Three important parameters have greatly influenced the recommendation by the Minnesota Association for Retarded Children for a Division of Mental Retardation within the Department of Welfare. These are:

1. Historical
2. Management Principles
3. Performance

Historical

When one goes basic to the beginnings in Minnesota, late in the Nineteenth Century, one finds that programs for the retarded were conceived as a need in education and evolved to custodial-type institution care. The type of program within an institution was very much dependent on the stature of the superintendent of an institution. A good man was able by virtue of his professional ability and promotional ability with the legislature to effect a good, humane program. The Faribault institution, for example, under Dr. Rogers, was regarded in the decade of 1920 as a model institution. People from all over the USA and the world came to Faribault to visit this outstanding institution.

As the number of mental institutions in Minnesota grew, it seemed advisable to place them under central control so they could be managed more efficiently, more uniformly, benefit by central planning, and lessen dependence of the program on the caliber of an institution superintendent. Thus, the Board of Control was established which in turn became the Department of Welfare with various divisions, including the mental health division. This division was responsible for institutions for both the mentally ill and the mentally retarded. The division, in time, was also expected to provide leadership over the broad spectrum of the total community of services for the mentally ill and the mentally retarded, for those who were under state guardianship and for those who were not.

Starting in 1946, the mental health programs in Minnesota benefited by a crusade to improve conditions for the mentally ill. This crusade was spearheaded by Governor Luther Youngdahl who must go down in history as the chief executive who did the most for the program. Youngdahl was benefited by a group of concerned citizens who were shocked at conditions they found in mental institutions, by high excesses in the state treasury (tax monies which accumulated during World War II and couldn't be spent because of priorities), and by a period of relative prosperity which contrasted sharply with the depression and the stringencies of the war. This movement was carried out largely in the name of the mentally ill who had organizations to speak for them. The Associations for the Mentally Retarded had not yet been formed or were in the organizational process. The mental health groups encouraged the formation of the mentally retarded groups and welcomed them into the mental health movement.

So, the emphasis within the Department of Welfare naturally focused on the mentally ill more so than on the mentally retarded.

With the advent of drug therapy in 1950, regarded by many as the single most important medical advance in our lifetime, the progress for the mentally ill achieved a real breakthrough. Within a few years it became evident that the program would no longer be haunted by the spectre of ever increasing numbers of patients who could not be reached and seemed destined to spend their life receiving custodial care in state institutions. Patients now became manageable and responded in a heartening way to various forms of therapy and treatment. The institution population declined and programs aimed at intensive patient attention during the initial six month period with real hope of returning the patient to the community as a useful citizen. Outpatient care, mental health clinics, and voluntary admission became key parts of the program. It is no wonder that the division of mental health concentrated their attention on this important, this exciting, this rewarding part of their overall responsibility.

The program for the mentally retarded benefited by no such great medical breakthrough. The retarded could be made quiet and placid by tranquillizer drugs, but little else could be promised. There were programs for the retarded which offered the

patient dignity and enlightened care, treatment, and training. But these are high cost and promise no dramatic benefits to the community to compare with programs for the mentally ill. In the absence of any real breakthrough, a Pandora's box of programs was offered to the public and the legislature by a bewildering army of experts, each of whom had his own pet program and had little good to say about anyone else's program. The Mental Health Division provided no strong leader to guide the public and legislatures through the confusion, and program excellence, by default, still remained centered on the institution superintendent. Community pro-grams were spotty in quantity and quality, each program being good, bad, or indifferent depending upon the community sponsoring agency.

Since 1950 the various Associations for Retarded Children have worked closely with the Department of Welfare, the institutions, and the legislators. We fault none of these good people for their professional ability and desire to serve humanity. Indeed, we have been inspired by their attitudes which give us the incentive to keep trying to better things for the mentally retarded. We are critical of the system which has not produced the leadership necessary to move the program forward. We must share the blame with them for this situation. The good people in the Department of Welfare, the institutions, and the legislature have also looked to the Associations for Retarded Children for the kind of common sense leadership which leads to recommendations which can be translated with reasonable cost into improved programs for the retarded. All too often we have been unable to agree amongst ourselves on program details and all too often make recommendations which are tantamount to sweeping away the old and replacing them with the new.

Performance

In short, the Minnesota Association for Retarded Children, as a matter of historical observation, has to conclude that programs for the mentally retarded have shown little progress when organized as part of the Mental Health Division within the Department of Welfare.

Press reports on the program read like endless verses of a horror ballad. Overcrowding, understaffing, and antiquated buildings are the endless refrains.

Program changes have resulted but miscalculations and inability to estimate cause and effect relationships have just about equated assets with liabilities.

Management Principles

These are not too well understood and practiced by Department of Welfare administrators. This is understandable since they are trained for specific professions, not management.

Several principles bear on the problems

1. An organization should be divided into manageable segments. The head of the Mental Health Division, for example, cannot handle all that he is charged with handling. This is no reflection on his professional competence. His management problems are compounded by a weak staff.

   To probe into the example further. A welfare worker with a B.S. or M.S. degree is hardly acceptable as a program director of men of the training and salary of those who head up our state institutions,

2. Responsibilities must be fixed.

   If responsibilities are vague and ill defined (and they are), it is hard to fix blame or credit. If things aren't right at a state institution, who is to blame? The Business Manager? The Medical Director? Ill defined staff consultants within the Mental Health Division? The Head of the Division? The Commissioner? The Governor? The Legislature? Etc.

3. The need for professional leadership.

   Who is a professional man? He is a man who, by virtue of his intellect and training, is best presumed by society to be able to handle matters falling within the scope of his profession and his professional responsibilities. Note that this definition does not say the professional man always has to be right. It is vital that he be able to make decisions in the

absence of all the data. If one waits to make a decision until all the data are in, so that the conclusion is so obvious that even a six year old child could make it, there would be no need for professional men.

Recommendations

In light of history, performance, and management principles, the Minnesota Association for Retarded Children feels that the missing leadership for programs for the mentally retarded can best be provided via a Division of Mental Retardation within the Department of Welfare. It should be headed by a top professional man of the caliber of Dr. David Vail or Dr. Cameron, and be staffed as indicated by its head.

Statement submitted by
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