MINNESOTA'S MENTAL HEALTH MENTAL RETARDATION PROGRAM in PERSPECTIVE

Minnesota's Mental Health-Mental Retardation Program in Perspective

A Comprehensive Summary

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INTRODUCTION

Prevention, growth of community resources, improved hospital care—these are the goals of Minnesota's program to counteract and reduce the problems of mental illness, mental retardation, and inebriacy.

Toward these aims, the state Department of Public Welfare is integrating its three major systems of services, emphasizing greater local responsibility and participation.

The comprehensive community-based program has been designed to connect the services of the state hospital system, the county welfare system, and the area mental health-mental retardation system with a focus on the active involvement of communities in developing and providing needed resources.

The foundation is the concept that no single agency or system holds the key to meeting the problems of mental disorder—only by close coordination, joint planning and action, and a concentration on preventive programs where it is needed most—in communities—can results be achieved. Through both therapeutic and social intervention at the source, factors such as ill health, delinquency, emotional disturbance, family disorganization, and other social and behavioral causes which could lead to a major disorder may be influenced and contained.

The area mental health-mental retardation programs act as catalysts not only in developing resources, but in bringing people and services together through consultation and referral to other community organizations: schools, churches, public and private agencies offering family case services, financial assistance, day care, rehabilitation, vocational training, recreation, child guidance, diagnostic services.

The county welfare departments, which have a traditional role in providing direct service to individuals and families with mental disorders, also are key motivators in generating and supporting needed community programs and services.

The state hospitals serve as treatment resources, and share responsibility with the counties, area programs, and other concerned groups for planning and implementing a comprehensive program within a specific region of the state.

The comprehensive program creates a network of community services in which the state hospital is an integral part. Today, a person needing assistance may be referred to an appropriate agency or treatment facility in his locality. He is more likely now, than in the past, to be treated in his home community than at a state hospital. The individual is provided appropriate treatment with a minimum of disruption of his family and social life; and for the state hospital, this minimizes the admission of patients who could better be served elsewhere, conserving the facility for more appropriate uses.

However, in some cases, the state hospital may be the most appropriate treatment resource. If hospitalized, the patient's stay can be shortened and made more effective not only because of better quality treatment programs, but also with the development of a continuing plan by the county welfare department, in

cooperation with the hospital, public health nursing and other rehabilitative services.

In retrospect, Minnesota's program, as well as those of other states, is marked by a seeming circularity that begins and ends with "community responsibility."

During the 19th century, the emphasis in most cases was on community and home responsibility for the "mentally incompetent" as such persons then were termed. This was followed by an era emphasizing institutionalization of mentally ill and mentally retarded persons in isolated state hospitals, a period which resulted in the overcrowded, understaffed state institutions that caused the indignation of the news media and the public shortly after World War II.

Again, the approach has shifted back toward community care and responsibility, with the state hospital as an integral part of the community. However, what seems to be a circle actually is not. In the 19th century, communities and homes were responsible for the care of mentally ill and mentally retarded individuals primarily due to the lack of institutional and professional facilities.

Today, communities are increasingly assuming responsibility since it is accepted that early diagnosis and treatment can prevent and reduce major mental disorders, as well as lessen the period of hospitalization. Accessibility to services and care close to home usually is more beneficial to the patient, permitting a more rapid restoration to a productive life; most mentally ill, mentally retarded, and inebriate individuals can become contributing members of their communities through special therapeutic, educational, and vocational training programs.

The community as the "hub" of services is advantageous as well in helping to remove stigmas attached to mental illness, mental retardation, and inebriacy. Local responsibility also encourages more participation and direct involvement by concerned citizens in shaping programs and services.

SCOPE OF THE PROBLEMS OF MENTAL ILLNESS, MENTAL RETARDATION, AND INEBRIACY

Mental Illness

Mental illness can be described as inappropriate, irrational, or unrealistic behavior. In most physical illnesses, there is something wrong or abnormal with parts of the body; in mental illness, it is the behavior of a person that is not "normal". This leads many professionals in the field to question the appropriateness of the term "illness" in regard to these conditions.

Mental illness may be caused by physical, psychological or environmental factors, or a combination of all three. It may be characterized by exaggerated and abnormal feelings of inadequacy and tensions from coping with real or imagined problems of life, or in loss of ability to deal with reality. Curious and inadequate methods of adjusting to life may become fixed in an abnormal behavior pattern which may or may not fulfill its purpose. There are many kinds and degrees of mental illness, some mild, some severe, but all to some extent render a person either incapable of leading a "normal" life as defined by the society, or a satisfying life as defined by himself or those closest to him. The latter most often is described as "emotional disturbance." When the condition becomes serious enough to affect the person's behavior or ability to think rationally, it is termed "mental illness." The term "psychiatric conditions" includes both mental and emotional disabilities.

This disability is costly to an individual, his family, the community, state and nation. At least one person in every 10—20 million persons in the United States—has some form of mental or emotional illness needing psychiatric care. There are more people with mental disorders in hospitals than with all other illnesses combined. According to 1968 statistics and estimates of the National Association for Mental Health, mental illness and emotional disabilities are recognized as an important factor in many physical illnesses, even heart disease. It is estimated that over 50 per cent of all medical and surgical cases have additional mental or emotional complications.

The association's figures show over 1,700,000 persons are registered in public and private mental hospitals, psychiatric services of general hospitals, and Veterans Administration psychiatric facilities. Mental and emotional disabilities occur at all ages, including childhood—the association estimates that about 500,000 children and adolescents in the United States suffer from psychiatric disorders.

Statistics show that mental and emotional disabilities are a serious problem to the nation in terms of the waste of both human and economic resources. As President John F. Kennedy said in his 1963 mental health speech to Congress, ". . . mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition."

In Minnesota, the statistics are not much different.

The number of residents in the state hospitals for the mentally ill has declined in recent years, however, from the peak year of 1954. In September of that year, there were 11,348 mentally ill patients in the hospitals, compared with 3,872 in September 1968. Yet, at the same time resident populations are down, admissions to hospitals are up, with over 900 more mentally ill patients entering the hospitals and almost 1,800 more released in 1967-68 than in 1953-54. The reason: the average length of stay in a hospital has been shortened. The prognosis now is that a first-time patient will stay in the hospital only six weeks. This shortened stay has been brought about through improved treatment and rehabilitation programs, enabling staff to work with and discharge patients formerly thought hopeless. Another factor in reducing the resident population has been the transfer of geriatric patients, who do not require psychiatric care, to nursing homes.

Mental Retardation

Mental retardation is incomplete mental development. Mentally retarded persons are those whose normal intellectual growth was arrested at some time before birth, during the birth process, or in the early years of development. Because of their impaired ability to learn, mentally retarded individuals usually have some degree of difficulty in meeting the needs of everyday living. However, the degree of adjustment, as well as the ability to learn, varies widely with the degree of mental retardation.

The broad mental retardation classification ranges from those profoundly handicapped who cannot perform even the simplest of tasks and are completely dependent, to those mild cases in which the individual is able to maintain himself in the community.

There are about six million mentally retarded individuals in the United States, of whom the majority are mildly retarded. Recent studies have shown that the highest incidence occurs among families who live in poverty, and where deprivation has resulted in a slowing down of the learning process.

In Minnesota, prevalence is conservatively estimated at two per cent of the population, dependent on varying social and economic conditions in communities.

As of September 1968, there were approximately 5,047 mentally retarded patients in the state hospitals.

Until recent years, it was felt that once a person's condition was diagnosed as mental retardation and he was assigned to one of the intelligence or behavioral levels—profound, severe, moderate or mild—he would stay at that level the rest of his life. Advancement or further development was not considered as possible. As a result, the individual received little or no opportunity to develop to his potential.

Fortunately, medical science and education have gained new insights in recent years, and some programs are now underway which give mentally retarded individuals the challenge and opportunity for further mental and social growth. Many retarded persons are no longer expected to stay at the same level at which they tested originally, but are encouraged to move upward, with professional help.

Expanding governmental programs are based on the premise that many of the mentally retarded have the potential ability to improve their intellectual and social abilities, and that many can become productive citizens.

But how much each individual improves and develops depends in large measure on the type of medical, social and educational help he receives, and what opportunities the community offers.

During the past decade, the growth of public and private programs has effectively helped mentally retarded persons to become contributing members of society.

Research and other programs for the mentally retarded are geared to the whole life cycle from conception through pre-natal development, birth, childhood, adolescence, adulthood and old age.

Today, there are numerous—but still inadequate—efforts to prevent, alleviate and treat retardation, including research, to identify specific physical causes of the condition and the basic problems of behavior and learning processes; prevention, to arrest adverse biological, psychological, cultural-environmental factors causing retardation; programs, such as diagnostic and clinical services, residential care facilities, special education, vocational rehabilitation, social services and parent counseling.

National concern about the problem of mental retardation came to the forefront in 1961

when President John F. Kennedy appointed a panel of experts to study the problem. One year later the group published the comprehensive report entitled "A Proposed Program for National Action to Combat Mental Retardation." A follow-up White House conference was held to acquaint the states with the proposals.

In 1963 the President sent to Congress his special message on mental illness and mental retardation. "Our attack must be focused on three major objectives," he said. In brief, he listed them as follows: "First, we must seek out the causes . . . and eradicate them. Second, we must strengthen the underlying resources of knowledge, and above all, of skilled manpower which are necessary to mount and sustain our attack on mental disability many years to come. Third, we must strengthen and improve the programs and facilities serving the mentally ill and the mentally retarded."

In 1964 President Lyndon B. Johnson expressed the federal government's determination to continue to combat mental retardation:

"Thirty years ago, or even three years ago, if anyone had asked what was being done about mental retardation, the answer would have been a shrug of the shoulder . . . Our answer and our attitude are changing. We are answering with our hearts and our heads, not with shrugs and silence . . .

"Mental retardation afflicts nearly six million Americans. It affects 10 times more persons than diabetes; 20 times more than tuberculosis; 600 times more than polio. A retarded child is born every five minutes, 126,000 every year.

"Yet, until very recently, our knowledge of and interest in this crippler was little greater in the Twentieth Century than it had been in the First Century. Today, we can say objectively that more has been done in the government in the past two years than in the previous 200 years to meet the challenge of mental retardation.

"We have made progress. But our efforts have only begun. We will continue until we find all the answers we have been seeking, until we find a place for all those who suffer with the problem."

Significant federal legislation enacted since the report of the President's Panel on Mental Retardation reflects increased mental retardation programming in areas such as the provision of services, construction of facilities, research, training, and planning. Under this legislation, federal resources stimulate state and local governments and private action through a variety of grant-in-aid programs. The federal government also offers communities guidelines for action. But the major emphasis is on the local, community level, with the government offering seed money and ideas to be adapted to community needs and potentials. And the current program is but the beginning of national concern, with further developments now in the offing. The problem is complex, and cannot be attacked in any one area. The concerns are biological, psychological, educational, vocational, economic, social and legal, with need for a continuum of care throughout the life cycle.

In 1966, President Johnson established the President's Committee on Mental Retardation. Its report issued the following year identified trends and priority need areas in the nation wide effort to combat retardation.

In its 1968 report, the committee focused on three major need areas: residential care for the retarded, manpower for programs, and mental retardation in poverty neighborhoods. Among the recommendations were:

• Residential Care—Improve standards and develop a national system of accreditation. Es tablish a program to relocate and rebuild ob solete facilities. Develop an insurance system to give parents a free choice in selecting resi dential services. Develop programs for retarded persons who also are emotionally disturbed.

• Manpower—Increase grants to attract top professionals into the field. Develop grant pro grams for training needed supportive personnel; and to develop state wide volunteer service pro grams. Develop in-service training and educa tion programs for employee improvement and advancement.

• Deprivation—Make health and education services available to every child from birth. Develop community and neighborhood health and education centers to give preventive health care and screening, early education and day care. Develop fixed facility and mobile health, education and social service programs for rural areas. Expand career planning in sup portive health, education and social services in low income areas. Form a service group to teach and demonstrate home and health skills in low income neighborhoods. Urge youth or ganizations to undertake large-scale member ship and voluntary service program develop-

ment in poverty areas. Include the needs of the retarded in model cities planning. Intensify research into the causes of mental retardation associated with social and cultural deprivation.

In 1967 the State Mental Retardation Planning Council, which had been established to develop a comprehensive plan to combat retardation in Minnesota, issued its final report. Its activities continue through the Governor's Council on Health, Welfare and Rehabilitation.

The council identified the following needs for immediate action:

- Develop a viable system of diagnostic and evaluation services as related to the child development center concept.
- Establish a pattern of small, community-based residential facilities.
- Accelerate training and research activities, as related to the establishment of a univer sity-affiliated training and research center.
- Devise methods of recruiting sufficient trained manpower to provide needed services.
- Study and recodify state laws concerning the mentally retarded.

Inebriacy

One of the country's major medical-social-economic problems, approximately five million Americans—both men and women—may be classified as alcoholics, according to statistics from the Secretary's Committee on Alcoholism of the U. S. Department of Health, Education and Welfare.

An alcoholic is an excessive drinker whose dependence on alcohol has reached such a degree that it shows a noticeable disturbance or interference with his bodily or mental health, his relationships with others, and his satisfactory social and economic functioning.

Alcoholism is described as a chronic illness that shows itself as a disorder of behavior. It is characterized by the repeated use of alcoholic beverages to an extent that exceeds customary dietary use or compliance with social customs of the community, and that interferes with the drinker's health, or his economic or social functioning.

While knowledge of the causes of alcoholism is limited, available information views it as a multiple-caused illness. Scientific evidence suggests that alcoholism may have a physical or biological cause, may stem from inadequate psychological development, may emerge from specific social factors, or can be a combination of these factors. It is a progressive illness which develops over a period of years and is chronic in nature with acute episodes. Disorders associated with alcoholism include physical and emotional disorders, and brain damage.

Alcoholism is costly in terms of wasted human resources: family disintegration and divorce, child neglect, poverty, delinquency, crime, increased welfare costs, waste and inefficiency in business and industry, danger and death on the highways.

Individuals who have developed alcoholism are fairly well-distributed in society. About five to 10 percent fall into the group described as the chronic drunkenness offender, the skid-row habitue, or the homeless man. The institutionalized alcoholic is even a smaller percentage of the total. Within the nation's work force, it is estimated that three to five per cent may be classified as problem drinkers or alcoholics. The vast majority of the alcoholic population are at the point in the development of this illness which permits them to function more or less normally in their personal life situations. However, it does have a measureable effect on their families, their employers, and their communities.

For many years, alcoholics were regarded by the public and health professions as persons who could not be helped. Thus, interest in alcoholism problems grew very slowly. An attempt to control alcoholism via elimination of the chief agent, alcohol, was made through the passage of the Eighteenth Amendment and the Volstead Act. However, a concerted effort to change the picture did not begin until the early 1930's with the establishment of several national organizations and councils which were concerned with the problem. These groups, together with increased public and professional interest in recent years, have resulted in recognition of this condition as an illness. It also has been demonstrated that individuals who are alcoholic may respond to treatment successfully, can function normally within their families and communities, and can be self-supporting.

On the national scene, a series of conferences since 1961, sponsored by the federal agencies, have focused on the problem of alcoholism as related to vocational rehabilitation and safety. In his 1966 health message to

Congress, President Johnson called for a new national program to combat the illness. Since then, the National Center for Prevention and Control of Alcoholism has been established within the National Institute of Mental Health to implement a national program of prevention and control, including research, training, community education, treatment and rehabilitation services, cooperatively with state and local public and private organizations.

In Minnesota, the number of alcoholics is estimated at 110,950. A study of treatment facilities by the Minnesota Commission on Alcoholism Problems showed that 5,221 alcoholics received treatment at the state hospitals, federal hospitals, private hospitals and facilities in 1967.

Among the recommendations listed in the commission's programs survey report issued in 1968 were:

• Present facilities for alcoholism treatment in Minnesota are not adequate to accommodate all those needing treatment. The most urgent need is the provision of emergency treatment facilities for the sick alcoholic who needs immediate medical treatment and an intensive rehabilitation program. The detoxification and treatment centers should be strategically located throughout the state, and also should provide outpatient programs for working alcoholics who do not need hospitalization.

• A second type of urgently-needed facili ties is more half-way houses throughout the state. These facilities would offer alcoholics a place to live and receive help and moral sup port after release from formal treatment.

• A special alcoholic and drug abuse treat ment facility for women should be established near the Minneapolis-St. Paul area, with ad mission on a state wide basis.

• A special sheltered work-residential facil ity for the small minority of deteriorated alco holics, who are unable to live in the community, which would provide an opportunity for pro ductive work and longer-term treatment and supervision.

• A public education program to alert the population to the symptoms of alcoholism, and to remove the stigma of alcoholism and seek acceptance of the problem as a treatable ill ness.

A recent U. S. Supreme Court decision to the effect that alcoholics cannot be punished solely for drunkenness means that local governments will have to deal with alcoholism as a medical problem to be treated, rather than a criminal problem to be punished. Consequently, more adequate treatment facilities will have to be provided.

HISTORY OF THE STATE PROGRAM

Concern for mental problems in Minnesota dates back to 1851 when the first territorial legislature passed a law making probate judges responsible for the interests of "mentally incompetent" persons. But it was not until 1866 when 30 patients were admitted to newly constructed hospital buildings at St. Peter that the era of boarding out patients to other states ended, and the Minnesota program officially was begun.

The Minnesota program, as all states' programs, is a story which must be told from a point in time. The present cannot be effectively related unless it is seen in perspective—a point of view which allows that a century-long history of development permits some century-old concepts to be carried along; that social science is new and therefore experimental, inexact and sometimes scoffed, but necessarily more attuned to the future than the past; that the decades since World War II have seen more spectacular development of services and concepts than all the years previous, and thus the present program is innovative, continuously changing. The tendency could be to look back and see how far the state has come, but the look ahead is what keeps Minnesota a leader in mental health, mental retardation, and inebriacy programming and planning.

It is possible no coincidence that the development of Minnesota's program and those of other states has paralleled a change in society's attitude about mental illness and mental retardation. Mental disorders are no longer thought of as hopeless. Mentally ill persons are no longer considered as possessed by demons, or as less than human, or as a separate and frightening class of persons. The growth of this public attitude that mental illness is capable of cure or control, and that mentally retarded persons can be helped, has been partly responsible for the development of a state program with emphasis on prevention, community care and short-term hospitalization.

"Insane asylums" and "colonies for the feeble-minded" are gone. In their places are hospitals with vigorous programs aimed at returning patients to their communities, or where this is not possible, providing a homelike living situation that will enable long-term patients to live as rich a life as possible.

Through a continuous staff educational program, old institutional practices that dehumanize patients are being eliminated with hospital programs focused on the dignity and self-respect of its patients. The emphasis is on the needs of the person: privacy, open wards, contact with the community, encouragement of self-help, individualized therapy programs, independent living units, work assignments with pay, and patient councils.

Concurrently, as the dignity and rights of mentally ill and mentally retarded persons have become accepted, the emphasis has been to provide care and treatment, training and education in a normal and conventional setting. A web of community services now is being established—diagnostic centers, child development clinics, homemaker services, recreational

programs, day activity centers, special education classes, sheltered workshops, vocational facilities, psychiatric clinics, and day hospitals —enabling the mentally ill or mentally retarded person to remain in familiar surroundings whenever possible.

LEGISLATIVE ACHIEVEMENTS

Minnesota Laws

In broadest terms, these are the major legislative enactments that have led the state to its present position.

The program actually began in 1851 when the first territorial legislature assumed responsibility for the "mentally incompetent" through the probate judges. In 1866 the state opened its first institution in St. Peter with the admission of 30 patients—both mentally retarded and mentally ill—who formerly had been boarded out to other states.

By 1879 it was recognized that some of the "feeble-minded" children could benefit from training, and they were transferred to the "asylum for the deaf and dumb" at Faribault. In 1887 the "school and colony for idiots and imbeciles"—now Faribault State Hospital—was made a separate institution.

The basis for a state wide and all-inclusive program for the mentally retarded was established in 1917. Laws passed in that year, which still serve as the state's guidelines, placed responsibility for administration on a board of control and county child welfare boards—now the commissioner of public welfare and county welfare departments — and empowered the board of control to assume guardianship and accept responsibility for mentally retarded individuals.

In 1937 county welfare departments were established and given the responsibility for supervising mentally retarded wards of the commissioner in their communities.

But in 1947 the wheels really began to turn. The end of the war brought a chance for citizen attention to turn toward problems at home. Throughout the nation, citizen groups and the news media began calling for improvements in public facilities, including mental hospitals; concerted public attention was focused on institutional practices some called inhumane, some called unhealthy. Institutions were overcrowded. Patients were provided little more than custodial care, except in the hospitals for the retarded, where special education classes were furnished for some.

So the recent history of Minnesota's program really began in 1947 when Governor Luther W. Youngdahl appointed a Governor's Advisory Council on Mental Health. Recommendations were made for an adequate program of treatment for mentally ill and mentally retarded patients. Subsequently, the Mental Health Policy Act was passed by the 1949 legislature. Many of the provisions of the act underlie the state's program today.

The law recognized that new attitudes and treatment procedures could improve the care of the mentally ill and mentally retarded, geriatric, and inebriate persons. Standards of service and care for patients in state hospitals were set, and the director of public institutions was charged with maintaining these standards.

Chaplains were added to hospital staffs to offer religious services and spiritual guidance. Facilities and personnel were to be provided for occupational and recreational therapy, psychiatric, and social case work services.

Personnel training centers were established. Provisions were made for facilities and equipment for research and study in the field of modern hospital management, the causes of mental illness, mental retardation and related problems, and the diagnosis, treatment and care of those with mental disorders.

In addition, the law established a program for detection, diagnosis and treatment of mentally ill or emotionally disturbed persons through clinical services, and established a commissioner of mental health in the Division of Public Institutions.

In 1953 a new agency was given responsibility for the state program. That year, the divisions of Social Welfare and Public Institutions were consolidated into a newly created Department of Public Welfare. A medical director, who replaced the former commissioner of mental health, was given over-all responsibility for the state program and for the supervision of the department's Medical Services division which was to administer the program.

Also in 1953, the legislature made county welfare departments responsible for the aftercare of all patients discharged from the state hospitals. Further legislation enacted in 1959 made the county welfare boards responsible for all forms of public welfare programs, including the provision of mental health service.

Since 1953 major experimentations and developments in the state program have taken place, especially in the area of community programming. In 1957 the legislature passed a law setting up requirements for community mental health centers and providing 50-50 matching funds to communities meeting these requirements. Also in that year, a law was passed making it mandatory for local school districts to provide special education classes for educable mentally retarded school age children in their districts.

In 1961 this community-centered idea was carried further with the experimental establishment of day care centers for mentally retarded persons, also on a 50-50 matching fund basis. The experiment was successful and has become a permanent part of the state budget.

A significant advancement in hospital education programs was made in 1965 when the Special Education Act was amended by the legislature. This law requires public schools near the hospitals for the mentally ill to provide educational services to patients under 21 years of age. These programs are planned jointly with hospital staff teachers and therapists, and coordinated by the state Department of Education.

A major reform in state laws governing hospitalization and commitment procedures was enacted by the 1967 legislature. This progressive code protects the civil rights of patients, insures treatment and aftercare services, and streamlines admission and discharge procedures with safeguards for patients' rights.

To alleviate overcrowding at the state facilities for the mentally retarded, the 1967 legislature also directed the department to transfer patients to mental hospitals. Special units since have been opened at the Hastings and St. Peter hospitals; other residential treatment-training centers are planned at the Fergus Falls and Rochester facilities.

National Concern:
Studies and Legislation

The efforts of state agencies to evaluate their programs, upgrade and update facilities and treatment programs, and to expand services were recognized by the federal government in 1947 with the passage of the National Mental Health Act, and in 1955 with the enactment of the Mental Health Study Act. The Mental Health Study Act directed the Joint Commission of Mental Illness and Health, under a grant administered by the National Institute of Mental Health, to "analyze and evaluate the needs and resources of the mentally ill people of America and make recommendations for the national mental health program."

The report submitted to Congress in 1961 suggested that a stepped-up program for community care and facilities, research, personnel training, education, and improved treatment programs in state hospitals for the mentally ill was necessary to implement an effective national program to combat mental illness.

Some elements of this report were facilitated by legislation passed by the 1963 Congress granting funds to states for hospital improvement projects and inservice training; and for construction and staffing of community mental health centers, and local services for mentally retarded persons, such as diagnostic, treatment, educational, training, residential, and sheltered workshop facilities.

In another act of significance, the federal government in 1963 appropriated funds to assist states with mental health planning, to allow states the funds necessary to look at their programs from a long-range perspective and to coordinate services, as well as plan the development of facilities.

Federal legislation enacted in 1965 has greatly enhanced hospital rehabilitation programs.

The Elementary and Secondary Education Act augments state laws concerning educational services for the handicapped. Under its provisions, patients under 21 years of age in both the facilities for the mentally ill and mentally retarded are eligible for educational services beyond those which hospitals and local schools can provide.

The Project Teach program, funded through the same law, has produced dramatic results in the state hospitals for mentally retarded. Aimed at the severely retarded and multihandicapped patient, the project permits employment of additional staff to provide care and training toward increasing the patients' level of functioning in the areas of self-help, behavior and learning.

Under the Manpower Development and Training Act, potentially employable mentally retarded patients are being successfully trained in service occupations through area vocational-technical schools.

The Vocational Rehabilitation Act has resulted in cooperative vocational rehabilitation programs at the state hospitals. Through the projects, a variety of treatment and training services are provided to patients to reduce the extent of their disabilities and vocational handicaps.

The Foster Grandparent program, a special project funded through the Office of Economic Opportunity, has been instituted at the hospitals for the mentally retarded. Through it, low income senior citizens are employed and trained to provide needed care and attention to children who lack close personal relationships with adults.

MEDICAL SERVICES DIVISION

The mission of the state's comprehensive program is to lessen and prevent the problems of mental illness, mental retardation, and inebriacy through community-based programs and services, including the care and treatment programs of the state hospitals.

The Medical Services division has administrative responsibility for the state hospital system, and supervisory responsibility for the mental health-mental retardation programs of the 87 county welfare departments, and for contractual agreements with the area mental health-mental retardation boards and day activity center boards.

The program's components are organized at several levels: The state hospitals serve as treatment resources to residents of counties in their specific receiving districts, and also are involved in community educational, training, and organizational activities. The county welfare departments provide family and social services, including specific mental health services, and also participate in local program development. Area programs include both mental health centers and daytime activity centers for mentally retarded persons. The area mental health-mental retardation boards are responsible for a total area wide program to reduce the prevalence of specific mental illness and mental retardation problems.

The core of the program is the Medical Services division, which, through its staff, directs and supervises the treatment and rehabilitation programs of the state hospitals and other state-operated facilities. It also is responsible for program planning and development of resources; a state wide research program; education and manpower development which includes personnel training programs, public information and education; consultation and administration of state funds to community agencies.

Administrative Organization

The division director is responsible for the administration of the state's comprehensive program. These responsibilities are apportioned among sections comprised of community programs, research, education and manpower development, and the division and mental retardation program offices.

The central office personnel also includes a staff of consultants who assist the three systems—state hospitals, county welfare departments, and area mental health-mental retardation programs—in developing programs and services. The consultants function as advisors in practices concerning chaplaincy services, dental services, nursing services, psychological services, rehabilitation therapy services, social services, and volunteer services.

PROGRAM OFFICES

In 1968, two new staff offices were established: the division program office, and the mental retardation program office created to strengthen programs in the problem area of retardation. An inebriacy and a mental illness program office also are planned.

The division program office emerged from the study and planning section which was established in 1962 to study and evaluate Min-

nesota's total program. Its main function is to provide leadership and assistance in program design and development at the state, county and area levels to achieve the goals of the state program. The office staff work closely with other division personnel, and serve as liaison with other departmental units, and with agencies and organizations at the state, area, county and local levels which are concerned with mental health, mental retardation, and inebriacy programs.

The mental retardation program office is responsible for designing and executing a state wide program for mentally retarded persons. This includes the state hospital programs, and coordination with other state agencies, and with private and voluntary groups, in developing local services and facilities.

The division's guardianship service is part of this program. This service provides case consultation and assistance in determining the appropriate resources for mentally retarded persons committed to the guardianship of the commissioner of the state Department of Public Welfare.

To meet the increasing problem of alcoholism, an inebriacy office is proposed to advise on treatment and rehabilitation programs for alcoholics, as well as for persons addicted to narcotics and other drugs. In addition to further expansion of treatment services in the state mental hospitals, the program office would cooperate with other governmental agencies and with concerned groups toward increasing community rehabilitative facilities.

The projected mental illness program office would have similar responsibilities for developing a total program including hospital services and community resources.

COMMUNITY PROGRAMS

This section administers the state grant-in-aid program to community agencies: day activity centers for mentally retarded persons, and the area mental health-mental retardation boards which usually fund a mental health center as one part of their area wide program.

In addition to consultation to the boards and staff of these facilities, the section assists and advises the county welfare boards concerning mental health-mental retardation programs.

It serves as a liaison with the regional coordinating committees, with the county welfare departments, and with other departmental units, such as the Child Welfare division and Field Services division, which are involved in the state program.

The section also is responsible for the implementation of the Minnesota Hospitalization and Commitment Act through consultation with the area mental health-mental retardation program boards. The area boards, through their program director, work with community groups such as county welfare departments, public health nursing departments, probate courts, law enforcement agencies, clergymen, attorneys, and physicians who have a role in executing the law's provisions.

EDUCATION AND MANPOWER DEVELOPMENT

The section is responsible for the coordination of training programs in the state facilities; staff development programs; manpower development which includes recruitment, careers projects, and special careers training programs through the Office of Economic Opportunity; the state wide humane practices program; public information; mental health-mental retardation education.

The training program involves a continuously updating of staff knowledge and skills through workshops and conferences. It also insures the availability of future professional workers through a stipend program.

Mental health-mental retardation educational activities include cooperating with other state departments in presenting informational programs and seminars for secondary school and college educators. Other projects involve working with community, church, and youth organizations.

The section also is responsible for producing informational and educational materials, and for conducting a state wide informational program.

RESEARCH

Research is an important part of the Minnesota mental health-mental retardation program. Projects are coordinated through the central office staff, which includes a research coordinator, two research analysts and an information writer. The program has been considerably strengthened in recent years by increases in the legislative research appropriations. Funds are used to support personnel and obtain equipment for researches into such areas as

learning; metabolic and physiologic factors; the effects of a variety of hospital programs; the effects of treatment procedures such as group therapy, drugs or improved diet.

In 1968, individuals from the various segments of Minnesota's program—area mental health-mental retardation programs, county welfare departments and state hospitals—joined with representatives from private agencies to form a committee on cooperative research. This committee is to develop and maintain a state wide mental illness, mental retardation and inebriacy research program. This cooperation will allow for the consideration of problems which are beyond the scope of any one agency or hospital, as well as enable joint efforts involving individuals with a wide variety of experience and expertise.

All researches, whether under state funds or conducted without such grants, are coordinated through the research section. To assure scientific rigor and relevance of all researches, and regard for the rights and welfare of patient-subjects, all research also is reviewed by the state mental health medical policy committee, an advisory board to the commissioner established by the state legislature.

Regional Coordination

For purposes of local coordination of mental health-mental retardation programs and services, the state has been divided into seven regions which correspond to the receiving districts of the state hospitals. As of 1968, five have organized regional coordinating committees. Representation includes the area mental health-mental retardation programs, county welfare departments, and state hospitals, as well as spokesmen for public health, vocational rehabilitation, and other agencies actively concerned with the problems of mental health and mental retardation.

STATE HOSPITAL SERVICE

Hospitals and Residential Treatment Facilities

Each of the state hospitals serve a given region of the state.

The hospitals for the mentally ill are located at Anoka, Fergus Falls, Hastings, Moose Lake, Rochester, St. Peter, and Willmar. The Minnesota Security Hospital for the "mentally ill and dangerous" is located on the campus of the St. Peter hospital, and serves the entire state. Another specialized facility, the Minnesota Residential Treatment Center at Lino Lakes, receives mentally ill children on a state wide basis.

Three of the state hospitals — Hastings, Moose Lake and Willmar — provide treatment and rehabilitation programs for inebriate patients. The units at Hastings and Willmar also care for drug addicts. By July 1969, it is planned that all of the mental hospitals will be operating specialized centers for inebriate and addicted patients.

The oldest of the hospitals is St. Peter, where the first buildings were erected in 1866. The newest is Moose Lake which was constructed in 1938. Building programs have expanded the original campuses of several of the hospitals.

All of the hospitals are accredited by the Joint Commission on Accreditation of Hospitals.

The objectives of the state mental hospital service are to admit patients early in their illness; make a thorough diagnostic study of each patient's illness; formulate a comprehensive treatment program to best meet his needs; discharge the patient as soon as feasible with appropriate planning and arrangements for his return to the community, and any necessary aftercare services.

All of the state hospitals have adopted an "open door" policy which, except for rare and justified exceptions, eliminates locked doors or other physical restraints which inhibit patient movement. This policy has become a symbol of hospital treatment programs as it demonstrates respect for the dignity of the individual and emphasizes the patient's role as a responsible citizen of the community.

Many of the hospitals have instituted the "unit system" in which the treatment program is carried out in autonomous units, each designed to meet the specific needs of its residents. Generally, the psychiatric technician is the primary treatment therapist with other members of the unit staff available for supportive consultation and specialized services. Other unit personnel include a program director, physician, nurse, social worker, psychologist, rehabilitation therapist, and chaplain.

The geographical unit system is based on the counties served by the area mental health-mental retardation programs in the hospital's receiving district. Each unit operates as part of a community mental health team in coordination and aftercare planning with the county welfare department, area program, and other rehabilitative agencies and facilities.

The hospitals for the mentally retarded are located at Brainerd, the newest facility opened

in 1958; Cambridge; and Faribault, the oldest of these hospitals.

Other specialized facilities are the Owatonna State School which offers a residential-educational-therapeutic program for educable children and adolescents; the Lake Owasso Children's Home, an annex to the Cambridge hospital; and the Shakopee Home for Children.

The Cambridge hospital is fully accredited by the Joint Commission on Accreditation of Hospitals; the Brainerd hospital received accreditation for a one-year period in 1968.

To rectify overcrowded conditions at the hospitals for the mentally retarded, the 1967 legislature authorized the transfer of patients to the state hospitals for the mentally ill.

Since then, the Minnesota Valley Social Adaptation Center for adult retarded residents has been opened on the St. Peter hospital campus. Another unit, the Resident Opportunity Center for adult and adolescent patients, now is operating at the Hastings facility. Similar residential treatment-training programs will be established at the Rochester and Fergus Falls hospitals in 1969.

The Treatment Program

Each hospital has its own individual approach to treatment, but generally all approaches are characterized by interdisciplinary consultation and involvement in the diagnosis, treatment and follow-up of each patient. It is felt consultation between specialists in different phases of the behavioral and rehabilitation sciences help to pinpoint a patient's difficulties and promote thorough treatment of his whole personality.

HOSPITALS FOR THE MENTALLY ILL

The understanding of mental disorders has advanced significantly since the time of Freud, who attributed such disorders largely to conflicts between the conscious self (ego), unconscious desires, and a society which regulates fulfillment of these desires. Now there are several schools of psychiatry which agree that certain behavioral aberrations are mental illness, but disagree as to how these should be treated.

Principally, there are three lines of thinking —the lines that have led to separate treatment methods for mental disturbances. In hospital practice, however, these methods are not separate, but are used in some combination as decided by a treatment team or medical director. Somatic therapy for physically caused disturbances includes drug and electro shock treatment. Psychotherapy for unconscious disturbances is primarily talk-treatment designed to bring a patient's unrecognized fears and desires as well as his ineffectual behavior into conscious awareness. Social therapy is "action" treatment of the social man, treatment designed to facilitate interaction with others. This therapy includes the developing of social skills through group therapy and remotivation sessions that will permit the patient to feel serf-confident either in the hospital setting or in the community when he returns. It may include the development of job skills. Milieu therapy is a ward or hospital atmosphere which is conducive to treatment and the patient's well being. This environment is the responsibility of the staff.

HOSPITALS FOR THE MENTALLY RETARDED

In the hospitals for the mentally retarded, individualized treatment programs are designed to meet the varying needs of residents at different age levels and degrees of competence.

Programs for children and adolescents include care and physical rehabilitation, activation, social skills training, education, and prevocational training.

Adult programs provide vocational training and independent living experiences to equip residents with skills toward becoming serf-reliant, competent and productive workers in the community.

For those residents who must remain hospitalized, the program is focused on the development of the individual to optimum serf-reliance and social responsibility.

THE TREATMENT TEAM

The care, treatment and rehabilitation of patients is the responsibility of the medical director, a psychiatrist, who has the final authority on treatment procedures. He provides supervision for a staff of physicians, who make a thorough psychiatric and physical examination of the patient at admission to the hospital and prescribe necessary medication.

The conduct and efficient organization of the hospital is the responsibility of the hospital administrator. He establishes and maintains proper administrative procedures for an effective hospital program, and employs personnel

who will provide this program. Under the dual hospital administration system, the chief officer of a hospital is a graduate of an accredited hospital administration program. The chief of the medical staff is a licensed physician who is responsible for all medical care, treatment, rehabilitation, and research. This system is designed to free the medical staff from administrative duties and to assign these responsibilities to a specially trained person.

HOSPITAL SERVICES

Hospital personnel also include specialists in the following areas: chaplaincy services, dental services, nursing services, psychological services, rehabilitation therapy services, social services, and volunteer services.

Counterpart consultants in the Medical Services division's central office advise the professional staff on practices concerning these services.

Hospital Regions

The state hospitals and the counties served are:

Facility	Receiving District
Anoka State Hospital	Anoka, Hennepin, Sherburne, Wright
Brainerd State Hospital	Aitkin, Becker, Beltrami, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Hubbard, Itasca, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Red Lake, Roseau, St. Louis, Todd, Wadena, Wilkin
Cambridge State Hospital	Anoka, Benton, Big Stone, Chippewa, Chisago, Douglas, Grant, Isanti, Kanabec, Kandiyohi, Lac Qui Parle, Meeker, Mille Lacs, Pine, Pope, Ramsey, Sherburne, Stearns, Stevens, Swift, Traverse, Washington, Wright
Faribault State Hospital	Blue Earth, Brown, Carver, Cottonwood, Dakota, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Hennepin, Houston, Jackson, Le Sueur, Lincoln, Lyon, Martin, McLeod, Mower, Murray, Nicollet, Nobles, Olmsted, Pipestone, Redwood, Renville, Rice, Rock, Scott, Sibley, Steele, Wabasha, Waseca, Watonwan, Winona, Yellow Medicine
Fergus Falls State Hospital	Becker, Beltrami, Cass, Clay, Clearwater, Crow Wing, Douglas, Grant, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Todd, Traverse, Wadena, Wilkin
Hastings State Hospital	Dakota, Ramsey, Washington
Minnesota Residential Treatment Center	State Wide
Minnesota Security Hospital	State Wide
Moose Lake State Hospital	Aitkin, Carlton, Chisago, Cook, Isanti, Itasca, Kanabec, Koochiching, Lake, Mille Lacs, Pine, St. Louis
Owatonna State School	State Wide
Rochester State Hospital	Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Waseca, Winona
St. Peter State Hospital	Blue Earth, Brown, Carver, Le Sueur, Martin, Nicollet, Scott, Sibley, Watonwan
Willmar State Hospital	Benton, Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Sherburne (St. Cloud metropolitan area), Stearns, Swift, Yellow Medicine

COUNTY PROGRAMS

County Welfare Boards

The county welfare boards, first organized in 1937, are responsible for prevention, treatment, and control of the major problems of financial dependency, disability, and inappropriate social behavior. These responsibilities, carried out by the county welfare department staff, are shared with private social agencies, general and specialized vocational rehabilitation agencies, medical and psychiatric facilities, correctional services and institutions, and institutions for the handicapped and disadvantaged.

The boards generally are composed of five county commissioners and two citizens appointed by the commissioner of the state Department of Public Welfare.

Financial assistance programs and family service programs are provided by the county welfare departments in each of the state's 87 counties.

Financial assistance programs include general assistance, aid to families with dependent children, old age assistance, aid to the blind and disabled, and medical assistance.

Family service programs including counseling and assisting individuals and families with social problems. Planned programs of prevention and rehabilitation are provided to the aged, deprived and neglected children, the physically handicapped, mentally ill and mentally retarded persons, socially disorganized families, and to financially distressed families.

County welfare boards have two levels of responsibility for problems of social dysfunctioning. The first is the provision of specific case services to individuals and families. The second, and equally as important, is the shared responsibility with the area mental health-mental retardation program board and other appropriate agencies for the design, development, implementation, and evaluation of problems related to the public problems of mental illness and mental retardation. This involves identifying vulnerable populations, and designing the means necessary to reduce the prevalence and incidence of these problems among the identified high-risk groups.

The county system is a key element in the state's mental health-mental retardation program.

In the area of mental health services, the counties are responsible for providing an array of appropriate facilities for the temporary hospitalization of persons awaiting placement (informal or voluntary admission, or commitment) to a state hospital, or an appropriate community facility. The county welfare board has responsibility for providing a program of proper care and treatment for these individuals.

The county welfare department may provide continuous social services to persons receiving treatment in a state hospital. These services include pre-admission social studies in the case of a commitment hearing. Social histories also may be prepared for patients admitted on an informal or voluntary basis. Services also involve consultation with the hospital staff and with the patient's family during the period of hospitalization, and coordination in aftercare planning for the patient. Other community re-

sources may be utilized by the welfare department to provide the most appropriate services to the client after discharge from the hospital.

Planning for the mentally retarded individual, whether he is living in the community or hospitalized, is carried out on a continuous basis by the county welfare agency with the participation of his family or relatives, whenever possible.

The county agencies are responsible for assuring that the needs of retarded persons living in the community are met. This may necessitate the development of additional programs within the county, such as diagnostic services, utilization of public health nursing services, homemaker services, parental counseling, daytime activity centers, foster homes, and private residential facilities.

The county welfare departments also are directly involved in arranging admission of mentally retarded patients to the state hospitals, and in community placement after discharge. The agencies also are responsible for planning and implementing a program for retarded persons committed to the guardianship of the commissioner of the state Department of Public Welfare. If a retarded individual is unable to manage his own affairs, legal guardianship is arranged by the county welfare agency through probate court action. These wards may remain at home, may be hospitalized, or may be placed in foster homes or in private residential centers.

Aftercare planning and services for patients discharged from both the state hospitals for the mentally ill and mentally retarded are the major responsibility of the county welfare department. This involves joint planning with the hospital staff, community agencies, and with the patient's family. The county welfare department provides or arranges for aftercare services such as medical and psychiatric treatment, nursing care, vocational training; medical and financial assistance if the patient is eligible. The department also may assist the patient in locating employment and suitable housing. For some patients, no aftercare plan or services will be needed.

The county welfare departments, in cooperation with area mental health-mental retardation program boards and other concerned agencies, also have community organization responsibility to ensure the development of appropriate resources to deal more effectively with the problems of mental illness, mental retardation, and inebriacy.

These activities include community educational and informational programs, citizen advisory committees, volunteer services programs, and cooperation with community groups and agencies in organizing new prevention, treatment, and rehabilitation services and facilities.

Locations of County Agencies

The county welfare departments are located in the county seats:

Aitkin County Family Service Agency
Aitkin

Anoka County Welfare Department
Anoka

Becker County Welfare Department
Detroit Lakes

Beltrami County Welfare Department
Bemidji

Branch Office: Red Lake

Benton County Welfare Department
Foley

Big Stone County Welfare Department
Ortonville

Blue Earth County Welfare Department
Mankato

Brown County Welfare Department
New Ulm

Carlton County Welfare Department
Carlton

Carver County Welfare Department
Chaska

Cass County Welfare Department
Walker

Chippewa Family Service and Welfare Department
Montevideo

Chisago County Welfare Department
Center City

Clay County Welfare Department
Moorhead

Clearwater County Welfare Department
Bagley

Cook County Family Service and Welfare Department
Grand Marais

Cottonwood County Welfare Department
Windom

Crow Wing County Welfare Department
Brainerd

Dakota County Welfare Department
South St. Paul

Dodge County Welfare Department
Mantorville

Douglas County Welfare Department
Alexandria

Faribault County Welfare Department
Blue Earth

Fillmore County Welfare Department
Preston

Freeborn County Welfare Department
Albert Lea

Goodhue County Welfare Department Red Wing

Grant County Welfare Department
Elbow Lake

Hennepin County Welfare Department
Minneapolis

Houston County Welfare Department
Caledonia

Hubbard County Welfare Department
Park Rapids

Isanti County Family Service and Welfare Department
Cambridge

Itasca County Welfare Department
Grand Rapids

Jackson County Welfare Department
Jackson

Kanabec County Welfare and Family Service Department
Mora

Kandiyohi County Family Service Department
Willmar

Kittson County Welfare Department
Hallock

Koochiching County Welfare Department
International Falls

Lac Qui Parle County Family Service Center
Madison

Lake County Welfare Department
Two Harbors

Lake of the Woods County Welfare Department
Baudette

Le Sueur County Welfare Department
Le Center

Lincoln County Welfare Department
Ivanhoe

Lyon County Welfare Department
Marshall

McLeod County Welfare Department
Glencoe

Mahnomen County Welfare Department
Mahnomen

Marshall County Welfare Department
Warren

Martin County Social Service Department
Fairmont

Meeker County Welfare Department
Litchfield

Mille Lacs County Family Service and Welfare Department
Milaca

Morrison County Welfare Department
Little Falls

Mower County Welfare Department
Austin

Murray County Welfare Department
Slayton

Nicollet County Welfare Department
St. Peter

Nobles County Welfare Department
Worthington

Norman County Welfare Department
Ada

Olmsted County Welfare Department
Rochester

Otter Tail County Welfare Department
Fergus Falls

Pennington County Welfare Department
Thief River Falls

Pine County Welfare and Family Service Department
Pine City

Branch Office: Sandstone

Pipestone County Welfare Department
Pipestone

Polk County Welfare Department
Crookston

Pope County Welfare Department
Glenwood

Ramsey County Welfare Department
St. Paul

Red Lake County Welfare Department
Red Lake Falls

Redwood County Welfare Department
Redwood Falls

Renville County Family Service and Welfare Department
Olivia

Rice County Welfare Department
Faribault

Rock County Welfare Department
Luverne

Roseau County Social Service Center
Roseau

St. Louis County Welfare Department
Duluth

Branch Offices: Hibbing, Virginia

Scott County Welfare Department
Shakopee

Sherburne County Welfare Department
Elk River

Sibley County Welfare Department
Gaylord

Stearns County Welfare Department St. Cloud

Steele County Welfare Department
Owatonna

Stevens County Welfare and Family Service Agency
Morris

Swift County Welfare and Family Service Agency
Benson

Todd County Welfare Department
Long Prairie

Traverse County Family Service Department
Wheaton

Wabasha County Welfare Department
Wabasha

Wadena County Welfare Department
Wadena

Waseca County Welfare Department
Waseca

Washington County Welfare Department
Stillwater

Watonwan County Welfare Department
St. James

Wilkin County Welfare Department
Breckenridge

Winona County Welfare Department
Winona

Wright County Welfare Department
Buffalo

Yellow Medicine County Welfare Department
Granite Falls

Area Mental Health — Mental Retardation Programs

Minnesota's program has reached out to its citizens through the increased involvement of its communities.

The enactment of the 1957 Minnesota Community Mental Health Services Act, which provides matching funds on a 50-50 basis with county governmental units, has led to the establishment of 24 area mental health-mental retardation program boards representing both the urban and rural population in 86 counties. In addition, three privately-funded mental health clinics in the Minneapolis-St. Paul area receive a portion of their operating monies through the state grant program.

The area boards, composed of representatives of community agencies, organizations and citizen groups, are responsible for total planning and programming which involves coordination with other existing agencies, development of new programs and expansion of ongoing services; and community education with a focus on prevention and early intervention in mental problems. The board's service area may consist of one or more counties.

Usually, the area board operates a mental health center as one important element of its program. Professional staff of such centers usually consists of a psychiatrist, psychologist, psychiatric social worker, and other personnel determined by the area board.

The centers perform a broad range of services and activities: diagnostic, treatment, and counseling services; consultation to physicians, schools, law enforcement, judicial, welfare, other social service agencies, and professional personnel; collaborative and cooperative services with public health and other groups concerned with prevention of mental disorders and disabilities; in-service training programs for physicians, teachers, nurses, clergy, caseworkers and other professionals; informational and educational services to the general public, lay and professional groups; rehabilitative services to former hospital patients; research; community planning and organization.

AREA PROGRAMMING

Programming is varied, geared to the needs and problems of the communities within each area.

Some area programs emphasize the clinical approach with counseling, therapy and treatment services to clients.*

Other area programs serve the population through consultation with other community agencies, lay groups and professional personnel, and through public education and community organization. Preventive activities such as community consultation and education are designed to incorporate mental health prin-

*Any resident of the area is eligible for evaluation, treatment and other services. Eligibility depends on the availability of treatment resources and on the applicant's financial qualifications. Maximum fees are on a sliding scale based on one per cent of the federal income tax paid the previous year; if the federal tax exceeded $1,200, the applicant is eligible for only limited services. No resident is denied services because of the inability to pay. Race, creed or length of residence in the area do not affect eligibility.

ciples into the day-to-day work performed by agencies and institutions serving the community—teachers, guidance counselors, law enforcement officials, correctional personnel, welfare workers, public health nurses, and clergy—who come into contact with persons who may display symptoms of emotional disturbance.

The area boards, however, are charged with the responsibility for planning and developing services and facilities in their areas, alerting communities to needs, taking a leadership role and cooperatively working with professional and civic groups to expand services. The board may provide direct service through contractual arrangements with existing public, private and voluntary agencies, and with private practitioners.

COMMUNITY FACILITIES

Psychiatric Services

Federal legislation provides for construction and staffing grants to the area boards for community mental health and mental retardation facilities and services.

These mental health facilities are to offer both inpatient and outpatient services, partial hospitalization, and 24-hour emergency services. Additional hospitalization services may be provided by one or more community hospitals.

Such services now are available in some localities, such as the psychiatric day hospital service at the Hibbing General Hospital, arranged by the Range Mental Health Center, Virginia; and the inpatient and partial hospitalization service at the St. Cloud Hospital, through the Central Minnesota Mental Health Center, St. Cloud. A day-night facility at the Northwestern Hospital, Thief River Falls, arranged through the Northwestern Mental Health Center, Crookston, is scheduled for completion by July 1969.

Also through the federal grant program, a comprehensive community mental health center has been added to the Metropolitan Health Center, a joint project of the St. Barnabas and Swedish Hospitals, Minneapolis. In addition to inpatient services, the facility provides day hospital and rehabilitation services, emergency care, diagnostic and treatment services.

Services for Mentally Retarded

Other provisions of the federal law allow for construction and staffing of community facilities for mentally retarded persons.

A comprehensive facility providing diagnostic and evaluation services, remedial and special education programs for mentally retarded students will be constructed in the St. Paul metropolitan area early in 1969, sponsored by the St. Paul Board of Education. When completed, 12 school districts in Dakota, Ramsey, and Washington counties will utilize its services.

The Mount Olivet Rolling Acres Residential School at Victoria will be completed in the spring of 1969. It will serve approximately 48 school-age mentally retarded children on a state wide basis.

Other facilities developed through this legislation are the Lake Park-Wild Rice Residential School at Fergus Falls; Hammer Residential School, Wayzata; and the Louise Whitbeck Fraser School, Richfield.

Locations of Area Programs

Minnesotans in 86 of the 87 counties now are served by 24 area mental health-mental retardation programs.

The following are the current state-support programs and their service areas:

Area Programs	Sponsoring Counties
Anoka County Human Resources Office Anoka	Anoka
Carver-Scott Area Mental Health-Mental Retardation Program Central	Carver, Scott
Minnesota Mental Health Center St. Cloud	Benton, Sherburne, Stearns, Wright
Dakota County Mental Health Center Inc. South St. Paul	Dakota
Duluth Mental Hygiene Clinic Inc. Duluth	Carlton, Cook, Lake, Southern St. Louis
Five County Mental Health Center Braham	Chisago, Isanti, Kanabec, Mille Lacs, Pine
Hennepin County Mental Health Center Minneapolis	Hennepin
Hiawatha Valley Mental Health Center Inc. Winona	Houston, Wabasha, Winona
Lakeland Mental Health Center Inc. Fergus Falls Luther W. Youngdahl Human Relations Center Inc. Owatonna	Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, Wilkin Dodge, Rice, Steele, Waseca
Minnesota Valley Mental Health Center Inc. Mankato	Blue Earth, Le Sueur
Mower County Mental Health Center Inc. Austin	Mower
Northern Pines Mental Health Center Inc. Little Falls Northland Area Mental Health-Mental Retardation Program Inc. Grand Rapids	Crow Wing, Morrison, Todd, Wadena Aitkin, Itasca, Koochiching
Northwestern Mental Health Center Inc. Crookston	Kittson, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake Northern St. Louis
Range Mental Health Center Inc. Virginia	Ramsey
St. Paul-Ramsey County Mental Health Center St. Paul	Brown, Martin, Nicollet, Sibley, Watonwan
Sioux Trails Mental Health Center Inc. New Ulm	Faribault, Freeborn
Southern Minnesota Mental Health Center Albert Lea	Cottonwood, Jackson, Nobles, Pipestone, Rock
Southwestern Mental Health Center Inc. Luverne	Beltrami, Cass, Clearwater, Hubbard, Lake of the Woods, Roseau Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, McLeod, Meeker, Renville, Swift
Upper Mississippi Mental Health Center Bemidji	Lincoln, Lyon, Murray, Redwood, Yellow Medicine Fillmore, Goodhue, Olmsted
West Central Mental Health Center Inc. Willmar	
Western Mental Health Center Inc. Marshall	
Zumbro Valley Mental Health Center Rochester	

In addition, there are three privately-funded mental health clinics which receive a portion of their financing through state grants. These are:

Clinics	Service Area
Amherst H. Wilder Child Guidance Clinic St. Paul	Ramsey, part of Dakota and Washington
Hamm Memorial Psychiatric Clinic St. Paul	Dakota, Ramsey, Washington
Washburn Child Guidance Center Minneapolis	Anoka, Dakota, Hennepin, Scott

Daytime Activity Centers for the Mentally Retarded

The large majority of mentally retarded persons in Minnesota live in their home communities. It is essential, then, that communities adopt adequate programs for retarded persons at various age and functional levels to provide the best opportunity to develop to the highest level of their limited potential.

In 1961 the state legislature authorized funds for pilot-project centers to provide daytime activities for "School age mentally retarded children who are neither educable nor trainable under standards established by the state board of education; pre-school age or post-school age mentally retarded persons who are unable to independently engage in ordinary community activities."

The pilot centers proved so effective that the 1963 legislature adopted the Minnesota Daytime Activity Centers Act, and established a financial support formula whereby the state can match local funds on a 50-50 basis. This legislation has provided an excellent stimulant for the local communities to work toward development of the necessary services, and it is possible that every county in the state eventually may have a DAC program available to residents.

FUNCTION OF THE CENTERS

The centers are a major training and care resource for mentally retarded persons of a broad range of ages and functional levels. These centers have been organized to develop the abilities of retarded persons, and help them become better functioning individuals within their families and in the community.

Typically, each community operates a program to meet the unique needs that exist locally, employing a program director and program assistants, and the services of volunteers to assist in the center's activities. In all instances, the DAC board and staff attempt to utilize direct and consultative services of local agencies, such as the county welfare department and the area mental health-mental retardation program.

Generally, there should be a basic service focus on four groups of individuals:

- Pre-school age children of both educable and trainable level, with the program designed to assure and facilitate the individual's admission into the public school special education class.
- Post-school age educable and trainable level adults, with the program designed to assist with the transition into job training, sheltered or competitive employment, and over-all improved adjustment to family and community living.
- Sub-trainable level children and adults of all ages who cannot utilize existing community services.
- The parents (and families) of those retarded persons enrolled at the centers to aid them in gaining better understanding of their handicapped children.

In addition to these legally-defined responsibilities, the center board is intended to be a positive community force working toward expanded and improved services for all mentally retarded persons, cooperating with other local planning and service systems, such as the area mental health-mental retardation program board and the county welfare board. Center programs should be an effective demonstration to other groups, such as public schools, to initiate and expand special services to meet the needs of retarded persons in the community.

Locations of Centers

State-funded centers currently are operating in these counties:

Aitkin	Douglas	Lac Qui Parle	Norman	Sherburne
Anoka	Faribault	Le Sueur	Olmsted	Stearns
Becker	Fillmore	Lyon	Pine	Steele
Beltrami	Freeborn	McLeod	Polk	Swift
Benton	Grant	Marshall	Ramsey	Washington
Big Stone	Hennepin	Martin	Renville	Watonwan
Blue Earth	Itasca	Meeker	Rice	Wilkin
Carlton	Kanabec	Mower	Rock	Winona
Chippewa	Kandiyohi	Murray	Scott	Wright
Cottonwood	Koochiching	Nobles	St. Louis	Yellow Medicine
Dakota				

Information about individual centers can be obtained from the local county welfare department, or the Minnesota Department of Public Welfare.

A LOOK AHEAD: PROGRESS AND PROSPECTS

The state hospitals are fast becoming regional facilities with extensive programs of treatment, training, research, community education and service. In addition to providing specialized treatment programs for adult psychiatric, adolescent, geriatric, mentally retarded, inebriate and addicted patients, now, some of the facilities also offer day hospital and outpatient treatment services — bringing their services closer to communities.

While the hospitals are somewhat geographically isolated from the surrounding communities, successful efforts have been made to involve the community with the hospital, and the hospital with the community.

The total integration of the hospitals into their communities is being accomplished through the increased participation of volunteers, sponsorship of seminars and conferences for both lay and professional groups, utilization of the hospitals as training centers for professional personnel, involvement of hospital staff in community affairs concerning health and welfare problems, assisting local agencies in planning and programming, and developing closer working relationships with service agencies and other treatment and educational facilities in the community.

The quality of patient care, and continued progress in delivering a broad range of services, depends greatly on the availability of qualified personnel, adequate staffing to insure individualized treatment and rehabilitative care— coupled with sufficient funds for operating and continued modernization of the facilities— which will improve the therapeutic experience every patient has the right to expect.

While the once-separate hospitals have reached out into the community, problems and difficult tasks remain within. The staff-patient ratio in the state facilities for the mentally retarded is 1.86 per patient; in the hospitals for the mentally ill, 1.49 per patient. Low salaries are a serious obstacle in recruiting skilled personnel, particularly at the patient care level.

Buildings at many of the hospitals are outdated and overcrowded—particularly at the facilities for mentally retarded patients—resulting in "mass care" by an overworked and underpaid staff. Measures must be taken to convert large dormitories into smaller, more homelike living quarters. Increased staff complements would allow greater personal attention to patient needs. The daily expenditure for patient care in Minnesota's hospitals is markedly lower than spent in private facilities, general hospitals, and in federal psychiatric hospitals.

With new and different problems facing society today, the role of research into the fields of mental illness, mental retardation and inebriacy assumes greater and more widespread importance. Through it will emerge the knowledge and the techniques necessary to master and prepare for these problems in the years ahead.

These problems—the projected population increase, rapid technological developments, the occupational and geographical mobility of people, changing economic, social and environ-

mental conditions, the growing number of aged citizens, and others—have significant impact on human relationships.

The resulting problems create a demand for more and better services. But there are not and there never will be easy solutions to the problems of people.

One step toward preventing and correcting social and health problems of people has been to increase services in the community, where the problems originate and must ultimately be resolved.

Concerning mental problems, the training-consultation-education programs of community agencies will increase the number of individuals, both professionals and laymen alike, who are competent to deal with emotional and mental disorders, and expand their range of understanding of the problems, and knowledge of what can be done to prevent, control or eliminate the conditions. This is imperative not only from the standpoint of prevention, but because the limited number of specialists cannot possibly keep up with demands for services and treatment.

Continued public interest and support, and the active participation and cooperation of public and private organizations in communities, will provide the impetus to improve and augment the range of local services now available to Minnesotans.

The fusion of the state-county-area systems of services is a major step toward enhancing continuity in the care, treatment and rehabilitation of mentally ill, mentally retarded, or inebriate individuals with hospitalization, if it is necessary, as only one phase of the total treatment program. It is the guide to the direction for the future: a coordinated network of comprehensive, community-based care and prevention programs.

Minnesota has the blueprint, it has the organization; it has built a solid foundation for meeting the complex health problems of mental illness, mental retardation, and inebriacy today and in future years. More trained personnel, and more funds, inevitably will be needed. But the commitment will result in both saving human life, and in reducing and preventing human suffering.