Minnesota's Mental Health Program

In Perspective

Minnesota's Mental Health Program In Perspective:

A Comprehensive Summary

Produced by Minnesota Department of Public Welfare

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TABLE OF CONTENTS

Editor's note: The notes you will find in the margins of the booklet are designed to further guide you to information.

Mental Health Perspectives

The Forward Look

With A Backward Glance

INTRODUCTION

The Minnesota public program for care and treatment of mental disorders is characterized by two key concepts — individualization and continuity of care. But this program emphasis today can be understood only as an evolution of social trends during a century of state concern for mental problems.

The Minnesota mental health program includes services to both the mentally ill and retarded. Therefore, references to "the mental health program" will include both facets.

Concern for mental health in Minnesota dates to 1851 when the first territorial legislature passed a law making probate judges responsible for the interests of mentally incompetent persons. But it was not until 1866 when 30 patients were admitted to newly constructed hospital buildings in St. Peter that the era of "boarding out" patients to other states was over and the Minnesota mental health program was officially begun.

The Minnesota program, as all states' programs, is a story which must be told from a point in time. The present cannot be effectively related unless it is seen in perspective — a point of view which allows that a century-long history of development permits some century-old concepts to be carried along; that social science is new and therefore experimental, inexact and sometimes scoffed, but necessarily more attuned to the future

than the past; that the decades since World War II have seen more spectacular development of mental health facilities and concepts than all the years previous and thus the present program is changing rapidly. The tendency could be to look back and see how far the state has come, but the look ahead is what keeps Minnesota a leader in mental health programming and planning.

Changes in hospital treatment programs have paralleled changes in society's attitudes toward mental problems.

It is probably no coincidence that the development of patient-centered therapy programs in this state and others has paralleled a change in society's attitude about the mentally ill and retarded. Mental afflictions are no longer thought of as hopeless. Mentally afflicted persons are no longer thought of as possessed by demons, or as less than human, or as a separate and frightening class of persons. The growth of this public attitude that mental illness is capable of cure or control and that mentally retarded persons can be helped has been partly responsible for the development of a state mental health program with emphasis on rehabilitation therapy in the institutions, and especially on community care whenever possible.

"Insane asylums" are gone. "Colonies for the feeble minded" are gone. In their places we find mental hospitals, and schools and hospitals for the retarded, all bent on returning patients to their communities, or where this is not possible, providing a living situation that will enable long-term patients to live as rich a life as possible.

Through an attack on institutional practices that "dehumanize" a patient — practices held over from the old days — the Minnesota program has tried to increase the dignity and self-respect of its patients. The emphasis whenever possible is on the needs of the individual — open wards, encouragement of self-help, independent living units, therapy programs and work assignments, and patient councils.

The development of community treatment programs, in addition to hospital programs, also reflects changing attitudes.

Concurrently, as the dignity and rights of the mentally afflicted person have become accepted, emphasis in care and treatment has been to provide as human and normal a setting as possible for these persons. Thus, community facilities — mental health centers, day-care centers, sheltered workshops, foster homes and boarding homes and special education classes have begun. These facilities enable mentally ill and retarded persons to remain in the community, a service of double benefit — to the individual, who is permitted to remain in familiar surroundings, and to the community, which can learn much from the immediacy of the mental health problem.

Public education will continue to place emphasis on early diagnosis in the community; awareness will attune public servants such as teachers and clergy to intercept mental disorders early in their development. But this public awareness will create a need for more extensive facilities, and growing population will create yet another pressure. However, the hope is eventually to provide a continuum of services and care for all persons in the state needing such services and care. The spectrum would include state institutions, public community facilities, private agencies and the home.

HISTORY

It is often said that social movements are circular, that with time old concepts become new trends.

Community responsibility for treatment of mental disorders is an "old" concept reborn. But sometimes in the past, care for the mentally afflicted has not been so hopeful, or even forward-looking.

To a certain extent the mental health movement in Minnesota and other states is marked by a seeming circularity that begins and ends with "community responsibility." During the 19th century the emphasis in most cases was on community and home responsibility for the "mentally incompetent" as they were termed. Then came an era of emphasis on institutionalization for mentally ill and retarded persons, an era which resulted in the overcrowded, understaffed institutions that raised the indignation of the press and public shortly after the Second World War.

Now the emphasis is moving back toward community care and community responsibility, an emphasis which has developed largely since the war. However, what seems to be a circle actually is not. In the 19th century communities and homes were responsible for the care of mentally ill and retarded largely because there were not institutional and professional facilities; today communities are shouldering responsibility because social scientists believe that early diagnosis of mental disorders and care close to home are beneficial to a person, and that community-centered emphasis will help remove stigma from mental conditions and bring more persons to participate in mental health programs.

Legislative Enactments

In broadest terms, these are the major legislative enactments that have led the state to its present position.

The program actually began in 1851 when the first territorial legislature assumed responsibility for the mentally incompetent through the probate judges. In 1866 the state opened its first institution in St. Peter with the admission of 30 patients — both retarded and ill — who formerly had been "boarded out" to other states.

By 1879 it was recognized that some of the "feebleminded" children could profit by training and they were transferred to the "asylum" for the deaf and dumb at Faribault. In 1887 the "School and Colony for Idiots and Imbeciles" (now Faribault State School and Hospital) was made a separate institution.

The basis for a state-wide and all-inclusive program for the mentally retarded and epileptic was established in 1917. Certain laws passed in that year still serve as the state's guidelines. They were the laws placing responsibility for administration on a board of control and county child welfare boards — now the commissioner of public welfare and county welfare departments — and empowering the board of control to assume guardianship for and accept responsibility for the retarded and epileptic.

In 1937 county welfare departments were established and given the responsibility of supervising mentally retarded wards of the commissioner in their communities.

But in 1947 the wheels really began to turn. The end of the war brought a chance for citizen attention to turn toward problems at home. All over the country citizen groups and the press began calling for improvements in public facilities, including mental hospitals; concerted public attention was focused on institutional practices some called inhuman, some called unhealthy. Institutions were overcrowded. Patients were provided little more than custodial care, except in the schools and hospitals for the retarded, where special education classes were furnished for some.

Successive legislatures have enacted various mental health measures, but the 1949 legislature passed the most extensive legislation dealing with reforms in institutional care for the mentally ill and retarded.

So the recent history of Minnesota's mental health program really began in 1947 when Governor Luther W. Youngdahl appointed a Governor's Advisory Council on Mental Health. Recommendations were made for an adequate program of treatment for the mentally ill and retarded. Subsequently, the Mental Health Policy Act was passed by the 1949 legislature. Many of the provisions of the act underlie the mental health program today.

The Act, (Chapter 246, Minn. Statutes, 1949) recognized that new attitudes and treatment procedures could improve the care of the mentally ill and retarded, and

senile, epileptic and inebriate persons. Standards of service and care for patients in state institutions were set up and the Director of Public Institutions was charged with maintaining these standards.

To provide for patient's other needs, ministers and chaplains were added to hospital staffs to offer religious services and spiritual guidance. Facilities and staff were to be provided for occupational and recreational therapy, psychiatric and social casework services.

Personnel training centers were established. Provisions were made for facilities and equipment for research and study in the field of modern hospital management, the causes of mental illness and retardation and related problems, and the diagnosis, treatment and care of those with mental disorders.

In addition the Act established a program for detection, diagnosis and treatment of mentally ill or nervously ill persons through clinical services and established a commissioner of mental health and mental hospitals in the Division of Public Institutions.

The foundations of the program were there in 1949. The standards were set. Some of the provisions were fixed goals that could be reached and checked off a list, for example, a dietitian in each hospital. Other provisions were changing goals, less easy to tabulate and check off. Research, in-service training, sufficient hospital staff and supplies were not fixed goals. The years since 1949 have been spent trying to redefine and reach toward these goals.

The Medical Services Division

In 1953 the Medical Services Division of the Department of Public Welfare was given responsibility for the state mental health program.

In 1953 a new agency was given responsibility for the mental health program. In that year the Division of Social Welfare and the Division of Public Institutions were consolidated into a newly created Department of Public Welfare. A medical director in the department was given over-all responsibility for the mental health program and supervision of the departmental division that was to administer this program — the Medical Services Division. The medical director replaced the former commissioner of mental health.

The Medical Services Division is so-named (rather than Mental Health Division) because it has a wider responsibility than mental health. It is also responsible for the state TB control program.

Since 1953 major experimentations and developments in the state program have taken place, especially in the area of community programming. In 1957 the legislature passed a law setting up requirements for community mental health centers and providing 50-50 matching funds to communities meeting these requirements. In that year also an act was passed making it mandatory for local school districts to provide special education classes for the retarded in their district.

In 1961 this community-centered idea was carrier further with the experimental establishment of day-care centers for the retarded on the same 50-50 matching basis as community mental health centers. The experiment was successful and has become a permanent part of the state budget.

In Washington

Minnesota is not the only state looking critically at its mental program in an attempt to upgrade and update facilities and treatment procedures. Similar movements have been afoot in many states since the 1940s. These efforts were recognized by the federal government in 1947 with the passage of the National Mental Health Act and in 1955 with the passage of the Mental Health Study Act. The Mental Health Study Act directed the Joint Commission of Mental Illness and Health, under a grant administered by the National Institute of Mental Health, to "analyze and evaluate the needs and resources of the mentally ill people of America and make recommendations for the national mental health program."

Federal legislation has enabled studies of mental health needs, and has supported state and community mental health planning and development.

The 100,000 word report submitted in Congress in 1961 suggests that a stepped-up program of community care and facilities, research, personnel training, education, and an improved treatment program in state hospitals for the mentally ill are necessary to implement an effective national program to combat mental illness. The report says that in this program one matter takes priority over all others, "and that is to obtain vastly increased sums of money for its support. Without adequate financial resources, we cannot take care of patients, we cannot educate professional personnel for public service, and we cannot pursue the basic knowledge needed for the prevention and cure of mental illness."

Some elements of this report were facilitated by legislation passed by the 1963 Congress granting funds to states to help them with hospital improvement projects,

in-service training, and construction of community mental health centers and facilities for the retarded. The legislation was precipitated by a presidential message to Congress from John F. Kennedy February 5, 1963. In it he said the time had come to act on a situation that had been "tolerated far too long." He said it was time for a bold, new approach, utilizing the tools of medical and scientific knowledge to combat mental illness and retardation. In his message he proposed a national program of mental health and improved care for patients in state institutions for the mentally ill and retarded.

In one other act of significance, the federal government in 1963 appropriated funds to assist states with mental health planning, to allow states the funds necessary to look at their programs from a long-range perspective and to coordinate services as well as plan the development of facilities.

THE FUNCTION OF THE MEDICAL SERVICES DIVISION

In the broadest terms the goal of the mental health program administered by the Medical Services Division is to provide the best possible mental health services needed by each individual, whether this be in the community or a hospital.

To implement this ideal the state maintains a network of hospitals for the mentally ill and retarded, provides supervision and financial assistance to community facilities such as community mental health centers and day-care centers for the retarded and provides for follow-up services for discharged patients through the 87 county welfare departments.

So it can be seen that the Minnesota "program" is actually several programs and quite decentralized. But at the center is the Medical Services Division, which through its special sections and consultants directs:

1) Supervision of the treatment program in the eight state hospitals for the mentally ill.

2) Supervision of the Minnesota Residential Treatment Center for Children at Lino Lakes.

The Medical Services Division is described in this portion of the booklet. The other divisions of the Department of Public Welfare, not described in this booklet, are Administrative Services, which supervises expenditures of funds; Child Welfare, which is responsible for a wide range of children and family programs; Field Services, which is the liaison between the state Department and county welfare departments; Public Assistance, which administers and supervises distribution of categorical aid and general relief funds; Rehabilitative Services, which includes services for the blind, deaf, and crippled children.

3) Supervision and program planning for the mentally retarded, both within the six state institutions for the retarded and in the community.

4) A state-wide research program.

5) Mental health training program.

6) Community mental health services — including consultation and administration of state funds to the community mental health centers located throughout the state.

7) Mental health information and volunteer services.

8) A mental health study and planning program.

9) Consultation and administration of state funds to day-care centers for the retarded located throughout the state.

Organization

Six section heads and a staff of consultants in the Medical Services Division are responsible for a 9-point program of supervision and planning.

There are six sections in the division, each with a section head responsible for his own broad program. The sections are community mental health services; children's mental health services; research; training; public information, mental health education and volunteer services; study and planning.

Community Mental Health Services

The function of the community mental health center in diagnosing and treating mental disorders and in providing consultant services to community facilities is growing yearly. Twenty state-supported mental health centers have been established and more are planned. In addition to out-patient services, these centers provide 1) collaborative and cooperative services with public health and other groups; 2) informational and educational services to the general public, lay and professional groups; 3) consultative services to physicians, schools, courts, welfare, health and other groups; 4) in-service training program for general practitioners, nurses, clergymen, teachers, case-workers and other professionals; 5) rehabilitative services; 6) a focus for mental health activities in the community.

Each center is responsible for providing these services in the manner most consistent with the demands of its community. But the program is directed by a psychiatrist and his assistant in the central office.

Children's Mental Health Services

Because of increasing emphasis on children's mental problems, a separate children's mental health services section was established in the division in 1961. The section directs a program which now includes emotionally disturbed as well as mentally retarded children.

Specifically, the section is responsible for supervision of the institutional care and training program for the retarded; development of plans for the community care of the mentally retarded (including day-care centers) and other psychiatric disorders in childhood; promotion of public and private community resources for children with mental disorders; consultation with institutions for the retarded; implementation and organization of psychiatric treatment programs; work with extra-departmental agencies, groups and individuals if necessary, in the development of programs.

This section also has the responsibility for one facility for mentally ill children. This facility, the Minnesota Residential Treatment Center at Lino Lakes, provides diagnosis and referral services as well as treatment for children with a wide variety of disorders.

At the same time, developments in state hospitals have also pointed toward specialized adolescent treatment in these institutions. Several hospitals now have adolescent wards or separate living units. These, too, come under the supervision of the children's section.

Research

Research is an important part of the Minnesota mental health program. Projects are coordinated through the central office staff, which includes a research coordinator and assistant-consultant. Their program has been considerably strengthened in the past few years by increases in the legislative mental health research appropriations. Funds are used to support personnel and obtain equipment for researches into such areas as learning; metabolic and physiologic factors; the effects of a variety of institutional programs; the effects of treatment procedures such as group therapy, drugs or improved diet.

Some research is done in cooperation with the University of Minnesota, and other research is supported by federal grants. Community mental health centers are leading in research on social and economic factors that correlate with mental health problems.

All researches, whether under state funds or carried on without such grants, are coordinated through the research section. In order to assure scientific rigor and relevance of all researches and regard for the rights and welfare of patient-subjects, all research is also reviewed by a 5-member advisory board to the Welfare Commissioner, the Medical Policy Committee.

Training

The training program is an important one because it helps insure the availability of future professional workers for the state program. Training is supervised through the central office by the director of the division and related to the department-wide functions of the departmental training coordinator.

Facets of the training program are a summer undergraduate training program in the state institutions and a week-long intensive training program in psychiatry for mental hospital physicians, begun in the summer of 1960.

Another valuable training project is the hospital in-service program for psychiatric technicians. The purpose of this training is to develop skill in the personnel that work most closely with the patients.

Public Information, Mental Health Education and Volunteer Services

This section is responsible for interpreting Minnesota's mental health program to the public, and the development of volunteer services and greater citizen involvement. Printed informational and educational materials, personal requests for information, and statewide informational and educational programs are handled by this section.

The state Volunteer Council, made up of representatives from civic, church and fraternal organizations, is a vital element in the total program of public information. Members of the council provide an organized communications network, and information is relayed through them to their counterparts in all areas of the state.

Study and Planning

A study and planning section, financed through a grant from the National Institute of Mental Health, was established in 1962 to study and evaluate Minnesota's mental health program.

A year later a federal law was passed providing funds for states to establish comprehensive mental health planning programs. With these funds Minnesota has been working to develop goals against which the state program can be measured. The next step will be the formulation of detailed plans to achieve these goals and a reporting system that can measure progress and signal the need for program changes.

In connection with the 1963 provisions, a Mental Health Planning Council was established consisting of representatives of interested lay and professional groups.

Consultants

In addition to the section heads, the central office staff includes a staff of consultants who assist the medical director, the institutions, the county welfare departments and community mental health centers in developing programs and services for the mentally ill and retarded.

These consultants give advice in psychological services, social services, rehabilitation therapies and education, nursing, volunteer services and information programs. In addition, a section supervisor and staff caseworkers coordinate the program for the mentally retarded and epileptic.

The application of these specialized services is described in the sections for the mentally ill and mentally retarded.

LOOKING AHEAD

Much remains to be done in Minnesota's program. There is still a waiting list of 700 to get into the state's institutions for the mentally retarded, and patients on this list must wait 2-4 years for admission. The physician-patient ratio in institutions for the retarded is 1:362 and in the hospitals for the mentally ill 1:118; for psychiatric tech-

nicians the same figures are 1:30 and 1:14. In the institutions for the retarded on the average one registered nurse serves 370 patients.

Additional therapists and specialists of all kinds are needed, as well as a larger staff of psychiatric technicians to assure patients personal and rehabilitative care. But more money will need to be spent. The cost of care in Minnesota's institutions is $6.58 a day for the mentally ill and $4.60 for the retarded — compared with the national figures of $14.10 per day per patient spent in Veteran's Administration psychiatric hospitals and the $36.83 spent on the psychiatric wards in general hospitals.

Patients are still required to work in the institutions for no pay. A 1964 study showed that patient work saved the state taxpayers $9 million each year. But the justification of requiring patients to work in a manner not necessarily therapeutic has been questioned by state officials and the Medical Services Division. It is hoped that eventually through research programs that experiment with patient pay, the need for such pay will be established and written into institutional budgets, and administrative guidelines will be developed.

Work remains. Outdated and overcrowded hospital buildings, patients working for no pay, staff shortages and money shortages must be remedied. But there is hope. It is predicted that the patient of tomorrow can look forward to a greater variety of services, and an even shorter hospital stay.

Buildings at many hospitals are outdated and overcrowded. It is hoped building programs will alleviate some of the resultant problems such as lack of privacy.

By the end of 1964 four Minnesota state hospitals had been accredited by the Joint Commission for Accreditation of Hospitals. The goal is accreditation of all hospitals.

The program will continue to emphasize continuity of care and individual treatment in institutions. Work toward reduced populations plus continued emphasis on the individual's dignity and rights will hopefully remove some of the "mass-care" procedures overworked staff must use.

A greater variety of services will continue to be developed both in and out of the institutions. Along with better methods for continuity of care, day and night hospitals and sheltered workshops may be the first program additions. Complete coverage of the state by mental health centers and day-care centers is also a reasonable and immediate goal.

There is work to do. But it is such objectives as these that keep Minnesota's state program forward-looking.

Mental Illness

Number One

National Health Problem

Mental illness can be described as abnormal, irrational, or unrealistic behavior. In any kind of illness there is something wrong with a person that makes a part of the body or the whole body function in a way that is not normal; in mental illness it is the behavior of a person that is not normal.

Mental illness may be caused by physical, psychological or social factors, or a combination of all three. It may result in exaggerated and abnormal feelings of inadequacy and tensions from coping with real or imagined problems of life, or in loss of ability to deal with reality. Curious and inadequate methods of adjusting to life may become fixed in an abnormal behavior pattern which may or may not fulfill its purpose. There are many kinds and degrees of mental illness, some mild, some severe, but all to some extent render a person either incapable of leading a "normal" life as defined by the community, or a satisfying life as defined by himself or those closest to him.

At the signing of a mental health centers staffing bill in 1965, President Johnson called mental illness the number one national health problem. Statistics show why.

This disability is costly to an individual, his family, the community, state and nation. At least one person in every ten — 17.5 million persons in the United States —

has some form of mental or emotional illness needing psychiatric care. According to National Association for Mental Health statistics and estimates, mental illness is known to be an important factor in bringing on many physical illnesses and even industrial accidents. They estimate that at least 50 percent of all medical and surgical cases treated by private doctors have a mental illness complication.

Each year in the United States about 1,240,000 persons are treated in mental hospitals or the psychiatric wards of general hospitals. This means that at any given time there are as many persons in hospitals with mental illness as all other diseases combined.

These statistics show that mental illness is a serious problem to the nation in terms of the waste of human and economic resources. Public institutions for the mentally ill cost $3 billion each year — $1.8 billion is charged to taxpayers. But this does not indicate the cost to the nation in terms of lives affected or touched by mental illness. As President Kennedy said in his February 5, 1963 mental health speech to Congress, ". . . mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition."

Minnesota statistics support national figures. In Minnesota, as elsewhere, hospital populations have been declining. But this reduction in mental hospital population has been accompanied by increasing turnover, with more patients entering and many more being released now than ten years ago.

In Minnesota the statistics are not much different. The number of residents in hospitals for the mentally ill has declined in recent years, however, from the peak year of 1954. In September of that year there were 11,348 patients in the hospitals, compared with 6,785 in September of 1964 — a net decrease of 40 per cent. Yet at the same time resident populations are down, admissions to hospitals are up, with 700 more mentally ill patients entering the hospitals and over 1,700 more released in 1963-64 than in 1953-54. The reason: the average length of stay in a hospital has been shortened. The prognosis now is that a first-time patient will stay in the hospital only six weeks. This shortened stay has been brought about in part by the introduction of extensive drug therapy in the hospitals, enabling psychiatrists to work with and discharge patients formerly thought hopeless.

Another big factor in reducing the resident population has been the transfer of geriatric mental patients, who do not require psychiatric care, to nursing homes. The extent to which enriched therapy programs, the therapeutic community in the hospitals,

and community-based programs have fostered more rapid discharge cannot be measured, but it is generally accepted that these immeasurables contribute greatly.

In July, 1960, two goals were outlined for the state hospital treatment program by the newly appointed director of the Medical Services Division. He said he would like every hospital in the state to achieve full accreditation by the Joint Commission for Accreditation of Hospitals, and he would like each hospital to adopt an "open door" policy. The open door, except for rare and justified exceptions, eliminates locked doors or other physical restraints which inhibit patient movement.

Thus, the open door has become a symbol of a program of patient care in Minnesota because it is one aspect of the therapeutic community in which emphasis is on procedures that will benefit the patient.

There are five objectives of hospital care for the mentally ill.

In addition to these broad goals, other objectives of the hospital program have been outlined by the Welfare Department agency which supervises the program. These objectives are to:

— admit patients early in their illness
— make a thorough diagnostic study of each patient's illness
— formulate a comprehensive treatment program to best meet his needs
— have the personnel and tools necessary to carry out the plan efficiently
— discharge the patient as soon as possible and with appropriate arrangements for his return to the community, his job and any necessary follow-up care.

Hospitals and Facilities

In Minnesota there are eight state hospitals for the mentally ill and one center for mentally ill children.

Each of Minnesota's eight hospitals for the mentally ill serves a given region of the state (see map). These hospitals are located at Anoka, Fergus Falls, Hastings, Moose Lake, Rochester, St. Peter and Willmar. However, the Minnesota Security Hospital for the socially hazardous mentally ill serves the whole state. Although the Security Hospital is located on the grounds of the St. Peter State Hospital, the two were separated administratively by an act of the 1963 legislature.

Another specialized facility serves the entire state. The Treatment Center for Children at Lino Lakes has beds for 64 mentally ill children under 18. The Center was opened in 1963.

The oldest of the hospitals is at St. Peter, where the first buildings (some of them still in use) were erected in 1866. The newest of the hospitals is at Moose Lake, where original construction was completed in 1938. Building programs have expanded the original campuses of several of the hospitals. Examples of recent additions are the specially designed continuous treatment buildings at Rochester, the geriatric units at Fergus Falls, Moose Lake, Rochester and St. Peter, and the food and services building at Willmar.

Minnesota hospitals are 75 per cent open, which means that in most cases physical restraint is not used on patients, and as much as possible, wards are not locked.

These hospitals have been moving rapidly to implement the objectives outlined for the state hospital program. Their programs are moving forward with increased voluntary admissions—almost 50 per cent in 1964—an official open door policy and close integration of hospital-community activities. Early in 1962 Willmar State Hospital became the first completely open mental hospital in Minnesota and one of the five then known open hospitals in the country. Shortly after that, Moose Lake became open. By the end of 1964, Minnesota state hospitals were 75 per cent open.

Four hospitals had received accreditation by the end of 1964 — Anoka, Hastings, Fergus Falls and Rochester.

THE TREATMENT PROGRAM

Each hospital has its own individual approach to treatment, but generally all approaches are characterized by inter-disciplinary consultation and involvement in the diagnosis, treatment and follow-up of each patient. It is felt consultation between specialists in different phases of the behavioral and rehabilitation sciences help pinpoint a patient's difficulties and promote thorough treatment of his whole personality.

Treating the Person — Not the Disease

Understanding of mental disorders has advanced significantly since the days of Freud, who attributed such disorders largely to conflicts between the conscious self (ego), unconscious desires, and a society which regulates fulfillment of these desires. Now there are several "schools" of psychiatry which agree that certain behavioral aberrations are mental illness but disagree about how they should be treated.

Principally, there are three lines of thinking — the lines that have led to separate treatment methods for mental disturbances. In hospital practice, however, these treatments are not separate, but are used in some combination as decided by a treatment team or medical director. Somatic therapy for physically caused disturbances includes drug and electro-shock treatment. Psycho-therapy for unconscious disturbances is primarily talk-treatment designed to bring a patient's unrecognized fears and desires as well as his ineffectual behavior into conscious awareness. Social therapy is "action" treatment of the social man, treatment designed to facilitate interaction with others. This therapy includes the developing of social skills through group therapy and remotivation sessions that will permit the patient to feel self-confident either in the hospital setting or in the community when he returns. It may include the development of job skills. Milieu therapy is a ward or hospital atmosphere or environment which is conducive to treatment and the patient's well-being. This atmosphere is the responsibility of the staff.

The Treatment Staff

The care, rehabilitation and treatment of the patients is the responsibility of the medical director, a psychiatrist, who has the final authority on treatment procedures. He provides supervision for a staff of physicians, who make a thorough psychiatric and physical examination of the patient when he is admitted to the hospital and prescribe necessary medication.

Hospital treatment is characterized by an inter-disciplinary approach. This means that psychiatrists, physicians, psychologists, social workers, nursing staff, rehabilitation therapists, clergymen, and volunteers work together to design appropriate treatment for each individual.

The conduct and efficient organization of the hospital is the responsibility of the hospital administrator. He establishes and maintains proper administrative procedures for an effective hospital program and hires personnel who will provide this program. Since the 1959 legislature authorized the hospital administrator system, Minnesota is the only state with such a plan. Under the system the chief officer of a hospital may be a graduate of an accredited hospital administration course rather than a licensed physician as formerly. The chief of the medical staff continues to be a licensed physician who is responsible for all medical care, treatment, rehabilitation and research. This system is designed to free the medical staff from administrative duties and give these responsibilities to a specially trained person.

Hospital staffs also include the following specialists, who have a counterpart consultant on the central office staff of the Medical Services Division.

PSYCHOLOGICAL SERVICES

Clinical psychologists by means of interviews and tests help in the diagnosis of each patient's illness and in the planning of treatment. The psychologist's part in mental health teamwork is principally to apply the formal logic of science in understanding, modifying and predicting behavior. Accordingly, the psychologist tries to discover why the patient has trouble handling everyday stresses, and what conditions may help the patient be more comfortable and capable in meeting life in the community. He tries to help the patient learn new ways of looking at situations and acquire better skills in responding to them.

But psychologists' contributions to the staff team are varied. In addition to psychological tests they conduct individual and group therapies; assist with the selection and training of institutional personnel; organize, develop and conduct research projects; work to improve treatment and planning techniques.

SOCIAL SERVICES

In each of the institutions the psychiatric social worker compiles the case history of the patient and his family, consults with the county welfare worker (who may have helped in arranging admission), obtains additional information about the patient from relatives and at the time of discharge helps in making the necessary arrangements for his return to the community.

A great deal of emphasis in social service programs during the past few years has been focused on the needs and problems of discharged mental patients returning to the community. Thus, a major social service function has become consultation with community mental health centers and county welfare departments to encourage community resources to assist in the readjustment of discharged mental patients.

NURSING SERVICES

A registered nurse supervises the nursing services, directs the work of the psychiatric technicians and administers medications under the direction and supervision of the

physician. Nurses are increasingly responsible for training psychiatric technicians, hygiene courses for patients, and in some hospitals are responsible for training selected patients in nursing fundamentals so the patients can work on the wards.

Psychiatric technicians, who sometimes are also licensed practical nurses, have the 24-hour-a-day responsibility for the physical care and the general well-being of the patients under their charge. Because of close contact with the patient, the technician is a valuable source of information on the patient's attitudes, activities and progress.

REHABILITATION THERAPIES

There are three rehabilitation therapists found on most hospital staffs. All are specialists in helping mentally ill patients develop interests and skills that will keep them interested in their surroundings and help them live more productive and well-rounded lives when they leave the hospital. They are the recreation therapist, who plans entertainments and leisure time activities to help patients develop social skills; the occupational therapist, who uses arts and crafts activities to help patients develop hobbies and a feeling of accomplishment; and the industrial therapist who assigns patients individual work tasks to help them regain and improve work habits. In addition, academic educational programs are also included under rehabilitation therapies in many institutions.

Rehabilitation therapy and education programs vary from institution to institution, but the following are examples of patient activities:

Activities in daily living (a living unit in which the patients relearn living skills); public and institutional school programs; adult education; vocational training, for example in farm and homemaking skills and nursing techniques; patient councils similar to student councils in high schools and colleges; music education; private tutoring; art; camping; individual and group sport activities; garden clubs; home economics; speech clubs; independent and semi-independent living; work training and evaluation; woodworking.

Community facilities are being used by the rehabilitation therapists — rehabilitation centers, community job training programs, community workshop and recreation facilities — in order to provide realistic and educational experiences for the patients.

CLERGY

Staff clergymen offer religious programs and individual counseling to meet the spiritual needs of the patients. The institutions hire full and part-time staff chaplains, but several institutions also are served by chaplains sponsored by faith groups. Programs designed to acquaint local clergy with early signs of mental illness and to assist them in counseling emotionally disturbed persons before and after hospitalization are scheduled periodically at several of the institutions. All institution chaplains meet twice yearly to learn more about each other's programs and exchange views as to how the religious needs of their patients can be better served.

VOLUNTEER SERVICES

All state institutions have volunteer programs and a staff volunteer services coordinator. Volunteers work throughout the hospital under the supervision of professional staff. It is recognized that volunteers are important contributors to a hospital's program and often to patient therapy. The number of volunteers in the state is growing as the public becomes aware that, first, volunteers are needed, second, there is satisfaction and much to be learned from working on a regular basis in a mental hospital.

Volunteers serve in a variety of programs. The major emphasis has been the one-to-one program in which a volunteer assumes a personal relationship with a patient — visits him in the hospital, perhaps takes him shopping or invites him to his home. This one-to-one approach is designed to provide an individual situation for the patient and an opportunity for normal community and social contact.

Volunteers also assist in hospital canteens and run used clothing stores; operate nurseries for the children of out-patients; instruct courses; assume responsibility for special events such as carnivals and Christmas programs and gifts; raise funds for institutional and personal patient needs not provided for by state appropriations. Notably, volunteers have raised money or support for patient buses at several hospitals.

SPECIAL SERVICES

In addition to regular facilities for treatment of the mentally ill, a number of hospitals have specialized treatment programs. These include the alcohol treatment facilities

at Willmar for men and women and at Moose Lake for men from eight northeastern counties; the tuberculosis unit at Anoka; the Security Hospital at St. Peter; and the medical and surgical services at Rochester and Anoka.

ADMISSION PROCEDURES AND COSTS

Patients may enter a state hospital for the mentally ill either voluntarily or through a probate court commitment. Voluntary admission and most commitments to a state hospital are resricted to persons who have resided in the state for more than one continuous year. Exceptions to this policy can be made only with the approval of the commissioner of public welfare.

Voluntary Admission

In 1964 almost half of the admissions to state mental hospitals were voluntary. These free-will admissions are encouraged because the "voluntary attitude" of acceptance of treatment seems to lend itself to faster treatment and return to the home community. Voluntary patients also have certain privileges not available to committed patients. They may leave the hospital three days after submitting written notice to the superintendent, and they may retain their civil rights, such as the right to vote, enter contracts and drive a car.

Admission to a state hospital for the mentally ill is either voluntarily or through commitment proceedings. Cost of care depends on ability to pay.

Application for this type of admission is made by a physician directly to the medical director of the hospital in the patient's receiving district. Admission is at the discretion of the medical director and his staff.

Commitment

In those cases where a patient rejects institutional care and family or physicians feel hospital care would be best, admission may be arranged through county probate court procedure. Any relative or reputable resident may file a petition for commitment in the county court of the patient's settlement or presence. Actual court procedures vary, but in all hearings the county attorney represents the petitioner and the patient is represented by his own legal counsel or a lawyer appointed by the court.

Within the first 60 days after admission, the medical director must report to the committing court "the condition of the patient and his need for further care." The medical director has authority to retain the patient, place him on visit, or provisionally or completely discharge him.

Some probate courts request a complete psychiatric evaluation prior to the hearing. It is mandatory, except in emergency admissions, that the court obtain a complete social history from the county welfare department before the hearing is held. Exceptions are Hennepin, Ramsey and St. Louis counties.

Emergency Admission

If a physician feels that a patient is acutely mentally ill and likely to cause injury if not immediately restrained, and a court order cannot be obtained in time to prevent anticipated injury, he may sign a certificate requesting that the patient be admitted for a period not to exceed 72 hours, during which time a court order may be obtained. Such admissions are also at the discretion of the medical director.

Inebriates and Drug Addicts

Two state hospitals offer specialized treatment for the alcoholic or drug-addicted patient. Admission procedures are the same as those for mentally ill persons.

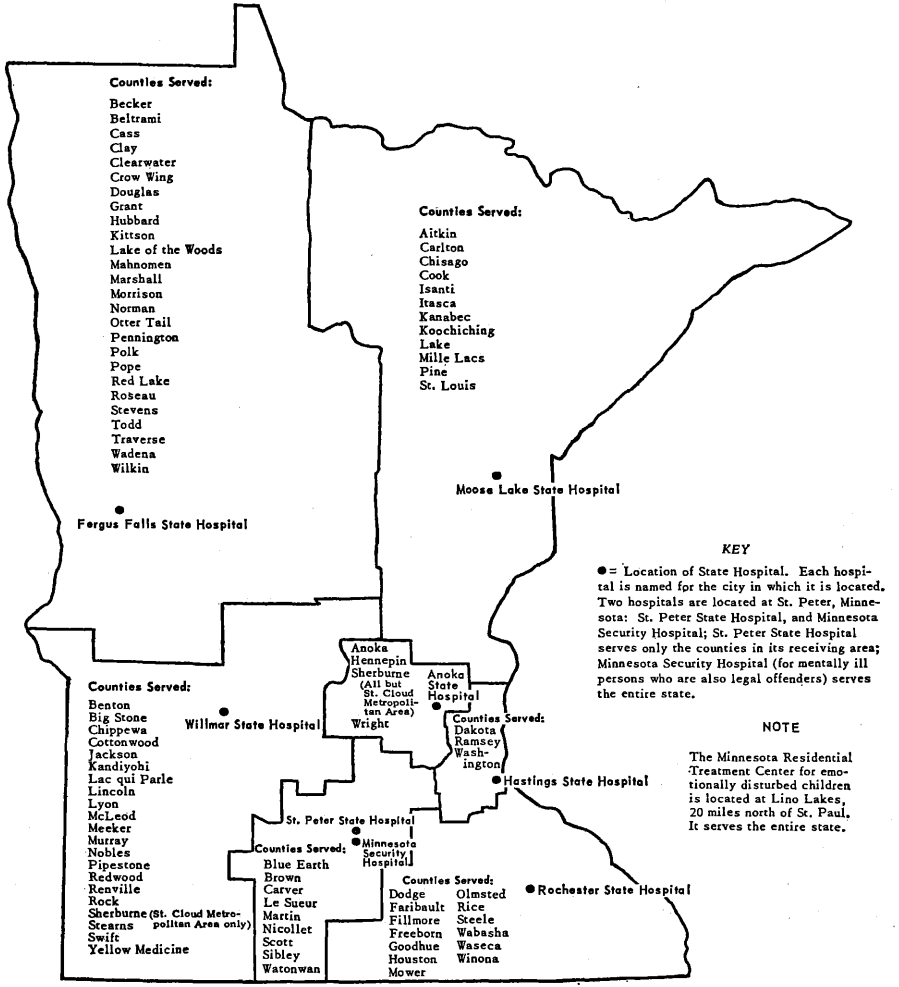
Moose Lake accepts voluntary and committed male inebriates from eight northeastern counties: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, Pine and St. Louis; and Willmar accepts voluntary and committed male inebriates from all other counties and female inebriates from the whole state.

Costs

The laws governing costs for care of patients in the state hospitals are necessarily complex in order to allow services for all regardless of ability to pay.

If patients are able to pay, they are charged for their hospital stay — approximately $7.50 a day. This fee includes the $10 that is charged to the responsible county. This amount is based on the average per capita cost of operating all hospitals in the previous fiscal year.

Hospitals for the Mentally Ill



The spouse, parents and children are responsible for 10 per cent of the average per capita cost if the patient is unable to pay the full cost, but charges are always adjusted according to ability to pay. No relative is required to pay unless his income exceeds $4,000 a year. The Department of Public Welfare may also adjust its rates so that the patient will not be required to pay the full rate if he is unable.

Here are brief descriptions of the programs of each of the state hospitals for the mentally ill and the Minnesota Residential Treatment Center for Children.

ANOKA STATE HOSPITAL, ANOKA, MINNESOTA

Opened in 1900 with the transfer of 115 patients from St. Peter. On July 1, 1964, the hospital's receiving district was changed. The present district of Sherburne, Wright, Hennepin and Anoka Counties includes 1,036,000 persons, or 29 per cent of the state's population compared with the former district's population of 400,000. Since the change, the admission rate has risen 60 per cent.

The hospital is accredited by the Joint Commission for Accreditation of Hospitals.

Programs and Emphases

1. *Tuberculosis service.* Since the 1950s Anoka has provided a tuberculosis service for all Minnesota State Institutions, including a maximum security ward for prisoners with tuberculosis and for patients committed as public health nuisances. In the 1950's the top population was 450 patients. This has been reduced to 40.

2. *Continued treatment program.* Emphasis on rehabilitation and discharge of the hospital's 500 long-term patients. Almost 80 per cent of the hospital's patients come under the category of "career mental patients." The hospital's task is to rehabilitate these patients and prevent others from joining their ranks.

3. *Adolescent program.* This federally financed program includes a living unit for adolescents. The goal is a specially trained staff to provide full education, training and therapy courses for an adolescent population of 70. The program is under the direction of a child psychiatrist.

4. *Night hospital—an emerging program.* Approximately 20 patients spend days in rehabilitation facilities in Minneapolis as part of the hospital's vocational rehabilita-

tion service and return to the hospital in the evening for treatment in a separate facility. This program helps patients who as a result of mental illness, lost or failed to develop vocational skills.

5. *Medical-surgical service.* Anoka State Hospital provides a specialized surgical treatment for patients from 10 other state institutions. Approximately 500 major operations are carried out each year by consultant and resident surgeons from the University of Minnesota.

6. *Research.* Research is being conducted at Anoka into the bacteriological problems of tuberculosis, and psychiatric problems relating to the prognosis in chronic schizophrenia. In addition, the University of Minnesota Department of Psychiatry maintains a research unit at Anoka for the evaluation of new drugs, and the University Department of Psychology maintains a small research unit studying learning processes and conditioning processes in schizophrenic patients and their families.

FERGUS FALLS STATE HOSPITAL
FERGUS FALLS, MINNESOTA

Opened in 1890, the third such hospital in the state.

Fergus Falls serves as the major in-patient treatment resource for a 26 county area: Kittson, Roseau, Lake of the Woods, Marshall, Beltrami, Pennington, Polk, Red Lake, Clearwater, Norman, Mahnomen, Clay, Becker, Hubbard, Cass, Wilkin, Ottertail, Wadena, Crow Wing, Stevens, Douglas, Pope, Todd, Morrison, Grant and Traverse.

The hospital is accredited by the Joint Commission for Accreditation of Hospitals.

Programs and Emphases

The Fergus Falls Hospital is organized in the Unit System — a programming feature that allows patients to be placed in a unit providing the type of care appropriate to their needs. Progressive care is emphasized, which means that as a patient begins to assume responsibility for himself he progresses from a unit requiring maximum care to one requiring minimum nursing service.

These units are:

1. *Intensive treatment unit.* This includes the newly admitted patient, the adolescent, and the patient that might benefit from an intensive but short term of care.

The children's unit is a separate part of intensive treatment because it is felt adolescents have different needs from adults. Between 30 and 40 adolescents out of a total group of 60 are on this program at any one time.

A major emphasis in the intensive unit is vocational rehabilitation through job training that may lead to eventual gainful employment outside the institution.

2. *Convalescent unit* for patients who are preparing themselves for discharge and can live on a unit with minimal or no supervision. Patients are given the impetus or opportunity to be as independent as possible.

3. *Acute treatment unit* designed specifically for the treatment of chronic patients, a big area of untapped treatment prospects. The attempt is being made in this unit to find ways to reach patients who, until recently, have been kept locked up and in 100-bed wards. It has already been found that persons in smaller units respond better to treatment.

Therapeutic community concept. The hospital, its buildings, its geographical community, the employees of the hospital, and the patients and their relatives, represent a major treatment resource — the hospital environment or social milieu. Frequent meetings are conducted among patients and staff. A special attempt is made to channel patients' natural understanding of each other toward better understanding and more adequate resolutions of their problems.

HASTINGS STATE HOSPITAL
HASTINGS, MINNESOTA

Established in 1900 as a transfer hospital for male patients from other state hospitals. In 1950 Hastings was made a regular state hospital with receiving district Dakota and Ramsey Counties. In 1963 Washington County was added to this district.

Hastings was given three-year accreditation by the Joint Commission for Accreditation of Hospitals in August of 1963.

Programs and Emphases

In addition to the therapeutic program planning for each patient found at most hospitals, Hastings emphasizes family counseling and educational training programs, both for hospital personnel and hospital affiliates. It is hospital philosophy that adequate and experienced personnel are essential to patient rehabilitation.

The Hospital is affiliated with the Methodist School of Nursing and the Faribault School of Practical Nursing. Education programs are being extended through affiliation with the University of Minnesota, College of St. Catherine, Macalester College and MacPhail School of Music in such areas as psychology, social work, rehabilitation (including occupational and music therapy).

Macalester College also has a 1-month interim course each year for 25 students who attend classes, live and work at the Hastings Hospital for college credit.

Under the clinical pastoral education program, theological students receive three months of courses as part of their training requirements.

Under a grant from the National Institute of Mental Health, Hastings offers an intensive training program for psychiatric technicians.

Also under a federal grant Hastings is conducting extensive research into therapy methods for long-term patients.

MINNESOTA SECURITY HOSPITAL
ST. PETER, MINNESOTA

In 1906 the Legislature authorized construction of the "Asylum for the Dangerous Insane." The first patients were admitted in 1911 to the institution, located on the eastern quarter of the St. Peter State Hospital grounds.

On July 1, 1963, the state legislature separated the administration of the Security Hospital from the state hospital, and directed that the Security Hospital should have its own full-time treatment staff, headed by a medical director, which would devote itself exclusively to the needs of the Security Hospital.

Male patients are admitted to this hospital from the whole state. Some are transferred from other state mental institutions for behavior problems or security reasons; some are admitted directly from probate court of the committing county when the court decides the patient requires more security than a regular mental hospital would offer. Patients are also admitted by order of the district court while awaiting trial or after a verdict of "not guilty by reason of insanity." About 20 per cent are admitted by transfer from correctional institutions.

(Women security patients are sent to the hospitals for the mentally ill in their receiving district and kept on security wards or other special arrangements are made for them.)

Programs and Emphases

The program at the institution is essentially new. Treatment rather than mere custodial care for the "dangerous" is a new concept in security facilities, and in many respects Minnesota Security Hospital is a national leader.

The new treatment program is based on the premise that the public mandate to the Security Hospital is not only to provide custody and security, but a program of treatment in a hopeful atmosphere, with emphasis on the details of living that may make the difference between a man who accepts himself as a human and one who does not. A growing professional staff, which now includes four women nurses, is helping provide this atmosphere. Professional staff includes a music therapist, social workers, a psychologist, rehabilitation therapist and part-time psychiatrists.

MOOSE LAKE STATE HOSPITAL
MOOSE LAKE, MINNESOTA

The hospital was authorized by the 1935 legislature and opened in 1938. The hospital currently serves mentally ill persons from 12 northeastern counties: Aitkin, Carlton, Chisago, Cook, Isanti, Itasca, Kanabec, Koochiching, Lake, Mille Lacs, Pine and St. Louis; and male inebriates from eight of these counties with the exception of Kanabec, Mille Lacs, Chisago and Isanti.

Programs and Emphases

1. *Open hospital.* Moose Lake is one of the state's two 100 per cent open hospitals, which means that, with the exception of maximum security patients, residents are not restrained by any physical means.

2. *"Total hospital"* program emphasizes community contact and the team approach to treatment.

3. *Remotivation training.* In 1962 Moose Lake was selected by the American Psychiatric Assn. as a regional training center for remotivation workers. (Remotivation sessions are small weekly group meetings at which topics of interest are presented by the remotivator and discussed by the patients.)

4. *Alcohol rehabilitation program.* This program includes group therapy session, a lecture series, medical, psychological and chaplaincy services.

ROCHESTER STATE HOSPITAL
ROCHESTER, MINNESOTA

Opened 1873 as an asylum for inebriates, paid for by an annual $10 tax on liquor dealers. This basis of payment was so bitterly contested, and the number of mentally ill in the state growing so rapidly that on January 1, 1879, the institution began receiving mentally ill — the second such institution in the state.

The Rochester Hospital has a 13-county receiving district: Faribault, Freeborn, Mower, Fillmore, Houston, Waseca, Steel, Dodge, Olmsted, Winona, Rice, Goodhue, and Wabasha.

The hospital is accredited by the Joint Commission for Accreditation of Hospitals.

Programs and Emphases

Southwest Regional Mental Health Center. Early in 1965 the Rochester-Olmsted Community Mental Health Center relocated on the hospital grounds. This move had the effect of making the center "comprehensive" in the sense that it could offer a full range of services, including hospitalization. The center is an important addition to the hospital, for its proximity facilitates continuity of care for patients, a full range of services including referral to community agencies. The proximity of the center in effect makes the hospital a "comprehensive" hospital.

Rochester State Hospital offers four types of service to meet the treatment needs of its patients.

1. *Psychiatric service.* The population of the hospital is concentrated in three buildings — each a psychiatric service headed by a psychiatrist. Each unit represents a cross section of the total population, from new admissions to chronic patients, for it is felt that this mixing and decentralizing of the treatment effort should eventually eliminate chronicity. It is felt that many chronic cases result from the effects of prolonged hospitalization, a mixture of rejection by the staff and apathetic resignation by the patient. The Psychiatric Service offers full time or day or night time hospitalization.

2. *Surgical service.* Patients are admitted directly to the service for surgical care and treatment from Rochester, St. Peter, Hastings, and Willmar State Hospitals, Faribault and Cambridge State Schools and Hospitals, Owatonna State School, St. Cloud Reformatory, Shakopee Reformatory for Women, and YVC at Rochester. Surgeons from Rochester State Hospital also visit the other institutions to consult on new or post surgical cases.

Rochester State Hospital was the first state mental hospital in the country to develop an accredited School for Nurse Anesthetists late in 1964.

3. *The medical service,* the newest of the services, is responsible for the medical, as distinct from surgical or psychiatric, needs of the hospital population. This service is primarily responsible for the geriatric population.

4. *Other services.* All other services, such as psychological services, social services, rehabilitation therapies, occupational therapies are centrally pooled and available to each of the above services on request. This organization according to professional skills is designed to allow flexibility in treatment, easy access to cross consultation and to stimulate each service to design its own program.

ST. PETER STATE HOSPITAL
ST. PETER, MINNESOTA

The oldest state hospital, established in 1866.

The St. Peter State Hospital receives all types of mental patients from its 9-county receiving district: Carver, Scott, Sibley, Nicollet, Le Sueur, Blue Earth, Brown, Watonwan, Martin. Occasionally patients from outside the receiving area are sent to the St. Peter Hospital under the provisions of the Psychopathic Personality Law, and patients referred under MS 246.43 for evaluation following conviction of a sex offense are sent to St. Peter from any part of the state. Occasionally children who have been found difficult to care for in other institutions are referred to this hospital.

Programs and Emphases

The goals of the treatment program at St. Peter are: to relieve the patient's fears, rebuild his confidence and his ability to deal with other human beings to enable him to assume a proper role in society; to restore his faith in some universal order in which he has a place, value, and dignity.

1. *Group participation.* Each department in the hospital has organized programs that encourage group participation by patients and personnel.

2. *Adolescent program.* In 1962 an intensive treatment program for the hospital's younger patients was launched under the supervision of a psychologist, a social

worker, the rehabilitation therapies supervisor, a registered nursing supervisor, and a psychiatric aide supervisor. This intensive and closely supervised program for both males and females is provided on a daily basis and includes a wide range of activities, physical fitness programs, and group therapy.

3. *Night hospital.* A service for patients who are able to work in the community during the day but require specialized treatment and supervision in the hospital. A second phase of the program is the school program for patients ready for training and education but not yet ready to leave the hospital on a provisional discharge.

WILLMAR STATE HOSPITAL
WILLMAR, MINNESOTA

Established by the legislature in 1907 and opened in 1912 as a hospital for inebriates. In 1917, mentally ill patients were also admitted to the hospital.

Willmar's receiving district for the mentally ill is a 20-county area in southwestern Minnesota: Benton, Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone Redwood, Renville, Rock, Stearns, Swift, Yellow Medicine, plus the city of St. Cloud. The hospital also receives male inebriates from the whole state with the exception of eight northeastern counties: Aitkin, Carlton, Cook, Itasca, Lake, Koochiching, Pine, St. Louis, and female inebriates from all 87 counties.

Programs and Emphases

1. *Alcohol and drug addiction program.* The program is conducted in three phases.

a. During the first phase the patient is given a complete physical examination and placed on special care until he is physically well and mentally clear. After this he is interviewed at group staff meetings so that appropriate follow-up studies can be ordered, his treatment outlined and work, room and counselor assignments made.

b. After this first phase the patient is admitted to group therapy coupled with interviews with his counselor.

c. The third phase includes a series of reorientation lectures given each weekday morning by chaplains, counselors, doctors and other members of the unit. These lectures deal with subjects related to alcoholism and drug addiction, personality, marital and religious problems, social adjustment — and are designed to expose the patient to many problems that face him, and give him motivation and insight.

Along with these lectures, meetings are held four nights a week to orient the patients to Alcoholics Anonymous. A recent program addition is a chapter of Narcotics Anonymous.

d. Post-treatment. One of the most vital parts of the Alcohol and Drug Addiction program at Willmar State Hospital is the post-treatment phase. Every effort is made to see that the patient is given some type of contact in the local community when he leaves the hospital — with A.A., the family doctor, the local mental health clinic or a social worker.

e. Counselor's training. As an adjunct to the Alcohol and Drug Addiction program, a 10-month counselor's training program instructs trainees in the treatment of alcohol and drug addicts. Trainees then return to their communities or industry to implement some type of alcoholics program.

In addition to the Alcohol and Drug Addiction program there are four other treatment programs, each housed and staffed relatively independently.

2. *The intensive treatment program.* During the past few years the majority of patients admitted and treated under this program were returned to their communities within three months.

3. *Medical-surgical service.* This deals with the diagnosis and short-term therapy of elderly patients who have been unable to adjust in nursing or convalescent homes, or who need short-term, intensive care to prepare them to return to their families or to be placed in rest homes. The program also provides services for inebriate patients needing major medical or surgical attention.

4. *Activation ward program for long term patients.* This program provides psychiatric supervision or rehabilitation and recreational facilities for several hundred patients.

5. *Research and training.* The program is focused mostly on alcoholism, but it also deals with short-term projects for research in the field of general psychology.

MINNESOTA RESIDENTIAL TREATMENT CENTER AT LINO LAKES

The Minnesota Residential Treatment Center at Lino Lakes, opened in 1963, is the principal facility for mentally ill children. The center was developed to provide psychiatric treatment services for 64 children referred through county welfare departments, or by mental health clinics, state hospitals, correctional facilities and private agencies.

The center has developed a treatment program which consists of psychiatry, psychology, nursing, social welfare, education, and rehabilitation services; and child care and pediatrics. The function of the center is three-fold: to treat mentally ill children and those with serious living problems; to serve as a training center both for the development of staff for institutions and also to serve as a training center in conjunction with the University to train professional persons; to conduct research into the problems of children and methods for testing them.

Referral Procedures

Referrals for admissions must be processed through the appropriate county welfare department. Initial diagnosis and evaluation studies to determine the need for residential treatment should be carried out by a community mental health center, a child psychiatry center or by a child psychiatrist in private practice.

The county welfare department then transmits referrals to the office of the director of children's mental health services in the Medical Services Division. In contrast with other referrals to state institutions, it is not necessary for the welfare agency to prepare

a detailed history and summary of findings. It is anticipated that the psychiatric facility evaluating the child will prepare a report including much of this information.

After screening at the state agency office, each referral will be sent to the staff at the Center for final determination of admission.

Any child who resides in Minnesota is eligible to make application. If accepted, the welfare department of his county pays 10 per cent of the actual cost of his care, and the parents pay the rest according to their ability as determined by the county welfare department. The upper age limit is 18; patients who pass this age are generally transferred to adult mental hospitals.

Experience of other successful residential treatment centers has demonstrated that the younger the child is when referred, the more likely he is to respond to treatment. Therefore, the Center advises that referral be made as early as possible, preferably by age 11 or under, even if the agency making the referral is not certain that residential treatment is indicated.

COMMUNITY MENTAL HEALTH CENTERS

In November, 1964, the mental health board at Winona received a state grant-in-aid to begin operation of a community mental health center. The activation of this center brought the total in Minnesota to 20, seven years after the passage of the 1957 Minnesota Community Mental Health Services Act which offered state support for such centers.

The rapid development of these centers has come in part from a realization that communities are responsible for their own mental health, and that community agencies and persons closest to individuals with mental disabilities are best able to provide support or remedy conditions that may have led to such disorders.

The strength of the community concept comes from the same principle that has led to a change in institutional practices from custodial to rehabilitative — the principle that a mentally ill or retarded individual is a whole person and should be treated as such. Thus, the most effective treatment procedures are directed to the whole personality.

The Community Mental Health Centers Act passed by the 1957 legislature authorizes 50-50 matching funds for communities to provide mental health services. However, the 20 state centers also maintain a flexibility in planning programs and selecting emphases.

In a community setting the patient does not give up that part of his person associated with his family and community, as he does when he is hospitalized. He can be treated in his own environment. This philosophy, coupled with the expediency of community facilities and the advantage of early discovery and treatment of mental illnesses, has expedited community mental health centers.

The centers operate under the Community Mental Health Centers Act passed by the 1957 legislature, an act which defines their areas of concern and outlines their over-all program.

This law provides that each community wishing to organize a center must first have a mental health board made up of representatives of interested community agencies which would be affected by such a center.

This board is to organize the center and apply for funds in a prescribed manner when it is ready to begin operations, and the board is responsible for the financial operation of the center, for obtaining funds and promoting the program. When so designated, it is to act as administrator of the center program.

This center program must provide at least the services of a qualified psychiatrist, clinical psychologist and social worker. Each center is required by the 1957 law to provide as a minimum: consultation services to physicians, schools, courts, health, welfare and other agencies and professional persons; collaborative and cooperative services with public health and other groups for a program of prevention of emotional and mental disorders; community planning and organization; in-service training programs; educational and informational services; diagnostic and treatment services; rehabilitation services for convalescent patients. In addition, centers were designed to participate in research and surveys.

With the passage of the federal Community Mental Health Centers Act of 1963, Minnesota centers which wish to qualify for federal construction funds must also add in-patient services, 24-hour emergency services, and partial hospitalization facilities to existing centers.

Programming

There is wide variation in programming among the mental health centers. The state policy has been to allow flexibility in these programs. Each center is encouraged

to develop a high quality program geared to utilize the experience, training and philosophy of each professional staff member in order to meet the needs and desires for services expressed by the communities.

Some centers emphasize direct services to patients — counseling, therapy and treatment. Other centers have found that they can best serve the population of their counties by consultation with other community agencies which then in turn deal directly with patients. This type of service is more feasible for centers with a very small staff. They teach physicians, teachers, clergy and social workers to work with emotionally disturbed persons; only unusual cases are handled directly by the center staff.

Most centers also are markedly involved in local, regional and state mental health planning, and are actively participating in the work of the groups designed to coordinate local mental health programs, the Regional Mental Health Coordinating Committees.

Several centers have begun research programs or epidemiological studies of their areas which will provide useful data to enable the center staffs to conduct more meaningful services.

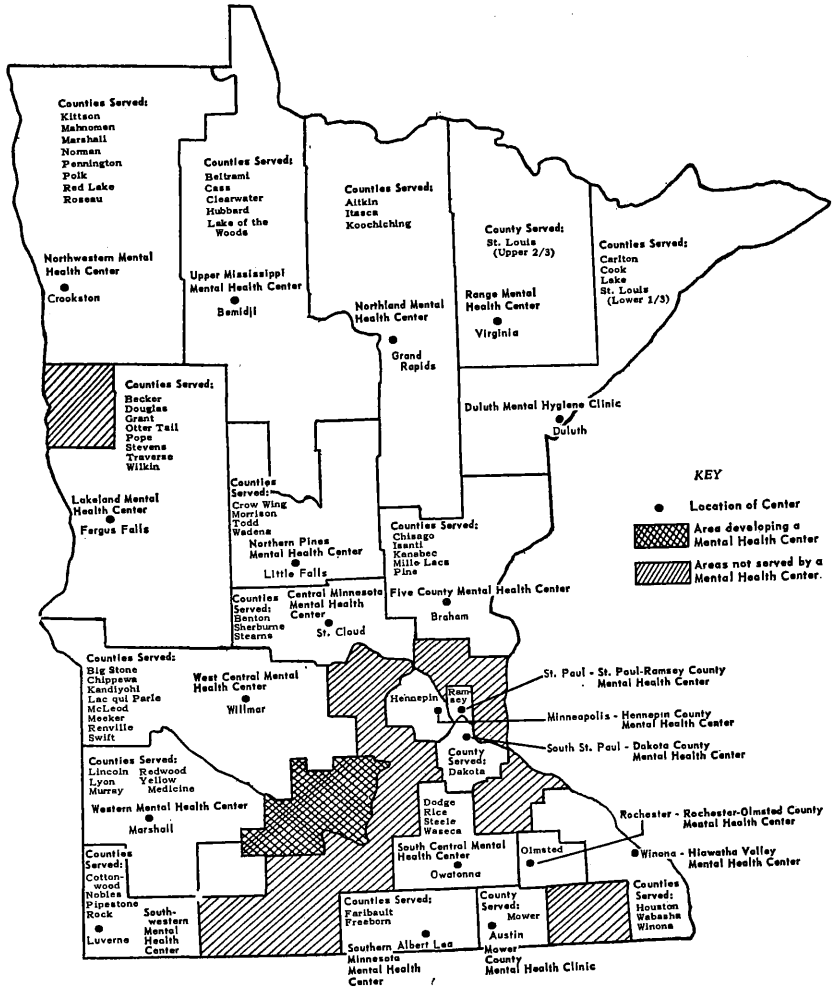
Any resident of a center's receiving area is eligible for evaluation. Eligibility for treatment hinges on the availability of treatment resources and on the applicant's financial qualifications. (Maximum fees are on a sliding scale based on one per cent of federal income tax paid the previous year; if the federal tax exceeded $1,200, the applicant is not eligible. No resident of the area is denied services because of inability to pay. Race, color, creed or length of residence in the area do not affect eligibility.)

Regional Coordinating Committees

For purposes of local coordination of mental health services, the state has been divided into regions according to the receiving districts of the state hospitals. By the end of 1964, five of the seven regions were being served by Regional Mental Health Coordinating Committees.

These committees, with representation from the state hospital staffs, concerned lay and professional groups and from the mental health centers in the region, are designed to provide cooperation and coordination between the programs of the hospitals and the centers in order to insure maximum continuity of patient care.

Community Mental Health Centers



Locations

By the end of 1964, 85 per cent of the population of Minnesota was served by community mental health centers — 71 of the 87 counties.

The following are state-supported community mental health centers:

Central Minnesota Mental Health Center, Inc.
215 South Third Ave.
St. Cloud 56301

Sponsoring Counties:
Benton
Sherburne
Stearns

Dakota County Mental Health Center, Inc.
229 Grand Ave. West
South St. Paul 55075

Sponsoring County
Dakota

Duluth Mental Hygiene Clinic, Inc.
1112 East Superior St.
Duluth 55802

Sponsoring Counties:
Carlton
Cook
Lake
Southern St. Louis

Five County Mental Health Center
Braham 55006

Sponsoring Counties:
Chisago
Isanti
Kanabec
Mille Lacs
Pine

Hennepin County Mental Health Center
619 South Fifth St.
Minneapolis 55415

Sponsoring County
Hennepin

Hiawatha Valley Mental Health Center
Winona 55987

Sponsoring Counties:
Houston
Wabasha
Winona

Lakeland Mental Health Center 121 Mill St. South Fergus Falls 56537	Sponsoring Counties: Becker Pope Douglas Stevens Grant Traverse Otter Tail Wilkin
Mower County Mental Health Clinic 914 First Drive N.W. Austin	Sponsoring County: Mower
Northern Pines Mental Health Center, Inc. Box 58 Little Falls 56345	Sponsoring Counties: Crow Wing Morrison Todd Wadena
Northland Mental Health Center, Inc. 415 South Pokegama Ave. Grand Rapids 55744	Sponsoring Counties: Aitkin Itasca Koochiching
Northwestern Mental Health Center, Inc. Crookston 56716	Sponsoring Counties: Kittson Pennington Mahnomen Polk Marshall Red Lake Norman Roseau
Range Mental Health Center, Inc. 324 First National Bank Bldg. Virginia 55792	Sponsoring County: Northern St. Louis
Rochester-Olmsted County Mental Health Center 2100 East Center St. Rochester 55901	Sponsoring County: Olmsted
St. Paul-Ramsey County Mental Health Center 495 Jefferson Ave. St. Paul 55102	Sponsoring County: Ramsey

South Central Mental Health Center, Inc.
215 South Oak St.
Owatonna 55060

Sponsoring Counties:
Dodge
Rice
Steele
Waseca

Southern Minnesota Mental Health Center
529 Hyde Bldg.
Albert Lea 56007

Sponsoring Counties:
Faribault
Freeborn

Southwestern Mental Health Center
306 North McKenzie St.
Luverne 56156

Sponsoring Counties:
Cottonwood
Nobles
Pipestone
Rock

Upper Mississippi Mental Health Center
510 Beltrami Ave.
Bemidji 56601

Sponsoring Counties:
Beltrami
Cass
Clearwater
Hubbard
Lake of the Woods

West Central Mental Health Center, Inc.
323 W. Sixth St.
Willmar 56201

Sponsoring Counties:
Big Stone
Chippewa
Kandiyohi
Lac qui Parle
McLeod
Meeker
Renville
Swift

Western Mental Health Center, Inc.
438 West Main
Marshall 56258

Sponsoring Counties:
Lincoln
Lyon
Murray
Redwood
Yellow Medicine

Mental Retardation

Why There Is Hope

At one time a family with a mentally retarded member had essentially two choices — to keep him at home or to institutionalize him. This either/or decision often was a difficult one to make, for on the one hand a family might not be able to provide the full-time special care required or the community might not be able to provide special education, while on the other hand the family might be reluctant to see a member "sent away" to an understaffed, overcrowded institution that might provide little more than custodial level care.

The situation is much different now. Increasingly, and especially since the Second World War, society has become aware of the problems of, and possibilities for mentally retarded persons and their families. Associations for Retarded Children have played a large role in decreasing society's anxiety and misconceptions and in drawing public attention and subsequent concern to the mentally retarded. As a result, communities have assumed a large part of the responsibility of caring for and training the mentally retarded. Today state institutions, while still understaffed and overcrowded, have made

In a sense, more positive statements could be made 15 years ago than today about the nature and effects of retardation because less was known then than now. Consequently, a booklet such as this cannot give all the answers but can merely present some of the many theories in this complex and rapidly changing field.

considerable progress in their attempt to provide additional rehabilitation and treatment programs. Thus, resident institutions and family care have become facets of a comprehensive program continuum rather than polar opposites.

It is the purpose of this section to outline the Department of Public Welfare's program for the retarded; describe the Department's facilities for the retarded; outline the service and treatment programs available at these facilities; describe the legal and organizational structure through which the Department administers its program; and risk a brief look ahead.

An Overview

In 1957 the Minnesota State Legislature passed a law requiring local school districts to furnish special education for the educable retarded in their district. By late 1964 there were nearly 250 districts providing such classes and almost 90 districts providing classes for the trainable retarded — the latter made possible but not required by state law.

Day care centers for the retarded, authorized by the 1961 legislature as an experiment and boosted by succeeding legislatures, often do much to enable families of the retarded to keep them at home. The day care program may ease the emotional and physical strain on a family by providing care for the retarded person part of the day, and it also provides the retarded person a chance to learn self-help, self-care and social skills.

Community mental health center services are also available for consultation and out-patient diagnosis. The centers collaborate and cooperate with other groups in programs of prevention of mental retardation and other psychiatric disabilities.

Sheltered workshops, special private homes for the retarded, foster homes and small special treatment facilities are all part of the multiplicity of facilities some communities now offer.

At the same time that community programs have been developing, the institutions themselves have been building therapeutic, training and social programs designed for the individual needs of retarded persons who for some reason cannot take advantage of

care in the community. Staff at state schools and hospitals includes specialists in education and recreation; speech; music; occupational physical and industrial therapies; and an array of medical services. In addition, a number of volunteer programs supplement those of the staff.

Comprehensive and individual planning for each mentally retarded person has become the emphasis of the Department of Public Welfare program for the retarded.

It can be seen that the Department of Public Welfare, which supervises and coordinates the programs of the state schools and hospitals, day care centers, and county welfare departments, has had to develop a flexible policy which can be adapted to changing institutional and societal demands. Thus the function of the Welfare Department with regard to the mentally retarded has emerged and grown. While its primary function once was the supervision of the state schools and hospitals and county welfare departments, now its function is to coordinate and integrate programs where Department facilities are involved and enlist non-Department agencies when needed. Programming for the retarded has become increasingly complex as it has become decentralized and individualized.

A Word About Epilepsy

Laws and older literature about mental retardation often included epilepsy in the same breath. In fact epileptics have historically shared the same treatment program as the retarded, largely because both conditions were regarded as permanent conditions of the brain and often requiring special resident facilities.

Medicine has virtually freed the epileptic to normal living so that now epileptics who are committed to mental retardation facilities, or who share community programs for the retarded, do so not because their primary condition is epilepsy but because their epilepsy is a secondary, complicating factor in their mental retardation. For this reason this program description does not mention epilepsy separately from retardation.

DESCRIPTION OF RETARDATION

Until recently mental retardation was defined as a condition in which the brain is prevented from reaching full development — hence a lifetime condition. This definition, however, ignored the impact of socio-economic factors on the development of a child,

and the importance of cultural factors in the definition of individual cases of retardation.

Mental retardation can be briefly defined as significantly impaired mental functioning. It is caused by a number of known factors, and an even greater number of unknown factors. There are many degrees of retardation, from near-normal to severe.

Three definitions of mental retardation are now in common use:

> The mentally retarded are children and adults who, as a result of inadequately developed intelligence, are significantly impaired in their ability to learn and to adapt to the demands of society.
>
> (President's Panel, 1962)

> Mental retardation refers to sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.
>
> (American Association for Mental Deficiency.)

> The mentally retarded person is one who, from childhood, experiences unusual difficulty in learning and is relatively ineffective in applying whatever he has learned to the problems of ordinary living; he needs special training and guidance to make the most of his capacities, whatever they may be.
>
> (National Association for Retarded Children.)

These definitions recognize a come-lately addition to the list of major causes of retardation — environmental factors. But what role environment plays in the development of a retarded person has not yet been thoroughly investigated. That is, it is not known whether retardation can be caused by educational-cultural deprivation at critical stages in development, or whether this deprivation merely complicates existing physical symptoms. It is recognized, however, that retarded persons, like all living beings, flourish in a rich environment and flounder in a poor one.

The influence of environmental factors on the definition of retardation is better known. Statistics indicate that a person who may be defined as retarded by one group in society may not be so defined by another — or that he may not be so defined at another stage in his development. For instance, it has been demonstrated that adults who are slightly retarded are reabsorbed into the community in many cases and are no longer defined as retarded after they leave the school system. I.Q. alone, therefore, is not a sufficient diagnostic tool in tracing retardation. A person's adaptive behavior becomes an important indicator.

But because retardation has been recognized as a changeable rather than a static

condition, programs in Minnesota and elsewhere have been developed to help retarded individuals realize the potentials they may have.

Causes and Degrees of Retardation

Retardation is a handicap of degrees. It may be so slight the person may only seem slow to classmates or friends, or it may be so severe the person may require complete care all his life. Most of the causes of mental retardation are not well known, although recent research has revealed much. Between 75 and 90 per cent of the cases of retardation have unknown causes.

The known causes are divided into five main categories by the National Association for Retarded Children.

Genetic disturbances, resulting either from incompatibility of genes from the mother and father, or from disturbances of the genes during pregnancy caused, for instance, by over-exposure to x-rays, disease, or infection.

Difficulties during pregnancy. Certain conditions of the mother during pregnancy, such as German measles may prevent adequate development of brain cells in the child, a condition which cannot be overcome after birth.

Stress at birth. Any birth condition of unusual stress or which reduces the supply of oxygen into the infant's brain during birth may impair the baby's mental development.

Conditions after birth. Childhood diseases can affect the brain, especially in the very young. Glandular imbalance may prevent normal growth or an accident may damage brain tissue. It has also been determined that chemical imbalance in the blood may cause brain damage.

Environmental factors. A panel appointed by President Kennedy in 1961 also found evidence pointing to a socio-economic causitive role. Kennedy said in his 1963 mental health message to Congress that studies have shown that women lacking prenatal care

have a much higher likelihood of having mentally retarded children and that deprivation of a child's opportunities for learning slows development in slum and distressed areas.

Among the definite, known causes of retardation are:

German measles during the first trimester of pregnancy
meningitis
encephalitis
jaundice due to a result of carbon monoxide and lead poisoning
physical trauma, including automobile accidents
problems in the delivery process
anoxia
metabolic disorders

Determining whether a person is mentally retarded or not is a difficult procedure, for many factors are involved. Retardation is usually detected by observation, that is, a child appears to have difficulty mastering the fundamentals of learning or has great difficulty at some particular stage in his growth. But it requires specialists to determine whether his difficulty is the result of a physical impairment such as poor hearing, or of an emotional difficulty, or of mental retardation, or a combination of all three.

As was already said, the impairment may be slight, or it may be totally disabling. Twenty-five out of 30 mentally retarded persons are classified as "educable." This means they can look forward to near independence. Programs which emphasize social development and occupational training will enable them to handle normal living situations, although they may still require help under stress.

About four of the 30 retarded children are classified as "trainable," and may anticipate semi-independent lives. They will probably not learn to read or write, but they well learn to take care of personal needs, and may possibly master a simple job under conditions of close supervision. Some of these persons will be safest and happiest in an institution.

One child of the 30 is classified as "severely retarded." He will require nursing care all his life and be totally dependent.

How Widespread is Retardation?

An estimated 5.5 million Americans are mentally retarded — an estimated 6.4 million out of 214 million by 1970. Three out of 100 children born are mentally retarded, making retardation the major cause of disability in young adults who are receiving assistance under the federal program for Aid to the Permanent and Totally Disabled.

The average daily resident population in institutions for the retarded in the United States in 1963 was 179,022. There was a waiting list of almost 26,000. In Minnesota during the 1963-65 biennium institutional populations were decreased from 6,566 to 6,375 in an attempt to eliminate overcrowding and better structure a program. There was a waiting list of 700. In all, there are an estimated 100,000 retarded children and adults in Minnesota.

THE MINNESOTA PROGRAM BACKGROUND

The commissioner of the Department of Public Welfare is legally responsible for the welfare of the retarded in the state.

The responsibility of the commissioner of the Department of Public Welfare for the mentally retarded in the state is based specifically on a set of laws passed in 1917 which empowered a board of control — now the commissioner — to assume guardianship for the mentally retarded. The laws also placed responsibility for administration of this program on this same board of control and the county child welfare departments — now the county welfare departments.

Even farther back than that, the first territorial legislature in 1851 passed legislation placing responsibility on probate judges for mentally incompetent persons, which in that time meant both the "imbeciles" and the "insane." At the time of the opening of the St. Peter hospital in 1866 no distinction was made between the retarded and the ill.

By 1879 it was recognized that some of the "feebleminded" children could profit from training, and they were transferred to the "asylum" for the deaf, dumb and blind at Faribault. Until 1887 the mentally retarded and epileptic continued to be schooled with other handicapped persons, but in that year the Faribault School for Idiots and Imbeciles was made a separate institution under the state Division of Institutions.

The improvement of the institution program and the establishment of special classes in the public schools, which were made possible by the 1915 legislature, showed the increasingly responsible attitude of the state for the mentally retarded.

The 1917 laws firmly affixed mental retardation as a welfare concern and set the flexible framework within which the future programs could be developed.

Dates of Other Significant Legislation

1885 — The State School for Dependent Children was established at Owatonna — now Owatonna State School.

1925 — Cambridge State School and Hospital for Mentally Deficient and Epileptic established.

1937 — County welfare departments established, assume responsibility for state wards.

1945 — State public school may be used for mentally retarded (a temporary law then made permanent.)

1947 — Governor appoints Advisory Council on Mental Health.

1949 — As a result of the report of the Advisory Council, the Mental Health Policy Act was passed which established standards of care and treatment in state institutions for the mentally ill and mentally retarded. These standards were designed to make certain that the physical as well as the professional needs of patients would be met.

1953 — Present Department of Public Welfare succeeded state Division of Social Security and assumed duties of former Social Welfare and Institutions division. The aim of consolidation was to achieve "functional alignment of institutions with operating divisions in the central office organization, plus greater coordination of institutional activities with the county welfare boards and their important direct services to people entering or leaving state institutions." The Medical Services Division of the Department was given responsibility for state's mental health program.

1955 — Lake Owasso Annex (to Cambridge State School and Hospital) was established for mentally retarded children.

1957 — Law passed by the state legislature making it mandatory for local school boards to provide special classes for the educable retarded school-age children in their district.

1958 — Brainerd State School and Hospital for the mentally retarded opened.

1961 — Day care centers for the mentally retarded opened as pilot project.

1963 — Owatonna State School law amended to allow admission without guardianship proceedings.

1957 — Minnesota community mental health centers act passed.

THE DEPARTMENT OF PUBLIC WELFARE

The Commissioner of Public Welfare, through departmental facilities, is legally responsible for retarded persons in the state who have been committed to his guardianship — about 6,400 in the state schools and hospitals, and an additional 4,500 in the communities.

Not all retarded persons are wards of the commissioner, only those who have gone through court proceedings and have been legally committed to his guardianship.

Guardianship is transacted through a probate court procedure arranged by the local county welfare department. Briefly, the arrangement brings in the state as a partner in the family's planning for and support of their retarded member. Until recently admission to all state schools and hospitals was only through this probate court procedure. More recent legislation has made voluntary admission possible.

Guardianship is a legal proceeding which brings the state in directly—as a partner in the planning for a retarded person.

But all wards do not go to institutions. For many of these retarded individuals remaining in their homes guardianship simply means that in emergencies, difficulties, or at the death of the parents the state will assume a greater share or total responsibility for the person. While the parents live, no decision regarding the ward's welfare will be made without parental consent, except where action must be taken for the protection of the retardate or community.

The Formal Structure

The Medical Services Division, one of several divisions of the Department of Public Welfare, is responsible for supervising the entire public mental health program for the state. Within this division, the children's mental health services section carries out the details of these responsibilities for the mentally retarded. One of these responsibilities, in addition to the institutional treatment program, is the administration of funds to communities for operation of day-time activity centers for the retarded. The 87 county welfare departments, under the Field Services Division, are the arms of the commissioner in supervising and planning for the retarded in local communities.

In addition, a staff of consultants in the central office serves the specialists in the state schools and hospitals in the fields of nursing services, social services, psychology, rehabilitation therapies and volunteer services.

On a less formal level the Department maintains close liaison and contact with other agencies working in the same area — notably the Education Department, which supervises special education classes; the Minnesota Association for Retarded Children, a voluntary organization powerful in promoting understanding of the retarded and working for their interests.

A Change in Emphasis

These informal contacts are the result of a growing departmental emphasis on coordination in addition to supervision; and this emphasis itself is due in part to the growing body of knowledge about retardation, knowledge which indicates "retarded children can be helped," as the National Association for Retarded Children slogan indicates.

It is no longer thought that institutionalization is the sole public answer to retardation. Rather, the emphasis is on individual planning and training. Ideally, after a realistic determination is made by a group of specialists of the extent of retardation and of any complicating factors such as emotional or physical disability, a training or education program to suit each person should be designed. This may involve residential facilities,

day-care centers, a foster home, special education or sheltered work. In any event, coordination of facilities for its wards has become a Department function.

THE INSTITUTIONAL TREATMENT PROGRAM

The supervision of the state institutions and the further development and improvement of programs and services still remains a primary function of the Department in carrying out its responsibility to the retarded. There are three state schools and hospitals for the retarded and three smaller, specialized units.

Faribault State School and Hospital is the oldest of the institutions and has the capacity of 2,200 Cambridge State School and Hospital, with a similar program of care, treatment and training, has a capacity of 1,600. The relatively new Brainerd State School and Hospital has a capacity of 1,300.

Owatonna State School offers a residential school program for approximately 250 educable children between the ages of 8 and 21. The Lake Owasso Children's Home, an annex to the Cambridge State School and Hospital, has a capacity of 130 patients. A special program for 30 girls between 4 and 12 is provided in the Shakopee Home for Children.

Because of the life-time prognosis of retardation, the aim of treatment is habilitation, the equipping of the person with skills that will enable him to meet life as he will find it. Many persons leave the institutions. Between July 1, 1962, and June 30, 1964, 690 persons were discharged from the institutions for the retarded. It is important that these persons be equipped with as many skills as possible, and for the persons who will remain in institutions, it is important that their facilities for maximum development, self-help and enjoyment be developed.

The Staff

This training and development is carried out by a staff of specialists which include:
MEDICAL SERVICES

A staff of doctors, supervised by the medical director of the hospital, attends to the physical needs of the patients. This supervision includes administration of drugs and

The program for a mentally retarded person at a state school and hospital involves a number of specialists and volunteers.

necessary medical procedures and enforcement of health standards. Physicians are also important in the evaluation of patients. They conduct regular interview sessions with patients and staff to determine progress.

A staff of nurses dispenses drugs, tends to the personal needs of patients, trains psychiatric technicians and in general attends to the hygiene of each hospital ward and the development and welfare of each patient on it.

Phychiatric technicians are responsible for the physical care and needs of the patients. This may include feeding and dressing and in some instances, (where time and staff allow) training the patients in self-care.

PSYCHOLOGICAL SERVICES

Psychological testing is a big part of the psychologist's job, who also conducts research, and who participates in evaluations of each person's ability. He occasionally assists with individual or group therapy.

SOCIAL SERVICES

The hospital social workers are involved with patients on an individual casework basis; and in arranging admission, discharge, vacations, and follow-up plans. The social worker also is involved with families. She plays an important part in helping the family understand their retarded member, and in interpreting institutional policies to them. At the institutions for the retarded the social workers have weekend office hours because so many families come to visit at that time.

REHABILITATION THERAPIES

The institutions employ a variety of therapists to help patients discover skills or interest. Physical and speech therapists help patients who have these handicaps, while music, occupational and recreation therapists work to develop a patient's interest in the world around him. Industrial therapy programs are an increasingly important part of the program, for they are designed to develop a patient's work skills and habits.

EDUCATION

Education courses are an important part of the day for patients who are capable of learning even the rudiments of reading and writing, or who could gain from a class-

room situation. Because institutionalization is recommended only when necessary, the institutions are receiving increased numbers of younger, more severely retarded patients who are more difficult to educate in the classical sense. Thus the emphasis in many of the classes is on self-care and social skills.

It should be noted that while these educational and individualized programs exist, due to shortages of staff they exist in limited numbers and for a very few.

PROBLEMS THE INSTITUTIONS FACE

More and more patients who are sent to the state schools and hospitals are those who are so retarded that community and home facilities are inadequate, or who have complicating emotional disturbances or physical handicaps. Realistically, these patients' conditions point to increased nursing and supervisory care on the one hand, and increased individual training on the other. Both require additional staff—even more staff than is now required to provide adequate care. However, the sad fact is that state schools and hospitals are so numerically lacking in staff that they are unable to provide more than minimal care for many patients, much less the intensive care and training required.

There are dramatic shortages, such as a cottage at Faribault which has only two psychiatric technicians attending 120 severely retarded, hyperactive men at night. There are subtle shortages, such as those demonstrated in the statistics: In June, 1964, there were

362	patients for each physician
616	patients for each psychologist
373	patients for each social worker
126	patients for each therapist or assistant
370	patients for each registered nurse on duty
30	patients for each psychiatric aide on duty
117	patients for each teacher

Institutions for the mentally retarded, even more than hospitals for the mentally ill, are faced with overcrowding and understaffing. The 1965 legislature, however, took a major step in increasing appropriations and staff for these institutions.

This employee-patient ratio does not reflect the help provided by patient workers. These patients assist with odd jobs around the hospital, with the feeding, dressing and escorting of less able patients, and work on the hospital grounds or on general duties in many areas of the institution.

However, with the emphasis on returning such able patients to the community whenever possible, this source of help is being dried up, for patients able to work are being replaced by more severely disabled. This return of able patients to the community is a notable movement which should be encouraged; patient work without pay is a controversial item which has been frowned on by many. Yet it still remains that these patient workers are vital to the hospitals and that they will have to be replaced with additional staff.

Looking Ahead

Because of public interest in the state program for the retarded, it is likely that at least increasing funds will be available for additional staff to develop more individualized care and treatment programs. This boost may break what is often a vicious circle. Initially, staff does not have time to train patients, for instance to feed and dress themselves and care for their toilet needs. Thus the nursing and technician staff spends much time in chores—feeding, dressing and changing patients—and in turn do not have time to teach them to take care of themselves. Extra staff will help the institutions toward full implementation of the programs described on previous pages.

A waiting list of almost 700 for admission to residential facilities indicates the need for more space. Although this waiting list may be diminished by increased community facilities, the need is still startling.

Additional facilities, however, would also require more staff.

ADMISSION AND COST OF CARE

Admission to a state school and hospital is arranged directly with the institution by the county welfare department concerned. Fees are based on ability to pay.

Since Sept. 1, 1965, admission to state schools and hospitals for the mentally retarded is arranged with the institution directly by the county welfare department concerned. Formerly, admission was arranged through the mentally deficient and epileptic section of the Medical Services Division.

Admissions to institutions for the mentally retarded are carefully screened, not only because of limited space, but to be sure that institutional placement is in the best interests of the retarded individual.

Laws governing charges for care of patients allow services for all regardless of ability to pay. If patients are able to pay, they are charged—not more than $5.14 a day in the state schools and hospitals. This fee includes the $10 that has been charged to the responsible county. This cost figure is based on the average per capita cost of operating all hospitals in the previous year.

If the patient is unable to pay the full cost, the parents are responsible for 10 per cent of the cost, but charges are always adjusted according to ability to pay. No relative is required to pay unless his income exceeds $4,000.

The programs and emphases of each state institution for the mentally retarded are described briefly on the following pages. There are three state schools and hospitals, one state school, and three smaller special state facilities for the retarded in Minnesota.

BRAINERD STATE SCHOOL AND HOSPITAL
BRAINERD, MINNESOTA

The newest of the Minnesota state institutions for the care of mentally retarded persons. Opened June, 1958. Total planned capacity—2,000. 1965 capacity 1,378.

Program and Emphases

A 1964 survey of 1,105 patients at Brainerd showed that the institution must program for 704 with an I.Q. of less than 40; 500 who cannot dress themselves; 381 who are not toilet trained; 376 epileptics; 309 who cannot feed themselves; 225 who cannot talk.

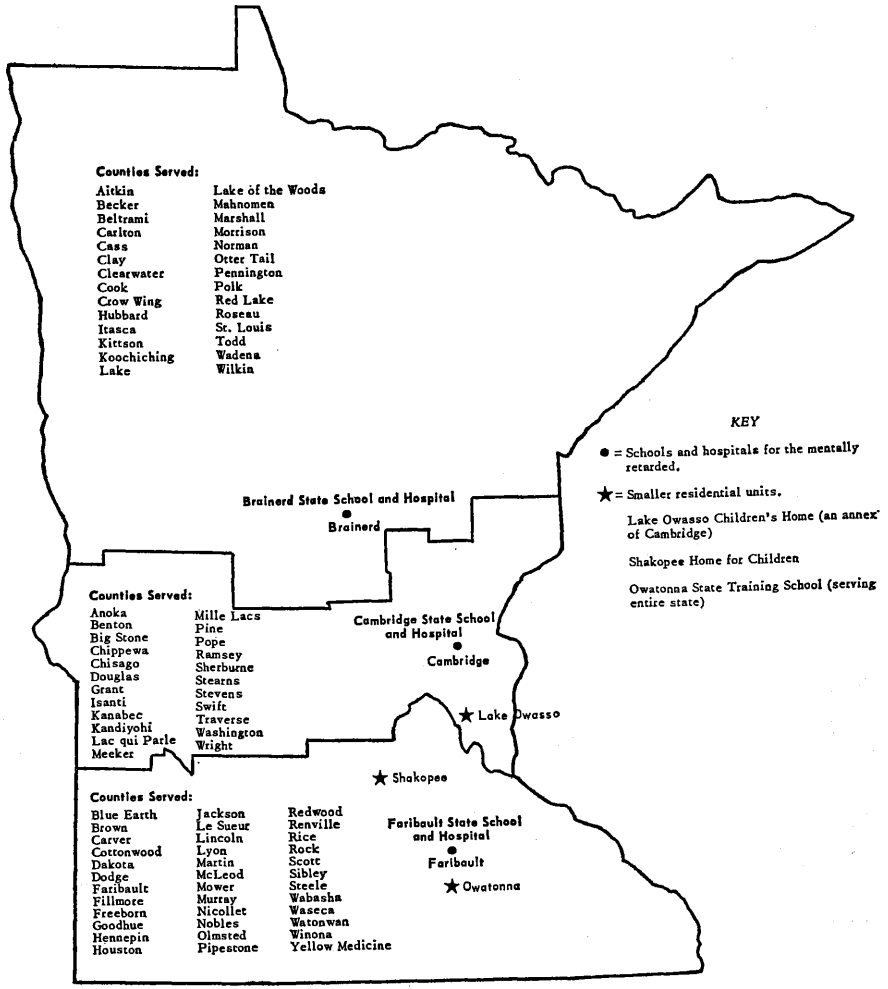
The following programs which Brainerd has developed or plan to develop when staff is available are based on these facts.

1. *Program for the severely physically handicapped patient.* This involves mainly nursing services, physiotherapy department and the recreation and handicraft departments.

2. *Children's program.* A program is planned for about 90 children which would involve a nursery class, sensory and habit training, school, work, remotivation and recreation if the additional staff is obtained to such a unit.

3. *Adolescent unit.* Plans have also been made for an adolescent unit for 60 mildly

State Schools and Hospitals for the Mentally Retarded



or moderately retarded girls and boys who lack social skills or work habits. The program would include work training, formal education, and social education.

4. *Program for adult non-working ambulant patients.* This program, under the direction of the recreation department, involves about 450 patients in small-group arrangements.

5. *Geriatric program.* This program would involve the recreation department, volunteers in a remotivation project.

6. *Brain injured children program.* This is a specialized program in which children who cannot tolerate noise or too many people live in a quiet ward, each with a separate room.

7. *Industrial patients' program.* This program is designed for the 450 adult patients who work in the hospital but are not likely to leave. This program involves the industrial therapist, the recreational staff, handicrafts department and the ward technicians. It is hoped eventually to establish an on-the-grounds-sheltered workshop for these patients.

8. *Program for adult patients with the potential to leave the hospital.* This group, compromising approximately 10 per cent of the population, will be among the foremost users of the Rehabilitation Building when it is completed. These persons will be trained under the supervision of the industrial therapy and social service departments for work outside the institution.

CAMBRIDGE STATE SCHOOL AND HOSPITAL
CAMBRIDGE, MINNESOTA

Authorized by the 1919 legislature for institutional care of epileptics.

Program and Emphases

The program at Cambridge is designed with the following goals in mind: 1. Answer all the needs of the mentally retarded, including super-imposed physical, emotional and

psychiatric problems; 2. Provide the best possible total service to the total care patient; 3. Return as many as possible to a healthy capacity in extramural society; 4. Develop the individuals who must remain to a level of dignified citizenship in the institutional society.

Plans call for dividing the hospital into 6 major treatment areas, each staffed to handle specific problems. These are:

1. *Vocational and community living,* for approximately 200 patients who are able to care for their own needs.

2. *Industrial program* designed for the chronically dependent patient who is not likely to leave the institution.

3. *Physical rehabilitation.*

4. *Total care.*

5. *Special education,* designed to give the educable and trainable patient an opportunity for educational growth and development.

6. *Psychiatric.* Recent investigations indicate that the admissions of emotionally disturbed and psychiatric retarded persons is on the rise. The hospital would like to develop a special unit for these patients.

Ramsey County Preventorium Annex to Cambridge State School and Hospital

The Lake Owasso Children's Home, located in suburban St. Paul, has been an annex of the hospital since July 1, 1961.

Three buildings house a total of 130 girl patient-residents. The girls are moderately retarded, not physically handicapped and the degree of emotional disturbance is mild to moderate.

Program and Emphases

The goals of the Cambridge State School and Hospital apply as well to this facility.

FARIBAULT STATE SCHOOL AND HOSPITAL
FARIBAULT, MINNESOTA

The oldest and largest of Minnesota's institutions for the mentally retarded. Established in 1879.

Program and Emphases

The institution has eight treatment programs based on the present phases of the individual needs of the patients, with the objective that each patient will attain optimal self-reliance and social responsibility.

1. *Intensive therapies, physical,* for 24.8 per cent of the population who require medical care, reconstructive surgery and an intensive self-care curriculum.

2. *Intensive therapies, psychiatric,* for the 21 per cent of the population who have a diagnosis of emotional disturbances, hyperkinesis, severe behavior problems, social pathology or mental illness superimposed on retardation.

3. *Geriatric,* for the 12 per cent of the population who are elderly ambulant patients in moderately good health but with sensory-motor and social handicaps and marked dependency. The nursing and rehabilitation departments help stimulate initiative and interest.

4. *Activation therapies of regressed patients,* for the 15 per cent of the population who are apathetic, unmotivated under-achievers.

5. *Activation therapies of chronic dependent patients,* for the 9 per cent of the population who cannot adjust to community living because they have come to depend on the institution. Rehabilitation and nursing again are involved in activation.

6. *Vocational training and community living,* for the 10 per cent of the patients who are achieving emotional maturity and appear to be making social and vocational progress toward community placement and at least partial self-support. Emphasis is on training in social responsibility and work habits.

7. *School and pre-vocational,* for the 9.4 per cent of the population. Children who can possibly benefit are placed in an individualized "trainable" curriculum. School occupies one-half of their time and rehabilitation therapies the other half.

8. *Research and training program.* Medical research is being conducted by the Faribault pediatrics department in biochemistry, and the psychology department in doing behavioral research.

An in-service training program is provided to all personnel.

OWATONNA STATE SCHOOL
OWATONNA, MINNESOTA

The school was opened in 1886 as an institution for dependent and neglected children. In 1945 the state legislature authorized the use of the facilities to provide academic educational and vocational training for those children who were committed as mentally deficient and who could become self-supporting. In 1961 the requirement of commitment was deleted from the law, so Owatonna can accept volunteer admissions. Approximate population, 250.

Program and Emphases

1. *Primary program.* Children between 8 and 13 are assigned to this program, which is manned by nine full time counselors and five teachers. This program is designed to provide educational and behavioral training for younger children who have had difficulties serious enough to make it necessary to remove them from their homes.

2. *Intermediate program.* To this program are assigned those children between 14 and 16. This program is manned by 12 special school counselors and three full time teachers and some part time help. This program provides education and behavioral training appropriate for the needs of this age group. Many new admissions go directly into this group and do not have the benefit of the primary training.

3. *Vocational program for students between 16 and 21.* The student spends half of each day in school and the other half in an on-campus vocational assignment. Twenty-one counselors, four teachers and a vocational coordinator serve this program full-time. The purpose is to assist the children to meet the demands of society in the area of work, leisure time activities and community living.

Independent living for older students is an important part of this vocational train-

ing. Another important aspect is community work evaluation, a program for 15 students who work downtown in Owatonna during the last six months of their residence.

The majority of students return from Owatonna to the communities. In some cases transfer to another institution for the retarded is necessary, but residency is terminated at 21 years.

SHAKOPEE HOME FOR CHILDREN SHAKOPEE, MINNESOTA

Shakopee Home for Children, opened in September, 1951, for 30 mentally retarded, ambulatory female children between 4 and 12.

Program and Emphases

The function of the home is to provide care of the uneducable mentally retarded and develop a program within the capabilities of the limited trainable group.

Individualized treatment, in addition to custodial care, is designed to help the children expand their limited horizons. Each child is assigned to a small group of five children with similar abilities and is given special attention in developing new skills.

DAYTIME ACTIVITY CENTERS

It is estimated that 95 per cent of the retarded persons in Minnesota live in their home communities and will continue to do so. Then it is essential that communities adopt adequate programs if the retarded are to develop to their highest potential.

In 1961 the state legislature authorized funds for nine pilot-project centers to provide daytime activities for:

"School age mentally retarded children who are neither educable nor trainable under standards established by the State Board of Education.

"Pre-school-age or post-school age mentally retarded persons who are unable to independently engage in ordinary community activities."

The pilot centers proved themselves so effective that the 1963 legislature appro-

priated $155,000 to match local funds 50-50 to support additional centers. By the time the 1965 legislature met, 28 of these state-matched centers were in operation serving more than 350 persons, and additional centers had requested funds to begin operation. The 1965 legislature appropriated $425,000 for support of the centers during the 1965-67 biennium.

What is the Function of the Centers?

Daytime activity centers, operated by communities with matching funds from the state, are a major training and care resource. These centers have been organized to develop the abilities of retarded persons and help them become better functioning individuals in their families and in the community.

In a 1965 survey of the centers, the Minnesota Association for Retarded Children uncovered many everyday success stories that demonstrate some of the functions of the centers. Each center has an individual program, but in general the staff consists of a full-time director, part-time counselors and therapists, and volunteer workers, who provide recreation, training and stimulation for the participants. These activities might include arts and crafts, story-telling, music therapy, supervised outdoor play, rest periods and snack time.

The MARC survey tells of a boy who was hidden by his parents until they could no longer do so. When he was enrolled in the center he was uninterested in his surroundings and was color blind. At the center he learned to identify colors correctly, learned the days of the week and the months and always knows what day of the week it is when asked. The boy's parents have begun to take him places and he has developed social skills and a keen interest in the world around him.

The survey also tells of a boy who was so fearful of strangers when he first arrived at the center that he cried constantly. Now he enjoys coming to the center and gets along well with other participants. The boy's mother has been enabled to take shopping trips to a neighboring town, which she had never been able to do because the boy was so demanding she could never leave him alone.

Besides demonstrating the value of professional care and individual treatment, these cases demonstrate the value of the day-care centers as a resource for parents. The 1961 legislature included parent counseling as a required function of the state-matched centers.

And while nothing can replace parental love for a child, sometimes professional help and outside guidance can provide the extras necessary for realization of a retarded individual's potential or his adjustment to a community.

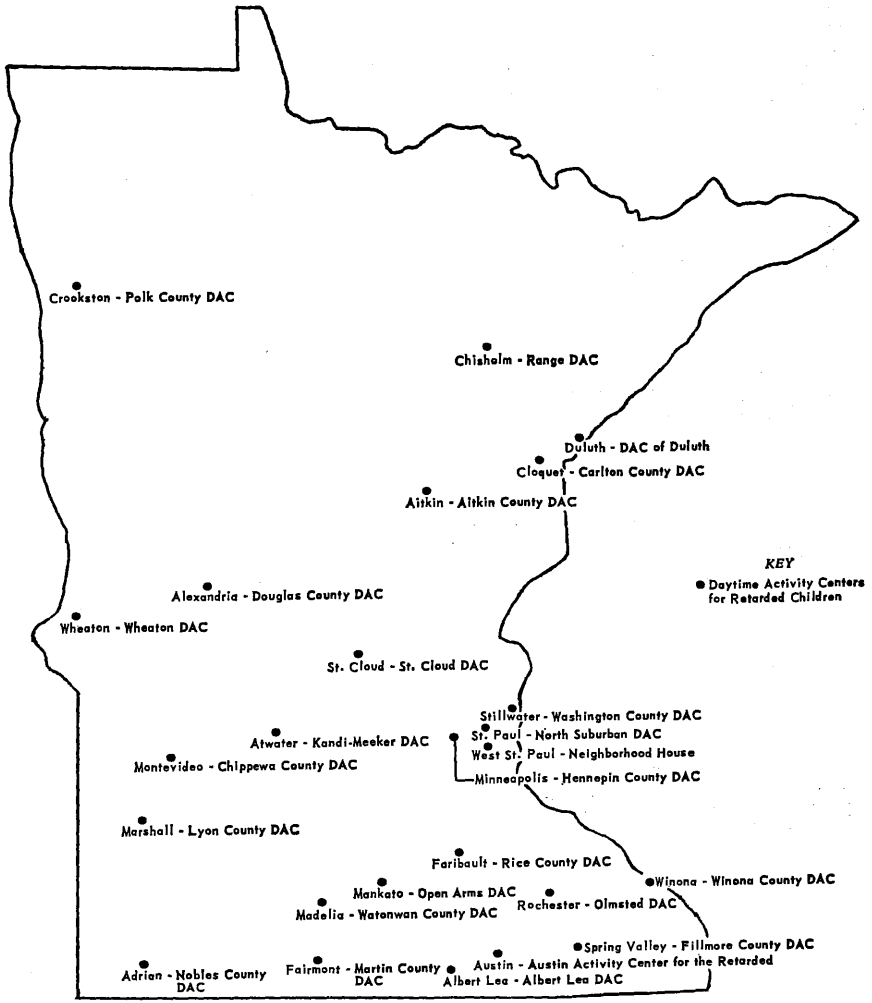
Locations

Early in 1965 the following state-supported day-care centers were offering services:

AITKIN DAYTIME ACTIVITY CENTER Aitkin	Hours	8:30 a.m. to 11:30 a.m.
	Age	16 years and older
	Capacity	10
	Days	Monday through Friday
	Dates Open	September through June
ANOKA COUNTY CENTER 1050 W. Moore Lake Dr. Fridley	Hours	9 a.m. to 2:30 p.m.
	Age	4-16 years
	Capacity	17
	Days	Monday through Friday
	Dates Open	September through June
AUSTIN ACTIVITY CENTER U. S. Highway 16 East Austin	Hours	9:00 a.m. to 4:00 p.m.
	Age	4 years and older
	Capacity	30
	Days	Monday through Friday
	Dates Open	September through June
CARLTON COUNTY DAYTIME ACTIVITY CENTER 45 Fourth Street Cloquet	First Session	
	Hours	9:00 a.m. to 11:30 a.m.
	Age	6 through 14 years
	Capacity	5
	Second Session	
	Hours	9:30 a.m. to 2:30 p.m.
	Age	16 years and up
	Capacity	10
	Days	Monday through Friday
	Dates Open	September through June
CHIPPEWA COUNTY DAYTIME ACTIVITY CENTER Montevideo 56256	Hours	9:00 a.m. to 3:00 p.m.
	Age	4 through 21 years
	Capacity	15
	Days	Tuesday, Wednesday, Thursday
	Dates Open	September to June

Daytime Activity Centers for Retarded Children

(Editor's note: Not all centers are shown on this map.)



DAY ACTIVITY CENTER OF DULUTH 1100 East Superior Street Duluth 55802	Hours Age Capacity Days Dates Open	9:00 a.m. to 2:30 p.m. 16 years and older 16 Monday through Friday September to June
DOUGLAS COUNTY DAYTIME ACTIVITY CENTER Bethesda Lutheran Church Highway 29 North Alexandria	Hours Age Capacity Days Dates Open	8:30 a.m. to 11:00 a.m. 4 through 15 years 12 Monday through Friday September 14 to June 1
FILLMORE COUNTY DAY ACTIVITY CENTER Elementary School Spring Valley	Hours Age Capacity Days Dates Open	8:30 a.m. to 11:00 a.m. 4 to 10 7 Monday through Friday September 2 to June 4
FREEBORN DAY ACTIVITY CENTER 308 Water Street Albert Lea	Hours Age Capacity Days Dates Open	9:00 a.m. to 3:00 p.m. 16 years and older 13 Monday through Friday September through August
HENNEPIN COUNTY DAYTIME ACTIVITY CENTER 1701 Oak Park Avenue North Minneapolis 55411	Hours Age Capacity Days Dates Open	8:00 a.m. to 3:00 p.m. 4 through 18 70 Monday through Friday September through July
KANDI-MEEKER DAY CARE CENTER Atwater	Hours Age Capacity Days Dates Open	9:30 a.m. to 2:30 p.m. 4 through 40 20 Tuesday, Wednesday, Friday September through June
LYON COUNTY DAYTIME ACTIVITY CENTER Ghent	Hours Age Capacity	1:00 p.m. to 3:30 p.m. 4 to 15 years 15

	Days: Monday, Wednesday, Friday
	Dates Open: September through May
MARTIN COUNTY DAY CARE ACTIVITY CENTER North Avenue and 12th Street Fairmont 56031	Hours: 9:00 a.m. to 3:30 p.m.
	Age: 4 years and older
	Capacity: 15
	Days: Monday through Friday
	Dates Open: October through June
MERRICK COMMUNITY CENTER 715 Edgerton Street St. Paul 55101	Hours: 9:00 a.m. to 3:00 p.m.
	Age: 16 to 40 years
	Capacity: 10
	Days: Tuesday through Friday
	Dates Open: Year round
NEIGHBORHOOD HOUSE DAY ACTIVITY CENTER Salem Lutheran Church Bernard and Hall West St. Paul 55118	Hours: 9:00 a.m. to 3:00 p.m.
	Age: 15 through 35 years
	Capacity: 12
	Days: Monday through Thursday
	Dates Open: September 14 to June 4
NOBLES COUNTY DAY ACTIVITY CENTER 849 Turner Adrian	Hours: 9:00 a.m. to 3:00 p.m.
	Age: 4 through 45 years
	Capacity: 20
	Days: Monday through Friday
	Dates Open: September through June
NORTH SUBURBAN DAY ACTIVITY CENTER OF ROSEVILLE 3000 North Hamline c/o Advent Lutheran Church St. Paul 55113	Hours: 9:00 a.m. to 3:00 p.m.
	Age: 4 through 25 years
	Capacity: 40
	Days: Monday through Thursday
	Dates Open: September through June
OLMSTED DAY ACTIVITY CENTER 1625 Salem Road Rochester	Morning Session
	Hours: 9:00 a.m. to 11:30 a.m.
	Age: 3 to 9 years
	Afternoon Session
	Hours: 1:00 p.m. to 3:00 p.m.

Age	10 to 20 years
Capacity	15
Days	Monday through Friday
Dates Open	September to June 1

OPEN ARMS DAY ACTIVITY CENTER
315 South Second Street
Mankato 56001

Morning Session	
Hours	9:15 a.m. to 11:30 a.m.
Age	3 through 12 years
Capacity	12
Afternoon Session	
Hours	1:30 p.m. to 3:45 p.m.
Age	3 through 12 years
Capacity	16
Days	Monday through Friday
Dates Open	September through May, plus a 5-week summer session

POLK COUNTY DAYTIME ACTIVITY CENTER
Washington School
Crookston

Hours	8:30 a.m. to 11:30 a.m.
Age	4 through 21 years
Capacity	10
Days	3 days a week
Dates Open	September through May

RANGE DAY CARE CENTER FOR RETARDED
Vaughan Steffensrud School
Chisholm

Hours	8:30 a.m. to 3:30 p.m.
Age	3 through 25 years
Capacity	20
Days	Monday through Friday
Dates Open	September through May

RICE COUNTY DAYTIME ACTIVITY CENTER
Old McKinley Elementary School
1130 Northwest First Avenue
Faribault 55021

Hours	9:00 a.m. to 3:00 p.m.
Age	8 to 36 years
Capacity	20
Days	Monday through Friday
Dates Open	August 31 to June 4

ST. CLOUD DAY CENTER FOR RETARDED CHILDREN 305 Fifth Avenue South St. Cloud	Hours Age Capacity Days Dates Open	8:30 a.m. to 3:30 p.m. 4 years and older 15 Monday through Friday September through June
WASHINGTON COUNTY DAY ACTIVITY CENTER St. Michael's Church Stillwater 55082	Hours Age Capacity Days Dates Open	9:00 a.m. to 12:00 noon 4 years and older 15 Tuesday, Wednesday, Thursday September through May
WATONWAN COUNTY DAY CARE CENTER Madelia	Hours Age Capacity Days Dates Open	1:30 p.m. to 4:30 p.m. 4 to 12 years 7 or 9 Monday through Friday September through May
WHEATON DAYTIME ACTIVITY CENTER St. John's Lutheran Parish House Wheaton	Hours Age Capacity Days Dates Open	8:30 a.m. to 11:00 a.m. 4 years and older 10 Monday through Friday September 8 to May 28
WINONA COUNTY DAY CARE CENTER 317 Market Street Winona	Hours Age Capacity Days Dates Open	9:00 a.m. to 11:00 a.m. 4 years and older 10 Monday through Friday September to June
WRIGHT COUNTY DAYTIME ACTIVITY CENTER 100 - 1st Avenue Northeast Buffalo	Hours Age Capacity Days Dates Open	8:45 a.m. to 12:00 noon 6 to 10 years 5 Monday through Friday September to May