A PLAN FOR THE DEVELOPMENT OF RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED IN MINNESOTA

The following plan is the result of extensive study and joint consultation by the Minnesota Mental Retardation Planning Council, the Minnesota Department of Public Welfare, and the Minnesota Association for Retarded Children. The development of this plan was in response to current developments at both the state and national levels which directly affect program development for the mentally retarded. Embodied in this plan are the recommendations of the President's Panel on Mental Retardation and the Residential Care Task Force of the Minnesota Mental Retardation Planning Council. This plan operationally outlines a proposal for the development of residential facilities throughout Minnesota during the ten-year period 1966 through

The successful implementation of the following plan for the construction and development of residential facilities throughout Minnesota is basically dependent upon the development of the following factors:

I. Changes in the present state law pertaining to the financial responsibility of the state for residential care of mentally retarded persons. The existing distribution of residential care costs between county and state regarding payment for residential care must be modified to eliminate the differential between payments made for persons residing in state-owned and operated facities and those residing in residential care facilities not owned and operated by the state. State financial support for persons in all residential care facilities must be equal in order that costs will not be a major factor in the placement of mentally retarded persons.

II. The results of merging mentally retarded persons into treatment programs at state hospitals for the mentally ill. The recently initiated program of placing mentally retarded persons into state hospitals for the mentally ill must prove to be a successful program of treatment, training and care.

HI. Availability of community services such as day activity centers, sheltered workshops, and special education classes for the educable and trainable retarded. Such services must be expanded in order that every mentally retarded person in the state may have ready access to an array of services which will facilitate the maximum development of his potential and that the number of mentally retarded persons in state residential facilities be stabilized at 6,200.

IV. The continued growth, expansion, and improvement of community residential facilities.

A. There are indications that increasing interest in mental retardation and increasing availability of federal funds for construction and program development will stimulate the development of these facilities.

B. The development and expansion of these facilities will be an important factor in maintaining a stabilized institutional population of 6,200 and in reducing the number of persons on the waiting list.

G. Nursing homes will provide services for some of the older mentally retarded persons in groups V and VI who are presently in state institutions or on the waiting list.

D. At the present time boarding homes are utilized as short-term placements for a relatively small number of mentally retarded persons. As improved standards and licensing procedures are developed, these facilities may be considered for long-term placement for certain mentally retarded individuals.

PRESENT INSTITUTION POPULATIONS

At the present time there are 6,213 resident patients in state institutions for the mentally retarded. The individual institutional populations as of October, *1965* are as follows:

1. Brainerd 1,334
2. Faribault 2,795
3. Cambridge 1,717
   Lake Owasso 128
5. Owatonna 210

6. Shakopee 29

The populations in the state institutions for the mentally retarded have been classified and grouped according to six categories developed by Dr. Richard Bartman, Director of Children's Mental Health Programs of the Minnesota Department of Public Welfare. (See appendix I) Table I below shows the present institutional population grouped according to these categories. It also shows the projected distribution of the stabilized institutional population in 1976.

TABLE I

1966		1976	
Group I	403	Group I	500
Group II	502	Group II	700
Group III	500	Group III	525
Group IV	640	Group IV	900
Group V	2092	Group V	1800
Group VI	2076	Group VI	1775
TOTAL	6213	TOTAL	6200

RESIDENTIAL CARE DEVELOPMENTS 1966-1976

A major factor of this plan is the recommendation that the total number of mentally retarded persons residing in various state facilities be stabilized at 6,200. Table II below shows the present (October, 1965) populations of existing residential facilities for the mentally retarded and the recommended populations of these facilities in 1976.

TABLE II

Institution	POPULATION 1965	1976	Change
Brainerd	1,334	1,500	+ 166 *
Faribault	2,795	2,000	- 795
Cambridge	1,717	1,500	- 217
Lake Owasso	128	130	+ 2
Owatonna	210	200	- 10
Shakopee	29	30	+ 1
TOTAL	6,213	5,360	- 853

* Institutional population may be slightly larger if the program is expanded to serve some mentally ill and alcoholic patients.

With the exception of Brainerd State School and Hospital the populations in the three major institutions will be decreased. The projected population increase at Brainerd will be cared for in buildings to be requested at the 1967 legislature.

The population at Faribault will be reduced about 800 and at Cambridge about 200. These persons will be provided for as follows:

1. Appropriate transfers to institutions for the mentally ill.
   Table III, page shows the numbers and types of mentally retarded patients who will be receiving care, training, and treatment in institutions for the mentally ill by 1976.

TABLE III

Institution	(1976) Number of retarded patients in residence	Types of retarded patients (Bartman's categories)
Moose Lake	60	V & VI
Rochester	120	I, II, IV, V, VI
Hastings	60	V & VI
Anoka	60	V & VI
Fergus Falls	60	V & VI
St. Peter	100	V & VI
Willmar	60	V & VI
TOTAL	520	

2. Construction of a new residential facility. This will be a facility for 160 patients which will be located in a community which is a major medical and educational center.

3. Utilization of other special state facilities. 160 mentally retarded persons will be placed into facilities for the blind, deaf, orthopedically handicapped, etc. where they will receive specialized care, training, and treatment not available in state institutions for the mentally retarded.

4. Transfer to Brainerd State School and Hospital and placement into community residential facilities. 160 persons will be transferred to Brainerd or placed into appropriate community facilities.

On the basis of this plan, the populations in state residential facilities for the mentally retarded will be distributed as follows:

1. Existing facilities for the mentally retarded (Brainerd, Cambridge, Faribault, etc.)	5360
2. Institutions for the mentally ill	520
3. Special state facilities (blind, deaf, etc.)	160
4. New residential facility for the mentally retarded	160
TOTAL	6200

It is anticipated that the stimulation, utilization, and development of community residential facilities will be adequate to provide care, training, and treatment for predicted population increases and many of the persons presently on the waiting list for admission to state institutions for the mentally retarded.

STATE INSTITUTIONAL BUILDINS RECOMMENDATIONS (Also refer to appendix II)

BRAINERD

Additional living facilities will be constructed in order that the resident population may be increased through transfers and new admissions to the stabilization

figure of 1500. It is proposed that this institution will be developed into a multi-functional facility. Incorporated into its operations will be facilities such as a diagnostic center and an out-patient service. A small unit to serve mentally ill and alcoholic patients may also be developed. Among results of the functional diversification of this facility are the availability of a wider array of services for mentally retarded persons in this geographic area and a greater degree of acceptance and integration of the institution into the community.

Cambridge

At the present time this institution is 117 overcrowded (based on the present requirements of 60 square feet per bed). In order to relieve this overcrowding and to reduce the population to the stabilization figure of 1500, 217 residents will be transferred to other facilities. During the next ten years, there will be no new construction of additional buildings at this institution. However, there will be an ongoing program of remodeling and replacement of inadequate and deteriorated existing buildings.

Faribault

At the present time 763 persons are living in substandard and deteriorated buildings which were scheduled for replacement several years ago. The following are the buildings which must be replaced: Ivy, Iris, Daisy, Chippewa, Hillcrest, Sioux, Springdale and Poppy. In the other buildings at this institution, there is an average overcrowding of about 23%. In order that the people in residence in this facility will be properly housed according to present standards (60 square feet per bed) 795 patients must be transferred to community facilities and other institutions and places for 450 persons must be constructed.

Lake Owasso

Continuing program of maintenance and remodeling.

Owatonna

Continuing program of maintenance, remodeling and replacement.

Shakopee

Continuing maintenance program.

TIME SCHEDULE FOR CONSTRUCTION OF NEEDED FACILITIES

1967	1969	1971	1973	1975
Faribault: Facilities for 150 patients	Faribault: Facilities for 175 patients	Maintenance, remodeling & replacement	Maintenance, remodeling & replacement	Maintenance, remodeling & replacement
Brainerd: Facilities for 216 patients	Maintenance, remodeling & replacement			
Cambridge: Remodel four cottages				
Authorization of enabling legislation for new facility for 160 patients				

BUILDING DESIGN

Special study must be given to building design and construction in order that newly constructed and remodeled buildings will be best suited to the types of patients being housed and be easily adaptable to changing populations and needs.

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APPENDIX I

CHARACTERISTICS OF THE PATIENT GROUPS IN THE SIX PROGRAMS ESTABLISHED IN THE INSTITUTIONS FOR THE MENTALLY RETARDED.

Program No.l

CHILD ACTIVATION PROGRAM This program is for children from birth to puberty who are non-ambulatory or bedfast. These children certainly usually suffer from major degrees of central nervous system damage, and also quite often have gross external physical abnormalities. When in a setting that provides a large amount of physical care and a high level of environmental stimulation quite often a significant number of these children become able to progress from bed to a wheeled conveyance, may become able to crawl or walk with assistance, and show the development of a high level of affective responsiveness to others.

Program No.2

CHILD DEVELOPMENT PROGRAM This program is for ambulatory children up to the age of puberty. This is a varied group and includes children who may be withdrawn and passive, overly active, or show evidences of cerebral dysfunction, and who show all degrees of intellectual handicap. These children do not have gross physical anomalies but may have mild congenital malformations. This group to be worked with effectively needs to be broken down into a number of subgroups but all these children benefit greatly from warm understanding relationships with adults, and from various types of special education and activity programs.

Program No.3

TEENAGE PROGRAM This program is for ambulatory children from puberty to approximately 16 years of age. This is a large and somewhat heterogenous group including adolescents who have various degrees of cerebral dysfunction, a wide range of intellectual handicap, and, in a state institution, includes a high proportion who may be delinquent. These children require special programming because of the unique characteristics of adolescence but the basic treatment modalities are much the same as for those in the child development program.

Program No. 4

THE ADULT ACTIVATION PROGRAM This program is for bedfast and non-ambulatory patients who may be late adolescent, adult, and aged. These patients benefit greatly from care somewhat similar to that described for the child activation program. This group includes "grown-up" cerebral palsied children who may have had considerable assets overlooked because of their expressive difficulties. Needs in the orthopedic area may also be very great. Many of these patients are able to be physically habilitated to the point of not requiring total care in bed but being able to get about in wheeled conveyances.

Program No. **5**

ADULT MOTIVATION PROGRAM This program is for ambulatory late adolescent, adult, and aged patients. The intellectual range of patients in this group is from "not testable" to around 35 to 40. They are characteristically passive, withdrawn, and manifest peculiarities of behavior such as rocking and making odd noises. Many of these patients show evidences of congenital cerebral underdevelopment and external congenital anomalies. They are, however, given adequate stimulation and opportunity, able to enjoy a large number of occupational therapy and recreational activities. Occasionally a patient in this group is found to be able to participate in a sheltered work program.

Program No. **6**

ADULT SOCIAL ACHECVEMENT PROGRAM This program is for active late adolescents, adults, and aged. It includes those residents who have become overdependent on the institution as a result of long term hospitalization, those who have various "character problems" such as antagonistic behavior or other difficulties in forming constructive inter-personal relationships, those who are able to achieve a high level of independence within the institution but have difficulty in developing social or work relationships outside the institution, and those who are potentially able to establish a satisfactory extramural adjustment but who have not acquired the skills required for such an adjustment.

APPENDIX II

PROPOSED 10-YEAR PLAN FOR CONSTRUCTION OF STATE RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED

	1965 mentally retarded population	Changes to be effected	New buildings Needed	1976 mentally retarded population
Faribault	2795	1. Reduce population to stabilization figure of 2,000 2. Raze substandard & deteriorated buildings (763 beds) 3. Eliminate overcrowding (467 beds) 4. Transfer 795 persons to other facilities 5. Construct living facilities for 450 persons	Living facilities for 450 persons (125 beds are already authorized)	2000
Brainerd	1334	1. Construct additional living facilities for 216 persons 2. Achievement of stabilization figure of 1500 through transfers and new admissions.	Living facilities for 216 persons	1500
Cambridge	1717	1. Reduction of population to stabilization figure of 1500 to eliminate overcrowding through transfer of 217 persons to other facilities.	None	1500
Lake Owasso	128	No changes proposed	None	130
Owatonna	210	No changes proposed	None	200
Shakopee	29	No changes proposed	None	30
TOTAL	6213		TOTAL	5360
Hastings		Transfer and admittance of selected mentally retarded persons from groups V & VI		60
Anoka		" "		60
Willmar		" "		60
Moose Lake		" "		60
St. Peter		" "		100
Fergus Falls		" "		60
Rochester		Transfer and admittance of selected mentally retarded persons from groups I, II, IV, V, and VI.		120
			TOTAL	520
Special State Facilities		Transfer and admittance of mentally retarded needing these services		160
New Residential Facilities		Construction of this facility in a major medical & educational center		160
		Total number of mentally retarded persons in state facilities		6200

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55101

February **24, 1966**

Mr, Gerald F. Walsh, Executive Director
Minnesota Association for Retarded Children, Inc.
6315 Penn Avenue South
Minneapolis, Minnesota **55423**

Dear Jerry:

Thanks very much for your note of February **3, 1966** concerning the suggestions for the Plan for Development of Residential Facilities for the Mentally Retarded in Minnesota. I am sorry to be so long in answering this note, but I fear I got way behind on my correspondence. Furthermore, I do not have the document right with me to make comparisons as I am dictating this at home while recuperating from a slight upper respiratory infection.

I will send this on to Morrie Hursh as the presentation before the Building Commission I expect must be made officially by the DPW. In the final analysis he is the one who will have to weigh these comments and other factors.

I think this is especially pertinent with regard to the problem of equalization of costs as between the state hospitals and other residential facilities as they will effect the counties. I think Morrie will understand the suggestions in your second paragraph much better than I do. As I read this it makes sense, but I am afraid this whole issue of sharing of costs is somewhat beyond my competence.

I am not sure about the suggestion in your third paragraph that adoption of the plan is contingent on adoption of all factors listed; I think this could be pushed in the verbal presentation, but unless handled carefully, it might convey the impression that we are laying down conditions and this never goes over too well.

The suggestions in the next paragraph about de-emphasizing ten years I think is very sensible. Again, I think this might be something to handle in the verbal presentation.

Finally the suggestion about not commiting ourselves to no new building at Cambridge I think also makes sense.

I do think that Morrie should be the one to make the decisions on the presentation, as of course, he is the one who is officially called to make the DPW request.

I have a problem of my own that I have been brooding about, and do not know whether it will require a rewrite of the whole plan. This is with regard to Brainerd. If it turns out that no new building is possible at Brainerd unless there is going to be a new $250,000 boiler installed, then this gets everybody off the hook very gracefully. The only one to my certain knowledge who really positively desires additional buildings at Brainerd is Harold Peterson. The problem is, of course, that if we cancel the 216 beds that Brainerd called for in the plan (which I personally would be very glad to do) we will then have to redo all the totals. I wonder if one way to do this might be simply to bring the overall total from 6200 down to 6,000? Otherwise we would have to show those 216 beds somewhere else as an alternative.

Although it would not necessarily require amendment to the text of the plan, I think it is interesting about the recent suggestions concerning Nopeming Sanitorium. I do not know much about Nopeming but if it is to be turned over to the state, this would not only provide the 160 new beds we are requesting in that part of the state, but it might also provide additional beds beyond that could again effect the totals we are talking about.

I am sorry about the long delay in answering and the general fumbling around with your suggestions, but this seems to be the best I can do just at the moment.

Best wishes.

Yours sincerely,

Dave

David J. Vail, M.D.
Medical Director

DJV/mel

Dictated but not read.