A STUDY OF THE INSTITUTIONAL NEEDS FOR THE MENTALLY RETARDED IN THE STATE OF MINNESOTA

REPORT LAYOUT

INTRODUCTION

The primary purpose of this report is to present factual data to support our belief that Minnesota needs a new institution for the mentally retarded.

As we parents and friends of the mentally retarded join together in groups to work to improve conditions for the mentally retarded, we find ourselves faced with the very difficult problem of deciding on the best methods to use to try and attain our objective. Our contacts have extended to the newspapers; to the professionals at the University of Minnesota; to the welfare workers in the County Welfare offices; to Minnesota state employees in the Division of public Institutions; to educators in the Minneapolis and St. Paul school systems; to educators in the Minnesota Department of Education; to legislators and to employees of the various institutions. We have found that these people, generally, are kind and humane, and quite willing to provide decent, minimum standard care for the mentally retarded. We have found, however, a wide difference of opinion amongst these good people as to what constitutes this decent, minimum standard care. Those who seem to know the least about the problems of the mentally retarded, also generally seem to have the strongest opinions on the subject. This divergence of opinions makes our job very difficult. Were we to come across a group that was admittedly hostile to our cause, we could arm ourselves and march into battle. But in the interest of prudence and fair play we cannot be militant with honest people with honest opinions.

Our only course, therefore, is to be honest ourselves and call our shots as we see them.

In dealing primarily with institutions, as this report does, we want to emphasize one point. Institutionalizing should be undertaken when no other decent, humane solution is possible. It should not be a convenient, handy solution to be taken advantage of. The administrative heads of Faribault, Owatonna and Cambridge all feel that whenever possible, an individual should not be placed in an Institution. The two old sayings "Man does not live by bread alone", and "Home Sweet Home" apply to the mentally retarded as well as you and I.

Another point we want to emphasize is that the large majority of the parents and brothers and sisters of the mentally retarded are not themselves mentally retarded. There was a period when this was not believed to be the case. But the science of genetics and the results of actual population surveys show that this is indeed the situation. Associated with most mentally retarded individuals, therefore, are three or four normal people whose mental health and well-being must also enter into the social picture, Any solution for the mentally retarded which tends to make these normal relatives lose some of their dignity or become less productive to society is indeed, false economy.

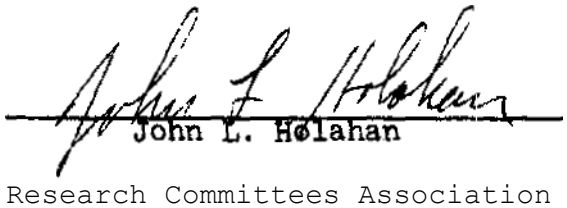
In this report we have shown, in Section One, how inevitable mental retardation is to any large population group. Approximately 1% of the population will be mentally retarded just as 1% of the population will have superior intelligence. A large percentage of these mentally retarded are children of normal parents. Every child born has about a 1% chance of being mentally retarded. It is also quite improbable that any parents are completely free of the gene combinations that result in mentally retarded children. Environmental factors also account for many of the mentally retarded. These are factors relating to the physical condition of the mother and father, the physical condition of the mother during pregnancy, conditions occurring at birth, and conditions occurring in or to the child after birth.

No doctor or geneticist holds out any hope, in the foreseeable future, for eliminating or greatly reducing the number of mentally retarded children born,

This being the case, it would be advantageous for society to make intelligent, long term plans for handling this segment of our population. This is the essence of the aims and objectives of the parents and friends of the mentally retarded. We don't want the mentally retarded set up in style, at great expenses to the tax-payers. Nor, do we want them ignored, left to their own devices, or withdrawn from the social scene.

While many people have contributed to this report, and checked it for accuracy, the handling of the data and the suggestions offered has largely been left to the author. Therefore, any criticism of the material or statements contained in this report must rest on the author's shoulders.

The author wishes to especially acknowledge the help given by Mrs. Louise Moskop, who has thoroughly checked the manuscript, cut the stencils and put the report together. Mrs. Moskop is not the relative of any mentally retarded person. She has performed this arduous task as a public service.



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SECTION II A STUDY OF COMMITMENTS AND THE WAITING LIST

I. OBJECTIVE

In Section I, we have given an estimate of the number of those who are mentally retarded in the State of Minnesota. We have also estimated the number of the mentally retarded who ought to be in suitable institutions. We will now try to determine whether or not our Minnesota institutions are being filled with those who ought to be there rather than with those who do not need Institutional care. We will base our appraisal of this on our own personal observations, and on a study of the Commitment List, the Waiting List, and the List of First Admissions to the Institutions,

II. CONCLUSIONS

1. There la a consistent policy in operation in the state both regarding commitments and the placing of cases on the waiting list. The policy operates to place in institutions those who need the institutional type of care.

2. The waiting list has decreased in number from 1,485 in 1942, down to 300 in 1952. The decrease in the waiting list has largely been brought about by the opening of Owatonna, adding new buildings at Faribault, overcrowding at Faribault, and providing temporary emergency facilities at Sauk Center and Shakopee.

3. Unless something of a completely unforeseen nature occurs, there is no prospect of relieving the waiting list, or keeping it down, other than providing more Institutional capacity.

4. It would seem that the continued presence of such a, large waiting list for at least 10 years ought to be convincing evidence that there is not enough institutional space in Minnesota for the mentally retarded. This fact, and the fact that the waiting; list is comprised largely of the low IQ types with the balance comprised of types generally unacceptable to society, makes one wonder Just what sort of evidence is needed to convince those who need convincing of the need for additional institutional capacity.

5. The relatively current low rate of commitments in spite of the great Increase in the population is partially explainable as follows;

Most parents do not take on the commitment proceedings until they have made the decision to institutionalize their child. Because of the large waiting list, the long time interval between commitment and institutionalization, and the adverse publicity attendant to lack of space and overcrowding at Faribault, there is little incentive for parents to take on the commitment proceedings.

Also, the economic status of the average American family is now relatively good so that the extra expense incurred in providing home care for the lower grade mentally retarded can be carried by the family. In hard times the income of many families is uncertain or seriously curtailed to the extent that money spent in caring for the lower grade mentally retarded member is literally "bread" taken from the mouth of some normal member of the family. In this case, there develops strong pressure to institutionalize the mentally retarded person. Thus, the rate of commitments was much higher during the depression era,

III. DATA

1. Commitments

In Fig. 3 is plotted the number of commitments against years, starting in 1928 and continuing to 1950.

In Fig. 4 is plotted the population of Minnesota, in thousands, against years.

The number of births in Minnesota for different years is as follows:

1940	52,915
1945	54,656
1946	67,266
1947	75,577
1948	72,780

Since mental retardation is a normal population characteristic bearing a rather constant ratio to the total population, one would expect the number of commitments each year to follow the same trends as does the general population itself.

It is quite clear from Fig. 3 and Fig. 4 that such is not the case. During the thirties there is some semblance of similar trends. The population increased to a peak in 1939. Likewise, the number of commitments increased gradually to a peak in 1939. The population then dipped because of the war and the large exodus of men into the armed forces. The number of commitments also dropped to the present rate of about 350 per year. However, as the men came back to Minnesota after the war, and the number of births Increased by over 50%, and the population rose steadily to new peaks, the commitment rate has remained almost constant.

Several explanations for this current low rate of commitments are advanced.

1. We are now living in an era of prosperity. Many of the relatives now care for their mentally retarded at home. With less overcrowding in homes, with modern conveniences such as washing machines, TV sets, radios, electric phonographs, and automatic heat the custodial job of caring for and amusing a mentally retarded person is made easier. With everybody working, the household enjoys an income sufficient to provide for the basic needs of the whole family. Money diverted to care for the mentally retarded is not begrudged as it is during hard times, when money is scarce, when the family income may be uncertain or insufficient to provide the basic needs for the normal members of the family, If and when we again have a recession, we can expect a definite trend to institutionalize the mentally retarded from homes seriously affected by the recession.

2. Many parents regard institutionalizing their children as the end of the road--the thing to do only when all else has failed. Once the decision is made, commitment proceedings are then undertaken. Until then, there is no rush. The proceedings can be put off, particularly when it has to be admitted that the waiting list numbers in the hundreds--that there is no space available, and that none will be available for an appreciable time in the future.

Experience in other states has shown that once institutional bed space is provided, the space is rapidly filled up. The word gets around, and those who have put off committing their mentally retarded child or adult then come forth and go through with the commitment proceedings.

On top of this has been the very unfavorable publicity given the institutions by the newspapers, magazines, movies, and radio. These accounts generally make capital of all that is evil, corrupt, or inefficient in the institutions. We have yet to read of a kindly account of the School and colony at Faribault, yet, for many years this institution has discharged its duties in *a* capable and kindly fashion. If all the mentally retarded in the state received the kind of care currently being given at Faribault, then our efforts could be restricted to the relatively simple Job of trying to relieve the overcrowding at Faribault and seeking replacement of some of the antiquated buildings and facilities. Suffice it to say, that except for the most calloused or desperate parents, the bad publicity given the institutions makes it mandatory that parents investigate the proposition of institutionalization very carefully over a period of years before the final decision is reached.

2. Commitments and the Waiting List

Table II is a compilation of figures covering a 10 year period showing the number committed to guardianship for each biennium since July, 1942, and the approximate mentality of those committed. The table also gives a breakdown of those under guardianship to the state but not in an institution.

For the 10 year period there were a total of 3,656 people committed, and approximately 62% of these were classified as low grade mentally deficient, with IQ's under 50. Note how the percentages of low grade and high grade have remained roughly the same.

About 42% of those committed have been from the three urban counties of Hennepin, Ramsey, and St. Louis. These three counties also contain about 40% of the population of Minnesota.

Over a 6 year period there appears to be a significant trend towards placing low grade babies under commitment rather than waiting until the child becomes older.

The total under guardianship, but not on the waiting list, has remained essentially constant over the 10 year period. The total on the waiting list has decreased by about 600 over the 10 year period. This reflects the opening of new buildings at Faribault, crowding more inmates into Faribault, and opening up Owatonna.

Other than what the figures themselves obviously show, the data of Table II shows a very good consistency as regards the general division in the mentality of the first commitments, and the relative rate of commitments between the rural and urban counties. This would indicate that the commitment policy in operation in the state is consistent, year in and year out, and as between the rural and urban areas.

In Table III is a more detailed analysis of the age and IQ type of first commitments, and of the waiting list as reported for the biennium 1946-1948? As indicated in Table II and mentioned above, the first commitments are made up more of the low grade types (IQ under 50) than the higher grade types, 58% against 42%. The waiting list is comprised of a much higher ratio of the low grade types to the high grade types - 79% to 21%.

Thus, it is clear that in the commitment cases, and especially in selecting cases for the waiting list, there is a very definite policy in selecting those most badly in need of institutional care, namely the low IQ types.

It can also be seen from the data of Table III that the lower IQ types are committed younger than the higher IQ types, and that the waiting list also is comprised more of the younger lower IQ types than younger higher IQ types. This is to be expected since the condition of mental deficiency is recognizable early, often at birth with the low IQ types, but is not often evident until later with the higher IQ types.

The policy used for selecting cases for the waiting list is given quite completely by Mildred Thomson ([10]) in the tenth biennial report. Those on the waiting list are generally comprised of:

1. Those requiring some physical care or direction. (This includes, roughly speaking, the idiots and imbeciles). Nearly 2/3 of those counted on the waiting list can be so classified.

2. Children needing the school training offered at the institution. Most of these children come from communities where schooling is not possible, or they have already shown tendencies making removal from the community advisable. The period of waiting for schooling gives time for anti-social habits to develop or increase.

3. Males with bad sex habits—not yet so serious as to warrant placement ahead of others.

4. Older boys and girls—or men and women—who are delinquent or showing emotional instability but again not yet serious enough to warrant earlier placement. This group is likely to increase whenever employment opportunities are lessened.

5. Some middle grade older persons who are not serious problems but are unkindly treated, and for whom there is no place outside where they will be more than tolerated—and. sometimes not even that.

We would like to expand a bit on the above points. When one visits the School and Colony at Faribault for the first time, one is generally quite repulsed by the whole thing. This is especially true of parents who are planning to place their child there, and have decided to go and look the place over. And yet, as one works at Faribault, or visits the institution frequently, this feeling of repulsion disappears and one then sees the place for what it really is—a fine home for most of the inmates, and for many of the employees. What is it then, that so repulses the first caller? For the most part, it is the physical appearance of the inmates themselves. Most of them,

in addition to being mentally retarded, have serious crippling and disfiguring physical disabilities. These people are conspicuous by their appearance much more so than by their low mentality. Their appearance alone makes it impossible for them to enjoy a quiet life outside the institution. They would be continuously subjected, at best, to puzzled and curious stares from normal people; and at worst, to ridicule and abuse from ignorant people who are too numerous to ignore. One such crippled man who is bright enough to be very articulate and expressive told me once, "I don't know what I'd do if I couldn't stay here, people on the outside would never help me," And he was right. They wouldn't. He was much too ugly, much too distorted physically for the normal world to put up with. And so, he is at Faribault.

3. Significance of the Waiting List

In Section I we presented in some detail a study of population characteristics to illustrate what society can expect in the way of numbers of mentally retarded, and the numbers of mentally retarded that should be institutionalized. That study indicated that we, in Minnesota, are not providing adequate institutional facilities for the size of our population, and because of that, it should be no surprise to us to find that we have a large waiting list.

That same conclusion must be reached from a study of the data thus far presented in Section II. We have had a terrific waiting list in Minnesota for at least 10 years. This waiting list is comprised, for the most part, of lower grade mentally retarded. The others on the list are socially unacceptable for the reasons stated above. The evidence is quite clear. We, in Minnesota, have not provided the needed spaces for the mentally retarded who qualify in a social sense for care in institutions. Thus, we have the waiting lists and the un-calculated human misery these lists represent.

4. The Current Waiting List

The people of Minnesota and their elected officials have not turned a deaf ear to the appeals that have been made to alleviate this condition. We parents of the mentally retarded are the first to acknowledge this and to extend our sincere thanks for what has been done so far.

These waiting lists have been reduced from 1,485 in 1942, to the present one, which, as of the spring of 1952, will number:

Waiting list	300
Overcrowding at Faribault School and Colony	100 or more
Temporary care at Sauk Center and Shakopee	120
	520 or more

TABLE II General

Analysis of Commitments

Biennium Ending

First Commitments	July, 1950 No.	%	July, 1948 No.	%	July, 1946 No.	%	July, 1944 NO.	%	July, 1942 No.	%	Grand Total No.	%
Mentally Retarded • Low Grade (IQ under 50)	409	66	420	58	401	56	425	61	600	67	2,255	62
High Grade (IQ 50-70)	212	34	303	42	315	44	271	39	300	33	1,401	38
	621		723		716		696		900		3,656	
Epileptics												
Mentally Retarded-Low Grade	21	23	55	51	40							
Mentally Retarded-High Grade	60	15	17	77	60							
Not Mentally Retarded				9								
			128	1								
Total First Commitments Low Grade High Grade Not Mentally Retarded	430	60										
	267	38			55							
	15	2			45							
	712											
Low Grade Infants under 2			471									
Low Grade Infants under 2-Died	117	33	380		60	11						
	28				18							
Total First Commitments Urban			851									
Counties (Hennepin, Ramsey, St. Louis)	309	43	43	13	301	42	286	41				
Rural Counties	403	57	30		415	58	410	59				
	712				716		696					
			304	42								
			419	58								
			755									
Total Under Guardianship On Waiting List			881				924					
Not on Waiting List			2,247				2,578					
	3,733		3,088				3,502					

Refer
ence:

The Ninth through the Thirteenth Biennial Reports of the Division of Public Institutions State of Minnesota	1,485 2,127 3,612

TABLE III

Detailed Analysis of Commitments
Detailed Analysis of Waiting List

Mentally Retarded	Age of first Commitment 0-6 yrs.	6-20 yrs.	over 20 yrs.	Totals
Low Grade	170 41% 3%	137 33%	113	420 58%
High Grade	179	26% 180 59%		303 42%
		114 38% 317		
		227		
	25%	44%	31%	

Composition of Waiting List	Age 0-6 yrs.	6-20 yrs.	over 20 yrs.	Totals
Low (IQ under 25	90 32% 18	90 32 5	99	279 36%
Middle (IQ 25-50	5% 74%	36% 128 39%		332 43%
High (IQ 50-70)	115	186 56% 47 28%		164 21%
		110 67% 555		775
		395		
	15%	**34%**		**51%**

Reference: The Twelfth Biennial Report (1946-1948) Division of Public Institutions State of Minnesota P. 32-33

SECTION III

FIRST ADMISSIONS TO INSTITUTIONS

I. OBJECTIVE

In order to throw further light on the type of mentally retarded and epileptic people who are now being admitted to our Minnesota Institutions a study of those "first admitted to the institutions" was undertaken.

II. CONCLUSIONS

1. There is a significant change over the last 10 years in the types of the mentally retarded being admitted to Faribault. The higher grade types (morons) are being replaced by the low grade types (imbeciles).

2. On an overall basis, the types being institutionalized in Minnesota are about the same as for the united States in general. This is another indication of the consistent policies existent, in this field, in Minnesota.

III. DATA

Table IV is a detailed compilation showing the numbers and mental types of the first admissions to the Minnesota Institutions for the Mentally Retarded and Epileptic.

This data is summarized and presented more simply in Figure 5 and Figure 6. Note particularly Figure 5 for Faribault.

We will pay particular attention to Faribault since the shortage of institutional space is for the types taken care of at Faribault. There is no appreciable waiting list for either Cambridge or Owatonna. This is an important point, and should constantly be borne in mind.

As can be seen from Fig. 6, the types of the mentally retarded being admitted to Faribault has changed very markedly from 1941 to the present, The IQ types between 50-70 (morons) are largely being replaced by the IQ types between 25-50 (imbeciles). The IQ type under 25 (idiots) is holding fairly constant,

The table below illustrates this. The year 1941 was not selected because it seems to be somewhat extreme in that 62% of the first admissions were morons.

MENTAL DIAGNOSIS OF FIRST ADMISSIONS TO FARIBAULT

	1942	1950	1951
Idiots	34%	24%	26%
Imbeciles	16%	48%	47%
Morons	44%	21%	21%
Neither	6%	1%	6%

This shift in the character of first admissions is having its effect on Faribault in that the working types are being replaced by the non-working types. At present about 1,000 out of the 3,000 inmates at Faribault are "workers" and the rest are "non-workers". This brings up an interesting point relating to the economics of institutional care. Obviously, the worker types are less expensive to maintain than the non-working types. This ratio of workers to the total population of Faribault is less now than it has been in the past, and if the present trend continues, and it is expected to, the ratio of workers to non-workers will become even smaller.

On the basis of type admitted to all institutions, the change is not nearly so evident, although again, the percentage of the Imbecile group is Increasing somewhat at the expense of morons, Over a 10 year period the average for the various types institutionalized has been:

	IQ	Number	%
Idiots	Under 25	644	18.9
Imbeciles	25-50	968	28.4
Morons	50-70	1,551	45.7
Others		238	7.0
		3,401	

It is interesting to compare this 10 year breakdown of IQ types admitted to institutions in Minnesota with those admitted throughout the United States to institutions.

Table V gives a compilation of such figures for the U.S. for the year 194f. Ho later figures are available at present.

This table gives the breakdown:

Idiots	14.6%
Imbeciles	23.8%
Morons	33.8%
Epileptics	15.0%
Others	12.8%

Thus, it can be seen, that in general, those institutionalized in Minnesota are not greatly different in IQ's than those institutionalized elsewhere in the U.S.

Again, this points out the fact that the policies followed in Minnesota are consistent and based upon sound practices.

In Table VI is given a detailed analysis of the age of first admissions to the institutions. The only trend in evidence is the one, since 1947, of more babies being admitted to Faribault. This trend is due to many factors including:

1. Parents committing their children younger. This is inevitable as the public in general becomes better and more accurately informed on the subject of mental retardation.

2. Space available at Faribault. The last four new buildings opened up were reserved for children in their early teens or younger. Two of these buildings were for babies or little boys and girls.

This trend, while a real one, may be reversed in the next biennium since the four newest buildings at Faribault, scheduled for occupation in the spring of 1952, have been designed for older people.

Table VII summarizes the detailed data given in Table VI. From this table, it is seen that the average age of first admissions over the last 10 years are as follows:

Age	Faribault	All Institutions	Faribault-1951
0-9 years	31%	28%	42%
10-19 years	35	40	28
20-29 years	18	16	14
30 and over	16	16	16

TABLE IV

MENTAL DIAGNOSIS OF FIRST ADMISSIONS TO INSTITUTIONS

	Year Ending																	
	June, 1950		June, 1949		June, 1948		June ,1947		June,1946		June,1945		June,1944		June,1			
	NO.	£	No.	%	NO.	%	No.	%	No.	%	No.	%	No.	%	No.			
Faribault																		
Idiots	27	24	33	21	78	22	50	25	127	31	60	31	43	26	64			
Imbeciles	55	48	88	56	216	61	86	42	184	45	! 39	21	37	23	58			
Morons Not M.R.*	24	21	29	18	45	12	55	27	87	21	81	42	83	51	102			
	8	7	7	5	17	5		6	11	3	11	6				23		
Cambridge	114	100	157	TOO	355	TOO	11 202	100	409	100	191	100	163	100	247 1			
Eplleptics-M.R.*	2		1		4		4		4		6		4		10			
Idiots																		
Imbeciles	5		10		4		9		11		9		8		19			
Morons	9		12		14		17		19		29		15		28			
Unclassified	5		10		25		26				11		37		19			
Epileptics-not M.R.			10		7		11		8		11		13		15			
	26		43		54		67		42		66		77		91			
Owatonna	0		0		3		5		14		0							
Imbecile																		
Moron	53		66		56		78		117		0							
St. Cloud	0		1		1		0		0		0							
imbecile																		
Morons	9		11		15		6		2		0							
Total - Idiots	29	14	34	12	82	17	54	15	131	22	66	26	47	20	74			
Imbeciles	60	30	99	36	224	46	100	28	209	36	48	19	45	19	77			
Morons	100	50	128	46	155	32	182	51	225	39	121	47	135	56	149			
Not M.R.*	13	6	17	6	24	5	22	6	19	3	22	8	13	5	38			
	202	100	278	100	485	100	358	100	584	100	257	100	570	100	338 1			

Grand Totals

Idiots	644	19%
Imbeciles	968	28
Morons	1,551	46
Not M.R.*	238	7
	3,401	

*Mentally Retarded

TABLE V

FIRST ADMISSION TO INSTITUTIONS FOR MENTAL DEFECTIVES AND EPILEPTICS, 1947[11]

	Total			State Institutions		Others		
	No.	%		No.	%	No.		%
Idiots	1,764	20.0	14.6	1,612	20.4	152	19	
Imbeciles	2,870	33.0	23.8	2,639	33.3	231	29	
Morons	4,084	47.0	33.8		46.5	402	51	. 3
	8,718			7,933		785		
Others	1,158		9.6	900		258		
Epileptics	1,803		15.0	1,686		117		
Neither Defective nor Epileptic	381		3.2	233		148		
TOTAL	12,060		100.0	10 752 89%		1,308		

TABLE VI

AGE ANALYSIS OP FIRST ADMISSIONS TO INSTITUTIONS

	June, 1950		June, 1949				1947	
	No.	%	NO.	%	No.	I	No.	%
Farib ault 0- 5	29	25	28	18	69	19	52	26
5- 9	17	15	20	12	62	17	41	20
10-19	28	25	55	35	123	3?	39	19
20-29	24	21	20	13	50	14	36	18
30-39	7	6		11	25	7	16 18	8
40&ove r		8	18	11	27	8	202	9
Cambridge 5 -9	9		158		555			
10-19								
20-29	4		15		6		7	
30-39 40 & over	5		10		17		22	
	12		8		7		12	
Owatonna	1		3		10		12	
5 - 9	3		7		14		14	
10-14								
15-19	10		21		13		20	
St. Cloud	28		31		32		42	
15-19	15		14		14		21	
20-29 30 & over	2		10		1		.	
Totals	3				10		3	
5- 9	4		1		5		3	
10-14								
15-19	29	15	28	10	69	14	52	15
20-29	31	15	56	20	81	17	68	19
30-39 40 & over	40	20	69	25	108	22	69	19
	38	19	51	18	79	16	55	15
	39	19	28	10	67	14	51	14
	12	6	20	7	38	8	30	9
	12	6	26	10	43	9	33	9
	201		278		485		358	

	June, 1946		June, 1945		June, 1944		June, 1943	
	No.	%	No.	%	No.	%	No.	I
Farib ault 0- 5	57	14		14	15	6	28	8
5- 9	90		a	18	41	16	52 147	16
10-19	153		89	36	108	42		44
20-29	51	13	42	17	48	19	59	17
30-39	19	5	19			10		11
40&ove r	29	7	20	7	2	7	38	4
Cambridge 5 -9	595		249		257		338	
10-19								
20-29	4							
30-39 40 & over	15							
	11							
Owatonna	5							
5 - 9	7							
10-14								
15-19	16							
St. Cloud	51							
15-19	64							
20-29 30 & over	1							
Totals								
5- 9	1							
10-14								
15-19	57	10	35	14	15	6	28	8
20-29	110	19	44	18	41	16	52	16
30-39 40 & over	134	23	50	20	56	22	72	21
	148	26	39	16	52	20	75	22
	64	11	42	17	48	19	59	18
	25	5	19	7	27	10	38	11
	574	6	20	8	18	7	14	4
			249		257		338	

TABLE VII

SUMMARY OF AGE ANALYSIS OF FIRST ADMISSIONS TO INSTITUTIONS - BY PERCENT

	Years Ending June											
Faribault Age	1950	1949	1948	1947	1946	1945	1944	1543	1942	1941	No.	%
0- 5 6- 9	25.3	17.7	19.4	25.6	14.2	14.0	5.8	8.3	13.9	14.3	405	
Total												
0- 9	15.0	12.7	17.4	20.4	22.5	17.7	16.0	15.4	14.2	6.5	437	
10-19	40.3	30.4	36.8	46.0	36.7	31.7	21.8	23.7	28.1	20.8	842	
20-29	24.5	34.8	34.6	19.3	38.2	35.7	42.0	43.5	36.2	31.4	964	30.9
30&over												35.4
All Institutions												
0- 9	21.1	12.7	14.0	17.9	12.8	16.9	18.7	17.4	19.2	26.6	477	
10-19	14.1	22.1	14.6	16.8	12.1	15.6	17.5	15.3	16.7	21.2	443	17.5
20-29	29.9	30.1	30.9	33.5	29.1	31.7	21.8	23.7	28.1	20.8	958	
30&over	38.9	43.1	38.6	34.5	49.2	35.7	42.0	43.5	36.2	31.4		
	19.4	10.0	13.8		11.2	16.9	18.7	17.4	19.2	26.6	545	
	12.0	16.5	16.7	17.6	10.7	15.6	17.5	15.3	16.7		533	

SECTION IV

ESTIMATE OF THE POPULATION REQUIREMENTS OF THE RECOMMENDED NEW INSTITUTION FOR THE MENTALLY RETARDED IN MINNESOTA

I. OBJECTIVE

In the last three sections we have presented data to show the need for additional institutional capacity for the mentally retarded in Minnesota.

In this last section, we will give our estimate as to the number of Inmates this new institution will have to accommodate.

We realize that the legislators must often ask themselves when, if ever, will the pressing demands for institutionalizing the severely mentally retarded end. We have indicated an answer to that question also.

II. CONCLUSIONS

1. The initial population requirements for the new institution are estimated to be such as to require 750 beds.

500 of these beds will be filled by those on the present waiting list, those temporarily being cared for at Sauk Center and Shakopee, and to alleviate overcrowding at Faribault.

The other 250 will be filled by the 100-150 people per year from new commitments in excess of those from the new commitments that can be accommodated in existing institutions.

These inmates will be of the same types now cared for at Faribault. The waiting list for Owatonna and Cambridge is small and constitutes no problem.

2. The new Institution should be built with the objective in mind of expanding it to accommodate an estimated 2,500 beds in about 15-20 years hence. The exact rate of expansion can be gradual and subject to frequent reviews so that the rate of expansion parallels the need. At the peak expansion point, the rate of discharges from all Minnesota institutions will approximately equal the rate of those seeking first admission to our Minnesota institutions for the mentally retarded. In other words, a break-even point can be achieved. As the population increases if the birth rate climbs to well above 75)000 births per year- then, of course, a corresponding increase in the number of mentally retarded will inevitably follow. The future reviews for the needs for expansion of the new institution can very easily take such factors into consideration.

3. Unless the new institution is built with the idea of expanding, the waiting list will grow at the rate of 100-150 people per year.

III. DATA

1. What Types of the Mentally Retarded need the new Institution?

The waiting list today, as in the past, is comprised largely of those who need space at the Faribault type Institution, the general institution. Neither Owatonna nor Cambridge has long waiting lists.

2. Education of the Mentally Retarded

Without digressing into other issues, we simply want to voice a warning at this time. Unless the State of Minnesota takes more positive steps than it has during the past years, and the past two years as a more specific example, in encouraging the formation of classes for the mentally retarded in the public school system, the facilities at Owatonna can become woefully inadequate. The numbers of the mentally retarded who can profit by the type of education being given at Owatonna number in the thousands.

For example: 23% of the population is between the age of 5 years and 20 years old. In Minnesota this amounts to 690,000, of whom over 400,000 go to school. Since 1% of the population is mentally retarded, we have at least 6,900 mentally retarded children in this age group. 75% of them will be in the IQ range 50-70, or roughly 5,200. If we again are conservative and say that only 60% of these 5,200 will be socially acceptable for a public school classroom, then we have about 3,100 who could profit by education facilities were they available. At present, as of November, 1951, only 826 such students are being trained in the public school systems, and 75% of these are being trained in Minneapolis, St. Paul, and Duluth. Please refer to Table VIII for an exact compilation of the number of sub-normal students in the public school system in Minnesota. Note that the greatest number of these students is in the IQ range above 70, a segment of the population much more numerous than those in the IQ range under 70.

Now, whereas Minnesota has become one of the leading states in the United States in providing decent, humane, minimum standard custodial care for those who need it, it is not providing comparable educational opportunities for the mentally retarded. Except for the initiative shown in the public school systems of the three large cities, and a few isolated towns like International Falls, there has been a lack of leadership elsewhere in this field of education in the state.

There are some who will argue that it is a waste of time to educate these retarded children, particularly those IQ is below 50. Some will argue that parents are too close to the problem to view it in perspective. So, we are told things to our faces quite differently from what is said behind our backs.

To answer such arguments we simply say this:

One has to view the training or educating of the mentally retarded in a broad social sense.

To begin with, the parents and brothers and sisters of the retarded are entitled to some consideration. As mentioned in Section I, these close family relatives, in the large majority of cases, are normal, responsible citizens. They are intelligent; they pay taxes, fight in wars, and contribute to society. Life would be much less difficult for these parents if they could place their child somewhere during the day for training or schooling. These people could then attend to other duties; the child would certainly learn something that would make his place in the family less demanding and trying; the parents would worry less about whether or not they were doing all they could be doing for their child; and the parents and child alike would benefit in many ways by the exchange of experiences with other children and parents. This is especially important for those living in a small house or apartment type of dwelling unit.

Denying these families this opportunity can be very costly to society. The effect of caring for a retarded person with no outside relief can have disastrous effects on the other members of the family. Anti-social and rebellious traits can develop in the normal children, and the mothers often are reduced to a household drudge, the welfare records are filled with case histories attesting to these undesirable side effects.

From the taxpayers point of view it is cheaper to educate children to become partially or totally self sufficient than to care for them in an institution. If they aren't trained, they will end up in an institution sooner or later after their parents die.

It is even cheaper to try and train those who can never accomplish much than to put them in an institution. In this case, the parents are paying the bulk of the custodial cost bill, which is the major item of expense in an institution. After the parents die, then the institution can take over.

Moreover, these children are entitled to the Joys of home just as much as anyone else is,

We are not asking education or training opportunities for children who are not socially acceptable—for children who cannot feed themselves or take care of their toilet habits, or who cannot be managed in groups. Children who can do these things are trainable. They can be trained to become even more socially acceptable.

3. Initial Population Requirements for the New Institution

The initial population requirements for the new institution are estimated as follows:

To relieve the present waiting list (as of spring, 1952)	300	100
To alleviate overcrowding at Faribault	or more	
Transfer of those receiving temporary care at Sauk Center and Shakopee	120 or more	520

As a matter of practicality, the overcrowding at Faribault need not be accomplished by actual transfer, but simply by not taking in any new first admissions for about a year and one-half.

The reason for closing down of Sauk Center and Shakopee will be very evident when the figures come in showing how much it costs to provide care at these spots. It simply isn't economical to provide care for such small numbers,

Although the figures aren't in yet, it is estimated that the yearly cost for caring for one inmate at Sauk Center or Shakopee will run two to three times the cost for doing the same job at Faribault.

On the basis of data presented in Tables XIII and XIV, we recommend that the new institution be built to accommodate an initial population of around 750.

4. Expansion Requirements for the New Institution

Our procedure for estimating the end size of the new institution is somewhat involved. The end result of our calculations is tabulated in Tables XIII and XIV.

Table IX contains tabulations showing the population changes as they have occurred at Faribault, Cambridge, and Owatonna,

Table X is a summary of some of these figures. In this table, transfers between Institutions are not included because these transfers have no effect on the overall rate of new first admissions to Minnesota Institutions.

It is Interesting to note from Table X that whereas the number of re-admissions and deaths vary somewhat from year to year, there is no trend up or down, one way or the other. This is to be expected since these figures aren't related to building programs or changes in population types. Accordingly, therefore, we nave calculated, as indicated, the 8 year averages for the rate of re-admissions and deaths per 1,000 inmates of the institutions.

In calculating these averages, the population figures for Owatonna for the years involved were left out, since no deaths or very few re-admissions occur there.

We have no further use of the death rate except to present it as a bit of information.

As the data in Tables IX and X indicates, the number of first admissions to the institutions varies considerably. This is caused by the building programs and other changes that have teen going on continuously in our institutions. From a statistical point of view, it is hard to handle these figures, unless a detailed knowledge of the exact reasons for these variations is known. Then correction factors, etc. would have to be applied to them before they could be used.

Another alternative is to assume that our present institutions are filled to capacity; and that as persons are discharged from the institutions for various reasons, including death, then new admissions can be taken in.

Table XI, therefore, is an analysis of the discharges from the institutions. These discharge numbers have been converted to discharge rates/100 Inmates.

In Table XII, these discharge rates are used to estimate the number of first admissions per year our institutions can now handle.

In explaining these figures, refer again to Table X.

The discharge rate for Owatonna is assumed to be 100. As shown in Table XI, this rate has fluctuated widely for Owatonna. This is because the institution is so new as yet, that its patterns are not evident as yet. The high rates for 1949 and 1950 are expected to continue, so a figure of 100 has been selected arbitrarily as being somewhere in between the 86 for 1950 and 144 for 1949.

The discharge rate for Faribault has been calculated as the average for the years 1949-1951. It is the opinion of Dr. Engberg and Miss Mildred Thomson that the number of discharges for these years is indicative of what it will be in the future. The figures prior to that no longer apply to the present Faribault because of the population changes described in the preceding sections. From this rate, 43, must be subtracted the re-admission rate, 14, as determined in Table X.

The discharge rate for Cambridge was determined as the average for the years 1945-1950. The two earlier years were not used because they seemed to be atypical.

Thus, as shown in Table XII, it is reasonable to state that we can accommodate about 200 first admissions per year in our present Minnesota Institutions.

As shown in Section II, in Pig. 3, the current rate of commitments has been running about 360 per year. And, as stated in the discussion, we can expect this commitment rate to increase in the future, rather than to decrease. But since we have consistently been conservative in all our estimates in order to be as reasonable as possible in our recommendations to the legislators, we will use the figure 360 as the expected number of commitments per year. (In 1951, the number of commitments will run around 380) The primary purpose of the commitment proceedings is to ultimately place the committed person in an institution. Even so, not all of those committed are actually placed in an institution. Therefore, we will assume that only 85% or about 300 per year need placement in an institution.

That means, therefore, that the new institution will expand at such a rate as to accommodate those above and beyond those that can go into existing institutions.

This difference, currently, amounts then, to 300-200 or 100 per year.

The number of first admissions per year for the new Institution can be arrived at another way.

As shown in Section II, the birth rate in Minnesota is currently running from 70,000-75,000 per year.

One percent of 75*000 is 750 mentally retarded per year. As indicated in Section I, 25% of these will be the low grade types being cared for at Faribault.

25% of 750 equals 188 - say 200 per year

As shown in Table XII, Faribault can handle about 100 of these/year.

The balance for the new institution will then be 200-100 or 100/year,

Since the new institution will handle types similar to those at Faribault, we can also apply there the same discharge rate we have used for Faribault-namely 29 or 30 per 1,000 Inmates.

Table XIII has been calculated on this basis. Note, that as the institution becomes larger, the number discharged per year increases, so that in time the population will increase until the discharge rate will equal the first admission rate. Now these figures, as calculated cannot be regarded as anything more than an approximation of what to expect. If the discharge rate should change, and it probably will, or if the number of commitments Increase, or if the population rises sharply, these figures will be in error.

For example, Table XIV has been calculated on the basis of a first admission need of 350 per year, which would place the expansion rate of the new Institution at 150 per year less discharges.

The following formula has been worked out to enable one to calculate the requirements of the new institution from any set of data one chooses.

Pn = Population of institution in n years Po = Initial population of institution A = First admissions, total, per year R = Discharge rate per 1,000 inmates

Then:

$$Pn - (1-R)^{n} Po + A \sum_{k=0}^{k=n-1} (1-R)^{k}$$

On the basis of these calculations, and all the data presented in this report, it would seem that the new institution ought to have an initial capacity of about 1,000 beds, but planned for expansion for 2,000-2,500 beds 15-20 years hence. This would accommodate the present waiting list, eliminate the temporary arrangements at Sauk Center and Shakopee, alleviate the overcrowding at Faribault, and bring everything up to date for the next three-five years. The exact expansion rate could be subject to a periodical review and tied in with existing current requirements.

Unless the new institution is built with such expansion in mind, the waiting list will continue to grow at the rate of 100-150 people per year.

Minnesota would then have the following institutions for the mentally retarded:

Faribault	3,200
New Institution	2,500
Cambridge	1,100
Owatonna	425
St. Cloud Annex	7,300

It's quite significant that this above figure of 7,300 checks so closely with the 7,500 figure given in section I.

The 7,300 figure has been arrived at from practical considerations based on analysis of the waiting list, the commitment list, first admissions, and discharge rates. The 7,500 figure was arrived at by applying to the population of Minnesota the results of surveys conducted in other areas.

The fact that the two figures check so closely is as good an indication as any as to the constancy and perpetually of the problems presented by the mentally retarded. It again supports our basic contention that the mentally retarded are as much a part of our general population as any other group; and that an enlightened society will recognize this and plan for their care on a long term basis rather than on an inadequate, hit and miss, emergency basis. These long term plans must embrace:

1. Those in institutions.
2. Those at home.
3. Those at home who could profit by some form of training and education were it available.
4. Those who are old enough and intelligent enough to be partially or totally self-supporting provided they can find employment and have adequate supervision both at work and outside work.

TABLE VIII

YEAR 1950-51 NUMBER OP SUBNORMAL STUDENTS IN CLASSES IN THE PUBLIC SCHOOL SYSTEM OF MINNESOTA

Location	No. Teachers	No. Students	IQ Range							
			Below 50	50-59	60-69	70-80	Over 80	Misc.	Total	%
Albert Lea	1	10		2	6			2	10	
Alexandria	2	21		4	6	11			21	
Austin	3	39		5	11	23.			39	
Brainerd	2	28		4	10	14			28	
Chisholm	1	9		1	2	6			9	
Cloquet	1	16		5	4	7			16	
Coleraine	1	13		2	2	9			13	
Duluth	12	211		20	61	124	6		211	9.8
Hibbing	3	45		3	13	29			45	
International	5	48		6	12	30			48	
Little Falls	1	11		3	5	3			11	
Mankato	3	48		5	11	32			48	
Minneapolis	50	818	1	62	201	554			818	38.1
Moorhead	1	14			3	9		2	14	
New Ulm	1	10		4	2	4			10	
Owatonna	1	18		2	13	3			18	
Red Wing	1	14		1	6	7			14	
Richfield	1.	17			3	6	7	1	17	
Rochester	2	29	1	1	7	19	1		29	
St. Cloud	2	28		5	6	17			28	
St. Paul	36	642		96	178	367		1	642	29.9
So. St. Paul	1	14		1	6	7			14	
Virginia	1	9		3	4	2				
Winona	3	35	1	4	12	18			35	
TOTALS 24	135	2,147	3	239	584	1,301	14	6	2,147	

TABLE IX

POPULATION CHANGES IN MINNESOTAINSTITUTIONS FOR THEMENTALLY RETARDED AND EPILEPTIC

	' 40-41	'41-42	'43-45	'43-44	'44-45	'45-46	'46-47	'47-48	'48-49	'49-50
First admissions to institutions	293	360	338	257	260	585	358	485	278	201
Readmissions	43	57	61	62	46	62	67	74	65	41
Received by Transfer	-	2	7	15	20	299	15	15	21	18
Total Admissions	336	419	4o6	334	326	946	440	574	364	260
Discharged										
As improved or under limited supervision	203	208	251	168	149	114	125	151	152	92
No improvement	33	36	21	47	31	28	42	19	19	13
Transferred to other institutions	21	29	21	20	24	312	49	49	59	39
Died	67		102	101	95	82	155		103	113
70 108										
Total Discharged	324	375	394	330	286	609	319	340	300	252
Net change in Population	+12	+44	+12	+ 4	+40	+337	+121	+234	+64	+ 8
Net change in vacations and escapes on books	-27	-19	-33	-10	-23	-103	-60	-42	-146	- 4
Commitments	500	400	348	348	359	359	362	361	356	356
Increase - commitments over first admissions	+207	+40	+10	+91	+99	-226	+ 4	-124	+78	+155
Institution's population										
Faribault	2,448	2,451	2,564	2,575	2,809	3,063	2,800	2,792	3,009	3,017
Owatonna						364	442	411	486	428
Cambridge	1,097	1,102	1,083	1,080	1,182	1,163	1,177	1,107	1,166	1,153
St. Cloud						6l	63	79	92	97
Total Population	3,545	3,553	3,647	3,655	3,991	4,651	4,482	4,389	4,753	4,695

Data obtained from Biennial Reports of the Division of Public Institutions, State of Minnesota

TABLE X

SUMMARY OF FIGURES RELATING TO THE CHANGE OP THE POPULATIONS OF FARIBAULT, CAMBRIDGE, AND OWATONNA

	1941	1942	1943	1944	1945	1947	1949	1950	Totals
First Admissions	293	360	338	257	260	358	278	201	
Readmissions	43	57	61	62	46	67	65	41	442
Discharges	236	244	272	215	180	167	171	105	
Deaths	67	102	101	95	82	103	70	108	728
Total population	3,545	3,553	3,647	3,655	3,991	4,482	4,753	4,695	
32,321									

Calculated rate of Readmissions, per 1,000 inmates, 8 year average =

442/30,995 = 14.2; say 14/1,000

Calculated rate of deaths, per 1,000 inmates, 8 year average =

728/30,995 = 23.4; say 23/1,000

Note: 1,326 = Owatonna population for 1947, 1949, and 1950
32,321 - 1,326 - 30,995

TABLE XI (Continued)

ANALYSIS Of DISCHARGES PROM THE INSTITUTIONS

	1950		1949		1948		1947		1946	
Cambridge	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Population	1,114		1,107		1,177		1,177		1,163	
Discharged - Epileptics										
Improved	2		11		16		10		5	
Not Improved	12		12		24		37		27	
Not Epileptic	1		3		5		3		1	
Total	15	14	26	24	45		50	42	33	28
Died	28			21	1		2		30	26
					9	16	2	19		
Grand Total	43	39	49	45	64	54	72	61	63	54
Owatonna										
Population	428		486		396		442			
Discharged	14		3		3		5			
Under 18	17		55				10			
Self supporting	4		8		1					
Partially self supporting	___		___4				0			
Incapable of partial self support	1				1					
							3			
Total	36	84	70	144	14	35	18	41		
Died	___	2	___0		0		0			
	1									
Grand Total	37	86	70	144	17	35	16	41		

Rate - Number per 1,000 inmates of the institution

TABLE XI ANALYSIS OP DISCHARGES PROM THE INSTITUTIONS

	1951		1950		1949		1948		1947	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Faribault										
Population	3,053		3,017		3,009		3,017		2,800	
Discharged										
Under 18	4		1		4		15		9	
Self supporting	36		32		44		76		61	
Partially self supporting	19		14		25		18		14	
Incapable of partial self support	0		0		0		1		2	
Not mentally retarded	7		7		12		10		13	
Total	66	22	54	18	85	28	120	40	99	35
Died	59	19	79	26	48	16	94		81	29
Grand Total	125	41	133	44	133	44	214	71	180	64

*These figures also include Cambridge.

Rate - Number per 1,000 inmates of the institution.

TABLE XII ESTIMATE OF FIRST ADMISSIONS PER YEAR AS REPLACEMENTS FOR EXISTING INSTITUTIONS

	Approximate Fixed Population	Total Discharge Rate/1000	Readmission Rate/1000	First Admission Rate/1000	First Admissions to the Institutions/year
Owatonna	425	100	0	100	43
Faribault	3,200*	43	14	29	93
Cambridge	1,100	52	13	39	43
				Total	179 say 200

*Ultimate capacity as of spring, 1952

TABLE XIII

Estimate of Ultimate capacity Required for New Institutions so that First Admissions to Minnesota Institutions will equal Discharges {including Deaths) from Minnesota Institutions.

Assumptions

1. Two hundred first admissions per year can behandled by Faribault, Owatonna, and Cambridge (see Table XI).

2. Three hundred first admissions per year arerequired. (This is believed to be somewhat low)

3. Therefore, 100 first admissions each year will have to be handled by the new institution.

4. Since the new institution is needed for thesame type as are at Faribault, the Faribault first admission rate willbe applied - namely 30 per 1,000.

Year	Population	First Admissions	Discharge	Net Gain
1	750	100	0	
2	850	100	26	74
3	924	100	29	71
4	995	100	30	70
5	1,065	100	32	68
6	1,133	100	34	66
7	1,199	100	36	64
8	1,263	100	38	62
9	1,325	100	40	60
10	1,385	100	42	58
11	1,443	100	43	57
12	1,500	100	45	55
13	1,555	100	47	53
14	1,608	100	48	52
15	1,656	100	50	50
16.	1,706	100	51	49
17	1,755	100	53	47
18	1,802	100	54	46
19	1,848	100	55	45
20	1,893	100	57	43
21	1,936	100	58	42
22	1,978	100	60	40
23	2,018	100	61	39
24	2,057	100	62	38
25	2,095	100	63	37

TABLE XIV

ESTIMATE OF FIRST ADMISSIONS PER YEAR AS REPLACEMENTS FOR EXISTING INSTITUTIONS

Based on Institutional Needs of350 per Year in all Institutions

Year	Population	First Admission	Discharge	Net Gain
1	750	150	0	150
2	900	150	27	123
3	1,023	150	31	119
4	1,142	150	34	116
5	1,258	150	38	112
6	1,370	150	41	109
7	1,479	150	44	106
8	1,585	150	48	102
9	1,687	15051	99	
10	1,786	15054	96	
11	1,882	15057	93	
12	1,975	15059	91	
13	2,066	15062	88	
14	2,154	15064	86	
15	2,240	15067	83	
16	2,323	15070	80	
17	2,403	15072	78	
18	2,481	15074	76	
19	2,557	15076	74	
20	2,631	15078	72	
21	2,703	15081	69	
22	2,772	15083	67	
23	2,839	15085	65	
24	2,904	15087	63	
25	2,967	15089	61	

SECTION V

MISCELLANEOUS COMMENTS

I. TYPE OP INSTITUTION.

As indicated in the previous sections, the new institution is needed for the same general type of patients now placed at Faribault.

Also, as indicated in the previous sections, most of these patients will be the low grade types of the mentally retarded.

This opens up several possibilities:

1, The new institution could be another "Faribault" located in a different part of the state.

2. A different type of classification could be set up, whereby Faribault could specialize in one type of the mentally retarded, and the new institution another. For example, one could specialize in older patients, the other younger. One could specialize in the higher IQ types, the other in the lower IQ types. One could specialize in the types that could profit by the large land area and farm enjoyed by Faribault. The other could specialize in types that are generally less active and more confined in physical activity. In this case, the acquisition of hundreds of acres of land wouldn't be necessary.

   These are problems the experts must decide upon. Such decisions need not affect the decision to enact legislation for the building of the new institution.

II. LOCATION OP THE NEW INSTITUTION

In general, we parents of the mentally retarded are much more concerned whether the new institution is going to be built, rather than where it is to be built.

Since the institution ultimately will approach the size of Faribault, there are several factors to consider:

1. It must be located where it can attract good employees.

2. The employees must be able to enjoy decent living conditions,

3. Adequate transportation to the institution from the nearest town must be provided. For this reason, the institution should not be stuck way out in the country, but near or on the outskirts of the town.

4. The attitude of the townspeople to the location of the institution near or in their town must be favorable. The people should regard the institution as a business asset to their town, a place of steady employment. Moreover, they should display a generous spirit towards the mentally retarded. This may be asking for more than can be given, but it is something to look for.

5. The town should have adequate fire fighting facilities, and other necessary public utilities,

6. Special attention should be given to the problem of sewage and waste disposal. The effluent from a large institution will be considerable.

7. The plant should be served with a railroad siding,

8. The town should have an adequate supply of doctors, dentists, and clergymen who can be asked to render service to the institution.

9. The town should have an adequate supply of competent tradesmen, such as pipe fitters, carpenters, electricians, television and radio repairmen, welders or metal workers, tinsmiths, etc. No modern institution or factory can operate efficiently without having the services of such skilled workmen available. Such are the technical demands of our modern way of living.

10. The institution should be located off a good, modern, heavy duty highway, or else a good road will have to be built up to the institution. Obviously, if any such length of road has to be built, it could cost more than the institution itself,

11. With the requirements laid down above, it is hard to visualize such a town not being adequately served with bus and train service to other parts of Minnesota. But such indeed, must be the case.

12. The town should have an adequate hotel or other such facilities to accommodate overnight visitors to the institution.

13. Man does not live by bread alone! The mentally retarded derive considerable enjoyment and pleasure out of television and radio. Since there is no cheaper form of entertainment or diversion in an institution than television, it would be desirable to have the institution within receiving range of a TV station. This may sound like a trivial and inconsequential point, but consider the fact that the budget for the care of the mentally retarded

is largely set up on a custodial basis, Very little money is provided for recreation or entertainment. Those who can work derive the important benefits of work therapy. There is probably no better therapy for the mentally retarded than the work they are required to do. But those who cannot work just sit around most of the time, and literally, twiddle their thumbs. For such as these, TV provides a welcome break in their monotonous lives. For those who do work, TV provides at least the same enjoyment it does for us normal people. But it provides much more enjoyment for them, because it opens up for them a world which is forever out of their reach; but not completely out of their minds, since they catch glimpses of it from the institution windows as they watch the "world" pass them by.

14. Research — There is some discussion about whether or not research work can be done in the new institution if it is located more than an hour's drive away from large medical centers. It is true that public hospitals of all kinds benefit by being close to large medical centers. Doctors in these centers donate some of their time to these hospitals according to a plan set up by their professional societies.

    To what extent this matter should enter into the selection of the new institutions should be based on an authoritative statement from the medical profession, wherein the medical profession states their interest and intent in the matter of providing services to the institution, and particularly, as to their interest, research-wise, in the Institution.

    The author has been engaged in research work since 1938, and feels somewhat qualified to speak on the subject. To begin with, research work is expensive. Today, operating expenses generally run around $10,000 per employee per year, plus his salary. On top of that must be added the capital expenses for buildings and large capital equipment. The best results are obtained by hiring a very competent individual who has a real love and ability for research, and will devote his full time to the subject; the demand for such people is high. Over a period of some 5-10 years a small group of such people — even if it be only two or three — generally will come up with some significant, measurable results. The leader of such a small group must be competent to direct the activities of the group.

Even doing research work on such a modest scale as this will be expensive, and will require an appropriation from the legislation.

Another alternative would be to build good diagnostic centers at one or two of our medical centers. The mentally retarded could be brought to such centers, and given a very thorough and complete physical and mental check. Such results, if properly tabulated and filed, could, over the years; provide a source of some very valuable data for some future research people. One of the great drawbacks to trying to learn anything about mental retardation is the almost complete lack of a good accumulation of data on the subject. Such a center could also have associated with it, a small hospital containing leas than 50 beds so that interesting cases could be accommodated for more extensive and time consuming observations. This, of course, would require consent of the parents or guardian.

The University of Minnesota could also engage in some types of research projects if they were furnished the funds, manpower, and equipment.

The point we wish to make is this. Research results do not generally come through happenstance or as a result of someone's occasional, part time puttering around. It is an expensive, time consuming, money consuming, and manpower consuming sort of an enterprise. Over the long pull, it gives man more return for his money than anything else he has invested in. For the short pull, it offers nothing but unfulfilled daydreams.

15. Planning for the physical plant of the institution — an institution of the kind recommended in this report will not be small, nor will it be inexpensive to build.

    Just as important as the first cost of the institution is the matter of subsequent operational expense which will go on year after year indefinitely.

    The new institution will cost somewhere between $5,000,000 and $10,000,000 to build and will cost from between $500,000 to $700,000 per year to operate.

    This being the case, it would seem wise to spend at least one to two percent of the initial amount for an intensive pre-building planning investigation, The purpose of this investigation would be to estimate much more accurately than could be done by any other method the best kind of building construction and layout, and the best kind of

facilities to incorporate into the institution. By best is meant what is best for the patients, for the employees, and the taxpayers. In the long run, in order to have a sound policy for the mentally retarded, the interests of all three groups have to be protected.

Such an investigation would, of course, have to take into consideration the recommendations of the professionals like the doctors, psychiatrists, psychologists, architects, engineers, etc. But, it must also take into consideration the recommendations of the people who have spent many years working in institutions like the School and Colony at Faribault. Many of these people at Faribault have been working with the mentally retarded for 10, 20 or 30 years. These people have a working knowledge of caring for the mentally retarded that cannot be acquired by any other method than by working with the mentally retarded. Their ideas about what an institution should be like should also receive careful and studied interest.

The principal, general, overall conclusions which can be drawn from this report are:

1. Today, Minnesota does not have sufficient institutional capacity for the mentally retarded that need such care.

2. Today, in Minnesota, there are more mentally retarded people seeking admission, each year, to Minnesota institutions than there is space opening up each year as people die or leave the institutions. As long as this situation exists, there is no possibility of eliminating the waiting list, or preventing it from growing larger.

We want to emphasize that these are our main conclusions. We will presently attach numbers to these conclusions to give an estimate as to the number magnitude of the problem. Before we do this, however, we wish to state that this report was written and checked for accuracy by college graduates trained in the basic sciences, mathematics, statistics, genetics, and sociology. A good scientist must always admit to the magnitude of the possible errors in his work. This in no way detracts from the quality of his work. Were he not to do this, he would be extremely unrealistic and subject to criticism. And, so it is with this report. We freely admit that our figures may be somewhat inaccurate. We are also dealing with a changing subject. Our figures may be off as much as 25% as of January 1, 1952. We have consistently been conservative in our estimates in order to be free of any charge of padding figures in order to make our case stronger. Thus, we are confident that our overall conclusions as stated above will also be arrived at by any other group who might so choose to undertake an honest and comprehensive investigation into the subject.

The following are the specific conclusions which can be drawn from this report:

Section One: The Incidence of Mental Retardation in a General Population Group

1. It is logical, fair, and conservative to estimate that at least 1% of the people in Minnesota are mentally retarded.

   On the basis of a population of approximately 3,000,000 people, we have, therefore, in Minnesota, approximately 30,000 mentally retarded people. This number approximates the number of people living in Rochester, Minnesota

2. Of these 30,000, approximately 7,500 will require care in institutions. This number approximates the number of people living in Anoka, Minnesota.

Section Two: A Study of Commitments and the Waiting List

1. There is a consistent policy in operation in the state, both regarding commitments, and the placing of cases on the waiting list. The policy operates to place in institutions those who need the Institutional type of care,

2. The waiting list has decreased in number from 1,485 in 1942, down to fewer than 500 in 1952. This decrease in the waiting list has been brought about by opening up Owatonna, overcrowding at Faribault, providing temporary emergency facilities at Sauk Center and Shakopee, and adding new buildings at Faribault.

3. There is no prospect of relieving the waiting list, or keeping it down other than providing more institutional capacity.

4. The present waiting list, and those in the past, are comprised largely of low IQ types, or those generally unacceptable to society,

5. The following conditions work to keep the commitment lists low:

    a. Prosperous times. The economic status of the average American family is now comparatively good so that the expense incurred in providing home care for the lower grade mentally retarded can be carried by the family. In hard times the income of many families is uncertain or seriously cur tailed to the extent that money spent in caring for the retarded one is literally "bread" taken from the mouth of some normal member of the family. In this case there develops strong pressure to institutionalize the retarded person.

    b. Most parents do not take on the commitment proceedings until they have made the decision to institutionalize their child. Because of the large waiting list, the long time interval between commitment and institutionalization, and the adverse publicity attendant to lack of space and overcrowding at Faribault, there is little Incentive for parents to take on the commitment proceedings.

6. The following conditions will tend to Increase the commitment list:

    a. The trend in America to city living with the five room bungalow and the one or two bedroom apartment becoming the common units of housing. Caring for a severely retarded person in such confined quarters is extremely difficult at best.

    b. Improved conditions in institutions.

    c. An economic recession.

Section Three: First Admissions to Institutions

1. There is a significant change over the last 10 years in the types of mentally retarded being admitted to Faribault. The higher grade types (morons) are being replaced by the low grade types (imbeciles).

2. On an overall basis, the types being institutionalized in Minnesota are about the same as for the United States in general. This is another indication of the consistent policies existent, in this field, in Minnesota.

Section Pour: Estimate of the Population Requirements of the Recommended New Institution for the Mentally Retarded in Minnesota.

1. The initial population requirements for the new institution are estimated at 750 beds.

    500 of these beds will be filled by those on the present waiting list, those temporarily being cared for at Sauk Center and Shakopee, and to alleviate overcrowding at Faribault.

    Note: We have not investigated the extent and nature of overcrowding at Faribault. We do believe that space there is well utilized. We do know that the sleeping quarters in most buildings are very crowded. Since the Minnesota Department of Health is conducting a study into this matter, we have not felt it necessary to carry on a parallel study.

    The other 250 beds will be filled by the 100 - 150 people per year from new commitments in excess of those from the new commitments that can be accommodated in existing institutions.

    The new institution is needed for Inmates of the same types now being cared for at Faribault.

2. This figure of 750 is not an absolute. It may be scaled down or up depending on who thinks what about the subject.

   The absolute fact is that Minnesota does not now have enough institutional capacity for the mentally retarded that needs such care.

3. The new institution should be built with the objective in mind of expanding it to accommodate an estimated 2,500 beds in 15 - 20 years hence.

   The exact rate of expansion should be subject to frequent reviews so that the rate of expansion parallels the need. Here, again, the important fact is not the figure of 2,500, but that expansion will be required.

   At the peak expansion point, the rate of discharges, if they hold the same as current rates, will approximately equal the rate of first admissions. Then, a breakeven point will be reached, and waiting lists can become a thing of the past.

4. Unless the new institution is built with the idea of expanding, the waiting list will grow at the rate of 100 - 150 people per year.

BIBLIOGRAPHY

(1) R. Pinter, Intelligence Testing, Henry Holt and Co., New York, 1925, P. 76.

(2) R. s. Woodworth, Psychology, Henry Holt and Co., New York, 1936, p. 60.

(3) F. L. Ruch, Psychology and Life, Scott, Foresman and Company, New York, 1937, p. 162.

(4) R. R. Willoughly, American Journal of Mental Deficiency, pp. 50-7, 121-125, 1945.

(5) Tredgold, Mental Deficiency, Bailliere, Tindall and Cox, London, 1949, P. 468.

(6) Ibid, p. 13-14.

(7) P. Lemkan, C. Tietz, and M. Cooper, U. S. Public Health Report, Vol. 58, 12-31-43,

(8) K. G. Ecob, "Coordinated Planning for Mental Defectives", American Journal of Mental Deficiency, pp. 47-7, 100-103, 1942.

(9) Statistical Abstract of the United States, 1950, p, 86.

(10) Mildred Thomson, 1944 Biennial Report (the tenth), Division of public institutions, State of Minnesota, p. 25.

(11) Federal Security Agency, Public Health Service Annual Report, No. 89, Patients in Mental Institutions, 1948.

(12) Vocational Rehabilitation of the Mentally Retarded, Federal Security Agency, Rehabilitation Service Series No. 123, U. S. Government Printing Office, 1950, p. 21.