A MENTAL HEALTH PROGRAM FOR MINNESOTA

-- A SPECIAL MESSAGE --

To Members of the Sixty-third Legislative Session

by

Governor Karl F. Rolvaag

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Mr. Speaker, Mr. President, and Members of the
Sixty-third Session of the Legislature of the
State of Minnesota:

A welcome wind of change has moved through the nation's institutions for the mentally ill and the mentally retarded. In recent years, it has swept before it old attitudes of shame and fear and hopelessness. It has lifted clouds of ignorance and neglect from these institutions and exposed their poverty, their cruel isolation to public gaze.

The power behind its sweep has come from enlightened citizens and their elected officials.

Few states have been untouched by this needed wind of change. Certainly not the state of Minnesota which, I am proud to say, has been a leader in behalf of both the mentally ill and the mentally retarded.

And only a few months ago, President Kennedy revealed the concern of the federal government by announcing an invigorating, precedent-setting plan which, if passed by Congress, will bring even greater changes.

It is almost 100 years since Minnesota opened its first hospital for the mentally ill at St. Peter. And very near three-quarters of a century has passed since an institution at Faribault opened for the mentally retarded.

In the years between then and now, new buildings went up and patients moved in sometimes before the last brick was set. Serious overcrowding existed almost everywhere.

Low salaries and a harsh public attitude made qualified staff -- scarce under the best circumstances -- hard to get.

Efforts, sometimes heroic efforts, were made to provide treatment. But the struggling staff -- from doctors to aides -- was hopelessly outnumbered.

No one would claim that these conditions have been completely wiped out in the past 10 to 15 years. But we have made many significant beginnings and changes. I will mention only three here:

The number of patients in our mental hospitals is steadily declining. Ten years ago, there were more than 11,000 men and women patients. Today there are about 8,000. Behind this important trend are many reasons, including new drugs - dramatic in their results; increased staff; improved medical and psychiatric treatment, and more community services available, including the valuable, improved resources of the county welfare boards.

The per capita daily cost per patient has gone up. In 1953, we spent about $3.00 a day on each patient in a mental hospital and $2.62 for the mentally retarded. Today we spend $5.38 for the mentally ill ($5.40 is the national average), and $4.13 for the retarded. We could wisely and usefully spend considerably more, but this is, as I pointed out, one of our significant beginnings.

The community mental health center program, developed in recent years, now serves 80 percent of our state's population. These centers are, perhaps, the most potentially important, new development in the field of mental health.

Already they have helped focus the problem of mental illness in the community. Instead of locking the problem and the patient in a distant institution, we now have community centers where public health and rehabilitation programs can get at them. By making early treatment easily available, these centers also help greatly to reduce hospital loads.

There are 17 community mental health centers and we should commend these forward-looking communities for their efforts: Crookston, Bemidji, Virginia, Grand Rapids, Duluth, Fergus Falls, Little Falls, St. Cloud, Willmar, Minneapolis, St. Paul, Marshall, Owatonna, Rochester, Luverne, Albert Lea and Austin.

But so far this has been a look at where we have been, at what we already have accomplished. As is often the case with vast, long-term, complicated programs, public interest has dulled and legislative pocketbooks have tightened. We find ourselves on a plateau, perhaps half-way toward our goal. To move from this plateau -- and it could better be called a threshold -- may require infinitely greater sustained efforts than we exerted in the past.

In 15 years, our state made conspicuous progress in its care and treatment of the mentally ill and the retarded. But that progress must be measured against the long, hard distance we had to come, and much remains to be done. Our beginning efforts were courageous and much-acclaimed, but it is the sustained effort -- less exciting and more demanding that now requires our enthusiasm and support.

Minnesota, as I indicated earlier, has been among the states to lead the way in establishing these centers. But so much can be accomplished through them that I put their further development and expansion at the top of the following list of my recommendations:

(1) The community mental health services program must be encouraged to grow until it provides adequate coverage for the state's population. This goal can be achieved in the immediate future if the legislature approves a $2,000,000 grant-in-aid request now before it. This request will provide funds to maintain assistance to those clinics now operating and make possible the establishment of new ones. The community mental health act, adopted in 1957, permits us to expand these services and to take advantage of any federal aid. Each community clinic could also serve a "follow up" function by becoming arms of our Mental Health Hospitals, thereby providing prudent use of funds and avoiding duplication of services.

Quite aside from the direct benefit to patients, a network of mental health centers has at least another valuable function. No program in the entire mental health field can do more to mobilize the informed public opinion so necessary in the fight against mental illness and mental retardation.

(2) We must employ urgently needed new personnel for our mental hospitals. With enough trained workers, the hospitals can give the kind of treatment patients need. It's as simple as that. Without an adequate treatment staff, a continuing decline in hospital population is not possible. And contrary to some thinking, the powerful, new drugs do not do the job alone. Their most skillful and effective use is achieved only through careful supervision and co-ordinated therapy. Both require a highly trained staff. If personnel could be allocated on a basis of admission rates rather than on residential population, great flexibility of program could result.

Particular attention should be paid to personnel requirements of Anoka and Hastings State hospitals. With sufficient personnel, they could take patients from Hennepin county who now are sent to St. Peter. It is far more sensible to serve the metropolitan area with Anoka and Hastings hospitals

which are within a few minutes drive of more than a million people. In addition, it would further increase training and research affiliations with the University of Minnesota and would reduce the overcrowding at St. Peter.

(3) It is imperative that we employ the necessary professional personnel at Lino Lakes. This new facility, begun in 1957, will be ready for occupancy within a few months. In one section of this attractive group of buildings, we will treat emotionally disturbed children. Their problems have been with us a long time, but this is only the beginning of a state program to give them the separate, intensive care they need. In another section, we will provide diagnostic and treatment services for delinquent children and youthful offenders.

Lino Lakes thus represents this state's desire to help both sick and troubled youngsters toward good health and good citizenship. It would be tragic for them, and shameful for us, if Lino Lakes emerges from this legislative session as just another custodial facility.

(4) New personnel is also needed at the state's institutions for the mentally retarded. Currently understaffed, these institutions are having difficulty maintaining necessary services.

(5) The daytime activities center bill for the mentally retarded, now before the legislature, should be passed. It provides up to 50 percent grants-in-aid to cities, counties and non-profit corporations to establish and run these centers. Directly benefited would be school-age, mentally-retarded children not now educable and mentally retarded adults who cannot participate in the usual community activities. These centers also would offer counselling assistance for parents. The highly successful pilot project begun in 1961 is proof enough that these centers will fill a gap in our community resources.

In still another project with the mentally retarded, we are experimenting at our Cambridge and Owatonna institutions with what are called "independent living" units. A new concept of treatment, it permits a small group of carefully-selected patients to try getting along "on their own" while still in the hospital. They have a daily routine, of course, but with counselor-type supervision. The experiment is going well, and the staff at both institutions deserve high praise for their interest and efforts to initiate new programs.

(6) The building bill, presently before the legislature, should be given careful consideration. The expansion and improvement of physical facilities for our state hospitals is an important link in treatment of the mentally ill and mentally retarded.

(7) We should establish an interim commission to study the laws affecting commitment, treatment and release of mental patients. I am concerned that the law should provide our judges with all necessary legal machinery to safeguard rights of persons before they can be committed as well as after they are institutionalized. Our primary concern must at all times be for the welfare of the patient.

(8) Finally, the requests for increased mental health research and training must be supported to the fullest extent possible. Just as the key to proper treatment is trained personnel in sufficient numbers, so the ultimate blow to mental illness and mental retardation will come from research. The funds involved in the Department request are small, but the value returned can be very great. Nor should we forget that a sound research and training program also offers one of the best means for attracting and holding qualified personnel.

I mentioned earlier in this message that the University of Minnesota is working co-operatively with our state institutions both in research and training. Such co-operation has not always been the rule, and I am pleased to note that here, too, we have made a good beginning.

Among research projects going on is one on the tranquilizing drugs which is part of a nation-wide study. Still another concerns certain dietary factors. Some of our patients suffer from convulsive disorders and have both normal and sub-normal intelligence. Many can respond to specialized drug treatment so that positive rehabilitation can be achieved. We could be the foremost state in the nation in helping rehabilitation of these patients.

As for the training program, there are now 27 trainees in various specialties who will give our state institutions two years of their services -- and hopefully more -- after graduation.

I have, of necessity, touched only a few of what I believe are the most immediate requirements of our mental health program. Vocational training, or re-training, and job-finding, for example, are two needs that require both study and action. Many of these items I have mentioned require additional funds in order to accomplish our goals. There is much that we can do, however, where the investment is not so great. We should encourage voluntary admissions. We should expand visiting hours as much as possible. The positions of staff physicians must be elevated. We must offer training and research facilities integrated with care and treatment in our institutions to attract and hold top personnel in our programs. The opportunity is here if we but have the courage to accept the challenge before us.

You who have been so intimately involved with our recent history of concern and accomplishment for the mentally ill and the mentally retarded

know that we stand now at an open door. No medical program can stand still; it must move forward or it becomes obsolete. Changes brought about by new discoveries and new thinking are taking place every day. We must be willing and prepared to implement those that are relevant to Minnesota's problems.

Now is the time to move through that door to renewed interest and intensified efforts and new progress.