

CAMBRIDGE STATE SCHOOL AND HOSPITAL

Cambridge State School and Hospital is a residential facility for the mentally retarded located in Cambridge, Minnesota, a city of approximately 2,800 population. Cambridge is located about fifty miles north of the metropolitan area of St. Paul-Minneapolis.

This facility serves a heterogeneous population of 1,630 patients (on-books population, January, 1966). The following table shows the distribution of patients on the institution's books under twenty years of age;

Age Group	Total	Male	Female
Under 5 years	9	2	7
5-9 years	125	63	62
10-14 years	302	175	127
15-19 years	<u>305</u>	<u>177</u>	<u>128</u>
TOTAL	741	417	324

There are 741 residents under the age of twenty and 436 children in residence under fifteen years of age.

The following table shows the degree of retardation of the resident patients under twenty years of age:

Degree of Retardation	MALE			FEMALE			Total
	Under 10	10-14	15-19	Under 10	10-14	15-19	
Severe & profound	32	68	48	21	46	57	272
Moderately	7	41	64	10	38	28	188
Mildly	2	17	39	-	4	17	79
Borderline	1	4	4	-	2	3	14
Unclassified	23	43	20	37	34	20	177
Not mentally retarded	-	2	2	1	3	3	11

Many of these patients are severely or profoundly retarded (37%). Only 11% are classified as mildly retarded. Many of the severely and profoundly retarded patients are non-ambulatory, not toilet trained and are unable to feed themselves.

Admission to this institution is not dependent upon the criteria of age or degree of retardation. During the fiscal year 1963-64, 60 persons were admitted to this institution. Seventy-two percent of those admitted were under twenty years of age and 55% were under fifteen. Thirty-five percent of the persons admitted during that period were classified as severely or profoundly retarded.

To provide care, training, and treatment for the resident population at this institution, 643 persons were employed as of June 30, 1965. A breakdown of this total is as follows:

Patient Care Personnel — 455
 Administrative Personnel — 35

Training Personnel — 3
 Maintenance Personnel — 150

There exist many deficits in the programming for the mentally retarded and epileptic children in Cambridge State School and Hospital which can be ameliorated by the supplemental help of the Foster Grandparent Project. There also exist many deficits in the lives of both the mentally retarded children and the foster grandparents which can be ameliorated by the foster grandparent project.

The present staffing ratios at Cambridge State School and Hospital are so inadequate that it is impossible to provide a continuum of care which will ensure that the basic daily living needs of our children are being met. The level of care which now is provided is more custodial than developmental in nature. It is composed of a helter-skelter kind of need - meeting which varies from shift to shift and day to day. Stated simply: There are not enough staff to provide anything more than a "herd-type" care for our residents.

In attempting to provide for daily living essentials we are concerned about the psycho-bio-social development of the child. There are many elements of living, nurturing, maintaining, learning, experiencing, etc., which go into normal development, and the efforts must be even more concentrated and constant with a handicapped child. In a large institution where the attempt must be made to lower the level of pathology of the whole community, the emphasis has been on the group - the mass - and in getting the job done. Although there are about 600 children in this population, the concentrated individual efforts necessary for the development of the handicapped child are not possible.

Although we talk about and even attempt to program for individuals and the meeting of their needs, we realistically fail because one person on an 8-hour shift can meet the needs of just so many people. As a result, methods are being used which foster dependence, lack of initiative, retarded physical and emotional growth (emotional rickets) and the building blocks for institutional neurosis. Many methods utilized are dehumanizing as stress must nearly always be on survival, and rarely on growth.

There are many excellent teaching and therapy programs being provided, but the cottage child care staff are hard put to carry these program aspects through on a consistent basis in order that the child receives the maximum benefits of these programs. The patient frequently becomes confused and disinterested and seeks to meet his own needs in often less healthy ways.

Cambridge State School and Hospital has recently categorized and begun programming for its patient population on the basis of the following six program areas:

Program I: CHILD ACTIVATION PROGRAM

Patients in this program are children up to 12 years of age who are severely physically handicapped requiring wheelchair, help in movement, or bed care.

Program II: CHILD DEVELOPMENT PROGRAM

Involves ambulant children up to the age of 12 and is primarily geared toward child development.

Program III: TEENAGE PROGRAM

Involves the early teenage group up to the age of 16.

Program IV: ADULT ACTIVATION PROGRAM

Patients who are 13 years of age and older who are severely physically handicapped requiring wheelchair, help in movement, or bed care.

Program V: ADULT MOTIVATION PROGRAM

All patients 16 years of age and over whose IQ's are essentially below 40 and currently are not working or capable of functioning in a work setting.

Program VI: ADULT SOCIAL SKILLS PROGRAM

Our adult social skills program which deals primarily with patients who are 16 years of age and over whose IQ is essentially 40 and above, and who are participating to some degree either in a work training program, school, and related training programs.

The children to be included in the foster grandparent program will be selected from programs I, II, and III.

In discussing the foster grandparent program with various staff personnel, the consensus of opinion was that practically all of the children in this institution could benefit from participation in a foster grandparent program. As all children cannot participate in the program, decisions will be made as to who will be included. The selection of the children to be participants in this program will be the responsibility of the treatment teams assigned to children in programs I, II, and III. Factors which would influence their decision to include an individual in the program would be no visits from parents or other relatives and signs of regression, behaviorally and emotionally. The level of retardation or the presence of additional handicaps will not be decisive factors in determining whether or not an individual will participate in this program. The primary criterion utilized to determine eligibility for this program will be the team's decision that an individual can really benefit from a close, personal relationship with a foster grandparent.

For the purposes of Cambridge State School and Hospital functioning as a host institution, it is felt that we could effectively utilize 40 foster grandparents. The responsibility for the selection of these persons would be that of the sponsoring agency working through the Field Supervisor attached to this institution and through the surrounding county welfare boards, local senior citizen groups, and the local office of the Minnesota State Employment Service. The treatment teams would also have a role in the selection of the foster grandparents in that they would specify various characteristics which applicants for foster grandparents should possess, and also make a determination as to how many of the foster grandparents should be foster grandmothers and how many should be foster grandfathers. In discussing this program with the treatment teams, it was decided that each of the foster grandparents would work with two children, spending two hours with each one, five days a week. The schedules of the foster grandparents would be so arranged that they would be frequently working with their children on weekends when the staffing ratios in this institution are even more critical.

The role of the foster grandparents would be to establish warm, interpersonal relationships with the children. This relationship would be one much like that of a grandparent in a family situation where the grandparent-grandchild relationship is permeated with a rather permissive love. The foster grandparents would not function as assistants to Psychiatric Technicians but would devote their time to establishing close one-to-one relationships with their foster grandchildren. Their time would be spent in playing with the children, helping the children to develop self-help and social skills, and providing those individual attentions which are not available to children in institutional settings. The following is a more detailed outline of the role of foster grandparents in our institution:

SPECIFIC WAYS FOSTER GRANDPARENTS WOULD BE UTILIZED

I. Parent Surrogate

- A. Providing special attention and interest on a regular and anticipated basis.
- B. Someone to depend on, talk to, feel with, be near to, and loved by.
- C. Someone who has time and love to give regardless whether the child can respond and give in return.
- D. Someone to help the child know himself as a separate identity - to help build self esteem, develop self concept.
- E. Cuddling
- F. Conversing.

II. Teach Self-Help Skills

- A. Walking
- B. Speaking
- C. Feeding self (eating can be made a pleasurable experience).
- D. Learning to use toys and developing muscle control

III. Play and Recreation

- A. Games
- B. Coloring
- C. Stories
- D. Conversation
- E. Walks

IV. Taking Children on Trips into the Community

- A. Shopping
- B. Visits to FGP's homes
- C. Church
- D. Trips to community recreational facilities

There would be no limit of positive and helpful activities that foster grandparents could be involved in to provide better services and care to our children. Our ability to define activities, to train and involve the grandparents, and to carry through with support and stimulation would be the main determinants to the success of the program once grandparents have been recruited and hired by the sponsoring agency.

The environment at best in the Cambridge State School and Hospital (as in any large residential care center) is artificial. The Foster Grandparent Project will help change the climate of cold humanity and dehumanization to one of warmth and naturalness.

It is recognized that many secondary gains will accrue from having foster grandparents in our facility. The following are secondary gains we foresee:

(1) The positive relationships which develop between the child and the foster grandparent and the positive gains in terms of learning and behavior would provide a much needed stimulus to other staff members to attempt to develop similar relationships with children. This individual motivation could be used to great advantage to improve existing and develop new programs within the institutions.

(2) We visualize that this influx of new people will bring about a corresponding influx of new ideas.

(3) We believe this program will be a tremendous asset to the institution in terms of public relations and the improvement of its image in the surrounding communities.

(4) The presence of foster grandparents will be most effective in modifying the stereotype of the mentally retarded in institutions as being "patients in a hospital" and emphasize that these people are members of a sheltered community.

(5) The presence of the foster grandparents wearing "usual clothes" rather than uniforms will have a positive effect on both the patient population and the employees.

We believe other than financial gains will accrue to the foster grandparents working in this institution. The psychological aspects of aging can bring problems with which the elderly citizen often has difficulty coping. We feel that being a foster grandparent at Cambridge State School and Hospital will help mitigate some of these problems. The elderly citizens' sense of being "put on a shelf" and out of the "main stream of life" is accompanied by a feeling of loneliness, loss of personal worth, self identity, and dignity. These feelings can be assuaged through being a foster grandparent, for in this role the individual has the opportunity to utilize his experience and maturity in the development of mutually satisfying interpersonal relationships with children. The concomitant result will be that a primary need of having a meaning to life - which derives from meaningful, intimate relationships with others - will be met.

We feel the Foster Grandparents cannot help but feel a sense of pride and personal satisfaction in knowing they are meeting a challenge, and are enriching the lives and helping shape the future of handicapped and neglected children.

The foster grandparent will also benefit through the personal stimulation of utilizing old skills and developing new ones through encountering new experiences in the Cambridge State School and Hospital setting, and receiving recognition from contributing a much needed service to society.

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT Cambridge

TO : Mr. Herbert Gardner, Personnel Director
Department of Public Welfare

DATE: August 19, 1965

FROM : John H. Stocking
Administrator

SUBJECT: Sally Luther's Memo

I will attempt to categorically answer each complaint as presented by Sally Luther. Also, I have attached copies of certain minutes, letters, etc. to further clarify my answers:

1. The creation of the new Psychiatric Unit.

The psychiatric service, as it is officially called, had its conception sometime last spring through a series of conferences with Dr. Adkins and some of the professional staff of our institution, in addition to Dr. Bartman and his M.R.E. institutions' Medical Directors and Administration group, which he meets with regularly. (see attachment #1)

More importantly, part of the psychiatric service (the children's and adolescent section) had its conception through the expansion of our original treatment unit for twenty emotionally disturbed, adolescent boys. The expansion was made possible through a Federal H.I.P. Grant. (see attachment #2)

The psychiatric service is located in one building, cottage 11. The service is broken down into three components: Children's (20 male and female patients), adolescent (20 male and 20 female patients) and adult (20 male and 20 female patients). The children's and adolescent sections are located in three wards on the south and west sides of cottage 11, and the adult section is located on two wards in the north and east sides of cottage 11. All told, we presently have one hundred patients in our psychiatric service building with space for an additional 20 beds, if the need arises. Dr. Adkins has set the bed capacity of the building at 120 beds.

Prior to the establishment of the psychiatric service, there were 136 beds in the building (cottage 11), plus the above mentioned Treatment Unit for emotionally disturbed, adolescent boys. This unit had 20 beds. All total, the building had 156 beds.

Our non-professional staffing for the building prior to the establishment of the psychiatric service was as follows:

19 Psychiatric Technician I's and 2 Psychiatric Technician II's for the 136 beds.

10 Special School Counselor I's for the 20 beds in the Treatment Unit.

All told, were 31 non-professional staff assigned to the building.

With the establishment of the psychiatric service and awarding of the Federal H.I.P. Grant, the non-professional staffing pattern was changed to 42 special school counselors (see attachments #3 and 4). Concurrently, with the change in

staffing was the change in patients. Those patients presently in the cottage, who it was determined had no need for the psychiatric service, were transferred to other cottages. On the other hand, those patients who Dr. Adkins and the staff decided needed this type of program (psychiatric-service) were transferred from other cottages. The net result is a 56 bed reduction in the cottage. Or, if we fill up the additional space with another 20 beds, there would be an overall bed reduction of 36 beds in the cottage.

A breakdown on the new non-professional staffing pattern for the -psychiatric service building is as follows:

10 Special School Counselors retained from the treatment unit for emotionally disturbed adolescent boys.

9 additional Special School Counselors to be hired on the Federal H.I.P. Grant.

23 Special School Counselors to be hired from the reallocation of 23 of our Psychiatric Technician I positions (see attachment #4)

Total - 42 Special School Counselors (SSC)

29 of the Special School Counselors are to be used for staff in the children's and adolescent psychiatric service (60 patients) and 13 Special School Counselors are to be used for staff in the adult psychiatric service (40 patients). I might add that not all Special School Counselors have been hired as of this date due to a number of reasons, but primarily because of the usual delays in getting special certification lists, etc.

It is true that only ambulatory patients were transferred into the new psychiatric service. However, the primary reason for their transfer was not because of their physical ability, but because of their emotional and mental conditions.

It is true that past practice has permitted the free interchange of working staff from unit to unit or cottage to cottage. This might be possible in the future when the psychiatric service is up to their full complement of Special School Counselors. (I believe there are 11 more to be hired) This is something that can be worked out between the psychiatric service Directors and the Nursing Department. It should be brought out that the Special School Counselors in the psychiatric service do not fall under the direction and supervision of our Nursing Department. Under the new program organization, the Special School Counselors fall under the direction and supervision of the adult psychiatric service Director and the children's and adolescent psychiatric service Director.

2. This is not true at the present time. I believe one psychiatric technician has been called upon recently to assist in remotivation classes for the entire institution. Other than this I don't know what they mean by their statement that psychiatric technicians are being shifted to other types of work-----."
3. This is probably true, however, it is anybody's guess as to how much of this can be attributed to their hospital work.
4. Parts of the first statement are true. Also, razor blades have been somewhat of a problem. We buy two brands of razor blades - expensive and inexpensive we have purchased more of the latter because of financial difficulty in the 39 allotment (this is a problem all its own).

5. This is probably true. However, we are doing the best we can in granting vacation and overtime and still keeping our wards adequately staffed.
6. It is true that we are making every endeavor to get our "best" patients out of the institution and back to the community. If we were not doing this, we wouldn't be fulfilling our purpose of trying to rehabilitate, train and educate our patients so that someday they may be useful, productive citizens in the community. I might add that we will continue to work just as hard in the future as we have in the past in getting as many of our patients back to the community. In order to do this, these people must be afforded special on-the-job training, some of which cannot be provided at the institutional level (see attachment #5).

I am not aware of the fact that our work-training program outside the institution is resented by the downtown merchants. If it is, it has never been brought to my attention personally by any merchant. From what I can gather, we have had excellent cooperation with local merchants as far as our work-training program is concerned.

It is true that we transport a few of our patients, who work outside the institution, to and from work. We don't have bus service in this community yet. Those few that we do transport are not within a reasonable walking distance from the institution to their job.

7. We give absolutely no preference to age when hiring employees. If an applicant can pass a small ability test and his or her interviews with the Department Head, and if he or she does not come poorly recommended the person is hired. We are not in the habit of hiring anyone who applies for a job. We expect a great deal from our employees and make every attempt to set the highest standards for them.
8. No comment.
9. (see attachment #6) First of all, we were not appropriated 90 new positions, only 80. Out of these 80, only 45 were psychiatric technician I's. They will be hired as salary savings permit (see attachment #7). The psychiatric technician will be put on the wards permanently as soon as they have completed their six month training program. We will have one class of 13 finishing on Sept. 14th, (these were not in the 6 month training course) another class of 14 finishing Oct. 18th (these were not in the 6 month training course) and another class of 20 finishing Jan. 14, 1966. The last group is under the 6 month training course. We expect to start another 6 month training class sometime in October. The size of the class will depend on the amount of salary savings we have to hire on. The number of 6 month training classes we can start each year is limited because of the limited number of registered nurses we have to carry out the instruction and clinical work.

As far as our communications are concerned, we have repeatedly brought out information describing the new psychiatric service unit. We don't call together 373 psychiatric technicians every time we are going to make an important announcement. We follow our usual channels of communications from Nursing Department Head to Nurse Supervisor and Charge Technicians, and subsequently down to the Psychiatric Technician I's and trainees.

However, it has been extremely difficult to try to communicate every detail because details and plans change from day to day. The changes can be attributed to a number of things, but primarily are due to new ideas on the part of someone who is directly involved in the planning of our treatment programs.

10. This is true. But if they don't do it, no one else will. This is a most unfortunate situation and it is exactly what we try to bring out to the legislators when requesting more positions, particularly relating to custodial workers.
11. This could very well be attributed to the fact that we are discharging more and more of our "best" patients and admitting more helpless patients.
12. We hope the future will bring us some help. For instance, there should be, if no one resigns, 47 more psychiatric technician I's on the wards by January of 1966

In summary, I would like to point out the following:

At the present time the only increase in our non-professional staff in the psychiatric unit has been through the addition of nine Special School Counselors requested and authorized by the Federal H.I.P. Grant, with the exception of two additional psychiatric technician positions that were not originally assigned to the cottage.

Many of the complaints outlined in Sally Luther's memo are not completely factual, i.e. the number of psychiatric technician I's appropriated, number of patients in the new psychiatric service building, the hiring of young people over older persons, etc. Also the complaint about patients working off the institution grounds seems to indicate a more self-centered or employee-centered attitude, rather than a patient-centered attitude - only as it relates to our "better patients".

I appreciate and admire our employees concern for the patients they are caring for, and I certainly sympathize with them regarding the problems they are faced with from day to day in the wards. Nobody is more aware of these problems than the Nursing Dept. Heads, myself and many other professional staff.

With the reorganisation of our treatment programs and the necessity of intra-institutional patient transfers, there will undoubtedly be some dissention amongst our staff, particularly those employees who are faced with increasing responsibilities and with little or no corresponding increase in help to meet their obligations.