

"The State's Responsibility to the Mentally Ill
and the Mentally Retarded"
Speech prepared for delivery by Governor Karl F. Rolvaag
DFL Women's Forum
Capp Towers Hotel, Minneapolis
December 5, 1964

It is a great pleasure for me to participate in this session today -- the first of a series of seminars on the several grave issues which confront state government. Your topic, "The State's Responsibility to the Mentally Retarded and the Mentally Ill," is one of the utmost importance.

I know. I have been to the wards. I have visited the playrooms, the infirmaries; I have seen what is happening in our state institutions.

And I hear. Let me share this letter with you.

"I went to visit my daughter....she has been at the school for almost three years. She is severely retarded and it is good to know that there is a place for her.... Until this last visit I felt that she was well cared for. When I had to leave, I took her from the lobby to the day room where a male patient unlocked the door. I led her in and left her in this room with other patients -- perhaps ten or more of the same mental age....They were alone -- no one was looking after them. One child had opened a toy of some sort, and the stuffing was scattered on the floor. My girl eats anything, as I'm sure some of the others do. Then too, she bangs her head on the floor until it bleeds if no one stops her -- there was no one to stop her and the sore caused by her banging was infected and smelled bad. I hurried to the Administration Building and learned that for several hours a week these children are left unattended because of lack of help."

I could read you other letters but I will just give you one more. This is from a father of a retarded child. He is describing conditions in one of the buildings at one of our schools and hospitals for the retarded.

"There are over 200 patients in this building....there is only one aide on duty on the 11 p.m. to 7 a.m. shift. These are multiply handicapped patients -- many of them are not ambulatory. Many require medication once or twice during the night....In another building, it is necessary to commence to dress the patients at 4:30 a.m. in order to get them ready in time for breakfast."

This father pinpoints the real tragedy when he adds: "That retarded children who can be useful in society, and who can be returned to society are not given an opportunity to develop their full potential, and are thereby denied the opportunity of returning." "Their limited potential is stifled by the 'herd treatment,' and results in mental and physical regression," he writes. And concludes: "The cold fact is that a terminal cancer patient receives better care and treatment than these children who have lifetimes ahead of them."

Yes, I have seen these things and many, many more and I know them to be true. It would be wrong, however, if I did not also tell you about the many fine people who are working in our state institutions, oftentimes under very difficult circumstances, and of the many outstanding programs that have been developed and carried out.

We are helping sick people get well. We are rehabilitating many retarded so that they may learn to care for themselves, or even eventually return to the community.

During the tours which Mrs. Rolvaag and I took last spring, we saw much that was a credit to the people of Minnesota. Let me tell you about a little five-year old child, severely retarded and spastic. He was brought before us, quiet, unresponsive, with the appearance of lifelessness. A young woman -- a physical therapist using a technique newly developed in Europe -- worked with this tiny child to encourage him, through instinctive response, to use little muscles which had long since become almost useless.

It is difficult to describe, but what she did with this child was to place him on a large soft plastic inflated ball, on his stomach. Gently she rolled him back and forth and slowly his arms began to respond. His face brightened. He seemed to come to life.

We were told that treatment of this kind might eventually make it possible for this child to learn to use long-atrophied muscles, to sit up, possibly even to feed himself. We were also told that without this kind of treatment he might lie motionless for years.

In the hospitals for the mentally ill, I also saw dramatic therapy sessions that were effectively re-establishing a patient's sense of self-worth, rebuilding his confidence and his ability to adapt to the world around him.

Many leaders in the field of mental health and mental retardation joined me in the tours of the hospitals. We were all deeply impressed by the achievements and quality of Minnesota's program. But we were much disturbed by the unevenness of quality -- the isolated instances of inadequate staffing, of "herd" care, of systems and practises that lend themselves to dehumanization.

Perhaps the major value of the tours was that it crystalized our thinking about priorities of needs. It has permitted the evolvement of a program for essential reforms and improvements, not only in the state institutions for the retarded and in the state hospitals for the mentally ill, but also in the vast array of community services which help these handicapped persons.

It is that program that I wish to outline for you this morning, recognizing that in my preliminary remarks about the bus tours I have only touched on the roster of achievements -- and needs -- which are apparent to any visitor to these hospitals and community services.

1. Continuation of program to attack dehumanization.

Chief among the accomplishments noted during our tours was the program to get rid of the dehumanizing effects of institutionalism. I am deeply impressed by the full scale program initiated under the leadership of Dr. Vail, and carried out through the effective work of his associates (and his chief, Commissioner Morris Hurch) in the Department of Public Welfare and in the seven mental hospitals, to re-examine the traditions of treatment of mental patients -- to see if it was in fact necessary to "process" these unfortunate ill persons in a way that implied that they were somewhat less than human beings. For example, the gang shower, the absence of privacy, the restrictions on personal belongings. Herd care and mass handling are not the result of any indifference on the part of staff but are a natural result of too few people with too much to do and too many people for whom they are responsible.

I cannot say enough in praise of the changes that have been brought about and I wish and hope to see continued improvements along these lines. One thing that does not require major increases in appropriations is humaneness, simple kindness, recognition and acceptance of the worth of a human being. But it does cost more to give individualized care, to take time to single out one patient for help, to remotivate him to care about his appearance, his belongings, his associates, his life. I know that an increased staff could help more sick people and I will seek and press for added medical and other personnel to get this job done.

2. Experiments in industrial therapy programs.

I am enthusiastic in my support for the proposed study of the current practice of requiring patients in state hospitals to do various jobs at the hospital. A modest appropriation should be made by the next legislature so that we may experiment with different methods of providing patients who work with a token payment for their labor. Several thousand patients have for many years performed much-needed work, and while this work can be therapeutic under some circumstances, we must exercise great precautions to avoid any exploitation. And as we explore the possibilities of improving our patient labor program, I am hopeful that we will also bring about a change in the hospitals in the direction of providing for more extended vocational training as a part of the treatment program.

3. Increases, as needed, in hospital staffing.

With such a hopeful trend apparent to us, it becomes more important than ever that we make sure there is no relaxation in our efforts. The mental hospitals have emerged from a long period of neglect. With reduced population, the hospital authorities have been enabled to give much needed attention to the quality of care -- to more than mere custody. Today approximately fifty percent of the admissions are voluntary -- sick people who go willingly for help they know they will get. Our responsibility to provide that service continues undiminished.

In summary, with reference to the seven mental hospitals, we must continue the programs to combat dehumanization, we must re-examine the patient employment patterns, and we must hold and build on the gains already made.

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At the same time that the hospitals for the mentally ill have experienced a sharp decline in patient population, the state schools and hospitals for the

mentally retarded -- those at Faribault, at Cambridge, and at Brainerd -- have experienced no decline in population and are in fact under constant pressure to accept additional retarded persons. Around the state are hundreds -- the official list shows 700 retarded children who need and require care in one of the state hospitals -- but for whom there is no place.

4. Greatly increased support for the state institutions for the retarded.

My friends, it is a fact that these institutions for the mentally retarded have been seriously neglected. Many of the buildings at Faribault should be razed to the ground. The lack of staff is absolutely unbelievable. Special services -- physical therapy, recreation, education, trips and camping experiences -- programs of this type are far too limited.

I intend to do everything possible to provide a substantial increase in the number of persons who are charged with the responsibility of caring for, and rehabilitating the persons we have committed to these institutions. The estimate is that over 833 new persons should be added to the present staff -- and on the basis of my observations I cannot believe that estimate is very far off the mark!

It is often said that a measure of the character of a society is the way in which it cares for its handicapped. We do not come out very well when this measurement is applied to us and I am determined to bring about a change.

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5. Community-based services.

Perhaps the most significant change in the pattern of services and help for the mentally ill and the mentally retarded has been the development of the community-based facility.

5. A. Increased support for mental health centers.

Minnesota, as is so often the case, has been in the forefront of this movement. In 1957, we adopted legislation which set up the community mental health centers. As of this date, there are 20 centers in operation, financed jointly by local and state funds, and putting psychiatric help within reach of 85 percent of the people of the State of Minnesota. It is necessary now for the legislature to provide a substantial increase in the amount of money available for financing the operations of these centers.

Not only does the mental health center put immediate emergency care within reach of most of the population. It serves also as an important after-care resource for those persons who have left the state hospitals and returned to their communities. It can become a valuable adjunct of the courts and county welfare agencies, and will ultimately be an essential part of the diagnostic and evaluation services which must be made available to all children with mental handicaps.

We visited several of the mental health centers during our bus tours last spring and were impressed by the flexibility and innovation that is an essential part of their character, as well as by the value of their services to sick and troubled people and -- equally important -- to the key persons in the community, the pastor, the teacher, the policeman, the welfare worker -- who encounter and deal with the mentally ill.

Few things are permanent, but one principle that is unchanging is that every individual deserves a full opportunity to achieve health and development insofar as his capacities will permit, and this opportunity should be available in a setting most suited to his needs.

This means that the range of help which is available should include the community-based services, as well as the state institution and the state mental hospital. The mental health center is one of the essential ingredients in this pattern of service.

5. B. Increased support for day activity centers for the retarded.

It is the newcomer to this scene -- the day activity center for the mentally retarded. Once again, Minnesota was in the forefront, and since 1961, these centers have developed at a very rapid rate. There are at present 25 that are partially supported by state funds, in cooperation with local sponsoring groups, and several others are operating without state assistance.

I visited many of these day activity centers and I must say that they appear to provide great hope for the retarded youngster who might otherwise be spending

his lifetime in isolation with limited opportunities for expanding his world. I saw one youngster at the Olmsted County Day Activity Center whose mother and father drove from their home -- 85 miles -- three days a week just so that he might know the companionship of other children. His parents told me that during the few months he had been attending the center, he had learned to hold his own cup and to sit up -- achievements which they had felt were impossible.

This expansion of day activity centers I regard as a top priority program for action by the next legislature. The present appropriation is approximately \$155,000 and the request will be for \$522,000 so that these centers can be expanded, their programs strengthened, and their services made available to all youngsters who can benefit thereby.

5. C. State grants for sheltered workshops.

I want also to mention to you another type of community-based service which I visited on the tours and which we must make available to many more of the handicapped. I am speaking of the sheltered workshop.

In Fergus Falls, Mrs. Rolvaag and I visited a demonstration sheltered workshop which has been operated with a pilot grant of federal funds, and saw firsthand what a retarded person can learn through a supervised work experience -- handling power tools, lathes and saws. In some cases, the sheltered workshop may lead to fulltime employment in private enterprise. In other cases, the retarded person may require a sheltered setting throughout his working life.

The work which is done in the workshop is beneficial to the community and can be economically advantageous by serving private enterprise on a contract basis. I am told that we have stations for approximately 400 persons in sheltered workshop settings in Minnesota and that, in fact, there are 4,000 who could be so employed. I hope for broad support for a bill to provide state matching funds for the establishment of more of these sheltered workshops.

5. D. Increased aid for special education classes.

While we upgrade health and welfare services to the mentally retarded, we must also be cognizant of the importance of the work being done by the schools.

Minnesota adopted its mandatory special education laws in 1957, providing limited matching funds to every school to help meet this need. Today some 7,200 retarded youngsters are in classes geared to their special needs. But it is estimated that there are 30,000 who are not! Thirty thousand who are sitting idle at home, or in a foster home, or possibly even in a classroom of normal children, ignored, humiliated.

If we are to meet our responsibility to provide schooling for all children who can benefit from schooling we must make a substantial increase in the state's share of these costs.

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I have highlighted a program for immediate action to improve our hospital and community programs for the mentally ill and mentally retarded. Many of the recommendations call for increased financing -- new revenues -- tax dollars.

You have seen the headlines -- the total amount that the Department of Public Welfare estimates should be appropriated for programs specifically designed to help the mentally ill and the mentally retarded comes to about \$17,000,000. I am not yet prepared to spell out what portion -- we are currently going through long and grueling hearings -- I will recommend in my budget message to the legislature, but it will be sizeable. To some it will seem formidable. To others -- I hope to most of the people in Minnesota -- this will be money which must be provided. These are human needs which cannot be ignored.

In our affluent society, who among us is not willing to give up some one of our daily luxuries in order to pay another \$5 or \$10 in taxes per year to put a sick or handicapped person back on the road to rehabilitation and a fuller life?

I have asked this same question all over Minnesota during the past months and I have found a warm and generous response. The people of Minnesota are proud of what has been accomplished. They are determined to wipe out the continuing evidences of neglect and inadequacies. They will wholeheartedly support the financing of the programs that are so desperately needed! Minnesotans know our society is rich. I believe they want it to become great!

But I cannot let matters stand at this. While more funds are needed, more sheltered workshops, more day activity centers, more mental health centers, more research, more public understanding, more community action, more staff -- while we recognize and respond to these extensive needs, we must also stop and look and listen and plan.

You will hear a good deal more this morning about Minnesota's planning efforts in the field of mental health and mental retardation but let me just skim over some of the progress that has been made.

Under the leadership of President Kennedy, the results of years of extensive study into how to develop a national all-out attack on the problem of mental illness and mental retardation came to fruition -- embodied in sweeping federal legislation.

Not only does this new legislation, promoted by President Kennedy and signed into law by President Johnson, make matching funds available for facilities -- some of the kinds of facilities referred to earlier in this talk -- but almost more important, it provides the wherewithal and the impetus for each state to take a long careful look at its needs and the way in which it seeks to meet these needs.

To meet this challenge from the national government, Minnesota has set up two important planning bodies: (1) The Mental Health Planning Council, composed of some 65 representatives with special knowledge of the problem of mental health planning and (2) The Mental Retardation Planning Council, a smaller group, 25 persons, who have established ten task forces with a total membership of 182 persons exploring the ways of combatting mental retardation.

Both of these planning councils are studying these two important fields of mental disorder in great depth, and are preparing reports for a long-range program in Minnesota that will serve as an invaluable guide to policymakers.

Hopefully, we will derive from the work of these two councils directions and answers to the thoughtful questions posed by legislators as they encounter the tough reality of raising tax money to meet human welfare needs.

Questions like: How does the mental health center relate to the large state mental hospital?

Will population in the state mental hospitals continue to decline, and if so, what future role will these hospitals play in relation to the growing needs of the mentally retarded and other handicapped groups?

How can the developing pattern of sheltered workshops and day activity centers be best related to the many existing agencies?

What kind of staff and support is needed by the county welfare agencies -- those 87 offices which serve as the backbone of all our services to the ill and handicapped?

What can be -- what should be -- the inter-relationship between the schools and these other services?

How can we make further use -- in the community -- of the volunteers, who have over past years made such a significant contribution to the programs of the state institutions?

How can we find the retarded child soon enough to help him and help his parents, before all help is useless? How can we detect the signs of mental illness or of future criminality and delinquency and offer society's assistance and counsel before a tragedy occurs?

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In dismay one might throw up one's hands and say these are questions to which there are no answers. Certainly it will not be easy to find the answers. In theory, that is the assignment of these two planning councils.

In fact, it is the ultimate assignment for all of us. To take the knowledge of the 20th century and put it to work to solve the mental and social ills that confront us -- it is an assignment which we must all undertake willingly and responsibly.

Will we let a little child bang her head on the cracked and chipped terrazzo floor in the ward of a state institution until she is bruised and bleeding? Or will we det ruine that there are better answers -- for her, and for all of us? The answer li s ahead.

Because the law governing charges for care of patients in our state schools and hospitals for mentally retarded and epileptics is complex, many questions have been raised by the persons affected by it. Some questions apply to only a few cases and must be answered individually. Other questions are raised frequently.

This pamphlet has been prepared to clarify the provisions of the law that are most frequently misunderstood. It does not explain the law in detail.

The questions and answers contained in this pamphlet relate to mentally retarded or epileptic patients in any state institution.

Some of the questions that are asked most frequently are:

1. Q. Is there a charge for care of patients in state schools and hospitals for the mentally retarded and epileptics?

A. Yes.
2. Q. What is the maximum amount that may be charged?

A. \$4.68 per day, which includes the \$10.00 per month that has been charged to the responsible county. The amount is based on the average per capita cost of operating the schools and hospitals at Brainerd, Cambridge, and Faribault in the previous fiscal year.
3. Q. Who is required to pay these charges?

A. The patient or his estate.

4. Q. Under what circumstances are the relatives responsible?

A. The spouse and parents are responsible for \$10 per month if the patient is unable to pay the full cost and is under 21 years of age.
5. Q. Are relatives always required to pay the full \$10 per month?

A. No. Charges are always adjusted to ability to pay. No relative will be required to pay unless his income exceeds \$4,000 per year.
6. Q. What happens if the patient or the relatives responsible for the patient's care are financially unable to reimburse the state?

A. The state and county assume the cost.
7. Q. Are there other charges for care of patients?

A. Yes. The county in which the patient has settlement is charged \$10 per month.
8. Q. Who makes the billing for the patient's care?

A. The Department of Public Welfare.
9. Q. Does the Department of Public Welfare always require payment at the maximum rate?

A. No. Provision is made for adjusting the rate to the patient's ability to pay.
10. Q. Who determines the patient's ability to pay?

A. The Department of Public Welfare.

11. Q. How is the patient's ability to pay determined?

A. The patient's resources and income are taken into account in making the determination, and a monthly allowance is made for clothing and personal incidentals.
12. Q. Does the rate fixed by the Commissioner of Public Welfare remain in effect for the period during which the patient is in the hospital?

A. No. The patient's resources and income will be reviewed periodically, and the rate will be adjusted if changes in the patient's circumstances warrant such action.
13. Q. Does the Department of Public Welfare deplete the patient's resources before terminating the charges?

A. No. A reserve is permitted to remain for the future needs of the patient.
14. Q. When does the Department of Public Welfare make a billing for the care of mentally retarded or epileptic patients?

A. Bills are sent at the end of each month.
15. Q. Is any allowance made in bills when a patient visits his home?

A. Because space must be reserved for patients who are out of the hospital for a visit, no allowance can be made for periods of absence of seven days or less.

16. Q. Will the maximum rates be changed?

A. Yes. The law provides that the rate shall not exceed the average per-capita cost of operating the schools and hospitals at Brainerd, Cambridge, and Faribault in the previous year. If these average costs change, the maximum rates will be changed accordingly.

17. Q. Will payments for care of patients be accepted from persons not legally liable for such care?

A. Yes. Parents often voluntarily pay for the care of a patient even though they are not legally liable.

18. Q. Will the state file a claim against the patient's estate if he has one when he passes away?

A. Yes. The state has a valid claim for the full cost of care, given after July 1, 1961, minus the payments that have been made by the patient, his guardian, or his responsible relative.

19. Q. Will patients who are supported by their relatives or who are able to pay for their own care be furnished better care and treatment than those supported by public funds?

A. No. The same care is given to both groups. Hospital personnel do not know whose care is paid.

Persons having questions not answered here should direct their inquiries and any correspondence about a patient's account to:

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
DIVISION OF ADMINISTRATIVE SERVICES
Centennial Office Building
St. Paul 1, Minnesota

GENERAL INFORMATION

Payment for care and maintenance billed by the Department of Public Welfare should be made payable to "Treasurer, State of Minnesota" and mailed to the above address.

Payment may also be made in person at that address or to accredited field personnel when they call you.

Expense money for the incidental needs and pleasure of the patient should be sent directly to the superintendent of the school and hospital in which the patient is receiving care.

State of Minnesota
Department of Public Welfare

INFORMATION ON PAYMENTS for COST OF CARE AND MAINTENANCE OF MENTALLY RETARDED AND EPILEPTIC PATIENTS IN STATE HOSPITALS

(Extra Session Laws of 1961, Chapter 62)
Effective July 1, 1961

Division of
Administrative Services
July, 1964