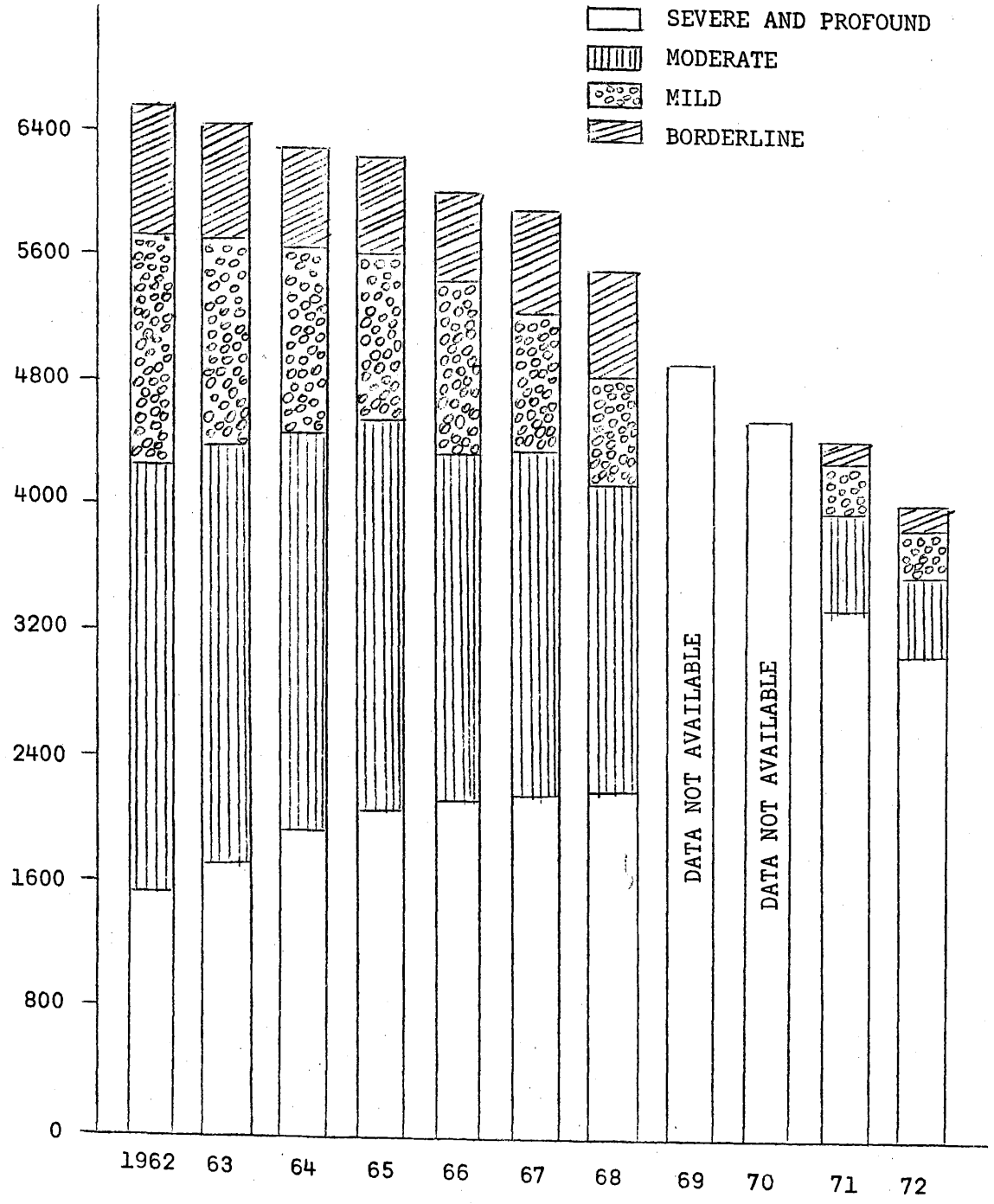
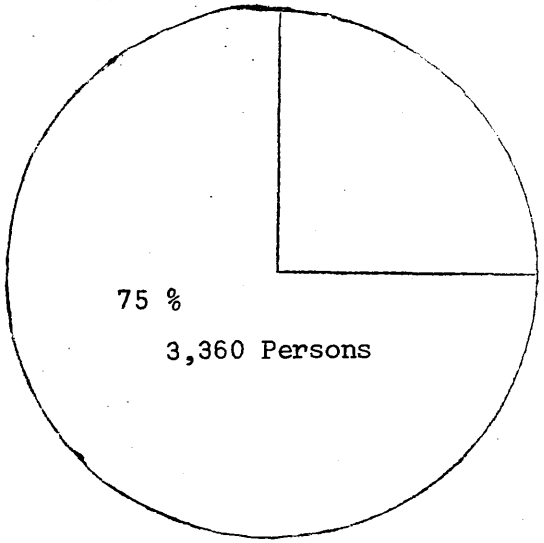
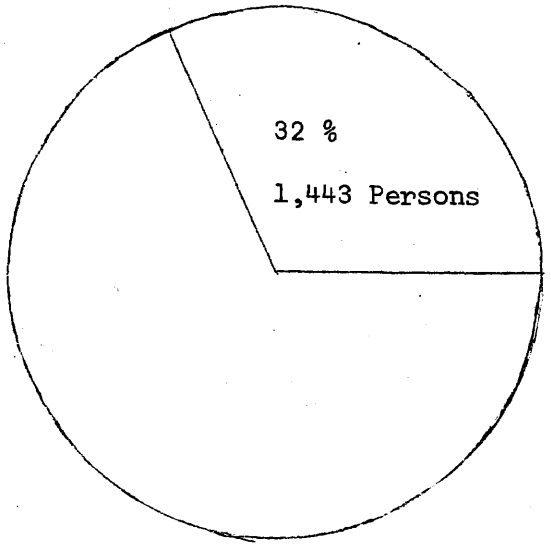


TABLE 5

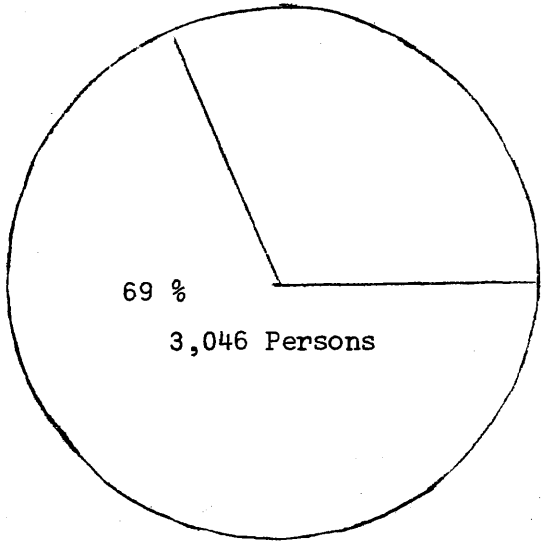
Persons who cannot order meals in a restaurant.



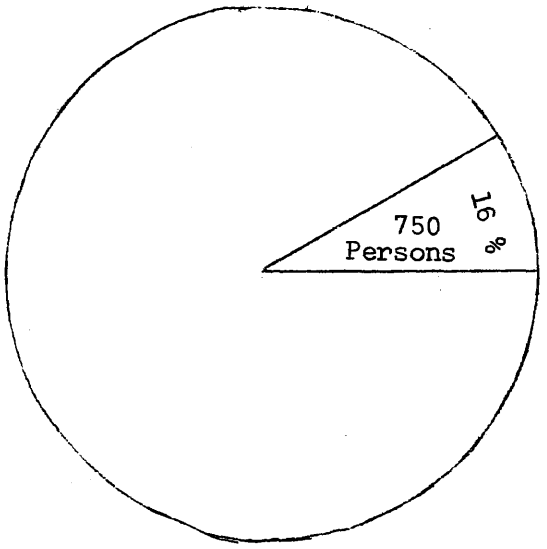
Persons who cannot drink from a cup without help.



EATING COMPETENCIES OF MINNESOTA MR RESIDENTS



Persons who cannot use all their eating utensils.



Persons who would die without someone to feed them.

TABLE 6

TOILETING COMPETENCIES OF MINNESOTA MR RESIDENTS

Persons who are not completely toilet trained.

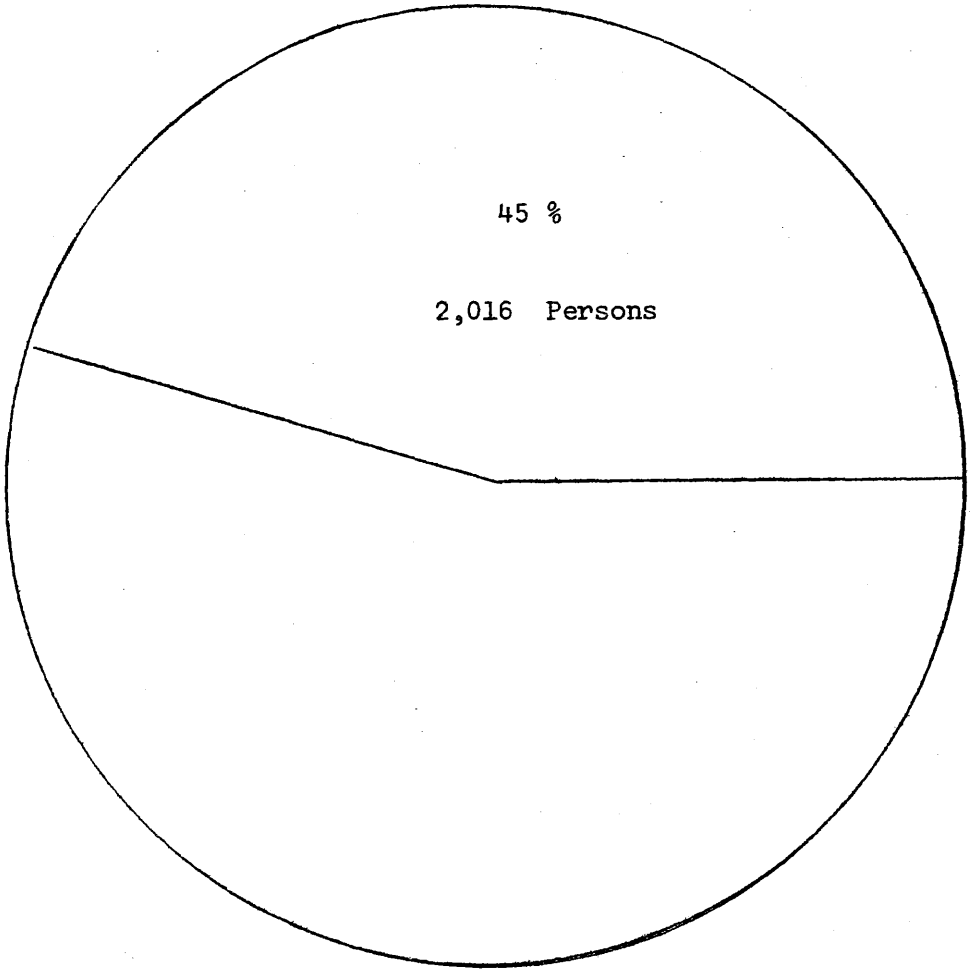


TABLE 7

SPEECH SKILLS OF

MINNESOTA MR RESIDENTS

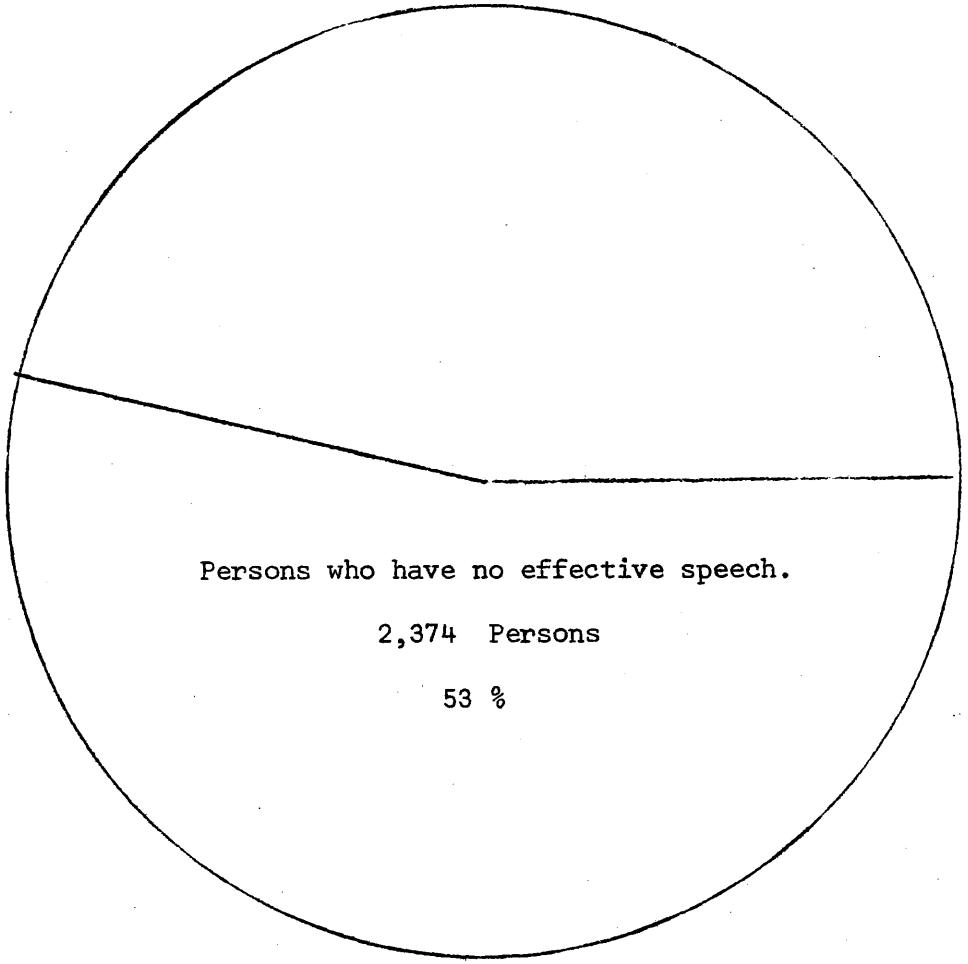
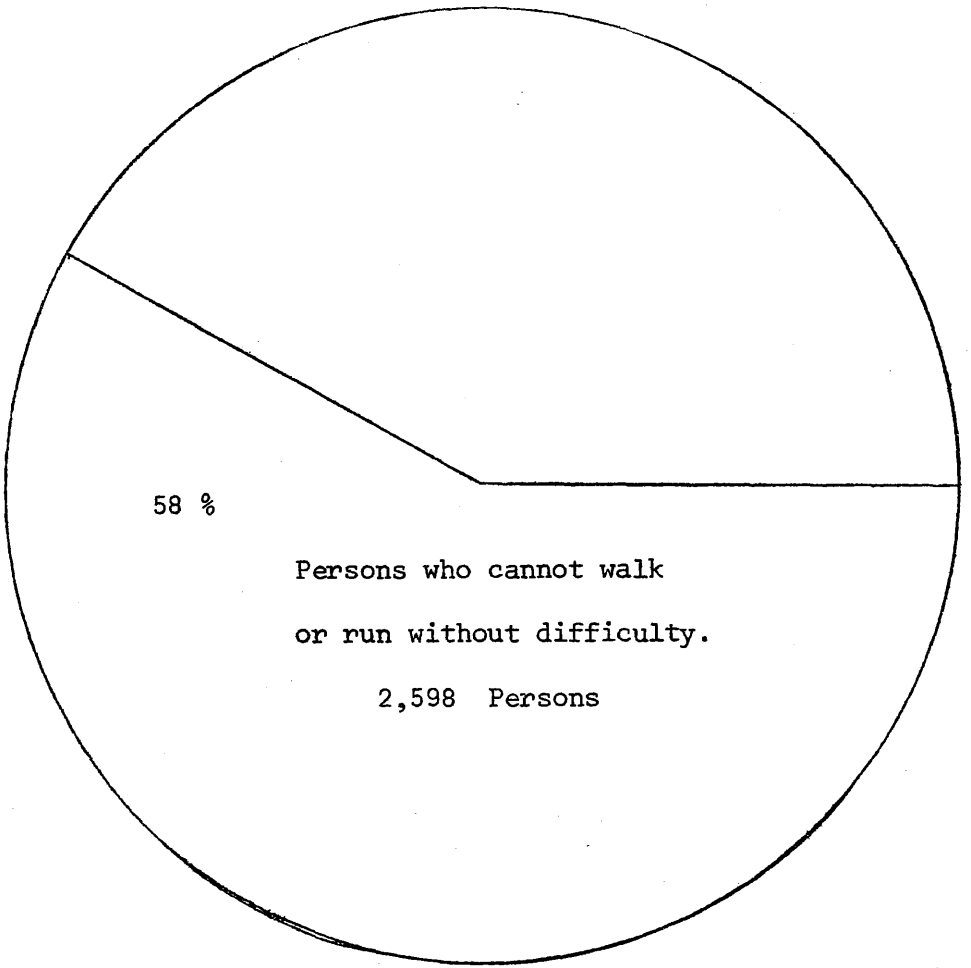


TABLE 8



AMBULATION SKILLS OF

MINNESOTA MR RESIDENTS

TABLE 9

DRESSING COMPETENCIES OF

MINNESOTA MR RESIDENTS

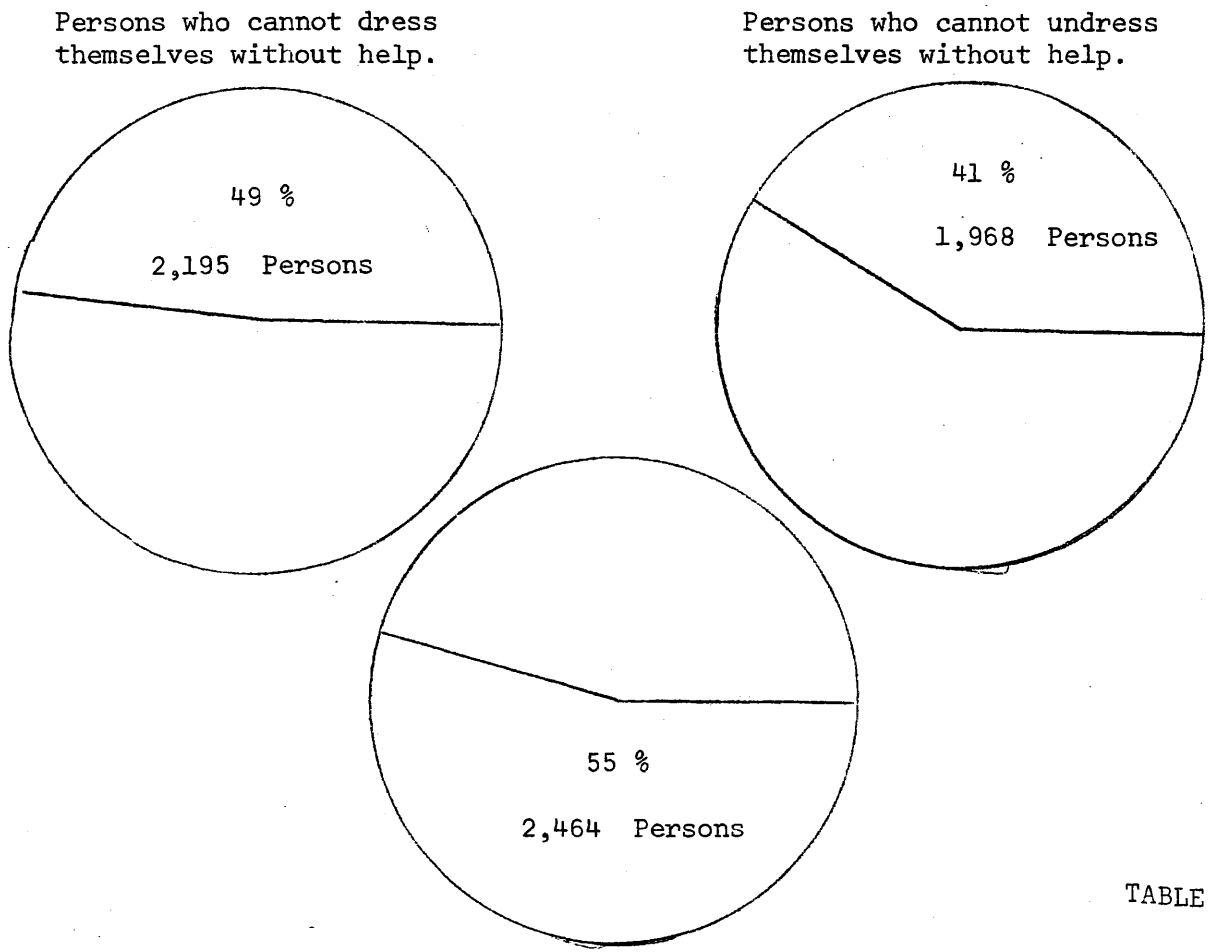


TABLE 10

SENSE OF DIRECTION OF

MINNESOTA MR RESIDENTS

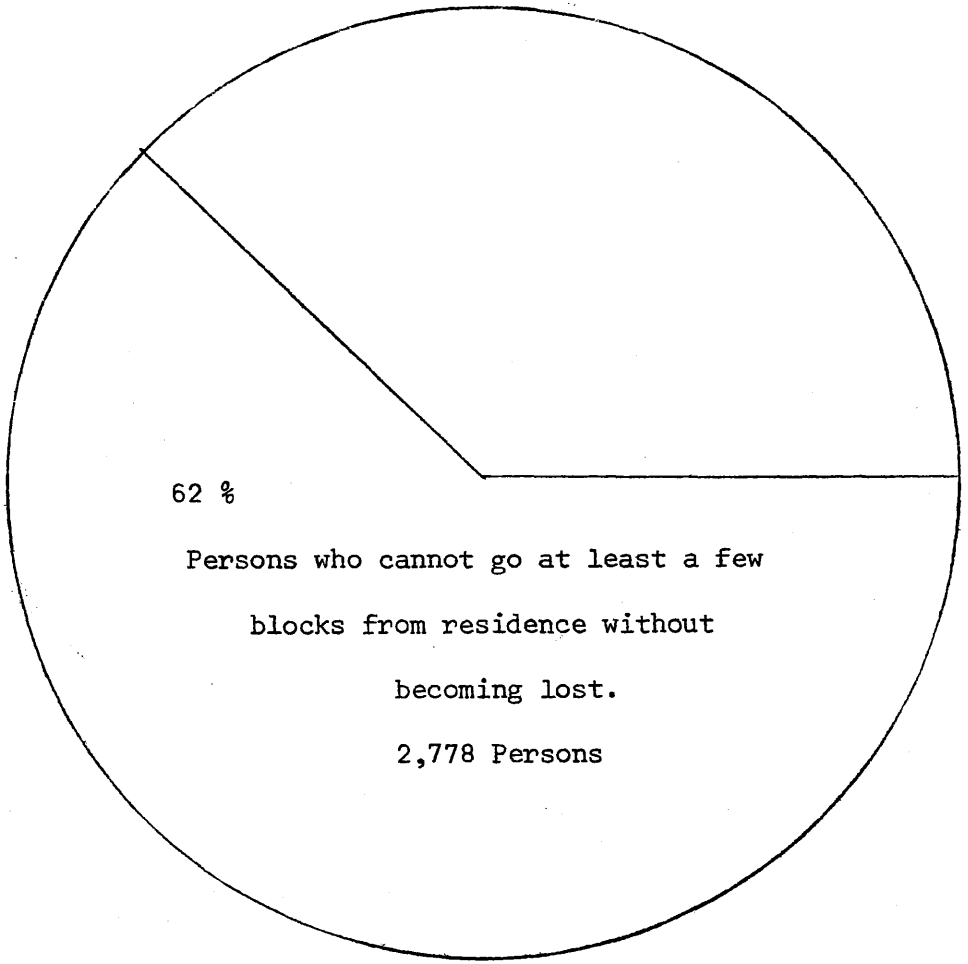


TABLE 11

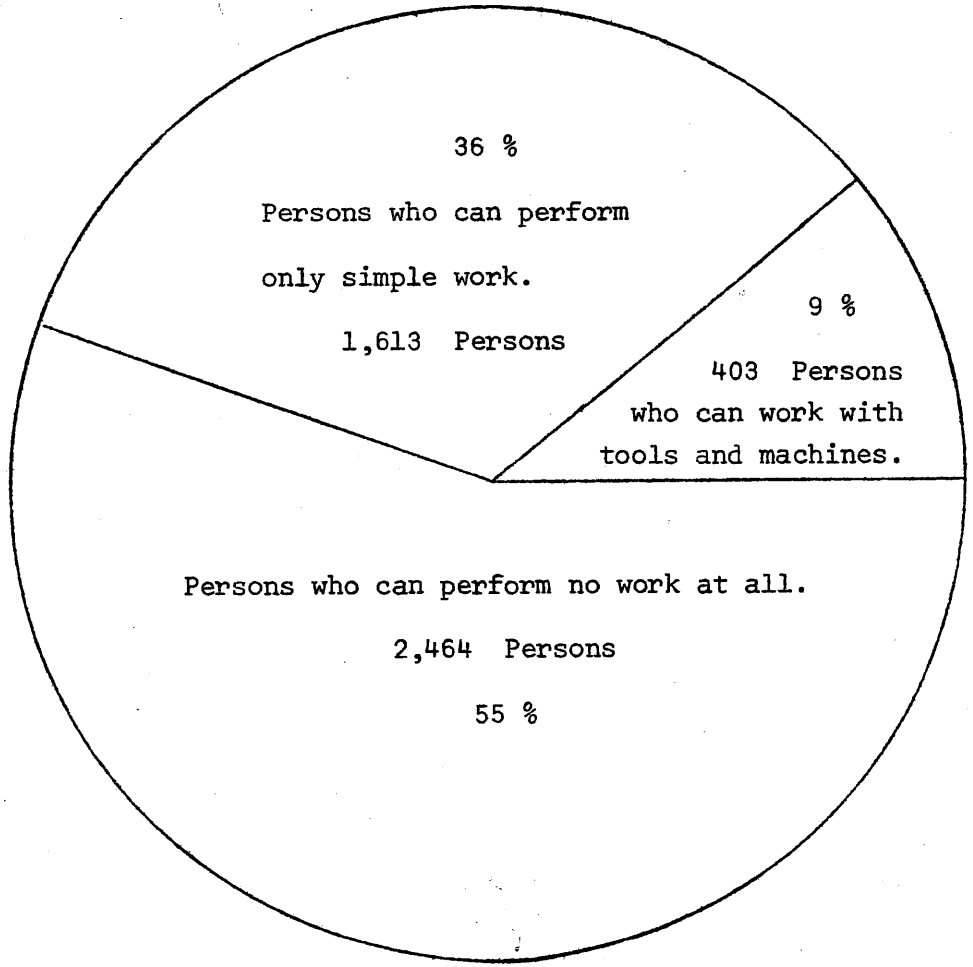


TABLE 12

WORK SKILLS OF

MINNESOTA MR RESIDENTS

PHILOSOPHY FOR CARE FOR THE MENTALLY RETARDED

1850 - 1973

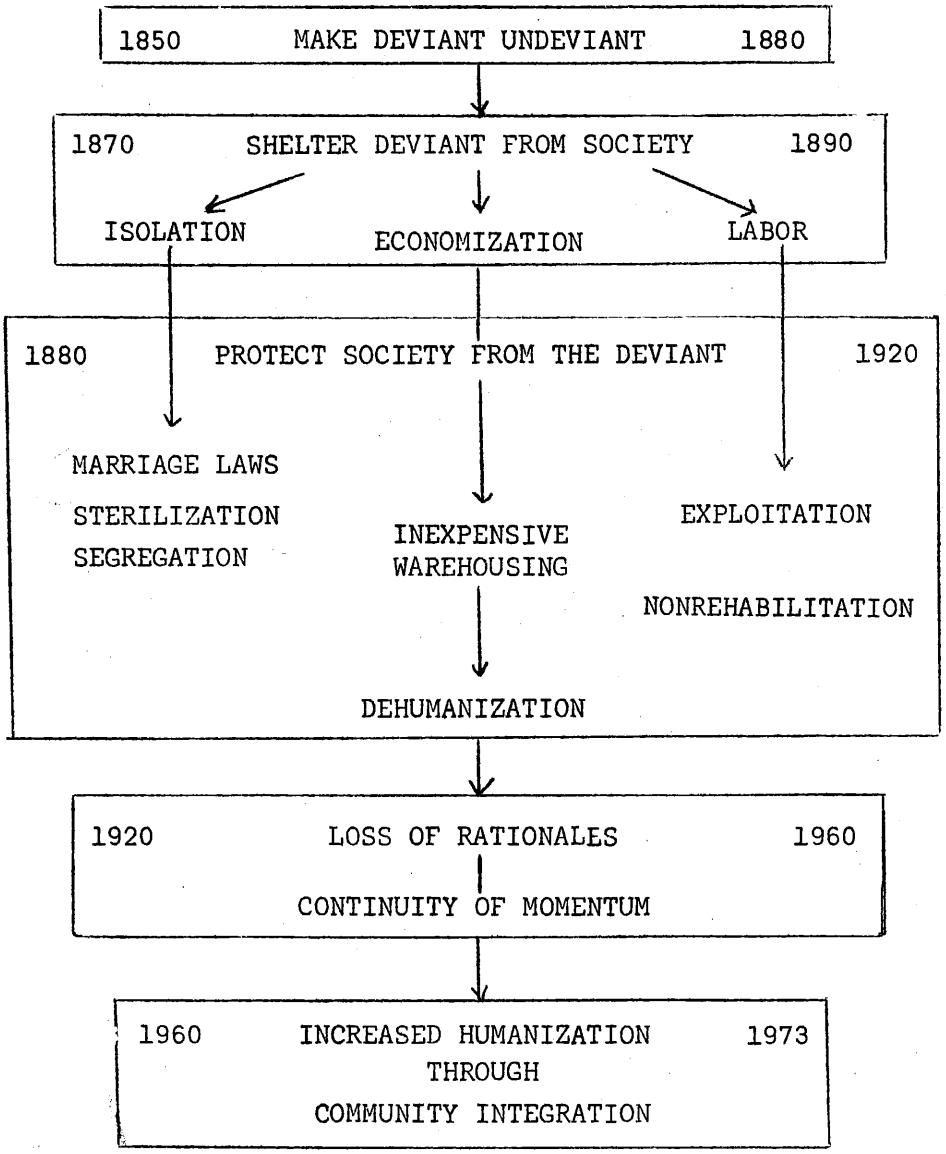


TABLE 13

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