Volume II Array of
Services: The Facilities
Construction Plan

A COMPREHENSIVE PLAN
TO COMBAT MENTAL
RETARDATION
IN THE STATE OF
MINNESOTA
VOLUME II. ARRAY OF SERVICES: THE

FACILITIES CONSTRUCTION PLAN

Prepared by the Minnesota Mental Retardation Planning Council

April, 1966

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Honorahle Karl F. Rolvaag  
Governor of Minnesota Room  
130 - State Capitol St.  
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Dear Governor Rolvaag:

It is with great pride that we present to you the report of the Mental Retardation Planning Council. The recommendations contained herein are the product of extensive investigation and deliberation. They reflect the work not only of the Planning Council, but also of the Task Forces and Regional Committees whose membership includes hundreds of professional and lay persons from all over the State.

The work of the Planning Council has been financed by Public Law 88-156, which provided for the preparation of a comprehensive State plan to combat mental retardation. Volume I of the plan consists of reports of the nine Task Forces, with many significant recommendations relating to needed improvements in Minnesota's array of services for the mentally retarded. Volume II comprises the Planning Council's recommendations concerning regional deployment of services and the facilities needed to house them. The latter volume also serves as the statewide construction plan, required under the provisions of Public Law 88-164 in order to qualify for Federal matching funds for construction of needed mental retardation facilities.

The neglect of mentally retarded children and adults in our population has moved the members of the Planning Council deeply. These are indeed "children in need". We thank you for the opportunity you have given us to serve them. We beg our fellow citizens to join with you and with us in a great campaign to serve them better.

Children must no longer lie alone on the cold terrazzo floor of an unattended ward, or sit idly in the back room of their home or of a foster home, without schooling or social opportunity or recognition or acceptance. Retardation can be prevented. It can be ameliorated. The retarded can be helped. This comprehensive plan will guide our efforts—though it is offered with full recognition of the constantly changing pattern of our knowledge, goals and attitudes, and of our abilities and our limitations.
All of us join in enthusiastic endorsement of the contents of these two volumes and look with relish on our new responsibility to implement the recommendations, to translate the dreams of the planners into real-life help and service.

The implementation process will go forward with a two-year Federally supported grant. While the Planning Council is to carry the major responsibility, we will depend heavily on your continuing leadership and will seek the support and understanding of the State legislature, the various State departments of government, the voluntary agencies, and the citizenry at large.

Respectfully submitted,

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I. INTRODUCTION

Definitions

Because mental retardation is not a static disease entity, but a changing symptom of a complex interaction of many factors which are not yet completely understood, it is difficult to find a thoroughly satisfactory definition. Three are in common use:

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

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

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

The last of these seems to best embody the limitation in functional characteristics which always attends the symptom called "mental retardation", regardless of how or when it occurs in the life of a given individual. "Sub-average" refers to performance which is greater than one standard deviation* below the population mean of the age group being assessed. Level of "general intellectual functioning" may be evaluated by performance on one or more of the individual objective tests devised for that purpose. The upper age limit of the "developmental period" may be regarded, for practical purposes, as approximately sixteen years. "Adaptive behavior" incorporates maturation, learning, and social adjustment. It is

* A statistical unit expressing difference from the mean of a range of measurements in a sample.
"impairment" in one or more of these aspects of adaptation which determines the need for special or professional services and sometimes for protective legal action.

The term "mental retardation", as used in this report, incorporates all of the meanings which have been ascribed historically to such concepts as amentia, feeblemindedness, mental deficiency, mental sub normality, idiocy, imbecility, moronity, and oligophrenia. "Mental retardation" was chosen because it seems at present to be the preferred and most easily understood term among persons of all disciplines.

It cannot be overemphasized that mental retardation is not a tidy, clearly defined, unchanging entity, but is a function of the way in which society defines, perceives, reacts to, and attempts to cope with the problem.

In the words of Sarason and Gladwin

Real understanding...can only be approached by paying more than lip service to the fact that this is a social and cultural as well as a biological and psychological problem. In our society the problem looms large—statistically, financially, and emotionally; in most non-European societies it is inconsequential, confined to cases of severe pathological defect who are cared for, as long as they live, with a minimum of distress or dislocation. The difference lies in culturally determined attitudes, behaviors, and criteria of social acceptability... Even a child with a severe defect must be viewed as deficient relative to cultural standards of acceptability; the cause of his deficiency may be organic, but its magnitude is dependent upon social criteria.

Philosophy of Planning and Coordination

The ongoing process of assuring that every retarded individual will receive the combination of services he needs when he needs them is the essence of planning and coordination.


In order to prescribe appropriate care, protection and support for a disabled individual at any given time, and for the mentally retarded in particular, an inclusive array of services must be available. Services for the retarded are usually provided by, through, or within instrumentalities which also minister to the non-retarded, i.e., the family, the professions, and the Departments of Health, Education, and Welfare, as well as other agencies which society has created. Ideally the elements in this array of services should be so intimately related to one another, and so accessible, as to be readily marshaled into a "continuum of care"—a selection, blending and use in sequential relationship of medical, educational, and social services which may be required by a retarded person at any given point in his lifetime. Provision of a continuum of care permits the individual to move freely from one service to another, as his own unique and changing needs demand. A necessary condition for the provision of a continuum of care is coordination, the mustering of all necessary resources in appropriate sequence in order to accomplish a specific mission.

In the past we have all too frequently tried to develop programs on a piecemeal basis without coordinated planning of programs. Numerous agencies and professional disciplines have been actively engaged in providing services for the mentally retarded, yet there has been no organized attempt to bring all of these interests and disciplines together to design a total program for the State.

The keystone to the development of effective services for the mentally retarded is comprehensive planning which takes into account State, regional, and local requirements, as well as the professional and voluntary resources of communities and the administrative and service agencies of government.

It is essential that local and regional programs be coordinated and consistent with State-wide programs and objectives. Communities need leadership, guidance, and consultation from the State level to assure that retarded children, wherever they live, have access to services. The State must develop standards for care and the means for enforcement; resources and facilities which transcend local capacity and responsibility; and financial subsidy for certain programs that cannot be supported from local tax avenues alone. The national government must also share in providing support and leadership. Only as responsibilities are fully shared among local, State, and national agencies can comprehensive community programs become a reality. It goes without saying that citizens and citizen organizations must contribute their full and active support. The challenge of translating these concepts of cooperative action into reality is difficult, but by no means insurmountable.

4 Guidelines for Program Development

1. The mentally retarded are entitled to opportunities for maximum development of their potentialities.

2. A mentally retarded population is heterogeneous and presents a diversity of needs requiring special attention.

3. Not all persons once identified as mentally retarded will necessarily require specialized assistance throughout their lives.

4. The multiple needs of the retarded require the concern of numerous professional groups and agencies.

5. It is desirable that the State assume leadership in the development of a comprehensive program. There may be State, regional, and/or community responsibility for administering various aspects of such a program, with provision at all levels for maximum communication and coordination.

6. The State and the community should examine critically the total needs of the mentally retarded and develop blueprints for a comprehensive program.

4. For a discussion of each of these statements, see "A Manual of Program Development in Mental Retardation", American Journal of Mental Deficiency, January, 1962, p. 33-48, from which they were adapted.
7. A comprehensive program designed to meet the needs of the retarded should be composed of many essential interrelated parts.

8. A comprehensive program for the mentally retarded should give emphasis to services which are available during the formative years, or as early in the life of the retardate as possible.

9. The integrity of the family unit should be preserved if at all feasible.

10. Programs and services for the mentally retarded should be integrated whenever possible into broad programs for handicapped and non-handicapped persons.

11. The success of any one aspect of an existing program may be highly dependent upon the presence and degree of success of other programs.

12. Since all the various aspects of a comprehensive program are never developed at the same time, consideration must be given to the question of priority of service and research programs which are developed.

13. Each State, region, or community must develop its own pattern of organization for the many aspects of the comprehensive program.

14. Meeting the needs of the retarded is basically a community problem.

15. Legal provisions for programs and services for the mentally retarded should be set forth in broad and flexible descriptive terminology.

16. Although the chief responsibility for providing programs for the mentally retarded should rest with public (governmental) agencies, voluntary agencies will always assume a vital role in this endeavor.

17. Provisions must be made for an adequate evaluation of the needs of the retarded, and often for a trial placement, as a prerequisite for acceptance into a given program.

18. A wisely planned and well-integrated program for the mentally retarded will give emphasis to research aimed at both primary and secondary prevention.
Minnesota's comprehensive plan to combat mental retardation is arranged in two volumes. Volume I is made up of the reports and recommendations of the nine Task Forces. The present volume, Volume II, comprises a detailed description of the array of services for the retarded which is being developed for each region of the State plus the construction plan for facilities to house these services.

The Facilities Construction Plan, prepared by the Department of Public Welfare pursuant to Title I, Part C, of Public Law 88-164, is based on guidelines to be found in Planning of Facilities for the Mentally Retarded, and in A Proposed Program for National Action to Combat Mental Retardation - The President's Panel on Mental Retardation, as well as on principles evolved by the Mental Retardation Planning Council in the course of developing Minnesota's comprehensive plan.

In September 1965, Governor Karl F. Rolvaag appointed a State Advisory Council on Mental Retardation Facilities Construction, as required by Section 134, a,3 of Public Law 88-164. Membership includes representatives of State agencies involved in planning, operation, and utilization of facilities for the mentally retarded, and of non-government organizations or groups concerned with education, employment, rehabilitation, welfare, and health, as well as consumers of services provided by the facilities. Members and their affiliations are listed in Appendix A.

The Advisory Council has considered and approved the Facilities Construction Plan and will likewise consider and approve any modifications thereof. The Council will review applications for construction funds and, with the help of guidelines set forth in the State plan, will determine which applications should be supported. It will also review complaints of parties under the Fair Hearing Procedures as set forth in Chapter VII, entitled "Methods of Administration".
Definitions

Section 54.101 of the Regulations for Grants for Constructing Facilities for the Mentally Retarded recommends the following definitions:


2. "Region" means the geographic territory from which patients needing services for the mentally retarded come or might be expected to come to existing or proposed facilities for the mentally retarded, the delineation of which is based on such factors as population distribution, natural geographic boundaries, and transportation accessibility. Nothing in the regulations in this part shall preclude the formation of an interstate area with the mutual agreement of the states concerned.

3. "Community service" means that the services furnished by the facility will be available to the general public.

4. "Comprehensive services" means a complete range of the services specified in §54.104 (a) in sufficient quantity to meet the needs of the mentally retarded within the region.

5. "Equipment" means those items which are necessary for the functioning of the facility, and which are considered depreciable and as having an estimated life of not less than five years. Not included are items of current operating expense such as food, fuel, drugs, paper, printed forms and soap.


7. For purposes of this plan "population" means the latest figures projected by the Minnesota Board of Health, Bureau of Vital Statistics, except for the seven county metropolitan area (Region 4) where projections are based on statistics developed by the Metropolitan Planning Commission.
8. "Regulations" means regulations for grants for constructing facilities for the mentally retarded (general) as authorized in Public Law 88-164, Title I, Part C.

Adequate Services and Facilities

Section 54.104 of the Regulations describes adequate services and facilities as follows: Adequate Services.

1. Diagnostic services. Coordinated medical, psychological and social services, supplemented where appropriate by nursing, educational or vocational services, and carried out under the supervision of personnel qualified to: (a) diagnose, appraise, and evaluate mental retardation and associated disabilities, and the strengths, skills, abilities and potentials for improvement of the individual; (b) determine the needs of the individual and his family; (c) develop recommendations for a specific plan of services to be provided with necessary counseling to carry out recommendations; and (d) where indicated, periodically reassess progress of the individual.

2. Treatment services. Services under medical direction and supervision providing specialized medical, psychiatric, neurological, or surgical treatment including dental therapy, physical therapy, occupational therapy, speech and hearing therapy or other related therapies which provide for improvement in the effective physical, psychological or social functioning of the individual.

3. Educational services. Services, under the direction and supervision of teachers qualified in special education, which provide a curriculum of instruction for preschool children, for school age children unable to participate in public schools, and for the mentally retarded beyond school age.

4. Training services. Services which provide: (a) Training in self-help and motor skills; (b) training in activities of daily living; (c) vocational training; (d) opportunities for personality development; and (e) experiences conducive to
social development, and which are carried out under the supervision of personnel qualified to direct these services.

5. Custodial services. Services which provide personal care including, where needed, health services supervised by qualified medical or nursing personnel.

6. Sheltered workshop services. Services in a facility which provides or will provide comprehensive services involving a program of paid work which provides: (a) Work evaluation; (b) work adjustment training; (c) occupational training; and (d) transitional or extended employment; and carried out under the supervision of personnel qualified to direct these activities.

Adequate Facilities.

1. The State plan shall provide for adequate facilities for furnishing community service for the mentally retarded for persons residing in the State and for furnishing needed services for persons unable to pay therefor, taking into account the caseload necessary for maintenance and operation of efficient facilities.

2. Facilities for the provision of diagnostic services (see paragraph (a) of this section) shall be planned to serve an annual caseload of not less than 150 or more than 300 retardates: Provided, that modification of this caseload requirement may be approved by the Surgeon General at the request of the State agency if he finds that such modification conforms with acceptable standards of program adequacy.

3. Facilities for treatment services, educational services, training services, custodial services (see paragraph (a) of this section) shall be planned to serve a daily caseload of not less than 40 or more than 200 retardates in facilities providing less than 24-hour a day service, and to serve not less than 40 or more than 500 retardates in facilities providing 24-hour a day service; provided that modification of these caseload requirements may be approved by the Surgeon General at the request of the State agency if he finds that such modifications conform with acceptable standards of program adequacy.
4. Facilities shall be planned by each State so that all persons in the State shall have access to facilities providing adequate services. **Duration of Plan**

The State Plan will be revised at least annually and will be published not later than July of each year. The statistical data included will comprise information for the calendar year previous to the publication of the Plan.

The data reported in this first edition of the State Plan cover the period from January 1, 1965 to December 31, 1965. **Planning Regions**

The regulations covering the administration of funds for Public Law 88-164 (Title 42, Part 54, Subpart B) specify that the State be divided into planning regions. Map 1 indicates the six regions which have been designated for purposes of this construction plan. Locations of services and facilities for each region are shown in detail on the six regional maps. Selection of regions was based on a number of factors:

The seven-county Metropolitan Region is so defined because of special characteristics such as rapid population growth, proliferation of services, complexity of governmental structures, and the existence of many planning organizations. In addition, the Metropolitan Planning Commission, a governmental agency created by the 1957 legislature, has compiled an abundance of data concerning this region as a whole.

The other regions were drawn around present population centers, taking into account the existence in each region of colleges, general hospitals, community mental health centers, area vocational schools, State residential facilities for the mentally retarded and mentally ill, and community services for the retarded. Many of the operating State departments which maintain field offices use the same population centers as bases of operation. Recommendations for services to the mentally retarded have been designed to achieve maximum utilization of these

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existing services and facilities. Mental Health Coordinating Committees, which have been expanded to include responsibility for the mentally retarded, exist in each region. Boundaries created by geographical factors and by patterns of transportation and utilization of general services were also considered.

With the exception of the Metropolitan Region, the mental retardation regions coincide with the mental health regions set forth in the Mental Health Construction Plan. This congruence is advantageous since the Department of Public Welfare administers both mental health and mental retardation construction programs. Mental retardation regions are also very similar to those used by the Department of Health in its hospital planning and construction program. The latter represent well established service areas but do not adhere to county lines. Data Gathering

Descriptive data pertaining to the regions are drawn from a number of sources. Population figures are based on the 1960 U.S. Census. Other demographic information has been culled from reports of the Metropolitan Planning Commission, the Upper Midwest Economic Study, the Bureau of Vital Statistics of the Minnesota Board of Health, and the Hennepin County Health and Welfare Council, as well as from the State Plan for Hospital Construction and the State Plan for Mental Health Construction. Demographic information has been far more readily available for the Metropolitan Region than for other parts of the State.

Required inventory data has been gathered by county so that it can easily be grouped in any manner that may be helpful to planning agencies. However, it is not intended that regions or counties should constitute rigid boundaries which would prevent individuals from other regions from obtaining available services.

Federal guidelines suggest that the required inventories of existing services and facilities list only those which devote at least fifty percent of their
efforts to serving the retarded. We have also included facilities which serve the 
retarded as identified in (1) the Public Welfare Directory of Services for the 
Retarded, 1965; (2) Hennepin and Ramsey County directories, which include some 
facilities not identified by the State publication; and (3) facilities licensed 
since these publications have been distributed. The inventories are tabulated by 
region and are appended to each regional discussion. Most important in these tables 
is the number of retarded persons being served, not what agency may be rendering a 
particular service. However, it should be pointed out that inadequacies of present 
reporting systems make accurate determination of the number of retarded persons in 
Minnesota, whether receiving service or not, virtually impossible.

Since Federal regulations governing administration of funds for community 
facilities for the mentally retarded have been interpreted as excluding develop-
ment of special education classrooms administered by public school systems, we 
have not incorporated projections of need for special classes. However, Map 7, 
which shows total numbers of special classes and special class students in the 
State, has been included in order to present a more comprehensive picture of 
existing services. Additional Considerations

Many other factors must be kept in mind in planning services and facilities, 
particularly when attempting to determine priorities and to weigh individual 
applications: (1) The possibility of establishment of a comprehensive facility for 
training and research. Grants for such facilities are made to institutions of 
higher learning under a separate program (Public Law 88-164, Title I, Parts A and 
B). (2) The proposed pattern of general hospital development, described in detail 
in the Annual Revision of the Minnesota State Plan for Hospitals, Public Health 
Centers, and Related Medical Facilities. (3) The Mental Health Center Construction 
Plan (Title II, Public Law 88-164), as well as the existence of twenty-
three State-supported Community Mental Health Centers. (4) The pending availability of funds under Public Law 88-101 for construction and staffing of sheltered workshops. This program would be administered by the Division of Vocational Rehabilitation, Department of Education. (5) The long-range effect of various Federal programs such as Medicare, Child Health Care, Economic Opportunity Program, Public Law 89-10, etc. (6) The actions of the biennial legislative session.

An over-riding consideration in planning for all services is feasibility. A given service may be badly needed in a given region, but unless there is at least a nucleus of staff and other resources present in the region it may be impracticable and even impossible to embark on setting up the service.
III. DESCRIPTION OF SERVICES

Diagnosis and Evaluation

Diagnosis is usually thought of as a medical term which implies evaluation of an individual's symptoms by a physician to determine causes and, if possible, to devise a plan for treatment. Although diagnosis of mental retardation follows a similar pattern, there are important differences. If a child shows behavioral symptoms which indicate possible retardation, a thorough physical examination is but one step in the diagnostic process. An adequate social history—personal, familial, and environmental—is indispensable. A complete psychological evaluation is often essential. Observation of the child's development over a period of weeks or months, together with parent counseling sessions, may be necessary in order to assess capabilities and limitations. Diagnosis becomes a continuing process of total evaluation and observation over a considerable period of time, generally requiring a team approach by members of various professional disciplines. Only through the interrelationship of these professional judgments does a complete and balanced picture emerge.

We know enough about causes of retardation to know that they are not always irreversible. We know that an individual is perceived as retarded in relation to the particular milieu in which he lives. We also know that suitable care and training can frequently enable retarded persons to become self-sufficient, productive adults who are able to make a contribution to the life of the community. Continuing evaluation, movement within and among programs, and the gaining of constructive life experiences are as necessary to the development of retarded persons as they are to "normal" development.

Comprehensive diagnostic services include the basic elements of total evaluation, as described more fully in the report of the task force on Prevention, Diagnosis and Treatment. (Volume I) The most desirable method of providing for
comprehensive diagnostic services is embodied in the concept of the Child Development Center, also outlined in the task force report. Such a Center ideally embraces a "core" team of pediatrician, public health nurse, social worker, and psychologist, with provision for consultant services, as needed, from psychiatrists, speech and physical therapists, orthopedists, ophthalmologists, dentists, and others. Extensive laboratory facilities should also be available.

While we do not know how many persons might be referred to a diagnostic service in any given community, rules of thumb are available to help place services in proper perspective. The U. S. Department of Health, Education, and Welfare suggests that a number of new referrals per year might be 200-300 per million population. This estimate does not include those clients who are not diagnosed as mentally retarded nor does it include re-evaluations. Addition of these two patient categories might easily double total intake. Experience at the demonstration project Child Development Center at Fergus Falls over a three year period indicates that the core team described above can evaluate approximately 150 new referrals per year.

Statements of County Welfare Department executives in response to a recent survey conducted by the project staff revealed that in most counties methods of diagnosing mental retardation are inadequate, as are the majority of definitions of mental retardation cited in the same survey. (See Vol. I). The current status of diagnostic services in Minnesota is illustrated on Map 2. At present the only comprehensive diagnostic facilities in the State (outside of the Metropolitan Region) exist at the Mayo Clinic in Rochester and at the Child Development Centers at Fergus Falls and at Owatonna. The latter is not yet fully staffed.

Other existing diagnostic services are too fragmented to be shown on the map. Comprehensive diagnostic services are proposed as follows:

1. **Rochester.** Rochester State Hospital, Mayo Clinic, and the Olmsted Medical Group to serve Southeastern Minnesota: Goodhue, Wabasha, Dodge, Olmsted, Winona, Mower, Fillmore, and Houston counties.

2. Existing Child Development Centers at **Fergus Falls** and **Owatonna** should be expanded to serve the following counties:
   
   a. **Fergus Falls.** To serve Clay, Becker, Wilkin, Ottertail, Grant, Douglas, Traverse, Stevens, and Pope counties.
   
   b. **Owatonna.** To serve McLeod, Sibley, Nicollet, Brown, LeSueur, Rice, Watonwan, Blue Earth, Waseca, Steele, Martin, Faribault, and Freeborn counties.

3. **Grand Forks, North Dakota.** To serve the Northwest: Kittson, Roseau, Marshall, Pennington, Red Lake, Polk, Norman, and Mahnomen counties. North Dakota is currently applying for a Federal grant to set up in Grand Forks a project similar to the Four County projects. The additional Minnesota population would supply a large enough population base to warrant such a center. Crookston, which has a Community Mental Health Center as well as a satisfactory medical complex, is only 25 miles away.

4. **Brainerd.** Brainerd State School and Hospital to serve Lake-of-the-Woods, Beltrami, Clearwater, Koochiching, Itasca, Hubbard, Wadena, Cass, Crow Wing, Aitkin, Todd, and Morrison counties. Brainerd would function as the "back stop" for this region. Traveling clinics would probably have to go out from Brainerd because distances in this area are great. Little Falls Mental Health Center would provide psychiatric consultation services. It is suggested that the Brainerd State School and Hospital initiate a two-year pilot project to test the feasibility of providing comprehensive diagnostic services. Funding might come jointly from Federal and State sources.
5. **Duluth-Superior.** To serve the Northeast: St. Louis, Lake, Cook, Carlton, and Pine counties. Duluth is a population center, with many resources including a Community Mental Health Center, three colleges, two daytime activity centers, a children's home, several hospitals, and a new rehabilitation center.

6. **St. Cloud.** To serve Stearns, Benton, Mille Lacs, Kanabec, Meeker, Wright, Sherburne, Chisago, and Isanti counties. St. Cloud has an excellent medical complex, a Community Mental Health Center, a State College, and two nearby private colleges. A group of physicians, educators, and others are considering establishment of a Child Development Center at St. Cloud.

7. **Southwest.** The West Central Mental Health Center is proposing a Child Development Center at Willmar, which would utilize the services of the Community Mental Health Center staff, as well as medical and hospital services available in the area.

    Long range planning should include the possibility of a small comprehensive State institution for the retarded in Marshall, which is also the site of the new Southwest State College and the Western Mental Health Center. Such an institution might provide diagnostic services as well. Until the community is built up to the point where it can attract the necessary professional personnel, it probably would be unwise to build this facility. In the meantime these counties should organize their medical communities for the purpose of developing diagnostic services, and should look toward Willmar, Mankato, Rochester, and Sioux Falls, South Dakota for necessary services.

8. **Metropolitan Region.** University Hospitals in Minneapolis provide the only comprehensive diagnostic service. However there are many partial services. St. Paul-Ramsey Hospital has received a Federal grant for a diagnostic facility which should be able to accommodate about 300 new cases a year. An evaluation center for physically handicapped children is proposed at Fairview Hospital in Minneapolis. Other locations mentioned are North
Memorial Hospital and Children’s Hospital in Minneapolis. It is not feasible to recommend establishing Child Development Centers where there is neither the professional community to offer services nor the population to support them. However, the use of such Centers for diagnosis of all handicaps could broaden the base of support in the following ways: provide a larger patient population; facilitate case-finding, since mental retardation often appears in conjunction with other handicaps; attract a larger and more diversified group of qualified professional personnel by virtue of the variety of presenting cases and the excellent opportunities for research which could be afforded by the clinic; increase eligibility for financial support, research grants, and training stipends from a wide spectrum of services. **Daytime Activity Services**

Daytime activity services are performed on a less than twenty-four hour basis and include daytime activity centers, religious education, and recreational activities.

**Daytime Activity Centers.** Daytime activity centers provide training services for retarded persons on a less than twenty-four hour basis. The task force on Community Based Services has spelled out in detail the ingredients necessary for a daytime activity center. Centers may offer activities for school-age retarded children who are not eligible for educable or trainable classes in the public schools; for retarded children who are too young to attend school; and for adults who are unable to engage independently in community activities. Centers should also provide family counseling services.

In Minnesota many daytime activity centers function in churches, public libraries, private homes, or remodeled buildings; there are no buildings in the State which have been specifically designed for this purpose.

The skeleton for a good Statewide daytime activity center program was created by the 1963 and 1965 legislatures, which appropriated funds to be made
available to local communities for the support of centers on a fifty percent matching basis. The program, is administered by the Department of Public Welfare, with advice from the Daytime Activity Center Advisory Committee. County Boards are empowered to appropriate money for matching purposes. Minimum standards for organization and programs must be met by applicant centers in order to receive State moneys. As greater experience is acquired, standards are being amended and improved.

Existing centers vary in numbers and ages of clients served, and in hours of operation per day or week. Programs should be expanded to include a greater degree of care and training for the severely retarded, many of whom at present spend twenty-four hours per day in their own homes. Regional questionnaires indicate the need for more adult programs. Full use should be made of the help which the center staff can offer in diagnosis and ongoing evaluation.

It is difficult to present a comprehensive plan at this time for the additional daytime activity centers needed in Minnesota. Much depends on local initiative, and available financial support both local and State. There could reasonably be at least one center in every county on a population basis alone. Map 3 shows only those Daytime Activity Centers which have already been established or proposed by local sponsoring groups.

**Religious Education.** The Department of Public Welfare directory, *Resources for the Mentally Retarded, 19-65.* lists forty-five religious education classes located in sixteen counties. Surveys conducted by the regional committees of the Mental Retardation Planning Council revealed strong demand for religious education opportunities for the retarded.

**Recreational Activities.** Public and private recreation facilities, social clubs, 4-H groups, Boy Scouts, YMCA, and other activities usually available to the general public are infrequently organized to serve the retarded. Camping opportunities are very limited.
MAP 3

DAYTIME ACTIVITY CENTERS

KEY

Daytime Activity Center  ■ State Grant-in-Aid  ◆ Private

See Map 11 for facilities in Metropolitan Region
Organization of recreational activities depends largely upon the leadership and participation of volunteers and citizens' groups, such as the Associations for Retarded Children, Jaycees, service clubs, and church groups. Residential Care

Residential care becomes necessary when a retarded person, for any of a variety of reasons, cannot remain in his own home. Residential care facilities should be located as close to home as possible. They are but one part of the array of services which retarded persons may need at some time in their lives. Although there are those retarded persons who will need lifelong care, the National Association for Retarded Children estimates that 85 percent of the retarded population can become self-supporting members of the community. Thus residential care should be therapeutic in nature, aimed at returning the individual to his home community. Dramatic results in recent years are awakening the public to the fact that many retarded persons can make this transition successfully. The notion that residential care for the retarded means segregating them from the rest of society through placement in a large, custodial State institution has long been moribund and deserves its fate. Yet Minnesota is lagging behind.

The problems involved in planning a cohesive residential care program for Minnesota are exceedingly complicated. Real progress cannot be made until we, as a State, adopt an entirely new philosophy of care, and remove the legislative and administrative barriers which presently stand in our way. An enlightened legislature coupled with aggressive leadership on the part of public officials, citizens, and administrators can open the door to a satisfactory system.

Philosophy and goals, together with numerous recommendations, are presented in detail in the task force report on Residential Care upon which the plan outlined below is based.
Tables 1 and 2 show the number of retarded persons residing in both public and licensed private facilities in the State as of June, 1965. Note that a total of 524 persons were residing in licensed residential care facilities, excluding the three major State institutions at Brainerd, Cambridge, and Faribault. Included among these are approximately 300 to 400 whose names are on the "waiting list" for admission to one of the State institutions. The total number of names on this "waiting list" exceeds 700, and it is assumed that those not in licensed residential care facilities are living in their own homes or in foster or boarding homes. (As of February, 1965 there were 430 boarding homes licensed to care for "other than normal children"; trend analysis predicts an increase to over three times this number by 1975.)

Exact information regarding numbers and location of persons in residential facilities at any given time is at present unavailable. The Department of Public Welfare does not have sufficient staff time to keep this mass of statistics up to date, particularly in view of the constant movement of patients back and forth between home (or foster home) and institution.

With two or three exceptions the private facilities listed in Table 1 accept residents from anywhere in the State. However, as a result of the present system of payment for residential care, these private facilities are generally viewed by County Welfare Boards as emergency placements pending admission to State institutions. The law specifies that the county must pay ten dollars per month for each retarded patient cared for in State institutions, which sum may or may not be recovered from parents or other sources. On the other hand, if a retarded person receives residential care in a boarding home, nursing home, or other private or non-profit facility, the county is responsible for the total cost of care. Not infrequently, this factor, rather than the needs of the patient and his family, determines choice of placement. The pressure is for placement in State institutions, and private facilities serve mainly as temporary placements pending institutionalization.
### TABLE 1 LICENSED

#### GROUP FACILITIES

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**Group Living Facilities for Adult Retarded**

| Greenbriar Home, Inc.                       | 112                   | 112               |
| Ottertail Group Living Project             | 7                     | 2                 |
| **Sub-Total**                               | **119**               | **121**           |

**Private Residential Schools**

| Hammer School, Inc.                         | 50                    | 42                |
| Laura Baker                                 | 54                    | 55                |
| **Sub-Total**                               | **104**               | **97**            |

**State Institutions**

<p>| Shakopee Home for Children                 | 30                    | 30                |
| Owatonna State School                      | 201                   | 211               |
| Lake Owasso Children's Home                | 130                   | 130               |
| <strong>Sub-Total</strong>                               | <strong>361</strong>               | <strong>371</strong>           |
| <strong>Total</strong>                                  | <strong>885</strong>               | <strong>913</strong>           |</p>
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*For description of Programs, see page 30-32.
### TABLE 2 (Cont’d.)

PATIENTS RESIDING IN FARIBAULT, CAMBRIDGE AND BRAINERD STATE SCHOOLS AND HOSPITALS FOR THE RETARDED AND LAKE/OWASSO CHILDREN’S HOME AS OF JUNE, 1965 GROUPED ACCORDING TO PROGRAM*, SEX, AND COUNTY OF RESIDENCE

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* For description of Programs, see page 30-32.
### TABLE 2 (Cont'd.)

Patients residing in Faribault, Cambridge and Brainerd State Schools and Hospitals for the Retarded and Lake Owasso Children's Home as of June, 1965 grouped according to Program*, Sex, and County of Residence

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* For description of Programs, see page 30-32.
**TABLE 2 (Cont'd.)**

PATIENTS RESIDING IN FARIBAULT, CAMBRIDGE AND BRAINERD STATE SCHOOLS AND HOSPITALS FOR THE RETARDED AND LAKE OWASSO CHILDREN'S HOME AS OF JUNE, 1965 GROUPED ACCORDING TO PROGRAM*, SEX, AND COUNTY OF RESIDENCE

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<td>1097</td>
<td>1071</td>
<td>883</td>
</tr>
</tbody>
</table>

**TOTALS**

|               | 5913 | 3133 | 2780 | 403 | 502 | 323 | 640 | 2091 | 1954 |

* For description of Programs, see page 30-32.
1. Child Activation Program. This program is for children from birth to puberty who are bedfast or non-ambulatory. These children have usually suffered major central nervous system damage; their physical helplessness is caused by their having severely damaged or under-developed brains. They do not, however, have such severe physical problems that they require complicated nursing care and special nursing equipment such as is found on a ward for seriously ill children. If these children are given large amounts of affectionate attention and are encouraged to see, hear, and move, a significant number may learn to sit in wheel chairs, crawl, walk with help, and to evidence in manner and appearance the development of the capacity to feel happiness and enthusiasm.

2. Child Development Program. This program is for children who can walk. Their ages may range from three to four up to eleven or twelve. Children within this group vary greatly: some may be constantly over-active, others quiet and withdrawn; some may be physically disfigured but fairly bright; others may be doll-like in appearance but not respond noticeably to people or to playthings. Epileptic seizures are fairly common. These children greatly need warm and affectionate mothering, appropriate disciplining, and special kinds of education and training programs. This program is called "Child Development" because all of these children are in a most important period of physical and personality growth. What happens to them at this time will have much to do with how capable and stable they will be when they become adults.

3. Teenage Program. This program is for ambulatory children who have passed the age of puberty, but are not yet old enough to participate in vocational training or other more adult activities. Some of the mildly retarded children in this
group frequently have been sent to an institution because their hostile, destructive behavior has excluded them from special education programs in their home communities. Others with mild degrees of retardation have been admitted to the institution because they have developed serious degrees of mental illness. This group also includes some mildly and moderately retarded children who cannot remain at home because their home communities do not provide classes for "educable" and "trainable" children. The more severely retarded children have come to this program from the Child Development Program and demonstrate behavior usually believed to be related to bodily and emotional changes which take place at puberty. Because of the cost of the services, such as psychiatry, psychology, occupational therapy, and special activities, which are required to program adequately for the complex needs of children in the Teenage Program, it is likely that this group will remain in residential care in State facilities.

4. Adult Activation Program. This program is for bedfast and non-ambulatory patients who are too old to be included in the Child Activation Program. These patients need close attention and constant watchfulness for indications for potential progress. Many of them, after years of bed care, have developed serious but correctable losses of use of arms or legs, or have become twisted and stiffened so that they cannot use wheel chairs or walk. The mental capacity of these patients may be very low, or it may merely appear to be low because they have suffered damage to those parts of the brain necessary for speech. This is essentially a hospital program for persons who require a great amount of care by physicians specializing in orthopedics, neurology, and neuropsychiatry, nurses and technicians specially trained to provide physiotherapy and other rehabilitative services.
5. Adult Motivation Program. This program is for ambulatory older adolescents and adults of all ages who have very limited intelligence and who frequently suffer from severe emotional disorganization. They may show very odd behavior and often seem to have little meaningful or understandable contact with people and things around them. Some of these persons wander around actively but aimlessly, while others sit on the floor rocking or making strange noises. Some make great efforts to communicate with friends or strangers, others appear to be withdrawn and frightened. These patients, however, often show a surprising capacity for taking part in occupational therapy and recreational activities. It may be possible to discover many secrets of how the mind and emotions function through neurological and psychiatric research with these patients.

6. Adult Social Achievement Program. This program is for those late adolescent and adult patients who have no serious intellectual handicaps, no serious physical problems, and no major degrees of mental illness. These patients find it difficult to adapt to the demands of society, generally because they have not had adequate vocational education and training and have spent so much time in institutions that they have never learned how to get along with non-retarded persons or how to use the work and recreation opportunities available in communities. Some persons in this program become panic-stricken at the thought of being independent, others have personality characteristics which cause others to dislike them. This program is called the Adult Social Achievement Program because it is designed to provide the educational, social, and psychological experiences which will enable these people to function successfully in the community – at – large.
The Mental Retardation Planning Council has recommended that the State assume the full cost of care regardless of whether placement is in a State or private facility. The county would still be responsible for ten dollars per month. This change would remove the cost element as a major consideration. It would also encourage private and non-profit groups to enter the field of residential care for the retarded. As for the additional burden to the State, it has been demonstrated that daily cost of care for some retarded persons in private facilities would be even less than the present cost of caring for the same patient in a State institution. Further the growth of numbers of small private nonprofit residential care facilities will partially relieve the State from additional construction costs.

Unless and until this distribution of costs can be radically altered, there is little hope of any real improvement in our present system of residential care. That the State itself could build and staff the many smaller facilities which are needed does not appear feasible because of the accumulated backlog of needs for services and for replacement of adequate existing facilities.

Another factor which will influence recommended construction of residential care facilities is the project currently underway in the Department of Public Welfare to spell out adequate programs for various patient groups and to ensure the provision of these by both State institutions and by private facilities. (See p. 30-32.) Table 2 enumerates six broad categories of patients by type of treatment, sex, and county of residence.

The Department of Welfare has agreed that Groups 1 and 6 could be cared for in community facilities if the latter were available. Placement in group and boarding homes of Group 6 would substantially reduce current population in the three institutions, two of which are severely overcrowded. Guidelines for the kinds of programs which should be provided in group and boarding homes are outlined in the task force report on Residential Care; in numerous publications
of the Federal government, the National Association for Retarded Children, and the American Association for Mental Deficiency; and in programs and licensing standards being developed by the task force and Planning Council, the State Department of Public Welfare, and various national agencies.

Building plans at the State institutions at Brainerd, Cambridge, and Faribault should be geared to meet the program needs of Groups 2, 3, 4, and 5. If the majority of patients in Groups 1 and 6 are moved to smaller private facilities, buildings which do not meet health and fire standards can be razed. Other buildings can be remodeled as necessary to make them suitable for the remaining groups. Replacement beds should not be limited to the standard 100-bed dormitories but should be planned to include houses for independent or supervised living. Cottages of eight to ten patients with house parent supervision is one such possibility. It has often been stated that many small institutions programmed for diverse groups of patients can be maintained on the same grounds, but this theory has never really been put into practice.

It is not necessary that services at the three institutions be identical. What is important is that imaginative programming to meet recognized needs should dictate the future use of State facilities. For example, it has been suggested that a high caliber, fully accredited medical facility be created at Faribault for patients in the Metropolitan Region who need medical services; substantial research and training ties could be developed between this facility and the University of Minnesota, Mayo Clinic, and Mankato State College. At Cambridge a program for hyperactive adults might be developed.

Brainerd State School and Hospital, being new, large, and well equipped, and located in the center of an enormous geographic area possessing a minimum of other services, should serve as a focal point for regional services to the retarded. Unfortunately, Brainerd, Minnesota's newest large custodial institution, has not been planned in accordance with precepts of modern residential care: it is over-
MAP 4
STATE AND PRIVATE RESIDENTIAL FACILITIES

KEY
- Residential Facility
- Proposed Residential Facility
- M. R. Institution
- M. I. Institution

See Map 11 for facilities in Metropolitan Region
sized and located far from the homes of its residents and from other medical and educational facilities.

Brainerd probably has enough beds now to serve its present thirty-six county receiving district, which includes all of Region 1, most of Region 2, and a portion of Region 3, if we adhere to the proposed pattern of placement of Groups 1 and 6 in smaller residential facilities.

Brainerd State School and Hospital might also become a multi-purpose facility serving all handicapped persons, including the mentally ill and mentally retarded, from the counties in the north central section of the State. Complete diagnostic services could be provided. Special education programs similar to those at Lake Park-Wild Rice Home, Christ Child School for Exceptional Children, or the State School at Owatonna, as well as sheltered work stations for all handicaps, might also be incorporated into the Brainerd program. These services are not likely to be developed by private organizations, since many counties in this region are classified as "economically distressed".

If integration of mentally retarded patients into hospitals for the mentally ill proves successful, the converse may well be true. Brainerd is flanked by Moose Lake State Hospital on the East and Fergus Falls State Hospital on the West. An exchange of patients living in the service regions would not greatly change the population at any of the three facilities and would serve to bring patients closer to their home communities.

Recommendations for the Northeast and Northwest Regions are based on the foregoing recommendations for multiple use of the Brainerd institution.

The Department of Public Welfare is exploring the idea of utilizing portions of Hastings State Hospital to house retarded patients. This proposal opens the door to a number of programming possibilities at Hastings; comprehensive diagnostic services might be provided; complex cases requiring specialized medical and paramedical services available only in the Metropolitan Region might be housed;
extensive research and training facilities could be developed.

Additional suggestions are offered as follows:

1. State institutions should afford sheltered employment and pre-vocational training for persons residing outside the institution as well as for residents; off-campus living quarters should be provided.

2. A residential facility should be part of every sheltered workshop. During non-working hours workers should receive personal and financial supervision, as well as encouragement to participate in organized recreational and social activities.

3. Boarding homes and other residential facilities should be considered permanent placements only so long as they meet the current needs of the patient. Retarded persons require different kinds of care at different stages of life movement. In any community a continuum of care should be provided by a variety of facilities, as opposed to a single facility whose admissions are generally restricted by age or degree of disability.

4. Half-way houses are needed throughout the State to help patients who are able to leave the institution to find their places in the community.

5. Facilities should be available for temporary care or "baby-sitting"—during the evening, or to permit parents to take a short vacation, or for a period of months when family problems become overwhelming.

Sheltered Workshops

This section is based on the combined thinking of the task forces on Employment and Education and Habilitation. The plan is contingent upon workshops throughout the State banding together in a broad cooperative venture as recommended in these task force reports.

Sheltered employment is that type of employment which enables partial self-support for the handicapped worker under conditions which cannot be reproduced in the usual work setting. These conditions allow for: (1) low production rate occasioned by the client's handicap, (2) need for special work supervision,
(3) inability to handle full range of job duties, and (4) need for special job engineering or adaptive equipment. Sheltered employment is usually provided in a sheltered workshop, or a rehabilitation facility authorized by the government to pay less than the accepted minimum wage. Sheltered employment may be provided by a private employer if the handicapped worker holds an individual sub minimum wage certificate. Sheltered employment is indefinite in duration and may be permanent. Often, however, a client improves his employability to the extent that he can be placed in competitive work.

It is impossible to predict how many mentally retarded adults in Minnesota might eventually benefit from long-term sheltered employment. However, an estimate can be made of the number of long-term work stations needed for all types of handicapped persons in Minnesota, based on the Division of Vocational Rehabilitation statement that one percent of the population can benefit from vocational rehabilitation services. Thus in a city with a population of 10,000 there would be about 100 persons who could benefit from Vocational Rehabilitation Services. Further, it has been found that about ten percent of all persons referred to Vocational Rehabilitation need some kind of long-term sheltered employment. This means that ten percent of one percent, or one out of a thousand persons of any given population, need long-term sheltered employment. According to these figures, Minnesota would have approximately 3,000 to 4,000 persons who could benefit from long-term sheltered employment (based on a State population of approximately 3,413,864 people *).

Map 5 shows the estimated needs for long-term sheltered employment together with available facilities. Figures cover all handicaps, including mental retardation.

* 1960 Census
EXISTING AND PROPOSED SHELTERED WORKSHOPS

KEY
- Sheltered Workshop
- Proposed Sheltered Workshop

See Map 11 for facilities in Metropolitan Region.

- Sioux Falls, So. Dakota
One way to meet sheltered employment needs in Minnesota would be to establish a "base workshop" in each of the four regions with satellite workshops in other parts of the region. The base-satellite workshop approach would offer the following advantages:

1. Provide an evaluation and training program for the region. It would be difficult and impractical, in terms of cost and recruitment of staff, for all of the workshops in a given area to offer evaluation and training services.
2. Provide a center for training workshop supervisors and other personnel who might later move to a satellite workshop in the region.
3. Provide supportive services to the satellite workshop until the latter became established in the community.

In Region 1 the base workshop could be located at Fergus Falls, where for four years a workshop for the retarded has existed. Map 5 also shows a portion of Region 1 which is presently being served by the Grand Forks and Fargo-Moorhead workshops. It is possible that Grand Forks might furnish the stimulus for a satellite in either Roseau, Crookston, or Thief River Falls, while Fergus Falls might help establish satellites in Bemidji and Brainerd. The need in Region 1 has been estimated at 400 work stations. If Fergus Falls, Brainerd and Bemidji each serves 100 clients and another fifty are served at either Thief River Falls, Crookston, or Roseau, this should provide for the needs of Region 1, since some clients are being served by the Grand Forks and Fargo-Moorhead workshops.

In Region 2 the logical location for the base workshop would be Duluth. Satellites could be established at International Falls, Grand Rapids, and the Hibbing-Virginia-Eveleth area. The need in Region 2 has been estimated at 390 work stations. The Duluth area would need to provide at least 150 work stations, and 100 would be needed in the Hibbing-Virginia-Eveleth area. If 100 stations were provided at International Falls then approximately 50 stations should adequately serve the Grand Rapids area.
The base workshop in Region 3 could be located in the Twin Cities area or in St. Cloud or Willmar with satellites in Marshall and Morris. The need in Region 3, excluding the Twin Cities area, is for approximately 450 work stations. The St. Cloud area would need to provide 150 work stations, the Willmar area 100, the Marshall area 100, and the Morris area 100.

In Region 4 there are three agencies which now offer programs—Rochester, Mankato, and Austin. A possible location for a satellite from one of these three bases could be Worthington. There is additionally, a workshop in Sioux Falls, South Dakota which should be considered when planning for the needs of the southwest corner of Minnesota.

According to the 1960 census the population of the Metropolitan Region (7 counties) is over 1.5 million. The need in the Twin Cities area is for 1,500 work stations. See Map 6 for possible locations of these work stations. In the Metropolitan Region the workshops could continue to specialize, as they have been doing, in serving different types of handicaps. The concentration of population warrants specialization of long-term sheltered workshop, i.e., United Cerebral Palsy Workshop for the cerebral palsied, Opportunity Workshop for the mentally retarded, Minneapolis Society for the Blind, etc. If the first ten agencies listed on Map 6 grow according to their expectations, and three new sheltered workshops for the mentally retarded are started at Hammer School, in Fridley, and in East St. Paul, a good start will be made in providing adequate sheltered employment in the Metropolitan Region.

The following criteria should be considered in choosing the location for workshops:

1. Population (100,000 or more desirable)
2. Industrial Center
3. Existing agencies which offer evaluation and training
4. Division of Vocational Rehabilitation Office
### Existing and Proposed Sheltered Workshops in Seven County Metropolitan Area

#### Work Stations Now Available For Retarded

<table>
<thead>
<tr>
<th>Organization</th>
<th>Stations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Opportunity Workshop, Inc.</td>
<td>50</td>
</tr>
<tr>
<td>2. UCP of Minneapolis</td>
<td>45</td>
</tr>
<tr>
<td>4. Christ Child School for Retarded</td>
<td>18</td>
</tr>
<tr>
<td>5. St. Paul Rehab Center-Community Wk.</td>
<td>15</td>
</tr>
<tr>
<td>6. North Star Workshop</td>
<td>9</td>
</tr>
<tr>
<td>7. Outreach International</td>
<td>5</td>
</tr>
<tr>
<td>8. Minneapolis Goodwill</td>
<td>10</td>
</tr>
<tr>
<td>9. UCP of Greater St. Paul</td>
<td>6</td>
</tr>
<tr>
<td>10. Jewish Vocational Workshop</td>
<td>7</td>
</tr>
<tr>
<td>11. Minn. Academy of Seizure Rehab.</td>
<td>10</td>
</tr>
<tr>
<td>12. Wayzata Area</td>
<td>0</td>
</tr>
<tr>
<td>13. Fridley Area</td>
<td>0</td>
</tr>
<tr>
<td>14. East St. Paul Area</td>
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#### Work Stations to Be Available in 3-4 Years

<table>
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<th>Organization</th>
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<tr>
<td>2. UCP of Minneapolis</td>
<td>60</td>
</tr>
<tr>
<td>3. St. Paul Goodwill</td>
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<tr>
<td>4. Christ Child School for Retarded</td>
<td>50</td>
</tr>
<tr>
<td>5. St. Paul Rehab Center-Community Wk.</td>
<td>50</td>
</tr>
<tr>
<td>6. North Star Workshop</td>
<td>50</td>
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<td>7. Outreach International</td>
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<td>8. Minneapolis Goodwill</td>
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<tr>
<td>9. UCP of Greater St. Paul</td>
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<tr>
<td>10. Jewish Vocational Workshop</td>
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<td>11. Minn. Academy of Seizure Rehab.</td>
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<td>12. Wayzata Area</td>
<td>100</td>
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<tr>
<td>13. Fridley Area</td>
<td>100</td>
</tr>
<tr>
<td>14. East St. Paul Area</td>
<td>100</td>
</tr>
</tbody>
</table>

#### TOTALS

<table>
<thead>
<tr>
<th>Work Stations</th>
<th>Now Available</th>
<th>To Be Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stations</td>
<td>200</td>
<td>835</td>
</tr>
</tbody>
</table>

-42-
An important consideration for the location of a base workshop should be the higher education facilities available in the area. These are a valuable source of personnel to be trained in supervision and evaluation for workshops, as well as of consultative personnel. The workshop might also offer a practicum for graduate students, which should help to attract qualified people into the sheltered workshop field.

Both the base workshops and the satellites should make use of supervised boarding homes for those clients who cannot commute. Since County Welfare Departments and the Division of Vocational Rehabilitation will be involved in this phase of the program, workshops should be located in proximity to County Welfare and Division of Vocational Rehabilitation offices.

Educational Services

Although the facilities construction program under Public Law 88-164 excludes public education facilities, educational services are included here in order to round out the picture of existing services and unmet needs.

The task force on Education and Habilitation has recommended that local school districts individually or through cooperative arrangement provide a complement of educational services consisting of: special classes from elementary through secondary levels for both educable and trainable retardates; work training programs; job placement and post-school follow up. In many instances, special classes are not coordinated to ensure this type of continuing program. The task force has also recommended strengthening the State Department of Education with additional consultants, who would help school districts to develop greater consistency in special education programs. Because of inadequate school district organization and consolidation, many districts cannot support the full range of services.
Cooperative arrangements with central coordination are needed to accomplish this end. Regional consolidation and reorganization of districts to form units large enough to support these services is essential.

Map 7 shows the pattern of special classes available as of the 1964-65 school year. Although the number of these classes has increased markedly in the last eight years, there are still many parts of the State not adequately served. Despite enabling legislation, school boards and superintendents as well as the general public still need to be educated to the desirability of special classes. Current estimates developed by the Minnesota Association for Retarded Children indicate that over 50 percent of those children who could gain from special classes are now enrolled.

Vocational training during and following school is perhaps the most neglected area in education services. Area vocational schools and State institutions have not been sufficiently utilized for this purpose. These resources could provide training in a wide range of skills and could arrange sheltered living for participants during the training period.
IV. REGIONAL PLANNING

Profile of the State

Minnesota is the twelfth largest of the fifty states, encompassing 84,068 square miles and 53,803,520 acres. Although the French Voyager's settled the State in about 1680, the present native population is of preponderantly Scandinavian and German origin.

Minnesota's most outstanding topographical feature is its lakes, which are variously numbered from ten to 22 thousand. These lakes provide the center for the rapidly growing industry of tourism, particularly in the North. Minnesota also is placed as second or third in the nation with regard to number of acres of fertile farm land, which has provided an agricultural backbone to the State's economy since her history began. However, the northeastern portion of the State is distinguished by its rocky, barren character, such that lumbering and iron mining have flourished in this region in the past, to be supplanted more recently by paper pulp plants and the processing of low grade iron ore (taconite).

While agriculture still ranks high in Minnesota's economy, most of the 3,413*864 residents* now live and work in cities, rather than on farms. Nearly one half of the population, or 1,513,023 people*, live and work in the metropolitan region. Cities of 2,500 or more, not in the immediate Twin Cities. Cities of 2,500 or more, not in the immediate Twin City region, account for some 609,543 residents.

The total State population is expected to increase 17.3% from the 1960 census figure of 3,414,000 to 4,005,000 by 1973. It should be noted that, of the 591,000 projected increase, 83% is expected to be accounted for by Anoka, Clay, Dakota, Hennepin, Olmsted, Ramsey, St. Louis, Stearns, and Washington.

* 1960 Census
counties. These same counties contained 56% of the State's population in 1960, and are expected to have 60% by 1973. Of the remaining 78 counties in the State, 28 or 36% are expected to have an actual population decrease.

There are distinct differences in the distribution of county population by age groups. The larger, rapidly growing counties have a very high proportion of their population under 20 years of age, and a small proportion in the older age groups. The smaller, slow-growing counties on the other hand have more than double the proportion of their population in the older age groups. These counties also have a relatively high proportion of their population under 20 years of age.

Although the rural population is still considerable—1,291,298—a declining number actually farm the land. However, many of these people live in municipalities of less than 2,500 population, where one of the principal functions is that of servicing the interests and needs of farm families.

Changing times and their effect on the occupation of Minnesota's wage earners are shown by employment figures. Approximately 958,400 Minnesotans are employed in nonagricultural pursuits, with 228,400 in manufacturing, 53,400 in construction, 28,900 in mining and quarrying, 25,000 in public utilities, 53,900 in transportation, 238,000 in trade, 49,500 in finance and real estate, 142,300 in services and 152,700 in government. Those regularly occupied in farming number some 155,600. Recent trends indicate a fairly rapid increase in those engaged in trades, service and manufacturing and a continuing decrease in farm laborers.

The 1960 median income in the State was $4,674. Very few (12) counties had more than the State median income. Half of these counties are in or adjacent to the Twin Cities Metropolitan area. The higher median incomes seem to be in the larger, fast-growing counties, and conversely the smaller, declining counties have the lowest median incomes.
Minnesota ranks fifth among the fifty in the value of agricultural products and is at or near the top in the production of honey, cheese, flax, milk, corn, soybeans, oats and peas. Minnesota ranks first in the nation in the production of butter, dry milk, Christmas trees and oats; second in honey production, turkeys raised and sweet corn processing; third in milk and egg production and in green pea processing; and fourth in cheese.

In addition to processed foods, manufacturing plants operate extensively in the production of machinery of various types, particularly of agricultural application, and in scientific instruments, printing and publishing, beer, electrical machinery, and plastics. The Twin City area was first known for the lumber which came from the saw mills, then for flour, and now ranks fourth in the nation in the field of electronics.

An emerging pattern can be detected with respect to the economic trends of the State: the number of farms is steadily decreasing, but farms are becoming larger, more valuable, and more productive; the size of cities is increasing; service trades and professions are proliferating; the processing of goods for the markets of the nation is becoming a major industrial focus. The ability of Minnesota's labor and management to compete in the production and marketing of highly finished and complicated equipment has only recently been discovered, but massive progress is being recorded in this arena as well. Regional Needs

In March, 1965, Regional committees working under the guidance of the Mental Retardation Planning Council developed broad appraisals of each region's need for mental retardation services. (See Appendix B for Regional Committee Membership.)

The similarity between these appraisals is striking, good diagnostic services, a variety of living arrangements close to home, special education classes, work training and sheltered work programs, daytime activity centers, and recreational activities are desired by all regions.
An over-arching deficiency which hampers activities in every region is the inadequacy of basic data relating to numbers of retarded persons known to agencies in Minnesota, their places of residence, ages, and degree of retardation. This information is indispensable when one is planning programs, deciding where to locate facilities, or constructing population projections which give some insight into the future. The need to include this data in the regular statistical reporting process of any agency, where it will be readily available to other agencies, should command the serious attention of caseworkers and administrators. As more Federal funds become available, statistical data will also be needed in order to develop project proposals, to secure construction funds, and to receive moneys for staffing and for direct service programs. Accurate quantitative information concerning retarded persons is also vital to planning programs in which the State Departments of Health, Education, Welfare, Corrections, and Employment Security are involved.

Another urgent need of all regions is the provision of consultant service in the area of mental retardation by the State Departments of Welfare, Education and Health.

When each region reports that it needs every conceivable service, it becomes very difficult to program specific services for specific communities. The recommendations which follow are only starting points for State and community action.