TO: HarryHallMD

FROM: Ralph Rossen, M. D.

SUBJECT: Planning for the Mentally Retarded in Minnesota

The major problems facing Minnesota relating to programs under the direction of the Department of Public Welfare, Medical Services Division, fall in the area of mental retardation, not mental illness.

These two problems are very different and the programs are directed toward different goals. In the case of the mentally ill, treatment and care is usually for a relatively short time. Many mentally retarded, especially the severely and profoundly retarded, need services over a lifetime. The majority of the mentally ill who receive service are adults, whereas most of the retarded who now are in desperate need of service are children. There is no waiting list for service in institutions for the mentally ill

I. STATE INSTITUTIONS. The differences in the present care and treatment programs at the hospitals for the mentally ill and for the retarded are appalling. This is especially true for those cases of mentally retarded infants, children, and adults who are most regressed and unable to help take *care* of themselves.

a. The ratio of employees to patients is about double in institutions for the mentally ill over the ratio in hospitals for the mentally retarded

b. Little progress has been made in the mental retardation system since 1950.

In 1950, there was great emphasis on the need to eliminate overcrowding, Serve those on the waiting list, provide new buildings, better food and more staff. Today, we are talking about the same problems because the programs for the mentally retarded have been relegated to a low priority.

The present situation in state institutions for the retarded is so critical that I feel immediate emergency steps should be taken. When I visited the Faribault State Hospital on April 19, 1967, I found the following staffing

Dakota Building 102 severely and profoundly retarded men. There are only ten Psychiatric Technicians for all three shifts and for week-ends. This means an average of one employee for 51 multiply handicapped, incontinent, disturbed and regressed patients.

The employees are not even able to keep the men dry or clothed. At night, usually one employee is in charge of the entire building. A minimum staffing for this building would be ten employees on each of the day shifts and three on the night shift.

Program staff is also desperately needed.

Spruce Building — 82 severely and profoundly retarded girls, ages 5 to *10.* 27 of these are bed patients who need total care. Most (72) are not toilet trained. A total of 51 are non-ambulatory; 58 must be individually fed. There is a total of eight Psychiatric Technicians assigned to this building, or an average of 1. 6 per shift — four in the a. m. two in the p. m., and only one at night. During the day, each P. T. cares for between 29 and 41 children. Minimum staffing for these children should be ten in the a. m., ten in the p. m., and five at night. In addition, there should be a separate physical therapy department in this building, with two physical therapists and at least three physical therapy aides. There should also be at least four trained patient activity workers and a pediatric nurse on each day shift.

Poppy Building 90 disturbed mentally retarded adult women. There are 11 Psychiatric Technicians to cover all shifts. All of these women are hyperactive; 65 are on regular medication. 36 of these are only moderately or mildly retarded. A great deal could be done for them if proper staffing were made available. A minimum staffing for this building would be ten Psychiatric Technicians on the a. m. and p. m. shifts, and four at night.

The three above buildings are representative of most of this institution. Recommended minimum staff for these three is 74, instead of the present 29!

2. DAY ACTIVITY CENTERS. These centers for severely retarded serve those who are not eligible for public school. Nearly 1,000 retarded are served in 50 centers at an average cost of $600 per year. Children who can live at home are given social, health, recreation and physical stimulation. An expansion of these is essential.

3. COMMUNITY RESIDENTIAL CARE. In my opinion, provision of a variety of types of community-level residential care facilities will not only relieve overcrowding in state institutions, but at a reduced cost to the state provide more normal living conditions for many retarded. Not all of the community facilities, such as boarding homes, small group homes and private institutions, are ideal at this time. State funding on a 90% basis will, however, aid their development and improvement.

Adoption of legislation to make this possible is not only wise but can also be considered an emergency measure.

4. PROGRAM DIRECTION. As I mentioned earlier, little has really changed in the state department programming and direction since 1950. There is still lack of staff, lack of program coordination and planning, and no long-range planning. Ideally, there should be a separate Department of Mental Retardation. At this time, however, there should be created and funded at least a separate Division of Mental Retardation in the Department of Public Welfare. Much of the cost of this Division could be paid from federal funds. This Division should have consultants for community programs, be in charge of institutions for the retarded, plan research and develop a system of regionalized services for the mentally retarded.

5. REGIONALIZED PROGRAM. A system of small, regionalized institutions should be planned. These would make it possible for the retarded to be nearer their own homes and would solve some staffing problems. Funds should be made available for planning and site selection.

6. SPECIALIZED INSTITUTIONS. Small special institutions for certain groups of the retarded should be developed close to several General Hospitals. The same power plant could be used, as well as kitchen, laundry, and maintenance personnel. Connected by tunnel to the General Hospital, specialists would be available for care and treatment. Such

facilities for about 200 each should be constructed in both Minneapolis and St. Paul. Federal funds could be used for much of the construction cost.

SUMMARY AND CONCLUSIONS. Minnesota's programs for the mentally retarded are just barely emerging from an era of neglect, lack of attention and understanding. We should not delay steps to make major improvements. The greatest cost will be for new staff. I do not, however, see how we can continue to provide so poorly for so many. At least 50% of the retarded in our state institutions are receiving survival or sub-survival care!