

# PROGRESS AND PROMISE . . .

*a report to the Governor  
on Minnesota's effort  
to combat mental retardation  
and what remains  
to be accomplished*



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The Planning Council wishes also to thank the many individuals in all levels of government, in voluntary agencies, and in the private sector who have given freely of their time and thought.

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STATE OF MINNESOTA

Prepared by the

**Minnesota Mental Retardation  
Planning Council**

**December, 1967**



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HAROLD LEVANDER  
GOVERNOR

STATE OF MINNESOTA  
MENTAL RETARDATION PLANNING COUNCIL  
CENTENNIAL BUILDING  
ST. PAUL, MINNESOTA 55101

December 31, 1967

Dear Governor LeVander:

I have the honor to transmit the final report of the Mental Retardation Planning Council.

This report reflects two years of progress made during the implementation period of the Council's three and one-half year federal grant to prepare and implement a comprehensive plan to combat mental retardation in Minnesota. The report also identifies needs which are yet to be met and suggests ways of meeting them.

It is our hope that the Governor's Council on Health, Welfare, and Rehabilitation, which you have designated as the successor to the Mental Retardation Planning Council, will carry forward with enthusiasm the work which we have begun.

The Planning Council is grateful to you for your continuing support and encouragement. We are confident that, under your leadership, the mentally retarded of Minnesota will become first-class citizens in every sense of the term.

Respectfully yours,

A handwritten signature in cursive script that reads "Howard L. Paulsen".

Howard L. Paulsen  
Chairman

Honorable Harold LeVander  
Governor of Minnesota  
St. Paul, Minnesota

## INTRODUCTION

In April, 1964, Governor Karl F. Rolvaag appointed the twenty-five member Minnesota Mental Retardation Planning Council, charging them to develop a comprehensive plan to combat mental retardation in Minnesota. In July of the same year federal moneys for this purpose were awarded Minnesota under Public Law 88-156, thus enabling the beginning of what was to become a three and one-half year effort to investigate, deliberate, recommend, and implement action to remedy the effects of many long years of neglect of the mentally retarded.

*To chronicle that neglect is not our purpose here. Enough has been written and said and shown of half-clad bodies herded together in vacant rooms, of children wallowing in their own excrement, of futile, unheeded headbangers, of outcast inhabitants of back rooms with drawn shades, of modern day lepers in an age of acceptance. We shall not speak of the innocent who have long been feared and ridiculed by the knowing.*

*Our dialogue is a happier one, of hope, accomplishment, and a promise for the future. Because while once we were able to say "the retarded can be helped," we perhaps for the first time can begin to say with assurance "the retarded will be helped," and even "the retarded are being helped."*

In 1966, at the end of eighteen months of planning, reflecting the work not only of the Planning Council, but also of nine Task Forces and seven Regional Committees whose members number in the hundreds, a two volume *Comprehensive Plan to Combat Mental Retardation in the State of Minnesota* was completed and published. Volume I consists of the reports of the Task Forces, including hundreds of recommendations for needed improvements in Minnesota's services to the retarded. Volume II comprises the Planning Council's recommendations concerning regional deployment of services and the facilities needed to house them; this volume, which is revised annually, serves as the statewide construction plan required under Public Law 88-164 in order to qualify for federal matching funds for construction of mental retardation facilities.

We will not repeat here the content or recommendations of the *Comprehensive Plan* except as they are related to action which has been taken, or, in some instances, not taken during the two year implementation period (January, 1966 through December, 1967). We will try to describe the progress which has been made in caring for the mentally retarded of Minnesota. We will also suggest what remains to be accomplished in the most immediate future, realizing that the ever-changing pattern of our knowledge, our goals and attitudes, and our abilities and limitations may enfeeble these exhortations before the ink is dry.

## PREVENTION, DIAGNOSIS, AND RESEARCH

*"As prevention is the ultimate goal in working with mental retardation, so research is the means to that goal . . . It is becoming increasingly clear that research must be carried on by teams that span the disciplines of the medical and behavioral sciences."*

*"Continuous casefinding must be complemented by completed diagnostic workup, including consultation with medical specialists and psychological evaluation, whenever mental retardation is suspected."\**

To assess change in "prevention" is impossible over so short a time period. We can only point to a climate of events directed toward prevention, with every confidence that these will bear fruit.

### Biomedical Prevention

- In July of 1965, testing for phenylketonuria was made mandatory in Minnesota. As of December, 1966, nine children had been identified and placed on corrective diets. Although this yield is statistically small, one has only to talk with parents of retarded children in whom the existence of phenylketonuria was *not* picked up to appreciate the human significance of this testing program.

- The 1967 legislature passed a bill requiring measles immunization of all children in Minnesota prior to public school enrollment. If national figures are proportionately valid for Minnesota, there might thus be prevented annually 20 to 25 cases of mental retardation. Prior to legislation, organized measles immunization programs existed only in Minneapolis, St. Paul, and Rochester, and these were federally funded.

- A new laboratory test to diagnose German measles in pregnant women is now available via the Minnesota Department of Health to physicians who suspect the disease during the first three months of pregnancy, a period in which there is a 20 per cent risk of infant malformation if the mother has the disease. Although the test is considered reliable, there is still no protection against German measles except for natural immunity gained through once having the disease. Researchers are at present trying to develop an effective vaccine.

- Dermatoglyphics (the science of palm prints) is under extensive study in Minnesota

as a preventive clue to the possible existence of "hidden abnormalities," including forms of mongolism and possible phenylketonuria. A pilot study is under way relating dermatoglyphics to microcephaly.

- Other ongoing studies which may have implications for prevention have to do with amino-acid metabolism in mongolism, PKU and other metabolic errors, the identification of genetic carriers in PKU, and a study of chromosomal abnormalities in the mentally retarded.

- The Comprehensive Clinical and Laboratory Study of Mentally Retarded and Neurologically Handicapped, which was federally funded in January, 1966, continues at St. Paul-Ramsey Hospital. Some important aspects of this study relate specifically to prevention: (1) Identification of high-risk mothers and newborns delivered at St. Paul-Ramsey Hospital; (2) intensive well baby and child programs stressing home accident prevention, early identification of physical and mental retardation, and comprehensive immunization and nutrition programs; (3) screening program for all infants delivered at St. Paul-Ramsey; (4) investigation of all stillborns by gross and histologic examination.

- Genetic counseling services are being expanded. New state cytogenetic laboratory services for special problems relating to chromosomal conditions, such as mongolism, sex determination syndromes, and multiple anomalies, are being utilized to capacity and will be enlarged.

### Sociocultural Prevention

- Project Teach, described as a "kind of Head Start Program" for severely retarded, multiply handicapped children, was launched at Faribault and Cambridge State Hospitals in March of 1967. The project aims to "change the life style" of severely retarded children in order to demonstrate that intensive programming in a day-to-day living and learning situation will have a lasting effect on their development. Project Teach embraces all aspects of care and service on a 24 hour a day, 7 day a week basis for a total of 415 children. Children are taught in small activity groups — no more than six children to a staff person — set up to simulate family structure. Project Teach is a three-way participation program involving Department of Public Welfare, institution and central office staff; community volunteers, parent organizations and part-time project employees; and De-

\*Unless otherwise noted, all quotations at chapter heads are taken from *A Comprehensive Plan to Combat Mental Retardation in the State of Minnesota*, 1966.



partment of Education, federal funding under Title I of Public Laws 89-10 and 89-313 (Elementary and Secondary Education Act).

- An operant conditioning program has been in progress since fall of 1966 at Brainerd State Hospital with a group of 36 severely retarded males. Specially trained technicians work with groups of six residents at a time in a program incorporating the teaching of self-care habits, as well as speech training, cooperative play, and work skills. These residents were formerly regarded as unable to learn; they required full time nursing care and were confined to their living quarters because of inappropriate social behavior. Many now wash, bathe, shave, and dry themselves. Some are now able to leave the ward to attend movies, baseball games, and other activities. The most advanced group has begun training in the laundry, learning to fold washcloths and towels; their rate has climbed steadily and is now over 500 an hour. One resident works independently in the laundry. Eight others help in ward work, such as making beds and cleaning. In May of 1967, the operant conditioning program expanded to include another ward.

- Breakfast programs have begun in at least five Minnesota communities under the Child Nutrition Act of 1966, for pupils who came from "deprived backgrounds." Participating school systems include Minneapolis, St. Paul, Crosby-Ironton, Middle River, and Motley; these systems serve 2,500 pupils in eight schools.

- The federally financed Children's Bureau programs for stepped-up prenatal and perinatal care projects in the core area of Minneapolis and the continuing statewide Head Start programs under OEO are both evidence of preventive progress.

#### **Child Development Centers**

Pivotal to the development of diagnostic services in Minnesota has been the concept of the Child Development Center. The germ of this concept is to be found in the pilot child development center at Fergus Falls, established in 1957 as a four-county project by a grant from the Children's Bureau and later expanded to serve eight counties. One of the Planning Council's major recommendations was that a network of Child Development Centers be established throughout the state to provide multidisciplinary evaluation and follow-up services to all handicapped children. The 1967 Department of Public Welfare *Manual on Mental Retardation* rec-

ognizes and supports the importance of comprehensive evaluation prior to placement: "No child shall be considered for placement out of the home without a comprehensive evaluation not only of the afflicted child but also of the family and community resources. Ideally such an evaluation is coordinated and multidisciplinary and includes pediatric, psychological, social and psychiatric studies." The Council envisaged that whenever possible existing facilities such as community mental health centers, local hospitals, state institutions, crippled children's services, and private facilities would be utilized for this purpose. It was hoped that one or more clinics would also be established on an interstate basis.

The need for such a network of centers is underscored by the knowledge that almost half the population of Minnesota lives in sparsely populated, often remote, and sometimes underdeveloped areas of the state where few, if any, specialized services are available. Child Development Centers would provide complete diagnostic evaluations, would make long-range recommendations and referrals to appropriate agencies, would provide counseling services to parents and families, would consult with physicians, schools and community agencies, and would serve as a vehicle for in-service training for various professional workers.

Myriad agencies have become vitally interested in solving this problem, e.g., Governor's Advisory Council on Children and Youth, Governor's Advisory Committee on Services to the Hearing Impaired, State Board of Education, Governor's Advisory Board on Handicapped, Gifted and Exceptional Children, Minnesota Council on Special Education, American Academy of Pediatrics, Minnesota Association for Retarded Children, Minnesota Council for Exceptional Children, Minnesota Association for the Brain Injured, St. Paul Society for the Blind, Governor's Interdepartmental Committee on Children and Youth, Minnesota Society for Crippled Children and Adults, United Cerebral Palsy Association, Minnesota Society for the Hearing Impaired, Minnesota Society for the Prevention of Blindness, Minneapolis Society for the Blind, and the State Departments of Health, Education, and Welfare.

During the latter part of 1966 and the early months of 1967, representatives of these agencies participated in a series of meetings with the purpose of drawing up a bill to establish a statewide system of Child Development Centers. Despite much controversy about the specific functions, staffing, and administration of the cen-

ters, a bill was finally written and introduced to the legislature in April, 1967. Although the bill did not progress beyond the Senate Welfare and House Civil Administration Committees, a high degree of professional and public interest has laid the groundwork for a new and more carefully developed effort in 1969.

Preparation began in this direction with a series of talks by Dr. Richard Koch, Director of the Child Development Clinic and the new Regional Center for the Retarded at Children's Hospital of Los Angeles, in November, 1967. Dr. Koch spoke to physicians and other professional groups in Minneapolis, Rochester, St. Cloud, and Duluth concerning the child development center concept, the role of the physician in provision of services to the retarded, and the utility of the multidisciplinary framework in providing services most effectively.

#### **Available Diagnostic Services**

In the meantime, diagnostic services along the lines envisioned in the proposed legislation are making their appearance either in plan or in reality:

- The West Central Mental Health Center of Willmar has made application for federal moneys to help expand diagnostic and referral services to include a social worker, a pediatrician, and other specialist or paramedical personnel as needed, primarily to serve more adequately the approximately 90-100 retarded children or adults seen each year. Excellent liaison exists between the center and the local sheltered workshop for retarded, the schools, and the general hospital. The center serves eight counties with a total of 150,064 persons (1960 census).

- At St. Cloud (East Central Region), a citizen's group of physicians, educators, and other interested professionals and laymen has acquired federal assistance under Public Law 89-10 for funding of a child development center. This project stems from the fortuitous existence in the counties to be served of an assemblage of medical specialists who have long met as an ad hoc diagnostic team to discuss and recommend for multiply handicapped children seen in private practice.

- At Duluth, the Duluth Mental Hygiene Clinic offers extensive service to the mentally retarded, including diagnostic and evaluative services, liaison with the schools, and parent counseling.

- At Brainerd, the school district has applied for federal funds under Public Law 88-164 to

build a comprehensive diagnostic and day care center which would serve Northern Minnesota.

- At Grand Forks — East Grand Forks, an interstate diagnostic center has recently begun operation with the help of a federal grant. This center will serve both Northwest Minnesota and North Dakota residents.

- The Comprehensive Clinical and Laboratory Study of Mentally Retarded and Neurologically Handicapped at St. Paul-Ramsey Hospital provides, with the help of a federal grant, intensive diagnostic services to a necessarily limited segment of the infant-child population. It is hoped that these services can be expanded as funds and staff time permit.

- The Pediatric Department of the University of Minnesota Hospitals is organizing a diagnostic service for multiply handicapped children, in conjunction with a resident training program. Exploration is being made of available means of additional support for the program.

- The projected Children's Hospital complex in Minneapolis would offer multidisciplinary diagnostic services including short term residential care for diagnostics and observation, as well as other specialized care services. However, the only progress to be reported so far is the merging of Children's Hospital with Mt. Sinai, Lutheran Deaconess, Kenny Institute, and Northwestern Hospitals, thus bringing closer to reality the future specialized role of Children's in a comprehensive medical complex.

#### **Multidisciplinary Research Institute**

The paramount goal of the Research Task Force, and of the Planning Council with relation to research, has been establishment of a Multidisciplinary Institute for Research in Mental Retardation and Human Development. Since 1964 federal construction and operating moneys have been available under Public Law 88-164 on a 75-25 matching basis to help establish such centers.

Several alternative possibilities were given serious consideration by the Planning Council:

- (1) Rochester State Hospital, in conjunction with Mayo Clinic and Mayo Graduate School of Medicine. The Rochester State Hospital Utilization Committee of the Department of Public Welfare has studied the problem, but no positive action has ensued.

- (2) Faribault State Hospital. This site would have the obvious advantages of a huge patient pool as subjects, case records which go back

many, many years, and an active ongoing research program.

(3) University of Minnesota. Attempts to arouse interest here in establishing a multidisciplinary research institute have met with no success. It appears unlikely that any such facility will be built on a University of Minnesota campus in the foreseeable future.

(4) Children's Hospital, Minneapolis. Interest was high in establishing a research center here as a part of a regional medical center for children, but as yet no concrete steps have been taken.

(5) Foundation support might be sought to provide the 25 per cent matching funds which the federal government requires before it will appropriate its 75 per cent share under Public Law 88-164.

### **Remaining Needs**

Preventive activities in Minnesota have at best kept pace with national happenings, prodded by the ready availability of federal funds. Much remains to be done.

One major need is the vigorous dissemination of present medical knowledge, since so much which is already known is neither applied nor utilized.

Another pressing problem concerns the whole area of the disadvantaged, the deprived, the "high risk" families. It is necessary, but not sufficient, that programs of increased genetic counseling, improved prenatal, perinatal, and postnatal care, enriched educational experience, and careful identification of high-risk infants and families be accomplished; these will be to no avail unless the disadvantaged public, as well as the middle-class lay and professional publics, are unceasingly educated to the value of these programs.

All available techniques which help to identify the handicapped child as early as possible must be utilized. Evidence is accumulating to support the pre-school years as those in which the child learns most rapidly. Yet the majority of children are not identified as mentally retarded until they reach school age, thereby wasting precious years in which the handicapped child could be given the "extras" which may help him to function more efficiently later. The recently passed permissive legislation enabling school districts to receive state aids to serve preschool children will help in the task of early identification. The State Department of Education is continuing to study the ways in which the school census procedure can be improved and used as a valuable "case-

finding" tool, as recommended by the Planning Council. Although it was clearly demonstrated in a pilot study financed with council funds that an accurate reporting system of all school children (under 16) excused or excluded from school can unearth an astonishing number of handicapped children who are receiving no services, the Department of Education has not yet established a statewide centralized system which would collect this information and ensure follow-up in provision of services.

The most important step in the guarantee of early identification of the handicapped child, with corresponding provision of ameliorating services, is the establishment of a well-organized network of child development centers. When comprehensive diagnostic and follow-up services become available in centralized accessible locations, when it becomes widely known in Minnesota that such services are available, when parents no longer have to go from one fragmented service to another in an expensive, exhausting search for answers and guidance, then the retarded child will be brought out into the daylight *before* it is already just a little too late.

The appearance of parts of these services in certain areas of the state is a heartening sign. But it remains of utmost importance that the state sponsor a network of centers if we are to be sure that all handicapped children in Minnesota, regardless of geographical location or socioeconomic status, receive the full complement of services to which they are entitled. Even in the metropolitan area, where most services are available, fragmentation results for many families in confusion and discouragement which the existence of a known center could eliminate.

Realistically speaking, it seems unlikely that a federally funded Multidisciplinary Institute for Research in Mental Retardation and Human Development will be established in Minnesota in the foreseeable future. Failing the establishment of such an institute, it is still possible, and would be highly desirable, to set up a central clearing house to facilitate interdisciplinary communication and dissemination of research findings, to concern itself with funding and to make available consultant services.

As important as the expansion of basic research into the etiology and prevention of mental retardation is the rapid translation of known research findings into a generally useful form. There is too great a lag in application of what is already known. The proposed clearing house could perform a valuable service in making information quickly and widely available.

## EDUCATION AND HABILITATION

*"Less than half the mentally retarded children in Minnesota who could benefit from special education are receiving it. It is assumed — conservatively — that two per cent of all school age children need special education programs for reason of mental retardation." (1965)*

*"A special concern is the need to develop sheltered work stations for an estimated three to four thousand retarded adults in Minnesota who will need such accommodations if they are to make an economic contribution to their communities." (1965)*

### Special Classes

Enrollment in special education classes in Minnesota grew from 8,008 during the 1964-65 school year to 9,383 in 1966-67. Although this total increase is not large, it is significant that the number of trainable classes has grown by about 50 per cent. There are at present 126 special education classes serving 991 trainable children; yet an estimated 3,500 more trainable children need these classes. It is important to realize that by law children with I.Q.'s of 30 to 50 are excluded from daytime activity centers and thus have no training resources available to them. Recognizing this need, the Planning Council recommended that trainable classes be made mandatory by the 1967 legislature. The Department of Education took issue with this philosophy but did draft a bill asking that trainable classes be made mandatory by 1971; the bill did not become law. Neither did the legislature grant increased aids for trainable class personnel, additional transportation aids, or the \$900 room and board allowance for non-resident trainable children requested by the Department of Education to match the \$900 presently allowed educable children.

A step forward in serving trainable children was taken when the State Board of Education approved modification of certification requirements for teachers of the trainable, such that those who have had a college major in psychology, sociology, nursing, or related fields may qualify to teach these children. This provision will be effective as of September, 1968.

A potentially exciting project is the proposed construction in St. Paul of a special school for the trainable retarded, which would be made possible with the help of federal funds. Robbinsdale, Minnesota is considering a similar project, a day school for 40 to 50 trainable children, ages 6 to 14.

### Legislative Gains

In other areas, moderate gains were made for special education in the 1967 legislative session.

- The school consolidation bill, number one legislative priority of both the State board of Education and the State Department of Education, was enacted into law. This law requires all state school districts to maintain a program with grades 1 through 12 by mid-1971; any district without such a program by July, 1970 must be dissolved and absorbed by districts with both elementary and secondary programs by July, 1971. By that date, Minnesota, which once had some 7,600 school districts and now has 1,000, will have only about 450 districts. Obviously consolidation is another step toward provision of more comprehensive, sophisticated services which smaller districts cannot furnish.

The consolidation movement is also a developing trend among urban public school districts in the form of regional or subregional "cooperation." For example, a Metropolitan School Boards Association is functioning; groups of districts share a special education program which none can afford separately; the Educational Research and Development Council of the Metropolitan Area, a research-oriented association formed in 1963, is now composed of 41 districts; 20 Metropolitan Area school districts have formed an association for common data processing of records, reports, and schedules and may soon move into instruction. This urban counterpart of rural school district consolidation will also help to assure provision of the special services and programs children need.

Another potentially significant development was the establishment by the 1967 legislature of an interim commission, funded with \$75,000 and assigned the job of "making a study and investigation of elementary and secondary schools, schools aids, and related educational problems with special emphasis on . . . the findings, reports, and recommendations which may be submitted by other significant research groups, governmental and private, during the 1968-69 biennium." It is also assigned the job of recommending to the next legislature "changes in departmental and school organization and in Minnesota education practices in the light of all such reports and studies." This project could afford an excellent opportunity to utilize Planning Council findings and recommendations in the field of education as related to mental retardation. The Council

has asked for a hearing before the interim commission.

- State aids to schools were increased from a support level of between 45 and 46 per cent to an estimated average of 47.85 per cent for 1967-68 and 47.31 per cent for 1968-69. Aids for the 1967-69 biennium will total about \$455.6 million or about \$94.1 million more than in the current biennium. Although the Department goal of 50 per cent was not reached, the allotted increase will help defray the cost to local school districts of providing special programs for the retarded and will stimulate growth of these programs.

- School districts may now provide classes for educable handicapped pupils of preschool age and will receive aid for each pupil in such classes. This law, in effect, enables the public schools to start pre-kindergarten classes for handicapped pupils and thus increases the possibility of earlier identification and amelioration of handicaps.

- Reimbursements to school districts for salaries for teachers of educable retarded pupils were raised from \$4,000 to \$4,400, the amount not to exceed two-thirds of the salary. Reimbursement for teachers of the trainable retarded, however, remains \$4,000 per year.

- Thirty positions in the Vocational Rehabilitation Division were approved during the legislative interim by the Legislative Advisory Committee. This enabled the hiring of vocational counselors at all of the state institutions for the retarded. During the 1967 session, twenty-five additional positions were approved, together with increased program funds.

- State matching funds for sheltered workshops were increased from \$15,000 to \$60,000, with the stipulation that \$20,000 be used to start new workshops.

#### **Federal Legislation**

The leadership role which the State Department of Education must assume in the nurturance of handicapped children is taking shape, primarily as a result of the infusion of federal moneys under Public Law 89-10, the Elementary and Secondary Education Act, which specifically provides for the strengthening of state departments of education. For example, Title VI of P.L. 89-10 authorizes grants to states to expand and improve special education services based on the number of children between the ages of 3 and 21 who need these services. In order to qualify for such grants, the Special Education Section

must prepare a comprehensive state plan for special education; this task is being carried forward with the help of a \$42,000 federal grant. The State Plan will describe current efforts and present needs and priorities in special education in Minnesota. Funds will then be allocated to school districts according to these needs and priorities. It is hoped that Planning Council findings will be thoroughly studied as the special education plan is being developed.

Title I of Public Law 89-10 has as its purpose to improve education for educationally deprived children, that is, "those children who have need for special educational assistance in order that their level of educational attainment may be raised to that appropriate for children of their age." To date approximately 70 programs, some of them cooperative district projects, have been mounted for handicapped children alone, including educable and trainable retarded.

The addition of an assistant administrator for special programs to the Title I staff has done much to improve the quantity and quality of special programs, as has the use of regional consultants to help in the development of local applications. At this writing, Special Programs under Title I serve approximately 4,000 children in more than 30 public and private institutions for the mentally retarded, mentally ill, crippled, blind, deaf, emotionally disturbed, and neglected and delinquent. This year eligibility under this program has been gained for an additional 527 mentally retarded children in state institutions. Minnesota's grant to institutions under Public Law 89-10 totaled \$503,993. Almost half this amount went to institutions for the retarded. In addition many more children are being served in public school special education programs and summer programs for children of migrant agricultural workers.

Apart from moneys and programs under P.L. 89-10 specifically earmarked for handicapped children, the total preventive impact on the "cultural taproots of dysfunction" of programs in which 528 schools have participated, with total funding of \$19,362,416, should not be underestimated.

#### **Vocational Rehabilitation**

The Division of Vocational Rehabilitation of the Department of Education has completed its comprehensive plan for rehabilitation facilities and sheltered workshops. After extensive study, the conclusion has been reached that long-term sheltered workshops continue to rep-

resent the area of greatest need. It should be noted that Minnesota in 1965 passed a long-term sheltered workshop law, which provides for a subsidy of up to 50 per cent of all operating costs of long-term sheltered workshops in Minnesota; the law also enables counties to levy a tax to build and support long-term sheltered workshops.

The following description of progress in sheltered workshop expansion in Minnesota is taken from the Division of Vocational Rehabilitation plan: (1) The Duluth area, with two new workshops planned, is close to meeting its needs. (2) The Minneapolis area has good facilities; a \$165,000 expansion of Opportunity Workshop (Richfield) has increased the capacity of that workshop to 200. Adequate residential accommodations must also be developed. (3) The St. Paul area, with problems similar to those of Minneapolis, has a number of small workshops, one new, and expansion in the offing for others; however, long-term sheltered workshop facilities are badly needed. (4) The Rochester area now has an excellent long-term workshop and is in the process of expanding evaluation and training services. (5) Mankato has progressed quite rapidly. With establishment of a contemplated long-term workshop and expansion of existing services at Mankato Rehabilitation Center, immediate needs could not be met in the future. However, the presence of Faribault State Hospital and Owatonna State School in the area should be noted. (6) The Bemidji area has no existing facility or workshop; thus the pressing need here is self-evident. (7) The St. Cloud area, encompassing Cambridge State Hospital and Brainerd State Hospital, has only one small workshop. At least two more workshops must be established in the St. Cloud area before it can begin meeting its needs.

A vocational rehabilitation planning project is now underway within the State Planning Office, financed by \$200,000 in federal money. Initially, a proposal has been made to establish seven regional committees to plan services for handicapped persons. Each region would be staffed full-time, using DVR federal funds. The goal of the vocation rehabilitation project is to assess the need for rehabilitative services and to ensure provision of these services by 1975.

### **Work-Training Programs**

During the last few years, a variety of "work-training" programs have developed, as described below:

- **School Rehabilitation Program, Minneapolis.** This program operates a separate building which houses classrooms and work laboratories for secondary students in the "mechanical, manipulative, and service employment areas," as well as resources for securing on-the-job training. A student remains in the work-study part of this program until he is "ready" to work; this period may be anywhere from a few weeks to more than a year.

- **School Vocational Rehabilitation Program, St. Paul.** This is a program for senior high school students designed originally for the mentally retarded and aimed at building social independence as well as employability. The student undergoes a work evaluation at the St. Paul Rehabilitation Center, after which the Vocational Coordinator works with the classroom teacher to integrate the academic program, psychological studies, and other school diagnostic resources with the findings of the work evaluation and consults with the teacher throughout the students stay in the program. The coordinator also counsels students and provides liaison with the state Division of Vocational Rehabilitation, whose funds are used to purchase diagnostic training services from community agencies. Work adjustment training outside the classroom is arranged through community agencies such as the St. Paul Rehabilitation Center and Sheltered Workshop. Job placement is also arranged by the Vocational Adjustment Coordinator. Responsibility for the student ends when he is satisfactorily established in community employment.

- **Cooperative School - Rehabilitation Center, Glen Lake.** The work-study aspect of this program, sponsored by the Educational Research and Development Council with the help of a federal grant, offers classroom instruction, a vocational adjustment program, and work experience to "less able" retarded adolescents (age 14-20) who commute from a number of school districts. Students are also offered direct teaching in skills related to service occupations and "home competence." On-the-job training is utilized, as are laboratories in which "elements of employability" and work sampling are learned. Students are also helped to find jobs and to establish themselves in community employment. A feature of this program is case management, a combination of school psychologist, rehabilitation counselor, and counselor roles.

- **Cooperative Work-Training Program, Duluth.** The Duluth school system has for a few

years operated a work center, which offers diagnostic and work training services. The student enters the program in his tenth year, spends part of that year in the classroom, part in the work center, amassing training in "life competence." During the eleventh and twelfth years, he spends half time in the classroom and half in the work center and community work experience, culminating in full time community placement with supportive service of the school and the Vocational Adjustment Coordinator. This program will eventually serve Superior, Wisconsin, as a good example of interstate cooperation.

- **Work Training Program, Anoka.** This program began in Fall of 1967, when a new area-vocational-technical school opened there. Part of the school's program will serve the needs of senior high retarded students, with the Duluth model being considered in development of the program. The services of a Vocational Adjustment Coordinator will be utilized, and it is probable that this program will serve as the base of an "interdistrict service complex" in the future.

- **In-School Work Stations.** Some schools provide this service as a supplement to classroom programs. The student may be classified as a trainee on a minimum salary or may be provided with competitive part-time employment on the same basis as non-students who work on school maintenance or cafeteria staffs. Usually the special class teacher supplies the impetus and support in this situation.

The Vocational Adjustment Coordinator program has undergone major expansion in the last few years, such that, for example, there are now fifteen Vocational Adjustment Coordinators employed within eight of the school districts in the Twin City metropolitan area alone. A Vocational Adjustment Coordinator is a rehabilitation counselor employed by the school district under joint agreement between a school district and the state Division of Vocational Rehabilitation. His job is to offer intensive vocational services to students who, because of physical, mental, or emotional disability, are vocationally handicapped and may benefit from his services. The Vocational Adjustment Coordinator's office is within the school system and he is considered a faculty member; however he also participates in all Division of Vocational Rehabilitation meetings and programs and may purchase or draw upon Division of Vocational Rehabilitation services for his clients. Thus he is in a unique position to utilize both school services and Division

of Vocational Rehabilitation resources to help the handicapped adolescent.

### **Remaining Needs**

As has already been stated, the State Department of Education is being thrust into a role of leadership by the emergence of a large number of federal programs and available moneys. The role of the Department in the development of the Child Development Centers is a critical one, since the vast majority of handicapped children will, at one time or another, receive school services of some sort. Federal stimuli such as Public Law 89-10, the provision of state aids to school districts which structure classes for educable retarded pre-school children, and the considerable growth of classes for the trainable retarded are all aspects of this deepening of responsibility for the handicapped.

Thus it becomes essential that the regional development in educational services recommended by the Planning Council, including the establishment of regional offices by the Department, consideration of "intermediate units" for administration of specialized, shared school services, and establishment of coterminous regions for various kinds of state services, be implemented. This has not taken place, with the exception of the use of regional consultants to help local school districts develop applications for funds under Public Law 89-10. Presumably, the completion of the state plan for special education as well as the investigations and conclusions of the legislative interim commission which is studying educational problems will re-emphasize the importance of these regional developments and give them the authoritative push they need.

As regional services continue to expand, the task of finding teachers and other school personnel looms even larger. Although the junior colleges are moving into the training of semi-professional personnel, no new four-year college programs in training special education teachers have been developed. Yet it has been amply demonstrated in Minnesota that, when special training is available, potential teachers of the retarded can be recruited from the immediate student body and from nearby communities. While certification requirements for teachers of the trainable have been somewhat moderated, they are still stringent enough to eliminate many interested persons well equipped with the experience and warmth necessary to teach the trainable effectively. Further, reimbursements to school districts for these teachers were not increased during the 1967 session.

Perhaps most disappointing was the failure to pass legislation to make trainable classes mandatory. The 1967 report of the President's Committee on Mental Retardation indicates that in those states which have mandatory legislation for special class establishment, enrollment in both educable and trainable classes is almost double that in states having permissive legislation. In Minnesota, approximately half the estimated 18,000 mentally retarded children who need special education services are receiving them. However, although the number of classes for the trainable has also grown, only about one-fourth of the children who might benefit from these classes are enrolled in them.

In the area of habilitation, much progress has been noted in the employment of vocational re-

habilitation counselors at each of the state institutions, the initiation of training programs for retarded persons at Anoka Area Vocational School, the important expansion of the Vocational Adjustment Coordinator program, and the Manpower Development and Training Program (see *Employment*). The increase in 1967-69 state appropriations for operation of community-based sheltered workshops, while modest, is significant. However progress in state administration of federal Vocational Rehabilitation funds for construction of long-term sheltered workshop facilities must be stepped up, most urgently in the Bemidji area, which has no workshop facility, and secondarily in the St. Cloud and Mankato areas, if the Faribault and Cambridge populations are to be adequately served.



## EMPLOYMENT

*"Employers have found that employing the retarded is not charity or kindness. It is business. They are good workers, and they are a good investment."*

*"Help for mentally retarded persons in gaining employment is one of the most important services that can be rendered to the nation and to those who are handicapped. Employment has both social and economic benefits and few aspects of life in our society are more important to the individual."*

### **Service Worker Class**

A most exciting development in employment of the retarded in Minnesota has been the creation of a service worker classification in the state civil service system. This classification eliminates testing of the retarded individual and substitutes screening by two alternating boards of review. Each board, comprised of a social worker experienced in mental retardation, an administrator from one of the state institutions, a representative of the Division of Vocational Rehabilitation, and a state personnel officer studies each case and designates it "pass" or "fail." Those who pass are classified as service workers. Cases are first recommended by state or private agency to the local county welfare board, then evaluated for work potential and social adaptation by experienced Division of Vocational Rehabilitation workers. Personnel people in all state departments have been asked to screen their jobs and to indicate those which could be filled by retarded workers.

It has been anticipated that the new system will be valuable not only to the retarded whom it enables to work, but also because it will provide personnel to work in service occupations in state facilities, such as institutions for the retarded. It is disappointing to report, however, that, to date, only nine service workers have been hired. Breakdown is as follows: Anoka State Hospital (1); Gillette Hospital (2); Department of Administration (1); Department of Health (1); Glen Lake (1); Highway Department (1); Willmar State Hospital (1); Faribault State Hospital (1). 37 persons have passed the review board and are eligible but have not been placed.

### **Governor's Committee on Employment of Handicapped**

Because of enthusiasm concerning this program, the Governor's Committee on Employment of the Handicapped has formed a subcommittee

to study the possibilities for employment of the mentally retarded in other governmental units — county, city, school district, village, township. As a first step, this subcommittee has initiated a survey project, beginning with the office of the Ramsey County (St. Paul) Director of Personnel, to ascertain occupations or job classifications in the county departments which might be filled by other qualified employable retardates. The Governor's Council is also coordinating similar efforts on the part of counterpart area councils in St. Paul, Minneapolis, St. Cloud, Rochester, and greater Steele County.

### **Private Industry's Role**

A number of private industries and business establishments have made notable strides in employment of the retarded in the last few years. The W. T. Grant Company, locally as well as nationally, has been a leader in employing the retarded and in establishing policy guidelines which should enable "normal" employees to interact with retarded employees with mutual understanding and benefit. Other companies which have been prominent in employing retarded workers are the Waldorf-Horner Paper Co., the Minnesota Mining and Manufacturing Company, and the Sheraton-Ritz Hotel Corporation.

### **Manpower Development and Training Program**

Another innovative project which has gone forward with the financial aid of the federal government is the Manpower Development and Training program at Faribault, Cambridge, and Brainerd State Hospitals and Owatonna State School. This project, which began in Fall of 1966 and graduated 79 trainees in Spring of 1967, was a cooperative venture on the part of the Departments of Education, Public Welfare, and Employment Security to train retarded persons as food service workers, house-keeping assistants, and nursing aides. In addition to the vocational training offered, self-management skills and essentials of independent living were also stressed. Courses were taught in the institutions by area-technical-vocational school instructors. Trainees were paid 31 dollars a week in adult programs, 20 dollars a week in youth programs.

This MDTA program was an excellent example of interdepartmental cooperation. Trainees were screened for eligibility by institution and Division of Vocational Rehabilitation personnel, as well as by the Department of Employment Security. Local area-technical-vocational school

directors and coordinators worked closely with local employment service managers and with institutional personnel in preparing and administering the program. District Division of Vocational Rehabilitation representatives, assisted by state institution administrators, cooperated with Employment Service representatives in selection and referral of trainees. A St. Paul based firm, Economics Laboratory, Inc., became interested in the potential of retarded workers, contributed course outlines and dishwashing equipment to the MDTA program, helped to train the participants in "warewashing," and has identified 200 jobs which retarded workers can perform.

Follow-up data obtained by the Department of Employment Security 90 days after conclusion of the MDTA program indicated the following:

| <i>Location</i>         | <i>No. of<br/>Trainees</i> | <i>No. of<br/>Job<br/>Referrals</i> | <i>No. in<br/>Trng. Rel.<br/>Employment</i> |
|-------------------------|----------------------------|-------------------------------------|---|
| Faribault S. H. . . . . | 21                         | 21                                  | 13*   |
| Cambridge S. H. . . . . | 21                         | 19                                  | 15  |
| Owatonna S. S. . . . .  | 21                         | 21                                  | 13  |
| Brainerd S. H. . . . .  | 21                         | 21                                  | 9   |

\*Five other trainees had been placed in employment but had returned to the hospital for medical reevaluation. Salaries range from \$.30 to \$2.25 per hour.

Application has also been made for a 1968 MDTA grant, its program to be conducted at Cambridge and Faribault State Hospitals. Retarded persons from the community and from Brainerd State Hospital may also be included. Instruction will again be offered in housekeeping, food service, and nursing aide work. The 1967 Warewashing Program initiated by Economics Laboratories of St. Paul will probably continue.

Problems which arose during administration of the previous grant and which will be avoided in the 1968 program include: (1) Working out satisfactory housing and supervision when employment is in Twin Cities and residence elsewhere. (2) Assigning responsibility for follow-through on placements (e.g., institution, county welfare office, etc.). (3) Providing for the situation wherein trainees were "ready" before the full training period had elapsed and regressed because counties would not accept them for placement.

#### **Problems of Retarded Workers**

In an effort to clarify the kinds of problems retarded persons meet on the job, the Employment Task Force studied 36 representative job placements of mentally retarded persons in Min-

nesota. One-third of the group had attended some kind of special class. Thirty per cent had received high school diplomas—16 per cent through special classes, 13.8 per cent in regular classes; 44.4 per cent had completed eighth grade or less. According to the study, 45 per cent of the sample group manifested on-the-job problems which required follow-up. Almost one-fourth of the reported problems related to "poor academic skills." Next in descending order of magnitude were "appearance," "lack of confidence and responsibility," and "social ineptitude."

#### **Remaining Needs**

A conservatively estimated 65,000 retarded persons in Minnesota are capable of learning to support themselves, with the help of proper job training and placement services, thus relieving the taxpayer of this financial burden. Although training programs such as Manpower Development and Training are important, the greatest impact in increasing employment opportunities will probably be made when we learn to tailor the job to the man, rather than to train the man for the job. Jobs can be broken down into parts and new job descriptions written to fit the particular abilities of the retarded, much in the manner that will have to be utilized to provide employment for the economically disadvantaged who, like the retarded, have little education and few job skills.

Another change which will enhance employability of the retarded is the establishment of homelike group living arrangements—apartments, foster homes, half-way houses, community hostels, and sheltered living arrangements, whose appurtenances include personal, social, and financial counseling, recreational services, and general supervision and guidance through the everyday problems of living and working.

Further, although the state has made a significant forward thrust in employment of the retarded through the establishment of the Service Worker class, it remains for private industry to take imaginative leadership in redefining jobs which the retarded can perform and in identifying, if not actually providing, training appropriate to these jobs. Although this is a humanitarian endeavor, the economic benefit to the private sector will be of considerable consequence. Its direct benefit will be to enable private industry to fill jobs with conscientious, able workers; its indirect benefit will be to shrink the welfare rolls and relieve the taxpayer of the support of many thousands of able persons.

## RESIDENTIAL CARE

*"The challenge to State institutions is how to accelerate the change from large, isolated facilities to smaller units close to the homes of the patients and to the health, education, and social resources of the community; and the challenge to both state and private residential facilities is how to replace the old concept of custodial care wherever it still exists with modern programs of therapy, education, and research."*

### Cost-of-Care Bill

The Planning Council has long felt that the establishment of a pattern of small, community-based residential facilities cannot move forward without changing the present inequitable distribution of cost of residential care. Under present law the county of residence pays only ten dollars a month for the residential care of any mentally retarded person placed in a state facility; the state pays the remainder. On the other hand, if the county places a retarded person in a non-state facility, the county pays the full cost of care. Thus it has been financially advantageous for counties to press for placement of patients in state institutions, rather than in smaller non-state facilities, irrespective of these patients' needs.

One of two key pieces of legislation\* sponsored by the Planning Council was the Cost-of-Care bill, which changed the distribution of financial responsibility for residential care of retarded persons as follows:

(1) The county would pay 10 dollars per patient per month whether residential care were provided by state owned facility or licensed private facility.

(2) Parents would pay up to 10 per cent of the cost of care (based on ability to pay) whether care were provided by state-owned facility or licensed private facility. The amount to be paid for care in a private facility would not exceed the amount which the parent would pay to a state facility for comparable care.

(3) The state would pay the remainder. Payment for care provided by a private facility would be by reimbursement to the county.

The Cost-of-Care bill passed the House and Senate Welfare Committees with the following amendments:

(1) Change county responsibility from 10 dollars per patient per month to 10 per cent per

\*The other: The Child Development Center bill.

patient per month, whether such care is provided by licensed private facility or state operated facility.

(2) Place a \$200 per patient per month limit on the amount the state would pay for residential care.

(3) Exclude rent, amortization, and lease as items in which the state would share the cost.

(4) Provide that financial records of any facility may be inspected by the Commissioner of Public Welfare.

The main stumbling block in getting the bill through the legislature was the sizeable appropriation required — an estimated \$2,600,000 for the 1967-69 biennium. The Planning Council urged that the legislature support the "equalization concept" even if at this time the state could only pay a portion of the total cost. However, the bill progressed only as far as the Senate Finance Committee and, having been reported out of the House Appropriations Committee with no appropriation, did not reach the floor of the House.

The most important effect of this legislation, if passed, would be the placement of every retarded person requiring residential care in the facility best suited to his needs, without the prepossessing concern for financial differential which now exists. Hand-in-hand with this benefit would go a second, the encouragement of private non-profit groups to construct and staff residential facilities, thus gradually relieving the state of much of this economic burden and enabling the retarded to live in smaller, home-like units closer to their home communities.

Two examples illustrate the way in which the inequity in cost of state vs. non-state residential care affects the placement process:

(1) A private non-profit group in Minneapolis operates a residential facility designed to serve 200 young retarded adults who live in and work either in the community or in a sheltered workshop on the premises. Because counties are reluctant to pay 130 dollars a month for the care of patients presently institutionalized at a cost of 10 dollars a month, this facility has suffered from scarcity of clients. Yet this type of retarded person should be returned to the community where appropriate services exist — for his own benefit and to alleviate overcrowding in state institutions.

(2) A private pediatric nursing home is licensed to care for 39 non-ambulatory retarded

children. It has never been full since it opened its doors in January, 1965. Again it may be assumed that counties are unwilling to pay the 200 dollar monthly fee, when for 10 dollars a month the same child can be kept in a state institution. Yet it is well documented that non-ambulatory retarded children benefit immeasurably from intensive care and attention which they cannot receive in massive, understaffed state institutions.

Additional help in maintaining a greater number of retarded children in private facilities would also accompany passage of proposed state legislation to remove the minimum age limit (18 years) for Aid to Disabled.

### **Cambridge-Moose Lake Project**

In Fall of 1965, an experimental program was initiated to transfer selected mentally retarded patients from Cambridge State Hospital to Moose Lake Hospital for the mentally ill. The transfer of patients began the following March (1966). A total of 28 mentally ill, mentally retarded adult patients were transferred. Patients for transfer were selected from the Cambridge population using the following criteria: ability to walk; ability to speak or communicate; absence of gross physical defect; existence of mental illness or "emotional problems;" some ability to adjust to the ordinary daily activities of living; agreement of patient or relatives to the transfer; and residence in a county in the Moose Lake Hospital receiving district. Intelligence test scores varied from about 30 to 73, with a mean of 53. Residents thus selected were assimilated into the already existing program at Moose Lake.

In July, 1967, representatives of the Department of Public Welfare met with Cambridge and Moose Lake hospital personnel to evaluate this program. Although no attempt was made to design a research study to assess the effects of the transfer, consensus of staff and administrators was that the program was generally successful. The anticipated problems of readjustment to a new environment, acceptance by other patients, and reorientation of staff were judged to be "minimal and easily resolved." All but four transferees improved in varying degrees and three have been discharged to their communities. None of the transferred patients seemed to show any serious regression in general behavior.

### **Use of State Hospitals for the Mentally Ill**

The Planning Council has given lengthy and careful consideration to the overall role of state hospitals for the mentally ill in caring for the

mentally retarded. The Council recommended further study of several alternative possibilities:

1. *Integration of selected mentally retarded persons into mental hospital programs.* Because of the apparent success of the Cambridge-Moose Lake program, plans to extend it to other state hospitals have been developed by the Department of Public Welfare, the Minnesota Association for Retarded Children, and the Planning Council. Subsequently the legislature issued a clear mandate to "utilize all available bedspace to relieve overcrowding of the mentally retarded," thus enabling the Department of Public Welfare to move forward in its plan to establish special units for the retarded at hospitals for the mentally ill. About 50 additional staff positions were authorized, to be added to participating institutions as transfers are made. (See p. 14 for details)

2. *Conversion of one or more of the state's seven medical hospitals to a facility serving the mentally retarded.* The Council has taken the position that conversion of a state mental hospital to serve the retarded *exclusively* could be a major tragedy in that it would perpetuate an outmoded system of massive impersonal "state institutions," substandard with respect to care, programs, and space in which to live as a human being. The Council has recommended that all substandard buildings be razed at the earliest possible date and replaced with small, home-like regional facilities which would be an integral part of general regionalization of education programs, daytime activity centers, sheltered workshops, private residential facilities, and other community-based services.

In an attempt to give further study to this conversion problem, with particular reference to Hastings State Hospital, Governor LeVander appointed a Blue Ribbon Committee, of which the Planning Council Chairman was a member. This Committee, after brief but intensive study, concluded that needs of the mentally retarded must be considered "on an entirely separate basis from those of the mentally ill group." The committee supported the concept of small, home-like facilities and called for long term planning to determine building needs prior to the 1969 legislative session. However, Governor LeVander observed in a letter accompanying the committee's report that "the question of whether mentally ill and mentally retarded patients can or should be treated in the same facilities has not been satisfactorily resolved." The Governor also recommended that a new study commission

(presumably a reference to the Governor's Council on Health, Welfare, and Rehabilitation authorized by Public Law 89-749) should "take full advantage of the previous work done by the numerous groups and organizations who have devoted so much time to the problems of mental retardation and mental health."

3. *Establishing separate programs and living quarters for retarded persons on the grounds of state mental hospitals.* The possibility of transferring a substantial number of patients from state hospitals for the retarded to hospitals for the mentally ill, with separate programs and living quarters to be set up for the retarded, is currently under consideration by the Department of Public Welfare, which administers both kinds of facilities.

The Council has urged that such transfer be effected *only after* provision has been made to structure programs specifically designed to meet the special needs of those individuals proposed for transfer. *At best a program such as this should be utilized only on a temporary basis until more appropriate facilities can be provided.* It could, however, be an acceptable alternative as part of a much broader program to bring residents closer to their homes.

It is a truism to say that working with the retarded is very different from working with the mentally ill. The primary goal in working with a retarded person is to help him make maximum use of his limited capacities in order to master the skills of everyday living. Professional and patient care staff accustomed to working with the mentally ill find it difficult to adjust to the severe limitations and slow progress of the retarded, while at the same time trying to meet the frustrating challenge of day-to-day demands of service to a variety of retarded patients, each of whom differs markedly from the other. Prior to effecting any large scale shift of residents, staff should be completely retrained.

### **State Building Plan**

How best to serve retarded persons who need residential care is a continuing urgent problem. As a partial solution, a long-range State Building Plan, designed to take full account of modern regional concepts of residential care, was designed in December, 1965 and further developed in December, 1966 and in October, 1967 by the Planning Council, the Department of Public Welfare, and the Minnesota Association for Retarded Children.

The State Building Plan would stabilize the number of retarded persons in state residential facilities at about 6,000, including about 730 anticipated placements of retarded persons in institutions for the mentally ill.\* The success of the building plans also depends upon passage of the cost-of-care bill, which by eliminating cost as a major factor in residential placement would help promote the establishment of private, non-profit community residential facilities; the latter could absorb many clients who would otherwise swell the rolls at state institutions. Growth of daytime activity centers and classes for the trainable retarded should also enable stabilization of population at the state institutions.

The Building Plan includes a Regional Plan designed by the Director of Medical Services, Department of Public Welfare, wherein four different types of residential facilities would be established, utilizing present state hospital sites, in each of seven regions as follows:

(1) A small multipurpose, central facility containing diagnostic, treatment, and child development units; (2) a larger primary facility oriented toward education and training of adults and adolescents; (3) a secondary facility to provide treatment for a variety of special cases; (4) an assortment of very small affiliated facilities or separate living complexes throughout each region. Under this plan central facilities at St. Paul and Minneapolis would serve children exclusively; Cambridge, Brainerd, and Faribault State Hospitals would serve adults.

Building requests to the 1967 legislature included \$2,000,000 for replacement buildings at Faribault — not appropriated; \$1,000,000 for building renovations and small units to house those displaced by remodeling at Cambridge — reduced to \$560,000 for remodeling; and \$500,000 for regional site selection studies and land acquisition in Duluth for a 200 bed facility — not appropriated. Further construction at Faribault on a dormitory for about 100 patients authorized by the 1965 legislature has been temporarily halted. The Commissioner of Public Welfare has stated that at present he does not plan to request new buildings for the retarded at the 1969 legislative session.

\*Eventually, 100 transfers will be made to Hastings State Hospital, 120 to Fergus Falls, 450 to St. Peter, and about 60 to Rochester. St. Peter will then get 20 additional staff positions and Hastings 29. At St. Peter and Fergus Falls, the retarded will be housed in buildings separate from the mental patients. At Hastings, about 50 retarded will be merged into wards for the mentally ill and another 50 will be housed separately.

At the October, 1967 meeting, two major recommendations were made to the newly formed Governor's Council on Health, Welfare, and Rehabilitation:

(1) "The state should encourage the expansion of private residential facilities primarily by the adoption of legislation providing reimbursement to counties for persons placed in private residential facilities, on the same basis as the state assumes the costs when a person is placed in a state institution."

(This is, of course, a reiteration of the number one priority assigned to passage of the cost-of-care bill in 1969).

(2) "Because of the pressing need for suitable facilities for retarded children and adolescents requiring specialized services and treatment, the state should build a residential unit providing for small living units, for 100 to 150 retarded children over 5 years of age and adolescents in the Twin Cities metropolitan area."

#### Placement Process

The placement process was also subjected to careful analysis by the Planning Council, whose recommendations centered around the necessity for comprehensive evaluation prior to placement and the importance of bringing the local agency and the family into more intimate relationship vis-a-vis the placement of a retarded member.

Reflecting a recognition of this philosophy, the 1966 Mental Retardation Manual prepared by the Department of Public Welfare states that "final decision on placement should not be made until the parents have been told of the variety of facilities and services available and given the maximum opportunity to consider their feelings both about caring for the retarded person and to consider the effects of separation for shorter or longer periods of time. . . . Placement should be considered as a step in a treatment plan." And further, that "case planning for the retarded should be done . . . at the local level among those agencies . . . dealing directly with the person."

Even more important in bringing placement service close to these receiving it was the Department's edict that, as of October, 1965, "application for admission to a state facility will be made by the county welfare department directly to the receiving institution, which will maintain its own waiting list. To this end, the Mentally Deficient and Epileptic Section will leave the in-

itiative for planning and decision with the local agencies."

Although the DPW Mental Retardation Manual also specifies the need for comprehensive evaluation prior to placement, evidence indicates that the state institutions for the retarded still house many who might well be discharged into the community if they were properly evaluated and appropriate followup provided. A systematic plan should be developed to screen all residents, as well as candidates for placement, in order to bring about the best and most appropriate care and service for each individual.

#### Program Standards

As regionalization of facilities for the retarded moves forward under the impetus of Public Law 88-164, which provides 50 per cent federal matching money for construction of mental retardation facilities when matched with 50 per cent by applicant, as well in response to burgeoning professional and popular awareness of modern concepts of care, the need to develop adequate program standards becomes more and more urgent. The Planning Council strongly recommended that program standards be devised and built into the licensing process, to apply to all individuals and agencies wishing to care for the retarded on a day or residential basis. The Council also recommended that standards be formulated in terms of well-defined needs of homogenous groups of retarded persons wherever they might be housed, rather than in terms of kinds of facility.

Although a special committee of the Residential Care Task Force held many meetings to explore Minnesota's "standards and licensing lag," their activities never really progressed beyond the argumentation stage. Therefore the Planning Council authorized its staff to prepare a federal grant application to finance an 18 month project to develop standards for services\* appropriate to homogenous groups of retarded persons in day and residential facilities. The application is presently being reviewed. Whether or not the federal grant is made, it is imperative that standards be written. They will be useful in both internal and external evaluation, program improvement, and licensing and accreditation. They will furnish indispensable guidelines for both the providers and consumers of services—the agency or individual who wishes to serve, the

\*Evaluation, treatment, care and management, education, training, rehabilitation, sheltered employment, recreation.

architect, the placing agency, and the parent or family—as well as for the licensing agency.

A system of patient grouping developed by Dr. Richard Bartman, formerly Director of Children's Mental Health Services, Medical Services Division, Department of Public Welfare, has been used to classify patients in Minnesota's state institutions for the retarded since June, 1965. Dr. Bartman structured six programs along the broad dimensions of age and ambulation and evolved a brief description of each group in terms of abilities, distinguishing intellectual and emotional characteristics, and needs—ranging from total care to a high degree of independence and autonomy. While this classification system is admittedly arbitrary and oversimplified, it does represent a beginning in the orientation of institutional staff to the concept of homogenous grouping as a basis for effective programming. This, in turn, is a first step in the evolution and acceptance of program standards.

It is hoped that an important long-term benefit of the development of a body of standards will be the participation of each state department responsible for service to the retarded in a concerted attempt to ensure that standards which fall within its area of concern are consistently met. The Departments of Health and Public Welfare and the Divisions of Special Education and Vocational Rehabilitation would mount a coordinated effort, perhaps even to the extent that a trilateral responsibility for licensing would replace the present confused and arbitrary licensing split between the Departments of Health and Public Welfare.

#### **Construction of Facilities**

The availability of federal moneys under Public Law 88-164 for the construction of mental retardation facilities has lent vital impetus to the growth of private non-profit facilities for the retarded. Under the stipulations of this law a Facilities Construction Plan was designed with the assistance of the Advisory Council on Mental Retardation Facilities Construction to guide development of services to the retarded and set forth terms of eligibility for these construction moneys. The first annual revision (1967) of the Construction Plan was approved by the Mental Retardation Division of the Public Health Service in July, 1967. The only major change was the inclusion of special education classes in the regional facilities inventories, reflecting the current eligibility of school districts for federal funds under Public Law 88-164.

Regional priorities have been modified accordingly.

In 1966 three construction awards were made, with all grantees matching federal funds on a 50-50 basis: (1) Hammer School, a residential school with an enrollment of 42 retardates, age 6 to 56, received \$107,685 to help build a new dormitory housing 29 pupils; total enrollment will be increased to 50 residents. (2) Fraser School, a day school for 60 children, age 3 to 20, received \$134,830 with which to construct an entirely new facility to replace its substandard buildings; enrollment will be enlarged to 100. These two facilities held dedication ceremonies in June of 1967. (3) Lake Park-Wild Rice Children's Home received \$150,000 to help construct a diagnostic-residential complex. At present Lake Park-Wild Rice cares for 25 moderately retarded, emotionally disturbed children (age 10-16). They plan to expand to a total of three residential treatment units housing 30 children, including the 25 now in residence, and one diagnostic residential unit housing 10 children on a short-term basis up to one year. The latter will be children who are in the process of being evaluated by the Child Development Center of the Lakeland Mental Health Center at Fergus Falls. The new unit will permit observation over a period of time to become part of the evaluation. Further, families living at considerable distances from the Center will be able to obtain evaluations without hardship. Approximately \$100,000 of the total will be used to construct the diagnostic-short-term residential unit.

Most recently the Mental Retardation Division approved a fourth application, that of Mount Olivet-Rolling Acres for \$343,574 in federal funds for construction of a 48-bed residential and training facility for ambulatory retarded children. The facility will be administered and matching money provided by Mount Olivet Lutheran Church.

After several months of negotiation, South Dakota agreed to transfer \$100,000 in federal construction funds to Minnesota. This transfer was effected by South Dakota when it became apparent that they would not have applicants to utilize the federal moneys; the \$100,000 will be applied toward the \$150,000 in federal funds previously awarded Lake Park-Wild Rice Children's Home.

At least two proposed projects will come up for review in fall of 1967. (1) The superintendent of schools at Brainerd has proposed a center to include diagnostic, training, and education

services for pre-school, post-school, and school age retarded persons. (2) A day-night center is proposed at Chisholm, to provide residential care, sheltered workshop services, and day care services for the Northeast region.

Construction of facilities has by no means been limited to those which are supported under Public Law 88-164. For example, Nor-Haven, a \$114,000 private residential facility for 112 retarded women, has just opened its doors in St. Paul. Its proprietors also operate a successful home for retarded men. The Robert Milton Home in Redwood Falls, a private residential facility for 100 men, is under construction with the aid of a \$327,800 loan from the Federal Small Business Administration.

#### **Remaining Needs**

It is evident that residential care in Minnesota has made some progress. Population in the state institutions is gradually being reduced. At the same time, a total of 825 new staff positions have been allocated to the institutions by the 1965 and 1967 legislature. The 402 positions allocated in 1967 are not "line items;" in other words, the Department of Public Welfare may decide how many nurses, how many psychiatric technicians, etc., are to be phased into each institutional program as a part of the total number of positions allowed. This flexibility offers a challenge and an opportunity for creative programming, since as staff is being phased in, considerable numbers of patients will be transferred out to the various mental hospitals.

Smaller private facilities are springing up throughout Minnesota, with and without federal assistance. Experimental programs, such as

Manpower Development and Training, Foster Grandparent, and those employing operant conditioning, are helping to develop institutionalized retarded persons to their greatest capacity and to combat the dehumanizing effects of institutionalization.

The fate of further significant progress rests on passage of the cost-of-care bill, in order to ensure stimulation of growth of private, non-profit, community-based facilities. The Commissioner of Public Welfare has stated that this is his first priority legislative request for 1969.

Moreover, buildings at the three state hospitals for the retarded have been judged unsuitable for retarded children and should be razed and replaced as rapidly as possible, as should many substandard buildings in which adults continue to be housed.

Program standards which will be useful in a variety of residential settings must be developed and enforced, along with clarification of the existing confusion of licensing authority.

Comprehensive diagnostic evaluation, with periodic review as a legal requirement, must be a prerequisite to placement. The Department of Public Welfare manual underscores this need: care must be taken to translate the recommendation into action, if we are to avoid the many tragic cases of irreversible deterioration from unjust placement in an institution.

Lastly, the professional and lay public must be educated to realize that only about five per cent of the retarded actually need residential placement and to know of, and consider, all other avenues for maintenance in the community before deciding on placement.



## COMMUNITY-BASED SERVICES

*"When the community makes available appropriate special services, retarded persons can develop to the maximum of their potential and can become responsible contributing members of society."*

In a sense, all services other than institutional care are "community-based services." The Planning Council limited its study to home training, nursery schools, daytime activity programs, religious classes, recreational and camping programs, and social activities.

With the exception of the daytime activity center program, it is difficult to assess progress in these areas without simply counting every program in every community in the state. In general, it may be assumed that improvements in Social Security benefits and in the administration of welfare programs must be affecting beneficially the lives of retarded persons living in the community by permitting improved levels of subsistence and some assistance with medical costs. Expansion of public health nursing, which presumably is occurring as a result of medicare and medicaid, should also be having an effect.

### Daytime Activity Centers

Minnesota's major advance in the provision of community-based services has been the growth of the daytime activity center program. In 1961 the State Legislature appropriated funds to subsidize centers on a matching basis and assigned administrative responsibility to the Department of Public Welfare, which also has authority to license and set standards for centers. The 1965 legislature appropriated \$425,000 dollars and authorized cities, towns, and counties to levy taxes for matching purposes. By February of 1966, 40 state-supported centers were functioning, and 7 more were operating without state support; a Daytime Activity Center Advisory Committee had also been appointed.

Today the state provides grant-in-aid funds to 61 centers, 22 of which received their first funds in fiscal 1967-68. The Department of Public Welfare, upon recommendation of the Daytime Activity Center Advisory Committee, asked the 1967 legislature for an appropriation of \$1,500,000 to expand this program. The legislature cut this request to \$900,000, still more than double the 1965 appropriation. In addition, an amendment to the original daytime activity center bill was passed, liberalizing the mill limitation on local taxing. Further amendments

which did not pass were: removal of the per capita limitation on local funding; inclusion of the "distressed county" formula; and designation of rent, lease, and loan amortization as matching items for state funds. It is anticipated that state participation in the Daytime Activity Center program will exceed \$2 million by fiscal 1969.

Another exciting development was the appointment in July, 1966 of an administrative consultant to daytime activity centers for the retarded, as a part of the community programs section of the Department of Public Welfare. Prior to this appointment, the group day care consultants of the Standards and Licensing Section, Child Welfare Division, Department of Public Welfare, provided all consultation service to the Daytime Activity Centers in addition to their multitude of responsibilities to the non-retarded. Employment of a full-time consultant whose activities are limited to centers for the retarded should do much to enhance and give dimension to this important program.

As an adjunct to the rapid growth of the daytime activity center program, the St. Paul Health Department has applied for a federal grant to help establish home care and routine medical services for clients of daytime activity centers and potential clients living at home. These services would be invaluable to parents, many of whom are frustrated and baffled by problems of home management.

### Camping Services

Camping services for the retarded have also experienced considerable growth in the last few years. The Minnesota Association for Retarded Children owns and administers Camp Friendship in Annandale, Minnesota, with a program of both individual and family camping. Camp Winnebago in southeastern Minnesota is presently under construction. It will be not only a camp, but also a multipurpose recreation center and possibly the site for a daytime activity center. The camp, which includes residential camping for children, family camping sites, picnic facilities, hiking trails, swimming, and fishing, is intended to serve retarded persons and their families from northern Iowa and western Wisconsin as well as from southeastern Minnesota; uniquely, it will also serve retarded families from throughout the nation.

#### **4-H Programs**

Another interesting development has been the launching in 1965 of the first 4-H program for special education students, at the request of the students themselves. This program has grown until it serves 186 educable retarded pupils, ages 8-15, in 15 upper elementary and junior high special education classes. As an outgrowth of the success of this movement a special 4-H program was initiated at Washington School Rehabilitation Center, Minneapolis, for 30 educable men, age 16-21.

#### **Metropolitan Planning**

The 7-county metropolitan region presents special problems in provision of community-based services, since it embraces a vast diversity of services and a complexity of private and governmental structures. Not surprisingly, communication among agencies is limited and the vested interest often takes precedence over cooperative provision of services. It is estimated that over one-half of Minnesota's population will reside in the 7-county metropolitan region by 1970.

Planning progress in this region has been virtually nonexistent, at least on a unified basis. Originally it was felt that a series of regional committee meetings would be an effective vehicle for stimulating the development of inter-county coordination and consolidation of such services as diagnosis, treatment, residential care, education, work-training, and daytime activity. It was apparent after the first meeting that the regional committee simply did not have the power necessary to command interest and to promote rapid implementation of recommendations.

A second proposed approach to metropolitan planning involved extensive personal contact with key individuals, in an attempt to educate them to the desirability of planning for the region as a whole, rather than in bits and pieces. The Planning Council decided to hire a half-time metropolitan coordinator who could give adequate attention to this major planning effort. The Minnesota Association for Retarded Children agreed to provide the other half of this individual's salary, in payment for half-time work for them as a metropolitan field representative. At this writing, it has not yet been possible to hire a qualified individual to stimulate and coordinate mental retardation planning and

implementation activities in the 7-county metropolitan region.

#### **Remaining Needs**

The mildly retarded, of whom 50 per cent need special services, and the moderately retarded, of whom 25 per cent need special services, can and must be served in the community.

The expansion of the daytime activity center program has presumably made it possible to maintain in the community many retarded persons who would otherwise have to be in residential care. It is important that more centers serve the post-school age retarded person and that programs be offered suitable for the profoundly retarded — available for a few hours a day or on a less than daily basis. The hiring of a full-time daytime activity center consultant should prove to be invaluable in providing guidance to the daytime activity centers so that they may make better use of social and medical services in the community, as well as to fill an important role in counseling with parents and helping in long-range planning for the center's clients. Diagnostic evaluations should be required prior to enrollment, with good health maintenance follow-up thereafter. Finally, the goal of a center in every county is yet to be reached.

Help is still urgently needed by the parents of retarded children who live at home in developing good techniques of management and care. Home health care and homemaker services must be developed by County Welfare Departments or County Nursing Boards and by private social agencies. Social workers and public health nurses must be trained and able to go into the home to offer assistance to parents. University-sponsored adult education seminars for parents of retarded children, covering such topics as social and educational development, learning, and home management and acceptance, have been successful in other states and should be attempted here in Minnesota.

Recreation and camping programs for the retarded are developing, partly because of the stimulus of the National Project on Recreation and Physical Fitness for the Mental Retarded sponsored by the Joseph P. Kennedy, Jr. Foundation, but it is equally important to work for acceptance of retarded persons into community Programs for "normal" persons.

## MANPOWER

*"Only when sufficient numbers of well-trained professional and semi-professional personnel are deployed throughout the state will the mentally retarded in Minnesota receive the care they deserve."*

### Health Careers Council

Although predictions do not always come true, there is every reason to believe the one which anticipates a severe shortage of trained manpower in all health and welfare fields for at least the next 20 years. In response to the acknowledged accuracy of this prediction, the Minnesota Health Careers Council was organized in November, 1966 as an affiliate of the National Health Council, to "seek solutions to the health manpower problems of the state through coordinated activities of individual agencies in this area." The broad goal of the Council has been designated as "coordination of recruitment and research efforts." More specific objectives are:

- (1) To develop a clearing house for information about existing programs;
- (2) To act as an advisory body to which educators may turn for help in defining needs for curriculum expansion, determining new career lines, patterns of instruction, and relationship between education and training, and deciding what programs are best suited to state colleges, junior colleges, and vocational schools;
- (3) To identify obstacles to the provision of health care while aiding in the development of continuing education programs;
- (4) To provide liaison between counselors and professional organizations in the recruitment of health workers;
- (5) To seek solutions to such problems as the "40 hour week" barrier, the "no degree - no teach" barrier, and the lack of training standards for semiprofessional personnel.

The Health Careers Council has thus far held a series of organizational meetings, drafted by-laws, formed sub-committees, and initiated fundraising activities. In order to assess the quantitative nature of the manpower need, and to gather and disseminate other pertinent information, a pilot project entitled "Upper Midwest Health Manpower Planning Project" has been submitted by the Council to Washington for federal funding.

The Minnesota Health Careers Council might well prove to be a vehicle which, by virtue of eclectic membership and broad financial support, can amass the power necessary to achieve its stated aims. It is imperative that, as Council

activities gain momentum, they be made widely known to professionals working in health, education, welfare, and rehabilitation fields throughout the state and that vigorous participation and support on the part of many individuals and professional groups be secured. Funds must also be sought to hire permanent full-time staff if the Health Careers Council is really to "get off the ground." The mentally retarded individual, along with every other citizen of Minnesota, could benefit greatly by effective functioning of this Council.

### Sources of Personnel

Apart from the diminishing pool of professional workers, there are at least five potential sources of personnel to work with the retarded: parents; volunteers; part-time workers; older workers; and semi-professional personnel.

### Semi-Professional Workers

The last named has received considerable attention in the past year or so, as a result of promising experiments in the mental health and education areas. Although the cult of the college degree (and of the graduate degree) has, if anything, gained in intensity, practical necessity is fathering at least verbal commitment to the possibility that "helpers" on various levels can simultaneously do a creditable job and relieve professionals of some of their time-consuming unprofessional duties.

One of the Planning Council's strong recommendations concerning the manpower shortage was that junior colleges, state colleges, and vocational schools should take responsibility for training persons to assume semi-professional positions in a variety of mental retardation facilities. A corollary recommendation was that agencies and professionals must recognize the qualifications of and seek to hire semi-professional persons for those jobs to which they are suited.

St. Mary's Junior College was a pathfinder in this field with its federally funded project to train Child Development Technicians to assist professional persons in daytime activity centers, recreation programs, special education programs, clinical and institutional settings, diagnostic centers, and health programs. The project includes a daytime activity center on the campus, used as a laboratory setting for training students. The center offers half-day services for fifteen children aged 4-11.

Brainerd Junior College has also submitted a proposal to the Commissioner of Education to establish an associate degree program to prepare "instructional technicians" to work with teachers of the retarded. Although this proposal has not yet been approved, the college began in Fall of 1967 a two year program to train teacher aides to work in state and private schools and hospitals.

An Advisory Committee to the Junior College Board has also been appointed and has been working on development of curricula appropriate for training semi-professional persons to work with the retarded.

The Department of Education adopted in September, 1965, a statement entitled "Guidelines on the Employment of Teacher Aides in the Minnesota Public Schools," which designated "clerical and housekeeping activities" as suitable for performance by aides and "non-clerical" duties as those reserved for teachers. During the past two years, experience in using teacher aides in experimental programs\* has pointed to the need for revising the Department's statement so as to take into account the critical issue of how best to utilize the services of teacher aides and other semi-professional helpers. Accordingly, in November of 1967 the Subcommittee on Teacher Aides of the Advisory Committee on Teacher Education has recommended that the Department of Education adopt new guidelines, which will let decisions as to how semi-professional helpers are to be used "rest in the hands of the professional who is being assisted." Presumably, then, the teacher aide would no longer be limited to clerical and housekeeping duties. It is anticipated that the proposed guidelines will be presented to the State Board of Education in about March of 1968.

A much more global effort must be made throughout Minnesota, by the University of Minnesota, the other state colleges, the junior colleges, and the vocational schools, to design and carry out semi-professional training programs. The vast majority of personnel needed to work with the mentally retarded in day and residential facilities need not be professionally trained in the conventional sense. Daytime activity center programs, sheltered workshops, recreational programs — all demand skills other than the traditional ones which accompany a four-year aca-

\*For example, 644 teacher aides were employed in 1966-67 projects in Minnesota under Title I of Public Law 89.10.

ademic career. Actually the larger problem is not how to train semi-professional personnel, or even how to recruit them, but how to break down the kind of uninformed professional and lay prejudice which insists that the director of a daytime activity center be a college graduate, that the administrator of a small "day-night center" have a doctorate in psychology, that a psychologist whose job is to administer standard psychological tests in a mental health center under supervision of an experienced Ph.D. psychologist have a Ph.D. himself.

### **Foster Grandparent Project**

A prototype of the kind of program which can help to dissipate the bias just described is found in the Foster Grandparent Project, an Older Worker program within the Community Action Program of the Office of Economic Opportunity, supervised by the Administration on Aging of the U. S. Department of Health, Education, and Welfare. The Foster Grandparent Project recruits, trains, and employs persons over age 65, with low incomes, to serve neglected and deprived children who lack personal relationships with adults.

In Minnesota the program serves 120 mentally retarded children, 40 each from Cambridge, Brainerd, and Faribault State Hospitals. Each Foster Grandparent spends two hours a day with each of two grandchildren, for a total of 20 hours a week. The Foster Grandparent Project staff, comprising a director, supervisor, and field person at each institution, plus an advisory board, works out policy, programs, and problems with the institution and the grandparents.

The Foster Grandparent Project, conceptually similar to the volunteer services approach to service, has brought an innovative program of individual attention and concern to institutionalized retarded children, in addition to providing remuneration and a high degree of emotional satisfaction for the elderly participants. Professionals who have participated in, and observed, the rewards of this program are uniformly enthusiastic in their descriptions of the heightened growth and development of individual children directly attributable to the program. Yet the Foster Grandparents cannot even be considered "semi-professional personnel," let alone persons highly trained in the care and handling of handicapped children.

### **Part-Time and Older Workers**

Obviously, the manpower resources available to us are enormous, if we have the creativity to

identify and utilize them with imagination. There is a vast and growing reservoir of older workers, such as those employed in the Foster Grandparent Project, people who are eager to engage in meaningful activity, many professionally trained and available on a consultant basis. Housewives are another large group which can be tapped on a part or full-time basis. Countless women who have been trained as nurses, teachers, physical therapists, and the like are not presently working in their career fields but could, with effective recruiting techniques and financial incentive, be re-employed. Countless others, without professional training, can be trained as aides or semi-professional workers.

#### **Parents**

Parents of retarded children and adults, although they often shy away from providing services themselves, are a critical factor in the future adequacy of services to the retarded. Dr. Richard Koch, president-elect of the American Association on Mental Deficiency and special consultant to the President's Committee on Mental Retardation, believes that the parents of the retarded, particularly through the powerful structure of the state and local Associations for Retarded Children, must be recruited to work in professional, semi-professional, and volunteer capacities if retarded persons are to have any hope of getting the services they need in the next few decades. If the success which the parent's groups, begun in the early 1950's, have had in obtaining improvements in services to, and treatment, of retarded children is any measure, Dr. Koch's confidence is well deserved.

#### **Volunteers**

Volunteers comprise another large and recruitable segment of the population. Volunteer services, in and of themselves, remove a great burden from the shoulders of staff members and help to enrich the lives of retarded persons in a variety of facilities; perhaps even more important, from the ranks of good and interested volunteers can come future trainees for semi-professional and professional careers in mental retardation. Although there is an abundance of volunteer activity in Minnesota, coordination and training are largely lacking. It was recommended by the Planning Council that enough volunteer services coordinators be employed by the state and by the county welfare departments to serve adequately the ten state institutions, the 87 counties, groups of counties, or regions of the state. To date, only six coordinators are employed (in six of the 87

counties). Training is spotty and most often is a matter of "finding out on the job."

One recent exception is a volunteer training program which was developed by Moorhead State College in conjunction with the Clay County Welfare Department. This program, whose purpose was to fit volunteers for "community service in a variety of settings," was funded by federal moneys under Title I of Public Law 89-10 (the Higher Education Act). It was the first social service training course in the country to be jointly sponsored by a college and a county welfare department. 57 people registered for the two month course, and regular attendance at the session averaged about 50. Results of the program are gratifying: ten women have shown enough promise and interest to warrant further training as volunteer therapists; 35 of the volunteers have decided to continue meeting on an informal basis; a volunteer coordinator will now be employed by the Clay County Welfare Department.

A special group of volunteers which offers unique potential from a recruiting standpoint is junior and senior high school students. The Public Information program of the Department of Public Welfare has laid the groundwork for vigorous recruitment efforts with this vulnerable age group through its recently developed curricula in mental retardation. These materials, in study guide and motion picture form, have been widely distributed to high school and junior high school classes throughout the state. They offer basic information about mental retardation, together with directories of community resources pointing up the kinds of jobs to be done in these fields. Extensive follow-through is needed in terms of engaging these same youngsters in volunteer work with the retarded children and adults and further interesting them and their counselors in pursuing professional or semi-professional degree programs leading to careers in mental retardation. The SWEAT Program (Summer Work Experience and Training), which offers Federal funds to support high school and college students who wish to work with the retarded, is one splendid source of career material which has not been exploited in Minnesota.

#### **Legislative Gains**

Despite the frightening scarcity of people to work with the retarded, some modest gains have recently been made: (1) State institution staffing was substantially increased by the 1967 legislature.\* A total of 404 new positions, will be

\*421 new positions were allocated by the 1965 legislature.

phased in at the four state institutions for the retarded by 1969 — 138 at Brainerd, 107 at Cambridge, 157 at Faribault, 2 at Owatonna. Although 749 positions had been requested, this discrepancy is mitigated by the gradual reduction of institution population. (See *Residential Care*.) (2) Approximately 50 additional positions were authorized at hospitals for the mentally ill, to be added as mentally retarded patients are transferred to these institutions. (See *Residential Care*.) (3) The Division of Vocational Rehabilitation had 30 positions approved during the legislative interim, and 25 more during the 1967 session. This enabled the hiring of Vocational Counselors at all state institutions for the retarded. (4) The Department of Public Welfare has recently appointed a Director of Mental Retardation Programs, a regional consultant for the Northeast region, and a consultant to daytime activity centers for the retarded. (See *Administrative Issues*.) None of these positions were allocated by the 1967 legislature, since the Department had requested no new mental retardation consultant or supervisory positions. (5) A moderate increase in state pay scales was granted by the 1967 legislature. One important benefit will be the increasing of the salary range of psychiatric technicians from \$292-\$400 a month to \$356-506.

#### **Provision of Training**

No noticeable advances have been made in the provision of training in mental retardation specialties. Although numerous in-service training sessions have been held in nursing, special education, and other fields of service to the retarded, no full-fledged mental retardation training programs have been developed in education,

in medicine, in psychology, or in social work. The junior colleges have made progress in the training of semi-professional personnel to work with the retarded, but the University of Minnesota and the other state and private colleges have lagged behind in analogous professional preparation.

Millions of dollars in federal funds are available for the establishment of university-affiliated training centers in mental retardation and associated disorders. The establishment of such a center in Minnesota would elevate mental retardation from the second-class status it has long suffered as a professional career field and would provide badly needed training in the multitude of areas involved in a holistic knowledge of mental retardation. Thus far no agency in Minnesota has applied for such a center.

In lieu of provision of interdisciplinary training, there are such possibilities as, for example, the offering by the University of Minnesota Medical School of yearly stipends to medical students, in exchange for four years of systematic exposure to training and work with the retarded and their families. (This is being done at University of Nebraska.) Hopefully, a goodly number of these young physicians would be inspired to continue in a mental retardation career capacity.

However they choose to implement it, the University of Minnesota, the state and private colleges, and the state facilities must form a true partnership for training and field experience in many kinds and levels of mental retardation specialties. Only in this way can we hope to find the people to make the programs work.

## ADMINISTRATIVE ISSUES

*"As with the air we breathe, we are most aware of coordination when it is in short supply."*  
**President's Panel. REPORT OF TASK FORCE ON COORDINATION**

The Planning Council and its various Task Forces held many discussions of how to change government organization, structure, and methods in order to improve the provision of services to the mentally retarded. The problem seemed to divide naturally into three main aspects: (1) The need for an on-going, committed structure or agency responsible for programs and planning for the retarded on a permanent basis. (2) The need for greater interaction and coordination among separate state departments and agencies. (3) The need to reorganize regional structure of separate state departments in order to achieve coterminous "zones."

### **Permanent Responsibility for Programs and Planning**

A plethora of suggestions and ideas finally reduced to two important considerations:

(a) *Should a new and separate Division of Mental Retardation be established within the Department of Public Welfare?* Those who favored such a structure felt that it would secure for the retarded the status and visibility\* which their problems merit, remedy existing inefficient fragmentation of services, facilitate the recruitment of high level effective personnel, and fill the vacuum created by the termination of the Mental Retardation Planning Council in December, 1967.

Governor LeVander spoke in favor of a Division of Mental Retardation and recommended in his inaugural address that a Director of Mental Retardation be hired.

A minority who opposed the establishment of a Division argued that the present structure, in which responsibility for the mentally ill and the mentally retarded is assigned to the Division of Medical Services, with additional responsibility for the retarded residing variously with the Di-

vision of Child Welfare, Public Assistance, Rehabilitation, and Field Services, is adequate assuming that the problem of insufficient staff be alleviated; and that creating a separate division to serve the retarded would perpetuate the fragmentation of services and isolation of the retarded which it was intended to remedy.

A bill to establish a Division of Mental Retardation in the Department of Public Welfare was drafted by the Minnesota Association for Retarded Children and presented to the 1967 legislature. The bill, which was introduced very late in the session, passed the Senate and House Welfare Committees but died in the Senate Finance and House Appropriation Committee.

Subsequently, a Director of Mental Retardation Programs was hired in the Medical Services Division of the Department of Public Welfare. His responsibility will be to design, organize, and execute a statewide program for the retarded. He will coordinate the services of the Medical Services staff; consult with federal, state, and local agencies and with voluntary organizations; and direct program development for the retarded in state institutions. The Director will also coordinate projects through various federal agencies, develop services through other state agencies, and relate to parent and professional organizations. He plans to design methods to implement Planning Council recommendations and to evolve programs to meet broad service needs.

Although the appointment of a Director of Mental Retardation Services represents a step forward in strengthening provision of service to the retarded, it remains to be seen whether sufficient central office or regional staff will be added to guide development of mental retardation services throughout the state. Further, the prestige of a Division and a Division Director necessary to ensure high level communication with other state and private agencies will still be wanting. Perhaps the greatest danger lies in the lack of adequate separate staff to carry out the ongoing responsibilities to the mentally retarded.

The chiefs of nursing, rehabilitation therapy, social services, volunteer services, and psychology, in their capacity as consultants, will continue to carry responsibility for both mental health and mental retardation services, as will the regional consultants. The dual responsibility of the latter is particularly troubling in view of

\*An interesting commentary on the lack of visibility of the retarded inheres in the "oversight" by the Department of Public Welfare in not requesting of the 1967 legislature any additional central office staff to work in programs for the retarded. That a request was not made is the more surprising when one realizes that many DPW staff people were heavily involved in the mental retardation planning and implementation process. Belated attempts to remedy this error by a supplementary budget request for ten additional staff persons went no further than the House Appropriations and Senate Finance Committees.

the pressing need for staff to man the regional agencies serving the retarded, to coordinate existing mental retardation services, and to bring new local services to the retarded into being.

The hiring of a new consultant, whose bailiwick will be limited to daytime activity centers for the retarded, has been mentioned earlier. Responsibility for the Mental Retardation Facilities Construction Plan, whose administration has been transferred from the MRPC staff to DPW, has fallen to this same individual. However, the Department plans to hire another full-time staff member to administer facilities construction for both mental health and mental retardation facilities. Both mental health and mental retardation construction plans must be revised annually, and consultation and guidance to various agencies and individuals wishing to apply for funds is a full-time job.

*(b) What is the relationship of the State Planning Office and the Comprehensive Health Planning process to future mental retardation planning?*

The State Planning Office, created by the State Planning Act of 1965, began active operation in October, 1966. The first tasks to be performed were set forth as "the design of the first state comprehensive policies plan and of a comprehensive state planning system for the next biennium." Included in the purview of the state planning agency are social resources planning, regional planning, and governmental needs planning, all of which would presumably embrace certain aspects of mental retardation planning; a \$100,000 federal vocational rehabilitation planning grant under Public Law 89-333; and, most important, a federal grant under the Comprehensive Health Planning and Public Health Services Amendments of 1966, Public Law 89-749, to develop a comprehensive plan for health services for Minnesota.

Public Law 89-749 requires that as of July, 1967, certain previously categorized federal grant funds, such as mental retardation moneys, be decategorized and spent by each state in accordance with that state's comprehensive health plan. This law authorized a total of \$125 million in decategorized grants during fiscal 1966. Under the new block grant system not less than 15% of available moneys are earmarked for "mental health" with the balance to be utilized by other decategorized disabilities. There has been much speculation as to whether it would be more advantageous to try to include mental retardation in the mental illness block or the lump sum grant

money. In any event, in order that services to the mentally retarded receive adequate federal support as well as sufficient attention on the state level, needs of the retarded must be well-defined and incorporated as priorities in the Comprehensive Health Plan for Minnesota. Governor LeVander named the Governor's Council on Health, Welfare, and Rehabilitation in September of 1967, describing this group as "the successor to the Governor's Commission on Health and Rehabilitation and the Mental Retardation Planning Council." (Both were appointed by former Governor Karl Rolvaag). Governor LeVander also said that the new Council will "serve as a clearing house for recommendations of the advisory committee on . . . mental retardation facilities construction."

#### **Coordination Among State Departments**

The Task Force on Volunteer Services and Public Awareness had recommended that the state Departments of Health, Education and Public Welfare be combined in order to obviate duplication of effort and to ensure a greater degree of communication and coordination in administering social programs, including mental retardation. After much deliberation, however, it was felt that such a combined administration would make for a department unwieldy in size and unable to muster community support; further, that it would be better to strengthen individual state departments rather than superimpose a central administrative structure on them.

Another suggestion was that the State Planning Office might assume a coordinating function, effecting communication and liaison among the various state departments, since all departmental planning would presumably filter through the Planning Office.

Coordination among health, welfare, education, and rehabilitation services seemed particularly weak at the county level. It has been suggested that Minnesota initiate a pilot project in which one county would be selected to merge all public welfare, health, and rehabilitation services under the County Welfare Board or the County Health Service, in order to demonstrate the improvement in provision of services which would ensue.

#### **Regional Structure**

The establishment of unified regional boundaries to supplant the confusing diversity of regions which exist (e.g., Department of Public Welfare, Department of Education, Department



of Health, hospitals, mental retardation, community mental health centers) would do much to facilitate interdepartmental communication and coordination at the "grass roots" level, improve staffing problems, and encourage maximum use of services (which would all be located in one place for any given region.) The zone center concept as presently employed in Illinois should be studied as an example of this kind of consolidation, which takes into account the crucial factor of natural travel and use patterns. The State Planning Office is in the process of determining the "best" regional structure to be used by all state departments and agencies for purposes of long-range planning.

The Medical Services Division plans to establish seven regional offices to serve as liaison between state and local units, and to provide assistance in developing and coordinating comprehensive community-based mental health and mental retarded programs.

The first of seven regional coordinators was hired by the Medical Services Division, Department of Public Welfare, in July 1967. He will coordinate mental retardation and mental health programs for the Northeast region, based at Duluth. The responsibility of the regional coordinator is "to develop comprehensive mental health and mental retardation programs" for an area which includes 5 community mental health centers, 12 county welfare departments, 3 state institutions for the mentally retarded and mentally ill (Brainerd, Cambridge, Moose Lake), and the many daytime activity centers in the region.

In accordance with the Department of Public Welfare plan for a "comprehensive community-based mental health and mental retardation program," community mental health center boards and program directors now have broadened responsibilities to plan, develop, and operate locally based preventive and care services. The regional coordinators will also serve as liaison persons between center boards and the Department of Public Welfare. They will also assist other public and private agencies and organizations in development and coordination of mental health and mental retardation programs.

One meeting has taken place, with six more in the planning stages, to explore the new regional program of coordinated mental retardation-mental illness planning and services. This meeting was held at Rochester to discuss the needs

of the 13 counties in the southeast region. Key agencies which were involved included county welfare departments, community mental health centers and their boards, state hospitals for the mentally ill, state hospitals for the mentally retarded, daytime activity centers and their boards, central office and field staff of Department of Public Welfare, mental health associations, associations for retarded children.

The aim of the regional program is to "reduce the incidence and prevalence of mental disabilities by 1) directly modifying individual functioning or behavior and 2) modifying the ways that committees deal with the problems." In order to accomplish these aims, an effort will be made to clarify at county, state, and regional levels the "responsibilities and relationships" of the three systems operated by the Department of Public Welfare: state facilities for the mentally ill and mentally retarded; mental health and mental retardation services of county Welfare Boards; and community mental health and mental retardation programs.

Perhaps this plan for widespread regional development was born with the Rochester utilization committee, which helped to shape the expansion of Rochester State Hospital to include on its campus a daytime activity center for retarded, community mental health center, and plans to add for the retarded educational facilities, a sheltered workshop, and short term residential care.

#### **Adequate Record-Keeping**

Adequate record-keeping on retarded persons in Minnesota, in a form easy to retrieve and communicate, remains an indispensable and unrealized adjunct to planning for a long and short term needs of the retarded. Agencies do not seem to recognize the need for this clear identification, not to be confused with a central registry, of retarded clients. Issues pro and con have centered around lack of agreement on an appropriate definition of mental retardation, the difficulty of making an accurate diagnosis and deciding whether retardation is a primary or secondary disability, fear of labeling, difficulty of changing existing recording methods, confusion about specific information needs, and staff time required to maintain an adequate system.

Attempts to encourage agencies to develop effective systems of recording currently active cases of mental retardation, by age, degree of

retardation, county of residence, and present disposition of the case, have not met with success. It should be noted that this information is available somewhere in most agency files but is not systematically incorporated into a routine re-

porting procedure. Were this to be done, not only would planning be facilitated but also the mentally retarded would be acknowledged as a visible and significant element in a variegated caseload.

## LAW

*"Justice will be achieved only when those who are not injured feel as indignant as those who are." Golan, Athenian Statesman and Author, 138 B. C.*

### **Recodification of Mental Retardation Laws**

The Planning Council drafted and introduced to the 1967 legislature a bill to create an interim commission to study and recodify all Minnesota laws pertaining to the retarded. (It will be recalled that mental retardation planning grant funds were used to finance the compiling of these laws, together with pertinent court decisions and opinions of the attorney-general, at the University of Minnesota law school.) Although the bill did not pass, the Senate Welfare Committee was activated as a permanent standing committee, with the suggestion that one of its study areas be mental retardation programs and laws. As a spur to this endeavor, the entire compilation of laws was reprinted and distributed to members of the Senate Welfare Committee and other involved citizens, and a presentation which included the need to recodify these laws was made to the Committee.

### **Guardianship**

A bill liberalizing commitment and guardianship laws pertaining primarily to the mentally ill but also to the mentally retarded was enacted into law by the 1967 legislature. It was the opinion of the Law Task Force that at the 1969 legislative session separate legislation more clearly applicable to the mentally retarded should be adopted and that the new commitment laws should be amended to exclude the retarded.

A step in the direction suggested by the Task Force was taken in a Department of Public Welfare policy statement dated July 26, 1965, stating as follows: "Commitment to guardianship as mentally deficient is not a necessary or desirable step in all cases. A non-committed person is entitled to the same services as a person under guardianship. A person need not be committed as a prerequisite to admission to state institution for mentally retarded. If commitment is desirable, it can be done at anytime in the retarded person's life and need not be done when the retardation is first discovered."

Dr. David Vail, Director of the Medical Services Division, Department of Public Welfare, has asked for a separate study of commitment and treatment procedures for the mentally retarded, encompassing the following areas: (1) Civil rights of the retarded. (2) Guarantee that institutionalized persons will have programs and treatment. (3) Guarantee to prevent institutionalization for too long a period of time.

### **Rights of the Retarded**

The Minnesota Association for Retarded Children has created a new Committee on the Mentally Retarded and the law to study the rights of the mentally retarded under existing state legislation. Its chairman is the same individual who chaired the Law Task Force of the Planning Council. The committee, composed mostly of lawyers and judges, will analyze present laws, draft and review proposed legislation, and seek adoption of a new improved commitment law for the retarded. They will also study the problem of the so-called "defective delinquent."

## PUBLIC AWARENESS

*"Intensive public information and re-education is needed before the negative failure stereotype concept of mental retardation is eradicated and the new positive hopeful approach is substituted."*

Unquestionably the professional and lay public has been made far more aware of the existence of the mentally retarded during the last three and one-half years of planning and implementation activities in the 50 states. These endeavors have stirred up considerable interest, and even a measure of understanding, as has the work of the President's Committee on Mental Retardation, the Kennedy Foundation, and the many federally funded programs aimed at helping the retarded.

There is a long distance to traverse between knowing that 5,000,000 mentally retarded persons exist, in many cases barely, and becoming sufficiently involved with their plight to seek actively to help them. However, it may be assumed that inroads into the public conscience have been made in Minnesota via such action as the following:

### **Governor's Conference**

Perhaps the single most important event in the career of the Mental Retardation Planning Council, from the standpoint of professional and law involvement, was the Governor's Conference on Mental Retardation, held on September 25, and 26, 1966. The 1326 persons who taxed the capacity of the Grand Ballroom of the St. Paul Hilton Hotel included state, county, and municipal officials, a variety of professional persons, parents, agency personnel, and just people who were interested.

The conference was jointly sponsored by the Jaycees, Mrs. Jaycees, Minneapolis Association for Retarded Children, Minnesota Association for Retarded Children, Minnesota Congress of Parents and Teachers, St. Paul Association for Retarded Children, and the State Volunteer Council.

At the Governor's Conference, the comprehensive plan and the Facilities Construction Plan made their public debuts. Mrs. Eunice Kennedy Schriver and Bert Schmickel of Connecticut were excellent drawing cards as well as provocative speakers. Governor Rolvaag shone as the star of the occasion and Mrs. Hubert H. Humphrey's presence lent a special charm. The conference was a vehicle through which public recognition was given to the entire membership of the task

forces, the regional committees, and the many professionals involved in both planning and implementation.

The real work of the conference was done on the second afternoon, in ten concurrent workshops focused on implementation of the comprehensive state plan, through financing, legislation, and public education and involvement. Each workshop was led by a resource panel comprised of a mental retardation task force chairman, a legislator, and a representative of a state department.

### **Research Conference**

Members of a specific "professional public," important and often difficult to reach through every day channels of communication, turned out in surprisingly large numbers to attend a statewide research conference on mental retardation. Here each educated the other in an exchange of ideas across disciplinary lines; the Planning Council merely provided the structure and little more was needed. Four important recommendations were framed at this conference and later embodied in the Comprehensive Plan:

- (1) Establishment of a multidisciplinary Mental Retardation Research and Diagnostic Center.
- (2) Regional diagnostic centers to be set up throughout the state.
- (3) A central clearing-house to facilitate and coordinate research activity and communication.
- (4) A permanent coordinating body to implement mental retardation planning.

### **Architect Institute**

Proliferation of facilities and of elaborate plans for facilities, stimulated by wider awareness of modern, regional concepts of care, as well as by federal moneys available under Public Law 88-164, inspired the Planning Council to convene a one-day institute for architects. "Design of Facilities for the Mentally Retarded" was held in January, 1967, with architects, institution administrators, operators of private facilities, and planners in attendance.

The morning session included slide presentations by two nationally known architects, A. Rorke Vanston, Division of Health and Medical Facilities, Public Health Service, and Arnold Gangnes, Architectural Consultant to NARC. The afternoon session was given over to informal group discussion led by the Planning Council

chairman, with architects, Department of Public Welfare personnel, and operators of private facilities as resource persons.

Some important points emerged from a spirited day of inter and intra-professional dialogue:

- We must find answers to such questions as: How small can a facility be and still function at an optimum program and economic level? What should be the optimum number of patients in a "small" facility? How few in number may the patients be without jeopardizing effective functioning? Answers to these questions must evolve in a framework which makes full use of generic and special services available in the community and contracts for these services which cannot reasonably be provided on the premises.

- In considering numbers of staff necessary to provide individualized care, one must realize that a ratio of one staff person to six residents is *not* the same as a ratio of four staff persons to 24 residents, despite mathematical equivalence.

- Communication between professionals planning new facilities for retarded and the architects who are supposed to design these facilities often bogs down in semantic misunderstanding. Seminars in which architects and administrators learn to speak each other's language would be invaluable.

- Budget requests of state residential institutions should include architectural consultant positions. This is day-to-day need, as well as a long-term need.

- Planning and design of new facilities should be accompanied by conference with the people who work in these facilities everyday — aides, technicians, nurses, etc. After all, one would certainly consult a housewife about what she would like in her kitchen.

- Program and physical standards which can guide architects and their clients in planning facilities for the retarded are badly needed. Architects simply have no reliable benchmarks. Program standards, although harder to devise than physical standards, are for the retarded the *sine qua non*. Even though concepts of care are constantly changing, standards must be drawn, albeit flexibly enough to be changed as the future dictates.

### **Regional Meetings**

Four series of regional meetings, covering the entire state, were held during the planning and implementation period.

- (1) Distributed "tentative rough draft" of the Comprehensive Plan together with questionnaires based on specific task force areas of concern, the latter to be answered by regional committee survey of each region.

- (2) Tabulation and summary of regional questionnaires was shared with each regional committee. A reassessment of needs was formulated into the Comprehensive Plan.

- (3) Reviewed Volume II of the Comprehensive Plan — the Facilities Construction Plan — region by region. Additions and suggestions of regional committees were later included to whatever degree feasible.

- (4) Focus was largely legislative, with greatest attention centered on cost-of-care bill and child development center bill. All pieces of proposed legislation related to mental retardation were reviewed in the context of the continuum of care concept and were assessed with regard to their role in actualizing this concept.

### **Meetings with Professional Publics**

The Public Awareness Task Force met with physicians, school administrators, clergymen, employers, and "teachers of teachers." Forty highly specific recommendations for the enhancement of awareness of mental retardation in each of these groups are to be found in Volume I of the Comprehensive Plan.

### **Visiting Experts**

Three distinguished visitors lent color as well as profound counsel on the needs of the mentally retarded during their stays in Minnesota.

- (1) Dr. Hallvard Vislie, Medical Director of the Oslo Mental Retardation Region, was brought to Minnesota during the summer of 1966 as consultant on mental retardation to the Department of Public Welfare. Dr. Vislie's report on services and facilities ran to many pages but can be summarized as follows:

- Minnesota's three state hospitals for the retarded need a "radical reduction in population." None of the buildings at these institutions are suited for mentally retarded children and none could be made suitable without great expense.

- Entirely new facilities for children should be constructed; some present buildings might be remodeled into small living units for adults. The units for children should have 8 to 12 beds, those for adults 16 beds.

- All three institutions need much more in the way of facilities for training, education, and

work therapy programs. Some of the inadequate living facilities could be remodeled for these uses when new living units were built.

- Seven regions should be established, each to have a central institution for the retarded, outpatient diagnostic services, and a regional office responsible for all services, state and private, in the region.

(2) Mr. Bengt Nirje, secretary-general of the Swedish Association for Retarded Children, visited Minnesota for two weeks in March, 1967 as guest of the Minnesota Association for Retarded Children. He saw in Minnesota "things I am deeply shocked by, that I didn't think existed." Mr. Nirje was referring to the large state hospital wards with "little staff and no program." He used such words as "horrible" and "inhuman" to describe these conditions. The Swedish expert termed the large institution system an "utterly costly mismanagement of human resources."

(3) Dr. Richard Koch, Director of the Child Development Clinic and the new Regional Center for the Retarded at Children's Hospital in Los Angeles and associate professor at the University of Southern California, spoke to hundreds of professional persons on a whirlwind tour of Minnesota November 2 and 3. Dr. Koch addressed physicians, social workers, psychologists, nurses, educators, and agency personnel in Duluth, Minneapolis and Rochester. Amid a wealth of fascinating material, several points stand out:

- More than 25 per cent of children who appear to be mentally retarded can be saved from actual mental retardation if they are seen early enough. This means by the age of 2 or 3. Dr. Koch pointed out that there are a "whole host" of problems which can cause a child to appear mentally retarded, among them vision and hearing impairments, emotional disturbances, cultural disadvantages, and medical problems such as thyroid disease or low blood sugar.

- About 96 per cent of the children who are actually mentally retarded can be helped to function far more successfully in everyday life — if they are found early enough. The vast majority of them can be helped to become "tax-payers instead of tax users."

- The key to helping all mentally retarded children develop as normally as they can is the provision of high quality comprehensive diagnostic, evaluative, and counseling services as early as possible. Dr. Koch stressed the inability of an individual physician or other professional

worker to give these children the help which a team of specialists studying them from various points of view can offer.

- Institutional care is a poor solution for two out of three retarded children, the third being the very severely retarded or completely dependent child.

- Mental health and mental retardation services do not belong together. The orientation and philosophy of those who choose to work with the mentally ill is usually quite different from that of professional workers in the field of mental retardation. However, under the "mental retardation umbrella" it is possible to save children with many other handicaps often associated with retardation.

- Universities must take the lead in provision of mental retardation services — training, research, and direct service. Only the university can lend the "dignity and stature" to mental retardation endeavors that they merit.

- Parents of retarded children must be fully utilized as a great manpower pool to provide many services their children need, in view of the critical nature of the professional manpower shortage during the next 20 years.

#### The Written Word

- Another public education device, which, although conventional in format, has aroused a gratifying response from professional and lay persons is the monthly newsletter. Circulation has been expanded to 2,500 and includes State legislators, probate and district judges, representatives of mass media, and a multitude of generic agencies. Some of the most lively letters in response to Newsletter articles come from busy physicians. The newsletter has provoked controversy, elicited praise, and piqued the interest of the indifferent.

- The two-volume Comprehensive Plan has, at least, reached the shelves of those to whom mental retardation is a vital interest. To date about 800 copies have been distributed.

- A 20-page digest of the Comprehensive Plan entitled "*Action Speaks Louder*" was prepared in connection with the Governor's Conference. This digest was distributed to all participants in the conference. Since then numerous requests for quantity orders of the digest have been received, and it has been widely disseminated in Minnesota and in other states.

- There has been ample press coverage of mental retardation issues and progress in rural

weeklies as well as metropolitan dailies. Articles have been placed in professional periodicals and journals.

#### **The Spoken Word**

- It was arranged that a variety of task force members, who were also excellent speakers, appear on a number of well known radio and television programs, in interviews and panel discussions concerning mental retardation. Two members of the Public Awareness Task Force, both professionals in the public relations field, prepared spot announcements about boarding care for the retarded for television affiliates.

- Project staff has had countless opportunities to speak on many aspects of mental retardation — local, statewide, regional, national.

#### **Remaining Needs**

Public education is not a job which can be measured in discrete units. It must be continuous and consistent to really take effect. The Planning Council has focused its efforts to educate the public concerning mental retardation on so-called "priority publics." This approach has engendered much fruitful dialogue with physicians, legislators, school administrators, clergymen, em-

ployers, teachers of teachers, architects, and "researchers." But only a modest beginning has been made toward implementing the rich pool of ideas and suggestions derived from these discussions. Further, many other specific publics remain to be canvassed, outstanding among them the hard-to-reach "high risk," lower socioeconomic segment of the population. Legislators and other public officials must also be given an extra measure of attention, for their actions can change the lives of the retarded in important ways.

It would seem to be the joint responsibility of the Director of Mental Retardation Programs, Department of Public Welfare, through the Public Information Section of the Department, and the Minnesota Association for Retarded Children, through its Public Information Director and its local chapters, to tell the people of Minnesota about the mentally retarded. What they have to tell, in this decade of the 'sixties is positive, hopeful, and filled with evidence that the mentally retarded are taking full advantage of the opportunities being offered them to grow, to realize their capabilities, and in most cases to become taxpayers instead of tax users.

That kind of a message always finds good listeners.

## EPILOGUE

*The most urgent "unfinished business" of the Mental Retardation Planning Council:*

- (1) The need to develop a viable system of diagnostic and evaluation services as related to the child development center concept;*
- (2) The need to establish a pattern of small, community-based residential facilities as related to the cost-of-care legislation;*
- (3) The need to assure development of good programs through the mechanism of an effective standards and licensing process;*
- (4) The need to develop an improved administrative structure at the state level to guide and direct an ever-broadening spectrum of mental retardation programs;*
- (5) The need to accelerate training and research activities, as related to the establishment of a university-affiliated training and research center;*
- (6) The need to devise methods to recruit sufficient trained manpower to provide needed services;*
- (7) The need to study and recodify state laws concerning the mentally retarded.*

*With your help, this "unfinished business" can become  
"a job well done."*

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